Southern DHB Hospital Advisory Committee

Board Room, Level 2, Main Block, Wakari Hospital Campus

21/12/2020 10:00 AM - 12:30 PM

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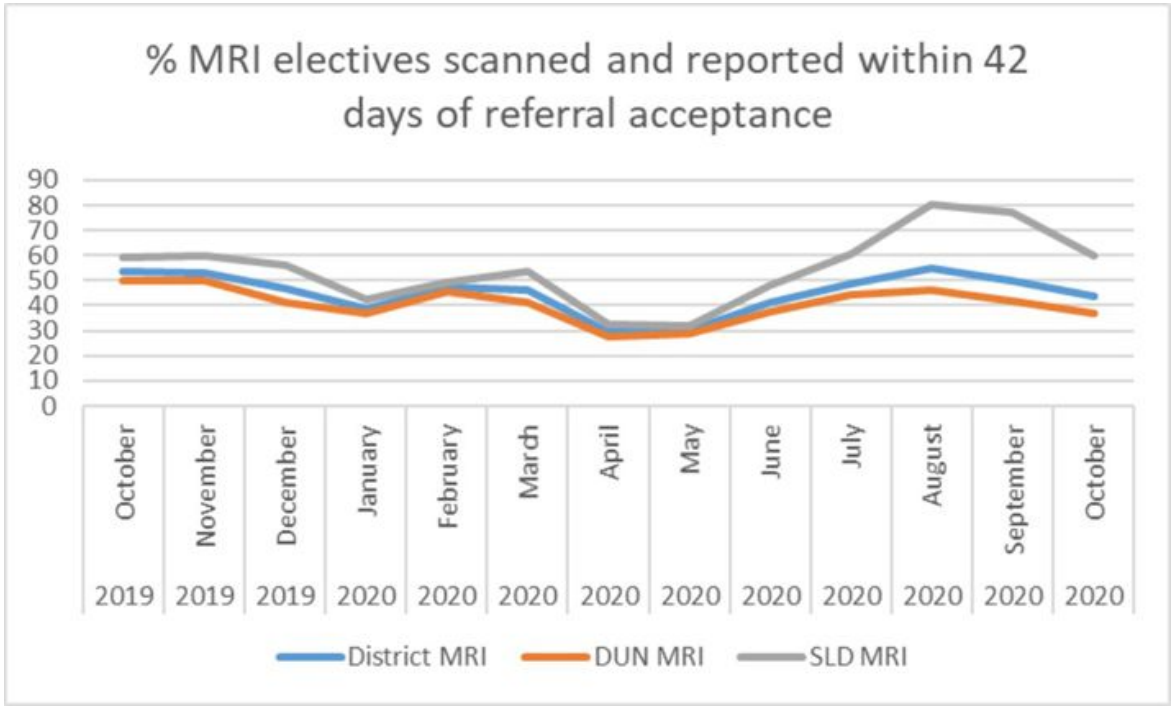
SDHB Radiology Service

Current situation and issues for Magnetic Resonance Imaging, Ultrasound and Computed Tomography

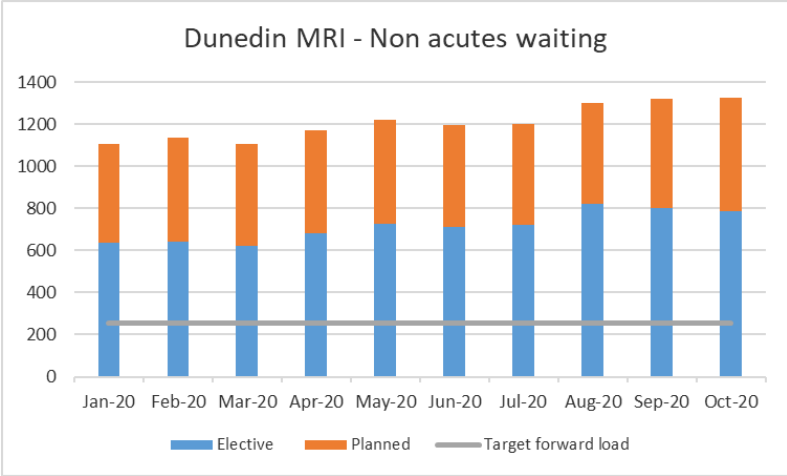
Presented by Stephen Jenkins, Service Manager, Dr Ben Wilson, Consultant Radiologist and Janine Cochrane, General Manager Surgical Services and Radiology

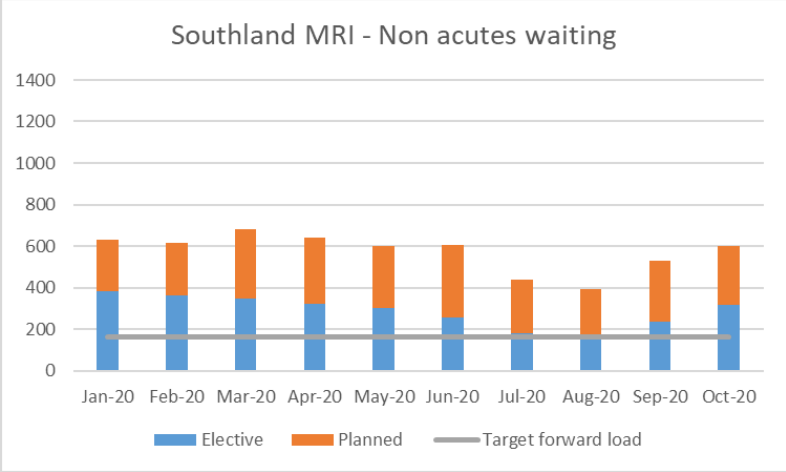
Magnetic Resonance Imaging (MRI)

How are we doing?



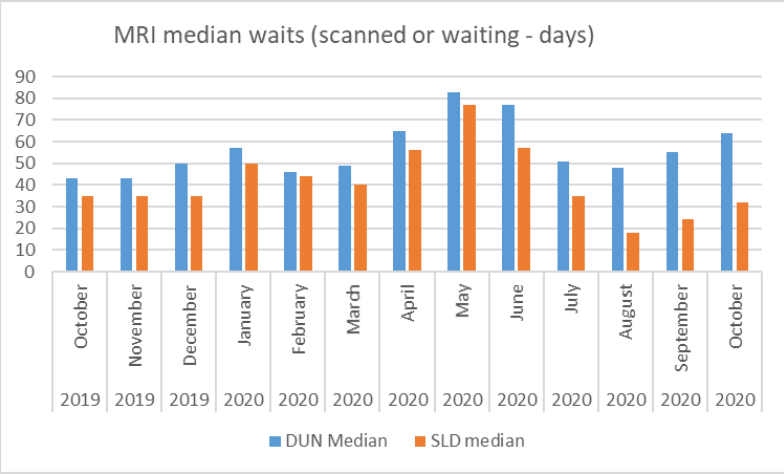
MRI – patients waiting by site

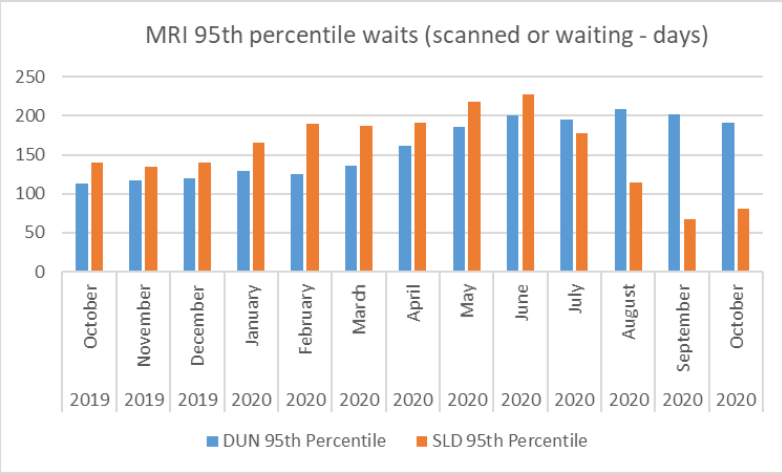




- Ministry of Health funded 120 additional exams for Dunedin Jun/Jul 2020
- Dunedin MRI then had outage for two weeks late August 2020, losing c. 130 elective appointments
- Southland MRI was replaced between 14 August and 30 September 2020 – work done before to reduce the waitlist, which grew by c.300 patients during this service closure

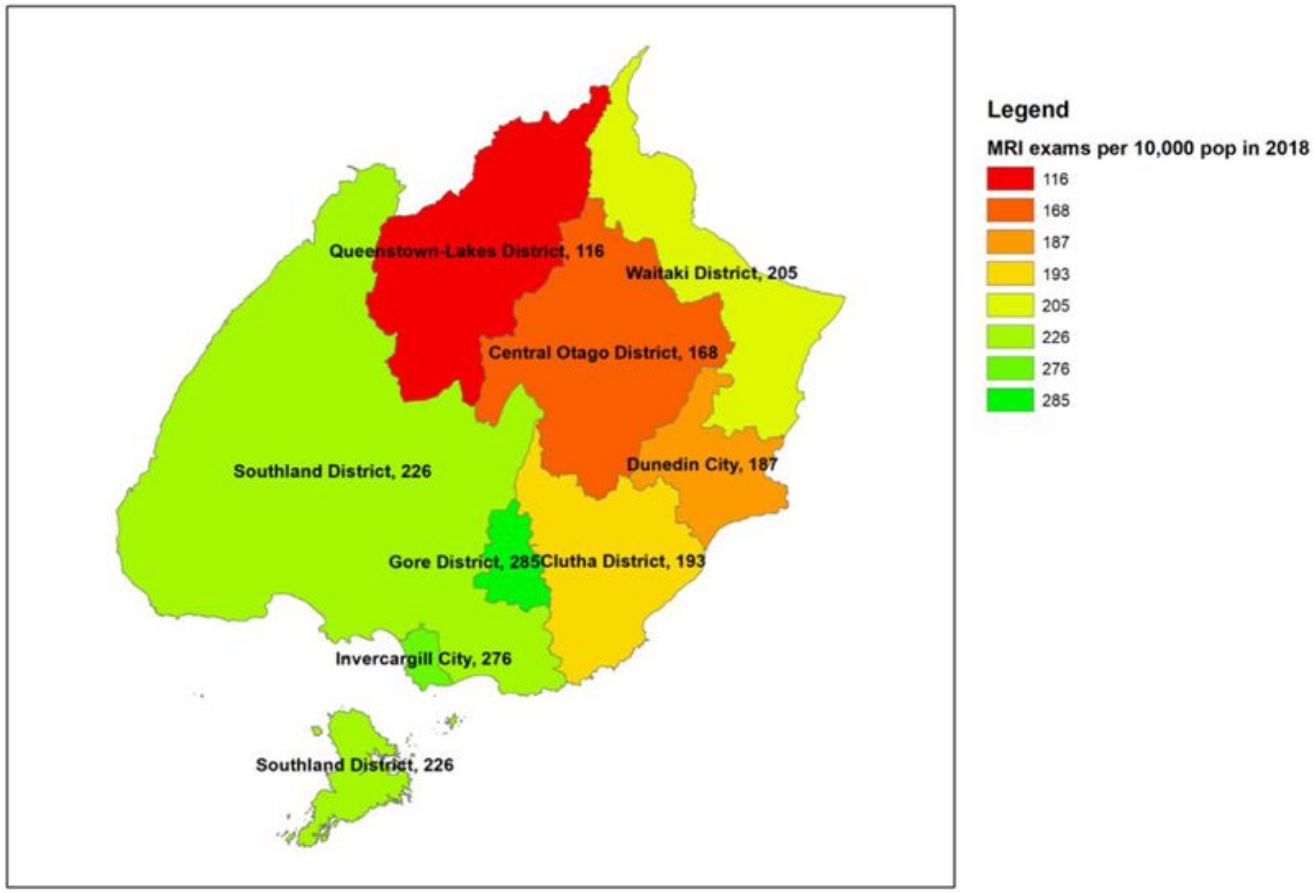
MRI – wait times at median and 95th percentile





MRI exams per 10,000 population

Invercargill 276/10,000 compared with 187/10,000

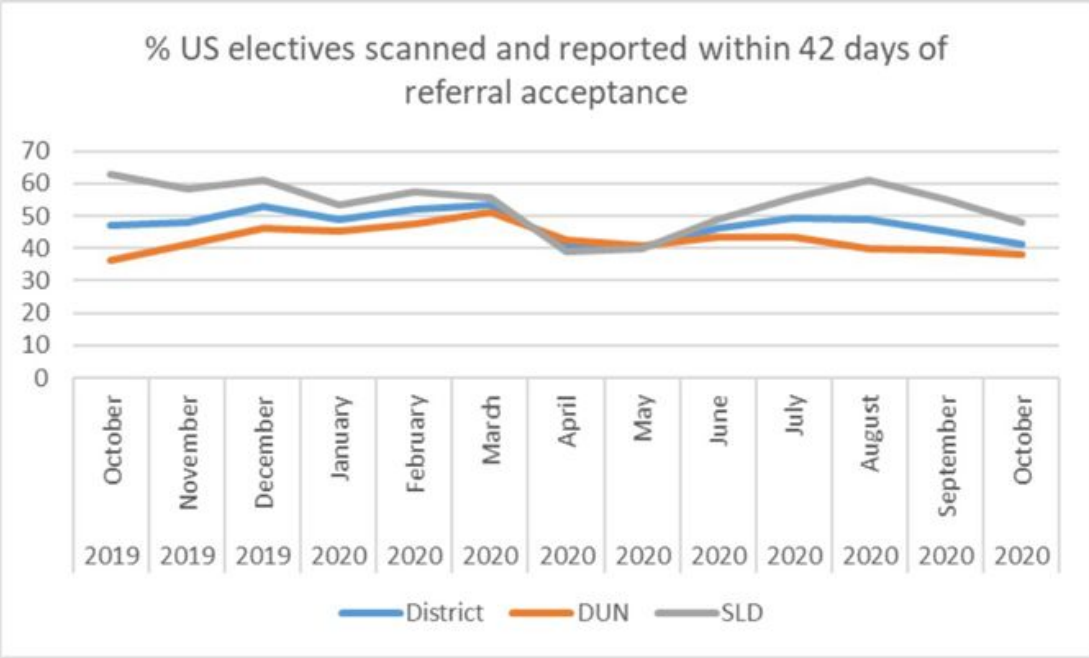


Breast MRI - District

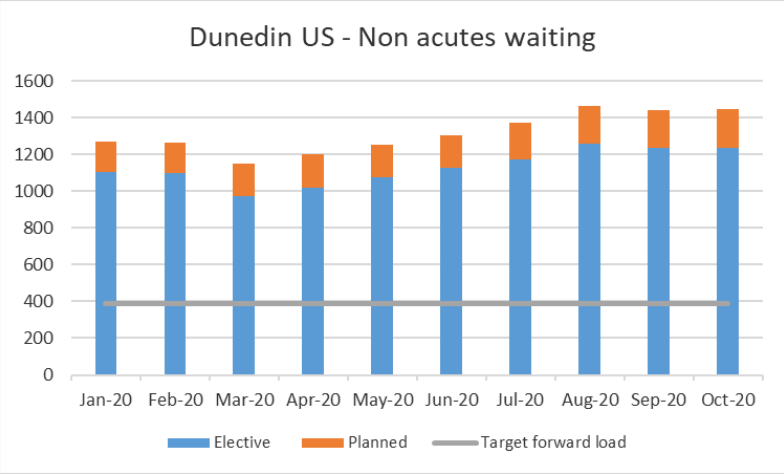
- Breast MRI examinations are currently only undertaken at Dunedin Hospital. The volumes able to be completed are constrained by capacity in terms of both the machine time and only one Radiologist doing this work – who is near retirement age.
- Requests for patients living outside Coastal Otago are sent to their nearest MRI scanner for outsourced imaging closer to home, i.e. Pacific Radiology (PR) Frankton and PR Invercargill.
- Options to undertake some of this work at Southland are being investigated but are dependent on a technological solution (some cost and image transfer issues) and a reporting solution being found (outsourced provider willing to undertake this work).

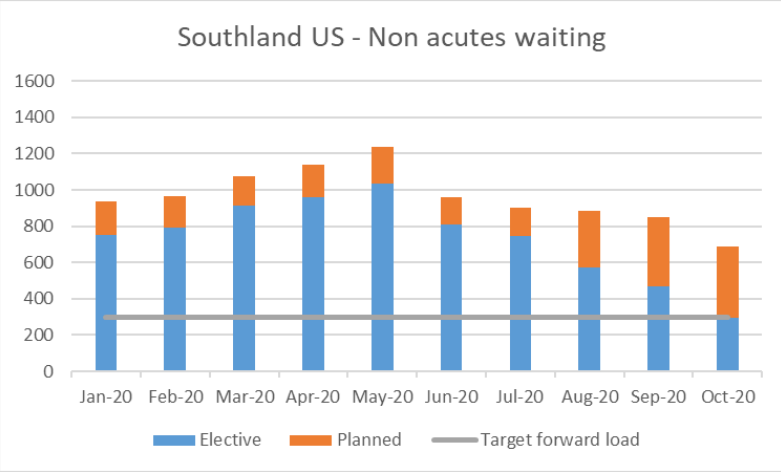
Ultrasound (US)

How are we doing?



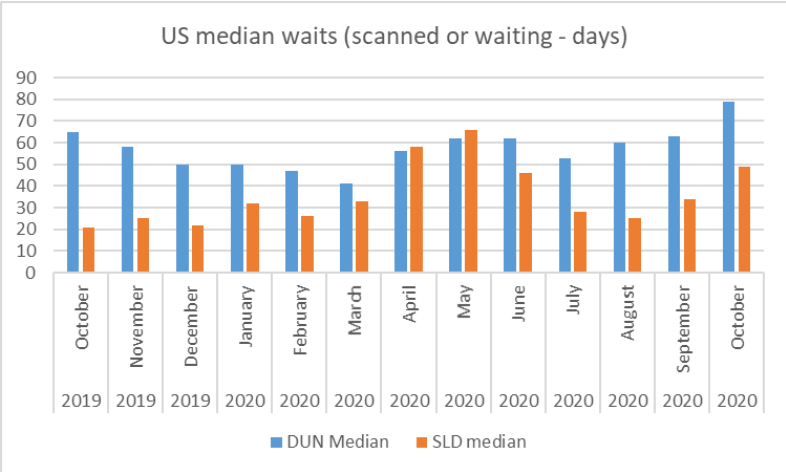
US – patients waiting by site

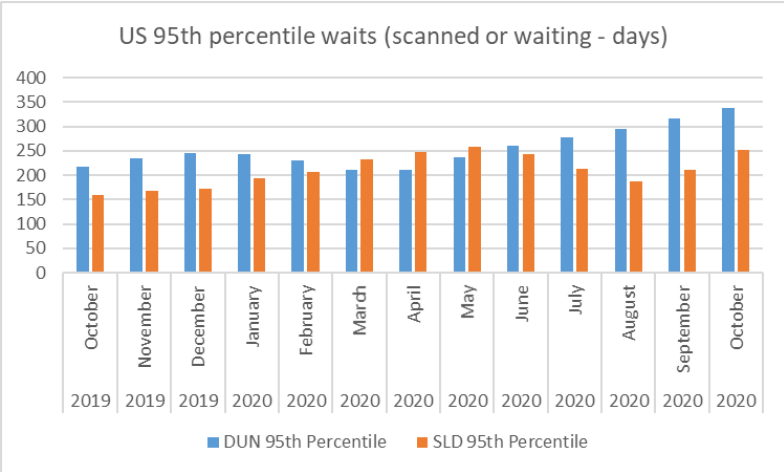




- Dunedin MRI had locums in place from Jan – Mar 2020 reducing numbers waiting. Ended Mar-20
- Southland MRI had locum in place from Mar-20 and evening shift from Jun-20. Sonographers undertook additional sessions between Jun and Aug-20
- Change in how obstetrics patients coded in Southland occurred Sep-20, further reducing numbers of elective patients waiting.

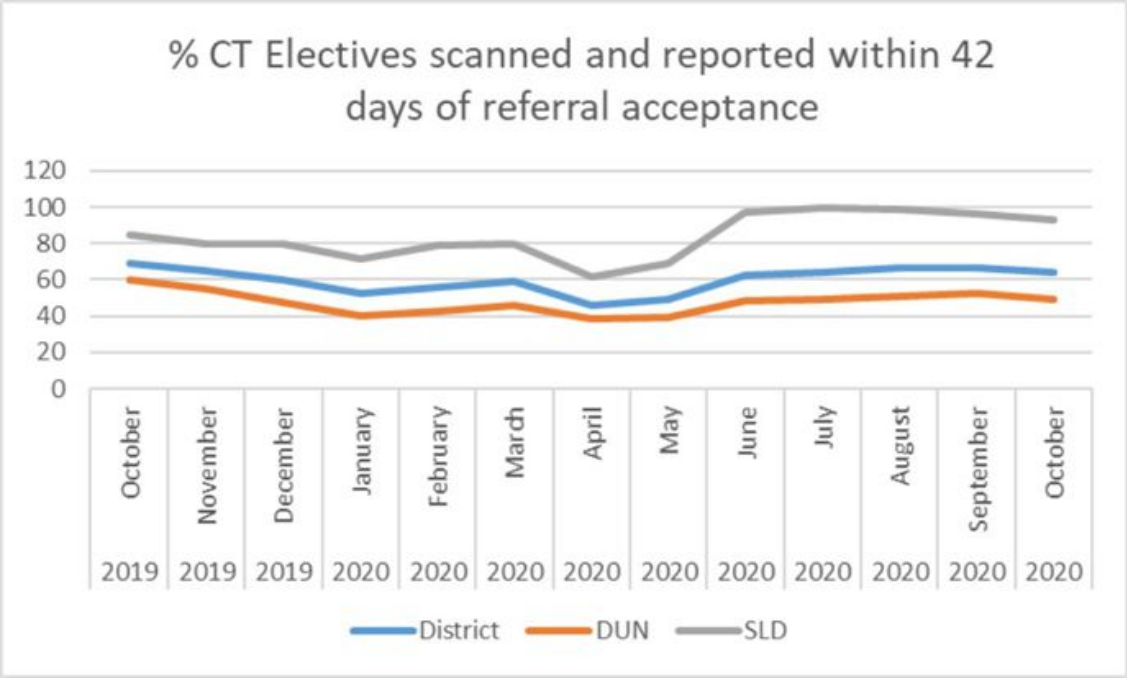
US – wait times at median and 95th percentile



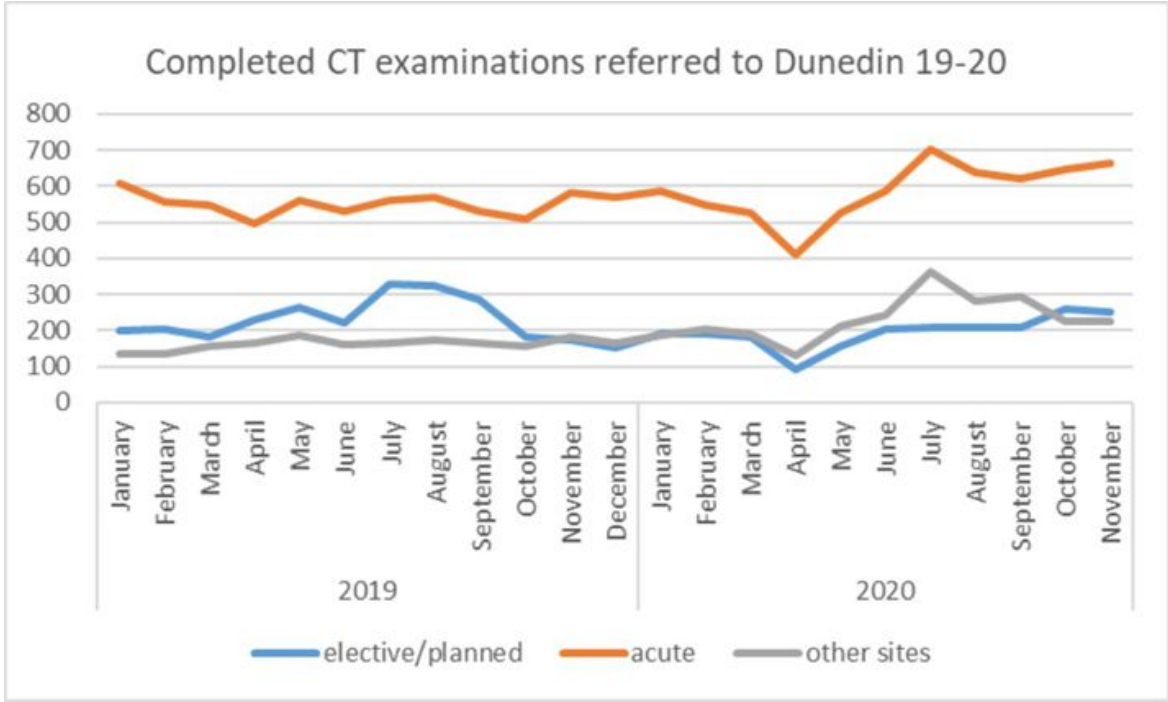


Computed Tomography (CT)

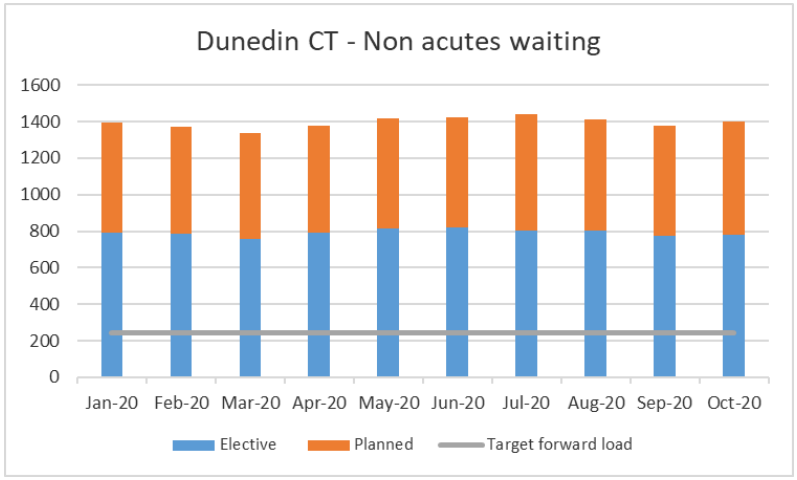
How are we doing?

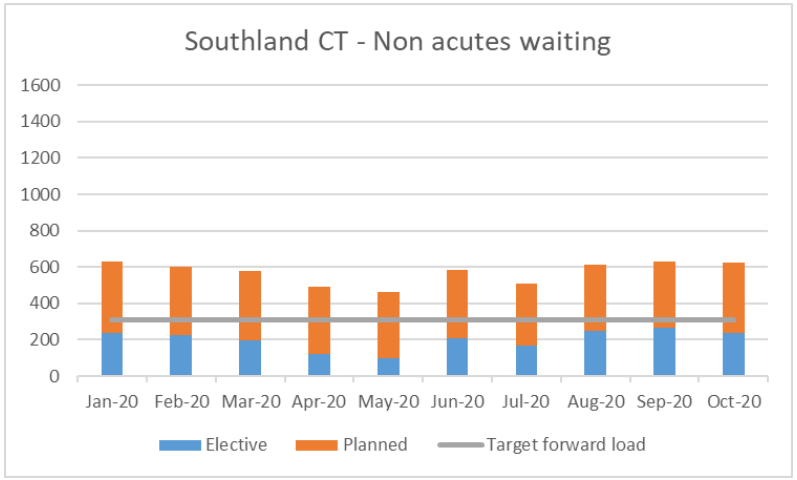


Dunedin CT – Acutes, Electives and Outsourced



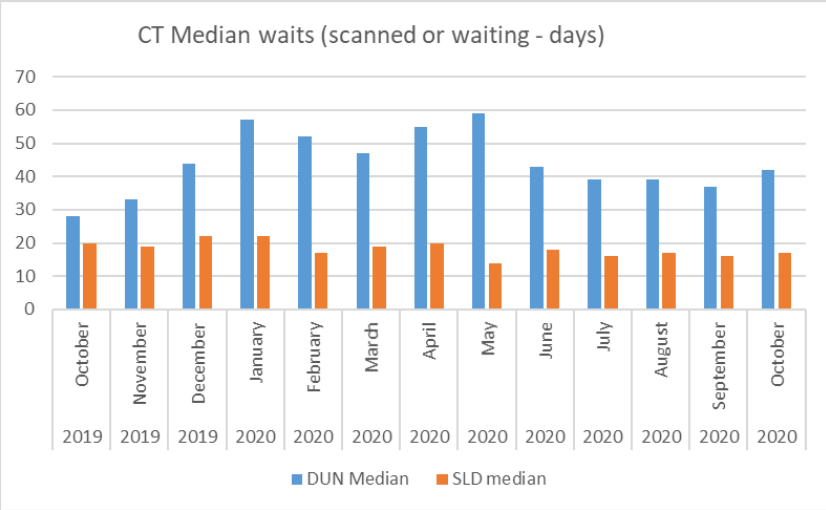
CT – patients waiting by site

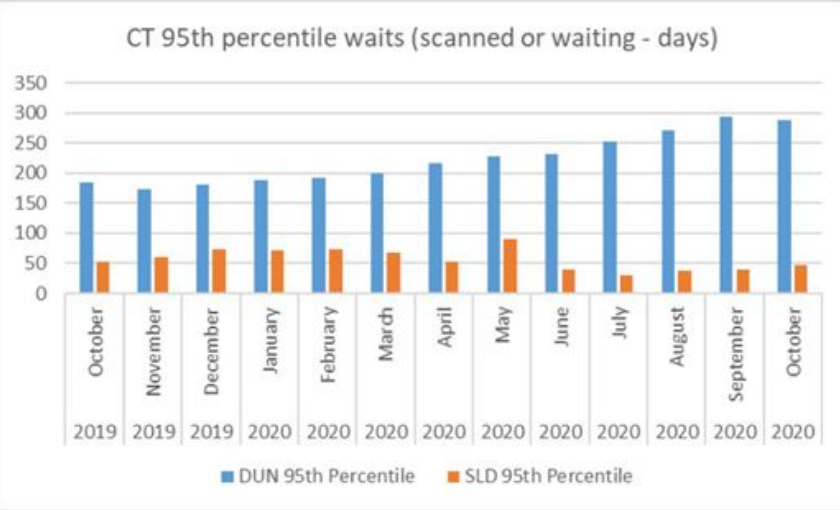




- Ministry of Health funded an additional 109 CT examinations Jun/Jul-20 for Dunedin
- Evening shift expansion commenced mid Sep-20 at Dunedin Hospital
- Earlier start time for morning shift commenced Dec-20 at Dunedin Hospital
- SPECT-CT training commenced Jul-20 at Dunedin Hospital

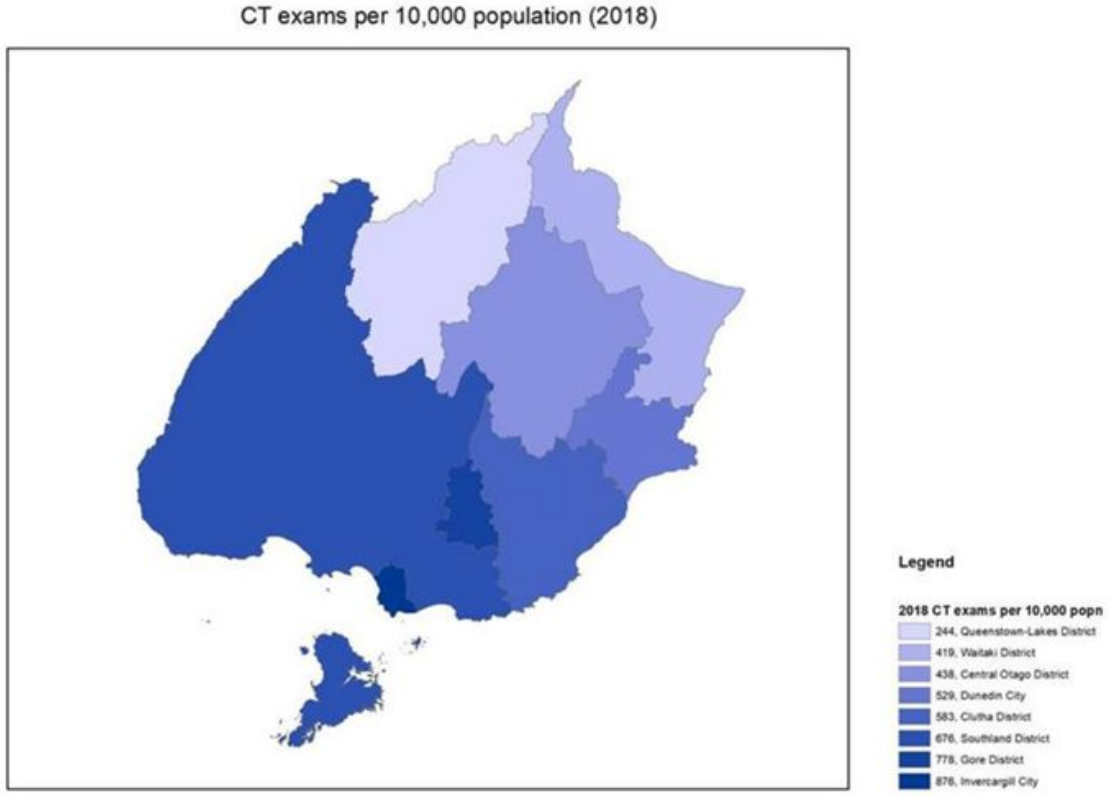
CT – wait times at median and 95th percentile





CT exams per 10,000 population

Invercargill 876/10,000 compared with 529/10,000



CT Update – improvement initiatives

Dunedin:

Configuration of Nuclear Medicine SPECT/CT for diagnostic CT work

- Training of staff underway – has limitations
- Increase in weekly outpatient throughput

Earlier start to workday – two more appointments available

Recently expanded evening shift, providing for:

- additional outpatient scanning four days per week
- Non-urgent acute patient scanning

Continuing increased utilisation of the Oamaru facility

- Funding for additional eight elective examinations per week

CT Update (2)

- Trialling an acuity tool to bring routine patients forward in scheduling.

Southland

Exploring shift changes at Southland Hospital as demand continues to increase. These could be by adjusting start/end times of existing shifts or introducing rostered shifts where there is currently on call.

Equipment replacement planned 2021/22 and suite redesign may enable some patients travelling to Dunedin (e.g. Cardiacs) to be imaged closer to home.

MRI update – improvement initiatives

Southland

Complete MRI suite renovations, resulting in some workflow improvements, should reduce appointment times, increasing capacity.

Some improvements in acquisition times as a result of scanner replacement.

Less down time/time wasted due to technical issues.

Increased FTE in MRI roster in order to regularly hold additional sessions.

- Initial priority is to recover waitlist to four week forward load.
- Second priority is to adjust catchment area to include South Otago patients.

MRI Update (2)

Dunedin

- New technology (aircoil and software upgrade) leading to improvement in scan times and some capacity increase.
- Change catchment for south Otago patients.
- Outsourcing of Breast MRI examinations to closest scanner to patient domicile.
- Outsourcing of long wait examinations – e.g. Cardiac MRI.

US update – improvement initiatives

Dunedin

- Fill remaining vacancy – now one position only.
- Sonographer training – one qualified December 2020; one underway; continue training thereafter.
- Review of service capacity to be completed once vacancies filled.
- Work on health pathways underway.

Southland

- Fill remaining vacancies (effectively two positions).

US update (2)

- Continue to seek locums where available.
- Start trainee from 2021.
- Explore local partnerships (e.g. with PR or others).

Additional relevant issues

Medical staffing

- SMO (Radiologist) shortages at each site are acute and do place some constraints on improvements which can be pursued. Additional examinations for example require outsourcing, more clinical oversight is required for new equipment, limited numbers constrain our ability to train RMOs.
- RMO (Radiology Registrars). More equipment and shifts require medical supervision. Current RMO numbers are insufficient to enable a 'legal' roster to be put in place as per MECA (RDA and STONZ) and thus conduct a run review likely to obtain agreement. Numbers are constrained by SMO shortages.

Future investments

Dunedin's MRI potential capacity is now almost fully utilised. Consideration of the purchase of an additional scanner is recommended, along with budget for staffing.

Additional staffing in CT and MRI at Southland Hospital would provide capacity, as evenings and weekends continue to be acute only and on call.

US capacity is primarily constrained by long standing Sonographer vacancies. Permanent FTE for trainees and a commitment to continuous training over an extended period would enable us to grow our own while still allowing us to recruit qualified staff when these are available.

As at the time of publication, an apology has been received from Committee member, Dr Moana Theodore.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Hospital Advisory Committee
Date of Meeting:	21 December 2020

Summary:

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

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

Additions to Interests Registers over the last two months:

- Andrew Connolly, Kaye Crowther and Tuari Potiki entries updated.
- Jean O'Callaghan – resigned from Geneva Health, effective August 2020

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

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

Prepared by:

Joanne Fannin
Minutes Secretary

Date: 14/12/2020

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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~~, Member, Spokes Dunedin (cycling advocacy group)		Updated 22.10.2020
	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.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
Jean O'Callaghan	~~13.05.2019~~	~~Employee of Geneva Health~~	~~Provides care in the community; supports one long term client but has no financial or management input.~~	Resigned, effective August 2020
	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~~	(Chair role ended 04.12.2020)	
	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)~~		Resigned 06.11.2020
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	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~~	(Role ended December 2020)	
	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	
	20.11.2020	Chair, South Island CIOs	
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

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
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	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 Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	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.	

4

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 2 November 2020, commencing at 1.30 pm in the Board Room, Community Services Building, Southland Hospital Campus

Present:	Dr David Perez	Chair
	Mrs Jean O'Callaghan	Deputy Chair
	Ms Justine Camp	Committee Member *(by zoom)*
	Dr John Chambers	Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member
	Dr Moana Theodore	Committee Member
In Attendance:	Ms Ilka Beekhuis	Board Member
	Tuari Potiki	Board Member
	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Andrew Connolly	Crown Monitor *(by zoom)*
	Mr Chris Fleming	Chief Executive Officer
	Mr Patrick Ng	Executive Director Specialist Services
	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.

2.0 APOLOGIES

An apology for lateness was received from Ms Justine Camp.

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 7 September 2020 be approved and adopted as a true and correct record."

D Perez/L Soper

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 4).

Nitrous Oxide Usage

The Chair advised that the Nitrous Oxide issue is work in progress and a request was made for the matter to be formally transferred to the Finance Audit and Risk Committee meeting.

Seven-day Hospital Services Initiative

Further work is to be undertaken on developing the seven-day Hospital Services Initiative with a view to registering it in the Strategic Plan. In discussion, the Committee were advised that:

- The outcome of a meeting with the New Build Team to discuss what they see as the need for seven days versus current needs will form the basis for what is fed in to the Strategic Plan.
- If the Generalism business case is approved in December 2020 it will be the catalyst for further discussion.
- The culture change required to move from a five day to a seven-day service.
- A seven-day service should result in enhanced patient safety.
- Phased steps should be implememnted prior to the opening of the NDH.

6.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director of Specialist Services Report

The Executive Director Specialist Services (EDSS) monthly report (tab 5.1) was taken as read and the EDSS, Mr Patrick Ng, drew the Committee's attention to the following items:

Ethnicity

An update was provided on the work undertaken in an effort to develop ethnicity reporting across Southern, with the first of the Power BI reports developed. The initial report identified a significant gap for Pasifika FSA rates and further work will be undertaken to explore and understand the results. The work done in the area of bowel screening to ensure rates representative of the population could be replicated. Concern was raised around the inference drawn from the results and the EDSS acknowledged the work to date is a starting point only and further work will be done to take prevalence into account. In addition to the First Specialist Appointment, ethnicity is to be looked at from a number of angles, including the proportion that move on to definitive treatment, impact where GPs have stopped referring, etc. A couple of large disease groups are to be chosen to follow prevalence and hospital service delivery. The EDSS is to work with the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) and members of the Strategy, Primary and Community team to advance the work.

Surgical Performance – Case Weights and Discharges

Management has worked with the Ministry of Health (MoH) to lock down Southern DHB's Annual Elective Surgery Production Plan. Southern is materially on plan for September year-to-date. Elective surgery has been impacted during the August/September 2020 period and will need to be managed carefully to stay on plan for the remainder of the year. Surgery recovery was undertaken prior to the MoH confirming what they would fund from a recovery perspective and Southern has done $1M more surgery than the normal plan year-to-date. There is a daily process in place to monitor elective cancellations. More accurate forecasting is now in place and Theatre cancellations are down from 400 per month to 70 per month across the two sites. Management responded to queries around the impact on

surgical flow from move of the Assessment Unit on the sixth floor of Dunedin Hospital to Wakari and the decision to return it to Dunedin Hospital.

Fifth Theatre in Southland

The MoH has confirmed new initiative funding to fund a fifth Theatre in Southland and the business case will be submitted on 6 November 2020. Southern DHB will be required to pay the capital charge. The Committee congratulated the EDSS and his team on their success in gaining the initiative funding for the capital requests.

Outpatient Performance ESPI 2

Progress made in recovering outpatient performance post COVID-19 and the on-going expectation of improvement in performance with the assistance of the pending recovery funding. Development of the prioritisation tool in a wider range of services and linkage to determining unmet need using Obstetrics and Gynaecology in Southland as an example.

Inpatient Performance ESPI 5

The challenges with resolving the inpatient wait list, with recovery in this area more dependent on recovery funding. The initial focus is on patients who have been on a waiting list for over two years and these are being looked at on a case by case basis. The reason for the long waits and potential patient harm will be documented.

Committee member, Ms Justine Camp, joined the meeting at 2.05pm.

Transfer of care is in line with policy but requires engagement with General Practice and fast tracking through the outpatient process when they meet the criteria for surgery. The Committee noted that the requirement to quit smoking or lose weight prior to treatment could adversely impact equity, with Māori over-represented in these areas. The Chief Nursing and Midwifery Officer, Mrs Jane Wilson, suggested that the Clinical Council look at the risk register and include this on the agenda for the next meeting with a view to a report being done on a number of factors including demographics and reasons for delay in treatment. The Committee asked for an assurance that where patients are referred back to General Practice there are programmes available for them to access ongoing assessment and there is a means of tracking them through the system. Management agreed to provide a report for the next meeting outlining the ESPI 5 status, including volumes added and taken off the waiting list, managing the backlog and the potential impact of recovery money and initiative funding. The Chief Medical Officer, Dr Nigel Millar, provided an update on managing the waiting list and the reasons for and impact on supply and demand. The recovery funding has been backdated to July 2020 and is available for three years at $5.2M per annum. Crown Monitor, Mr Andrew Connolly advised that no patient should be on a waiting list for two years unless their priority has been re-assessed. Whilst waiting list fluctuation is normal, CME and annual leave should be factored into production planning and the Surgeons need to manage the situation. With the exception of Vascular and Cardiothoracic, there are very few specialties where a patient who smokes would be denied surgery. The CEO advised that the work being undertaken within Specialist Services is on track and the EDSS confirmed the goal is to systematically reduce the waiting list.

Medical imaging diagnostics

CT Performance – progress made in CT performance, with an increase of 25 additional scans per week and an ability to further increase this in the coming months. Concerns were raised in relation to inpatients waiting in hospital beds on availability of CT scans and management advised that acute procedures are prioritised and the goal is to treat acute cases more quickly and provide more capacity for elective patients. The addition of CT scan capacity with contrast would be useful and options to use the CT facilities across the district are available for those able to travel. A request was made for the reporting on CT Performance to

be broken down specifically for Dunedin and Southland and for the longest waiting times to be recorded. A request was also made for the differential for acute scans to be reported separately due to the requirement for acute CT scans to be completed within one week. A request was made for clarification on who is being offered remote CT scans under the agreement with Oamaru and what the uptake rate is.

MRI Performance – improvement to MRI performance as a result of one-off recovery money funding additional activity. Two extended outages in September will impact the MRI performance reflected in the October 2020 results. The Chair requested that an options paper be provided on MRI and Ultrasound to identify what the wait limiting steps are for each and what the options are around those. Following discussion on delays in waiting times for biopsies and fine needle aspirations, Dr Nigel Millar and Dr Lyndell Kelly are to discuss this further and report back to the Committee on the waiting times and any other issues identified. Advice was received on the outsourcing of MRI for breast screening and challenges with recruiting Radiologists with breast MRI expertise within Southern DHB due to a nationwide shortage. In response to concerns raised, a request was made for a presentation on Radiology to be made to the next HAC meeting, with a focus on staff shortages and needs now and over the next five years, workforce planning and other challenges for the service including access by primary care to diagnostic tools.

Emergency Department (ED) – ED performance across the district and work being done by the Chief Medical Officer (CMO) and the General Manager Operations on the implementation of an escalation plan with a view to getting specialist assessments happening faster on the Dunedin site. An update was provided on the key initiative for the implementation of a generalist admitting model and the development of a Medical Assessment Unit (MAU) to be built next to the ED. Following discussions with relevant stakeholders the case will be put to the Board for consideration, but completion of the unit would be 18-24 months away. An options paper will be provided for a decision on whether the new CT should go in to the MAU, the ED or in to the community. There is pressure on the ED in Southland. Crown Monitor, Mr Andrew Connolly stressed the importance of the six-hour target in ED. It is a whole of Hospital issue with timeliness of discharge, effectiveness of communication on the Wards to clear the beds etc. critical. The CMO spoke on the importance of the Valuing Patients Time (VPT) Plan. An update on VPT is to be provided for the next HAC meeting. The CEO advised on the conflict between what the data is showing and the acuity and workload pressures being experienced by Charge Nurse Managers on the ground. Admittance rates to Hospital were also higher than in the past.

Faster Cancer Treatment – the Committee raised concerns that some people have been waiting seven weeks for treatment when the indicative time is four weeks. The CEO advised that DHBs are required to be transparent around their waiting times. The radiation oncology wait list has stabilised and the EDSS is to investigate and report back. A meeting has been arranged to discuss the longer term challenges for the Medical Oncology service. There is a challenge when Pharmac expand the scope of a drug as the resourcing implications are not taken into account in their budget. Concern was raised around the tone and content of a letter sent to an older patient by the Southern Cancer and Blood Service. In discussion, the CEO confirmed that pro-forma letters being forwarded to the community were to be considered by the Community Health Council. The wording of the letter is to be modified and needs to be empathetic, but honest and transparent. Management will review the process and provide feedback. Information was requested on the effectiveness of the whole of Cancer services, including performance against the 31-day and 62-day target and a comparison of those against other DHBs is to be included.

Gastroenterology – Ms Emma Bell has been appointed as Project Manager to run the improvement programme and support has been provided to Mr Andrew Connolly to develop the Terms of Reference (ToR) for the Endoscopy Oversight Committee,

with the first meeting held on 23 October 2020. A draft ToR has been developed for the Referral User Group which is scheduled to get underway over the next two weeks. An update was provided on referral practice and process. A workshop is to be held this week to enhance the electronic internal referral used for referrals into Gastroenterology. A key focus will be around data definitions and reconciliation of that so there is confidence in what is being reported to the MoH on a monthly basis. Mr Connolly acknowledged the work done by the EDSS and advised on the six recommendations in the Bissett report and progress against those. Issues have been raised in a report to the Board that require resolution, including the inability for a Clinician to seek an increase in priority for their case without changing categories. A recommendation has been made that an audit be undertaken of acute presentations, noting that an observational study was done on all cancers of any sort presenting acutely to the DHB over a three-month period in 2016. The Southland Surgeons advise they are getting a case a week of this type. The paper in the HAC agenda refers to encouraging greater referrals from primary care. Concern was noted around Southern DHB's colonoscopy decline rate of 15% compared to around 3% in most other DHBs and decision making should be based on need. The information on Intervention Rates by DHB is a quarterly report and will be included for members' information as it becomes available.

Caseweights - a request was made for the acute and elective volumes for Medical, Surgical, etc. to be added to the 'caseweight and discharge volumes graph'.

Financial Report

The EDSS presented the Financial Report (tab 5.2) then took questions, with the following highlighted:

- The adverse result of $1,027K for the month and $2,712K year-to-date was largely due to workforce costs ($745K year-to-date) driven by:
  - SMO costs – some prior year costs were not accrued for.
  - Timing issues with budgeted leave taken versus actual leave taken.
  - SMO CME leave balance being written off over five years instead of three with a $200K impact for the quarter.
  - Allied leave taken less than the 100% per annum budget assumption.
  - Allied leave expenses related to continued vacancies.
- Expenditure is unfavourable by $3,661K year-to-date. Work is being done to investigate the underlying causes of the key drivers for expenditure due to:
  - Higher rates of interventional cardiology than budgeted for in the first quarter. Feedback from Cardiology indicates this is due to Post COVID catch-up.
  - On-going over-expenditure in blood products and Haemophilia.
  - One off costs associated with the MRI machines in September 2020.
  - High Pharmacy costs for Gastroenterology and Rheumatology in September 2020 of approximately $200K.
  - Cleaning costs with the additional higher costs incurred during COVID continuing.
- The off-set of $1.6M in revenue is due to:
  - The outsourcing of $1M more surgery than planned.
  - $200K of radiology revenue from the MoH, which was spent on the outsourced clinical services line.
  - The remainder relates to Haemophilia.

The CEO advised on the growth in FTE. The Chief Nursing and Midwifery Officer and the Chief Allied Health Scientific and Technical Officer are taking a lead on work to understand the growth in FTE related to their respective areas.

The Recovery Plan work being led by the EDSS will be reported through the Finance, Audit and Risk Committee (FARC) with a high level summary provided for the HAC.

***It was resolved**:*

"That the reports to the Hospital Advisory Committee be noted.

7.0 GENERAL BUSINESS

The Chair tabled a one-page summary outlining Specialist Services Performance Measures in the 2020/2021 Annual Plan (AP) and highlighted the following:

- Of the 19 bullet points identified, only five are currently reported on through the HAC. Some of the others are reported through to the Board.
- Under the HAC ToR, the Committee should have oversight of all 19 Performance Measures.
- The report in the Southern DHB Board Agenda written by the Executive Director of Strategy, Primary and Community, Ms Lisa Gestro, providing a reporting matrix which goes to the MoH and the need for HAC to receive a copy of that report.
- HAC has responsibility to monitor the performance measures relating to Specialist Services in the AP and the focus should be to eliminate any areas showing as red, change amber to green and maintain green indicators.
- Discussion was deferred to the Board meeting to be held on 3 November 2020.

CONFIDENTIAL SESSION

At 4.00pm it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Dunedin Hospital Redevelopment	To allow 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.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board
HOSPITAL ADVISORY COMMITTEE
ACTION SHEET
As at 2 November 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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 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.	EDSS	Will be reported to CPHAC and HAC respectively from November. 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	2 November 2020 and ongoing Early 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				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.	
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. Noted the frequency of the VPT presentations.	Complete
Nov 2020	**EDSS Report - Ethnicity** (Minutes item 6.0)	Future work on ethnicity is to take prevalence into account and in addition to FSA, a multi angle approach is to be taken looking at definitive treatment, impact where GPs have stopped referring, etc. A couple of large disease groups are to be chosen to follow through with ethnicity reporting. The EDSS, CMHS&IO and EDSP&C are to work together to advance the work and reporting on ethnicity.	EDSS/ CMHSIO/ EDSP&C	A verbal update will be provided at the meeting.	Complete
Nov 2020	**EDSS Report – ESPI 5** (Minutes item 6.0)	The Clinical Council is to look at the risk register in relation to the wait list for Inpatients (ESPI 5) and this is to be included on the agenda for the next meeting with a view to a report being done for each patient, looking at a number of factors including demographics and reasons for delay in treatment. The Committee requested	EDSS		~~December 2020~~ First HAC meeting of 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		an assurance that where patients are referred back to General Practice there are programmes available for them to access and there is a means of tracking them through the system. Management is to provide a report for the next meeting outlining the ESPI 5 status, including volumes added and taken off the waiting list, managing the backlog and the potential impact of recovery money and initiative funding.			
Nov 2020	**EDSS Report – Medical Imaging diagnostics** (Minutes item 6.0)	Future reporting on CT Performance is to be broken down specifically for Dunedin and Southland and the longest waiting times are to be recorded. The differential for acute scans is to be reported separately due to the requirement for acute CT scans to be completed within one week. Clarification is required on who is being offered remote CT scans under the agreement with Oamaru and what the uptake rate is.	EDSS		December 2020
Nov 2020	**EDSS Report – MRI Performance** (Minutes item 6.0)	An options paper is to be provided on MRI and Ultrasound to identify what the wait limiting steps are for each and the options around those. Dr Nigel Millar and Dr Lyndell Kelly are to meet to discuss waiting times and potential harm in relation to biopsies and fine needle aspirations and report back to the Committee.	EDSS CMO		~~December 2020~~ First HAC meeting of 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		A report is to be provided to the next meeting on Radiology and is to include a focus on staff shortages and needs now and over the next five years, workforce planning, access to primary care and diagnostic tools and other challenges.	EDSS		First HAC meeting of 2021
Nov 2020	**EDSS Report - ED** (Minutes item 6.0)	An options paper will be provided for a decision on whether the CT Unit should go in the MAU, the ED or in to the community. An update is to be provided on the pressure on the ED in Southland and the need to reduce presentations. The VPT update is to be provided for the next meeting.	EDSS EDSS CNMO	Paper provided for the Board agenda.	Complete First HAC meeting of 2021 Complete
Nov 2020	**EDSS Report - Faster Cancer Treatment** (Minutes item 6.0)	An update is to be provided on pro-forma letters being considered by the CHC. This relates to a letter tabled at HAC from the Southern Cancer and Blood Service. A report is to be provided for Board on how well the whole of Cancer services is working. The report is to include an update on how well the referrals are handled by General Medicine and General Surgery through to access to diagnostics, how long it takes to get a letter typed or whether the referral can go electronically. Confirmation is required that the cancers are being considered at multi-disciplinary meetings.	EDQ&CGS EDSS	A paper is to be provided on the pro-forma letters in the New Year.	First HAC meeting of 2021 First HAC meeting of 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		A comparison with the 31-day and 62-day target for other DHBs is to be included.		Included in the EDSS report, for this and future reports.	Complete
Nov 2020	**EDSS Report – Caseweights** (Minutes item 6.0)	Acute and elective volumes for Medical, Surgical, etc. are to be added to the 'caseweight and discharge volumes graph' for future meetings.	EDSS	Included in the report for this and future meetings.	Complete
Mar 2020 August 2020 September 2020	**Clinical Risk Dashboard** (Minute item 8.0) (Minute item 7.0) (Minute item 8.0)	▪ Data to be added over time to indicate the gravity of risks. ▪ If available, national data to be added to dashboard graphs. ▪ Actual numbers and targets to be added to the graphs. ▪ MRSA and C.diff commentary to be updated. ▪ The Committee's expectation that discharge initiatives be taken up across clinical areas to be communicated to staff.	CMO/ EDQCGS EDQCGS EDQCGS EDQCGS/ CMO	Noted. Completed as far as possible Actual numbers added. There are no national targets set, a 6 month rolling average is shown on the graphs The C-diff measure has not been completed. IT have been unable to provide resource, due to conflicting priorities, to complete the measure to enable comparison to the UK and Australia. In Action ***Action transferred from October FAR Committee Meeting.**	December 2020
Nov 2020	**Medical Assessment Unit** (Board minute item 8.0)	Possibility of implementing some of the functionality of an MAU ahead of building the MAU facility to be added to the HAC agenda.	EDSS	Increasing demand on Dunedin hospital's performance has seen a significant reduction in ED performance and increase in acute occupancy. Although throughput	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				through the current 8-bed MAU on the 7th floor has increased with expanded admission criteria, the MAU LOS is increasing, and the unit risks being used as another ward. The location and processes for the current MAU are sub-optimal and relocating the MAU adjacent to ED will improve access to diagnostics, patient flow and patient experience. The biggest drawback is that the patient is distant from the admitting team which leads to the patient effectively being admitted into the hospital. This results in lost opportunities to discharge the patient without the need for admission and loses the ability to acutely monitor the patient alongside new patients further directing care. Additionally multiple specialties utilise this area all with differing models of care - the move to Generalism provides an opportunity to deliver a more responsive service and deliver better, more sustainable acute care for our biggest patient cohort.	
Nov 2020 FAR 634	**2021/22 Budget – Intervention Rates** (FAR Committee minute item 6.0)	Review of standardised intervention rates to be included in the HAC agenda for discussion.	CEO/ EDSS		First HAC meeting of 2021

The use of MRI for breast screening in Southland

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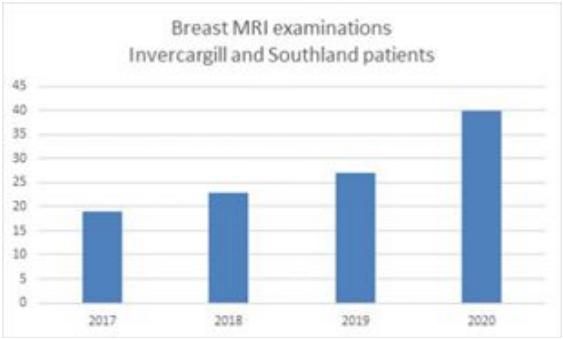
This update has been provided for the action as noted below from the Board actions sheet.

Oct 2020	**Southland MRI** (Minute item 10.0)	Further information to be provided on the use of MRI for breast screening in Southland.	EDSS	Will be considered by HAC as part of a broader view of radiology services across the district.	Will be part of HAC agenda

Southland MRI does not have Breast MRI functionality. This was considered and discounted at the time when clinical specifications for the new equipment were prepared:

- Recruiting suitably qualified Breast Radiologists (who can read breast MRI) to Southern DHB is not feasible owing to Breast MRI being the only Breast work being undertaken by Southern DHB. With Nationally funded screening as well as all other Breast diagnostic work being undertaken by Pacific Radiology (private), we do not employ Breast radiologists.
- Breast MRIs are low volume work - in 2020 using extrapolate data (due to COVID), 40 breast MRI were undertaken for Southland and Invercargill domiciled patients.
- Pacific Radiology (PR), which provides additional MRI reporting support for Southland Hospital does not remotely report Breast MRI examinations due to current technical constraints as described below.
- Breast studies are not reported using the initial images acquired during the examination. Instead these are post processed using specialised software on a separate workstation and these processed images are not amenable to transfer using Picture Archiving and Communication Systems (PACS). For this reason, patients are scanned and reported on Pacific Radiology scanner ad reported through. We are exploring the feasibility of whether purchasing of equipment and software ($45k) will enable patients to be scanned locally on DHB scanners and reported remotely.
- NB - Dunedin Hospital has only one Radiologist reporting Breast MRI for SDHB and he is close to retirement. Due to small numbers of reporting required, a single SMO, requirements for more double reporting, we are not looking to replace this specialty role.
- Southland Hospital has no on-site Radiologists with the sub-specialist skills required to report Breast MRI

Owing to MRI capacity issues at Dunedin (including a very limited number of available Breast MRI appointments), SDHB is outsourcing Southland and Invercargill domiciled patients to Pacific Radiology Invercargill for Breast MRI and Queenstown Lakes and Central Otago domiciled patients to PR Frankton. This means that patients can still receive their scan locally. The decision for outsourcing was also made to reduce demand on the Dunedin scanner and avoid travel for patients.



NB. Result for calendar year 2020 is extrapolated from 10 months YTD data.

Valuing Patient Time – Acute Patient Flow report for Nov 2020

Lead Executive: Jane Wilson

EXECUTIVE SUMMARY

SAFER is a Patient Flow bundle and practical tool out of the NHS to reduce delays for patients in adult inpatient services (excluding maternity) blending five elements of best practice to achieve cumulative benefits. Components of the SAFER bundle have been implemented in a number of wards such as Red to Green and Rapid Rounds, but a systematic approach is required to embed all best practices consistently in order to make the gains in length of stay, patient flow and improvements in patient safety. By making full implementation of the SAFER bundle an 'expectation' of all inpatient adult services through service level accountability (now endorsed by the Board, ELT and Clinical Council) significant gains should be made if followed through. CCD and Rapid Rounds are the priority components to be focused on over the next few months and this will require strong and visible leadership and coaching support to teams.

SAFER metrics have been identified, some existing and some new which provide reports by specialty, SMO and ward level. Once the suite of metrics are pulled together, this will form reporting at a service level through Service Level Accountability and to ELT and HAC on a regular basis from January 2021. Other performance metrics including run charts and safety metrics are already available and reported through Quality and Clinical Governance reports.

SAFER bundle service level accountability baseline assessment tool and survey has been modified and assessments have commenced. A refreshed VPT Patient Flow Action plan focusing on the SAFER bundle has been completed with an update due to HAC in December. SAFER now embedded in Generalism Business case and approved by the Board in December.

Elements (Safer Bundle)	Previous month	Current month	Commentary
S - Senor Review	→	→	• SAFER assessment templates developed for completion at ward level as part of Service Level Accountability (SLA). To be included in SLA roll out.
A - All patient have expected date of discharge (EDD & CCD)	→	→	• Rapid Round Audit tool customised to Southern DHB completed. Audits and survey commenced.
F - Improved flow from ED to inpatient wards	→	→	• SAFER bundle metrics developed – revised reporting to be ready January 2021
E - Early Discharge			• Dunedin Hospital Escalation plan drafted and presented to Clinical Council. To be presented to HAC December
R - Review (multi-disciplinary team review of stranded patients)	→ →	→ →	• Meeting held with IT to discuss and address functionality issues with 'Red to Green' on electronic whiteboard. System issues not resolved as yet but issues now understood. • Detailed implementation steps to be fleshed out under the Action Plan high level objectives

Current Issues	Update/Achievements	Upcoming key deliverables
Cultural engagement	• Refreshed VPT presentation and refreshed action plan completed to be used in engagement forums Nov/Dec • SAFER bundle presentation to Clinical Council in November	• VPT Sponsors to attend Clinical Directors meeting and engage on SAFER with a focus on CCD • Stakeholder Analysis to be completed • SAFER engagement to commence more widely
Governance/Sponsor-ship model	• Sponsors meeting held with Chiefs, EDQCG, QI Mgr and Principal Advisor to the CEO on 11 Nov to discuss plan and support going forward.	• Monthly Sponsors meeting to with presence at other key meetings ongoing
Dedicated VPT QIF role ending in Nov	• Extension of VPT QI support role to June 2021 to support SAFER roll out	• Completed and SAFER baseline assessments to be completed by QI lead with all services

Older Persons Health

Frailty work progressing to enact a whole of system approach to managing individuals with frailty across our health system with the aim to reduce average ED wait time, reduce frail elderly presentations and readmission rates.

Key secondary care level priorities relative to improving care for older people are to:

- Change the model of care for frail elderly when they present or admitted to secondary care service
- Have a joined up care plan visible cross the health system and for the person & family/whanau
- Redesign the transition of care back to the community
- Reporting on progress with be through OPH directorate reporting through EDSPC

Emergency Department

- Refer EDSS reporting regarding ED performance, and work on Southland ED and Discharge Lounge concept.
- Dunedin Hospital 'FiT to Sit' development in Dunedin Hospital officially opened on Monday 16 November. Unit named the 'Emergency Department Ambulatory Care Unit'.

Medicine

- Enhanced Generalism Dunedin Hospital Business Case presented to the Bipartite Action Group (BAG) on 17 November 2020 and to the Board in December

Acute Patient Flow –

SAFER Bundle Programme Plan

Update – Nov 2020

BACKGROUND

"Failing to achieve hospital-wide patient flow - the right care, in the right place, at the right time puts patients at risk of suboptimal care and potential harm. It also increases the burden on clinician's, hospital staff and can accelerate burnout. Optimizing hospital flow, and ultimately improving outcomes and the experience of care for patients, requires an appreciation of the hospital as an interconnected interdependent system of care." (IHI White paper 2018).

The evidence is clear that improving patient flow is critical to addressing the issues of long waits and delays, mismatches in bed and staff capacity with demand, unintentional harm and operational and financial stress including associated costs. A lack of inpatient capacity also results in delayed or postponed surgical procedures and underserved patient populations.

Work commenced in 2018 to further understand the impact of waiting from a patient, whānau, staff and organisational perspective. This involved evaluating current work to date; exploring frustrations, challenges and barriers to achieving improved flow, as well as considering the potential opportunities that could be realised if we made valuing patient time a strategic priority. An initial diagnostic assessment was undertaken and as a result of this diagnostic work, an assessment and proposed way forward was developed and the *Valuing Patients' Time* programme commenced in October 2018.

This programme continues to focus on supporting improvements to flow through the Emergency Department and Internal Medicine, and in end-to-end care of older people with frailty. The ambition is to provide patients with timely care and reduce unnecessary time spent in hospital. By doing so we:

- Ensure services provide timely, high quality, patient-centred care;
- Reduce deterioration associated with delayed assessment and treatment;
- Reduce the consequences of hospitalisation such as deconditioning, delirium, falls, sleep deprivation and treatment injury; and
- Improve the experience for patients and their families; as well as staff experience

2020 has brought with it significant challenges with Covid-19. This has resulted in a loss of momentum and we have not seen the expected gains at scale or pace, despite a significant amount of progress being made and sustained in some areas. An opportunity exists for Southern DHB to accelerate progress towards improving patient flow by fully implementing the SAFER patient flow bundle as a key enabler for change. Many components of the SAFER bundle have been introduced already such as Rapid Rounds and Red2Green; however not in all adult inpatient wards and not all components of the bundle e.g. criteria led discharge. The SAFER bundle complements many other initiatives such as HealthPathways, Generalism and Telemedicine that all collectively contribute to Valuing Patients' Time.

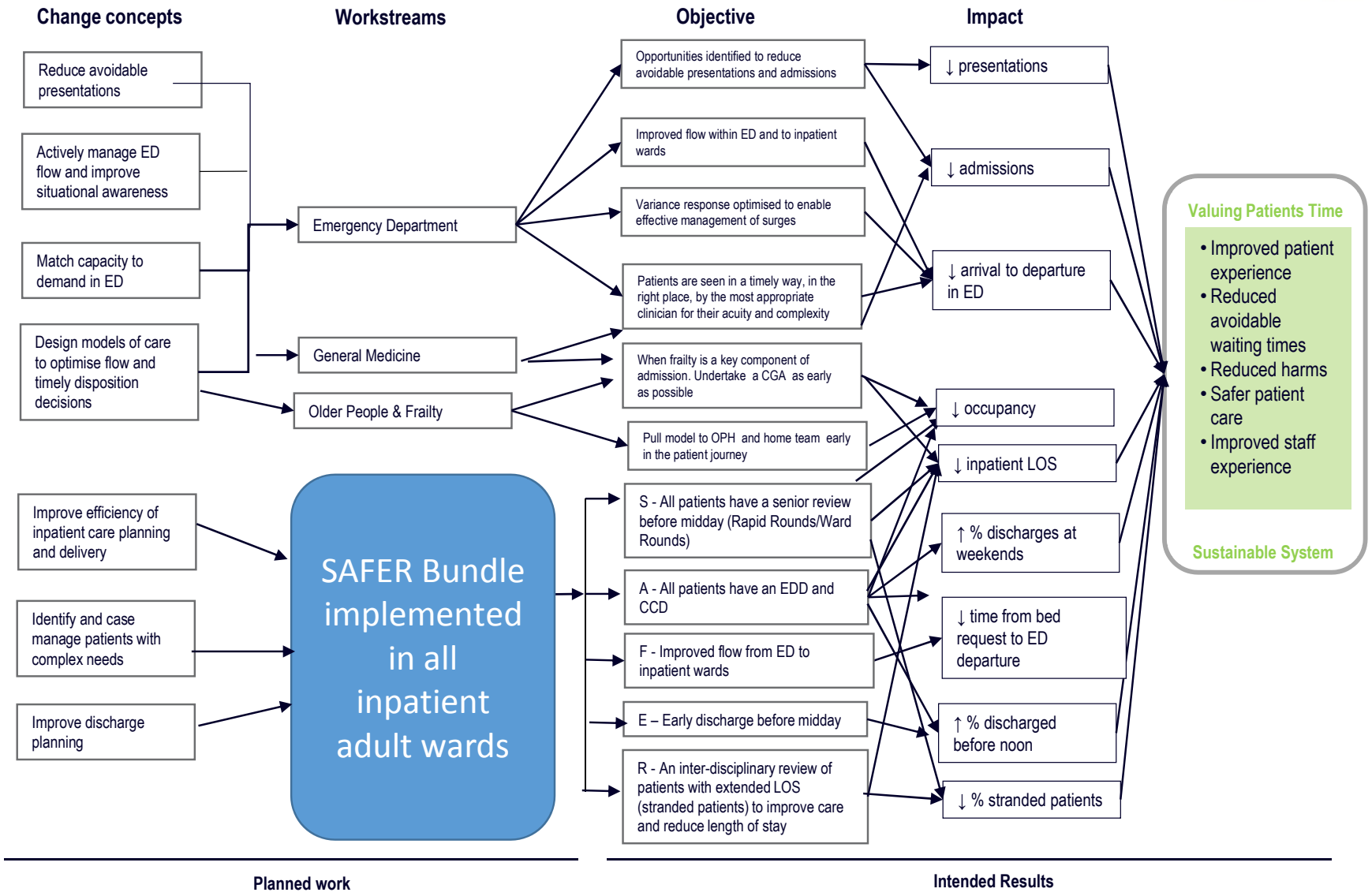
EXECUTIVE SUMMARY

Value Proposition:	
Opportunity / Strategy	Valuing Patients' Time is a strategic priority that Southern DHB committed to out of the Southern Future values work and identified improvement priorities as a promise to our patients, and community. A significant opportunity exists for Southern DHB to accelerate progress towards improving patient flow by using the SAFER patient flow bundle as a key enabler for change to maximise positive outcomes for both patients and the system, particularly due to the increasing pressure in our Emergency Departments and inpatient wards as well as the imperative that Southern DHB advances more contemporary models of care as part of the New Dunedin Hospital redevelopment. The SAFER bundle complements many other initiatives such as Health Pathways, Generalism and Telemedicine that all collectively contribute to Valuing Patients' Time. Our ambition is for patients to receive timely care and reduce avoidable delays in the system. By doing so we: • Return time back to patients; • Ensure services provide timely, high quality, patient-centred care; • Avoid patient deterioration associated with delayed assessment and treatment; • Reduce variation by aligning capacity with demand and the consequences of hospitalisation such as deconditioning, delirium, pressure injuries, falls, and treatment injury; and • Improve the care experience for patients and their whānau
Patient/Staff Experience:	• The SAFER bundle when all components are fully implemented will maximise positive outcomes for both patients and staff and reduce harm and delays in the system, resulting in safer patient care. • The SAFER bundle is a set of components that can be owned by staff to take ownership of flow through the hospital. Combined with measures, staff can benchmark their success with other services and reinforce ownership. • The association of poor patient flow to patient harms will align two pieces of work, the clinical council harms reduction for older people with VPT together these will create more momentum for improvement. • By valuing patient's time we will also value staff time and improve patient, whānau and staff experience.
Change Team/Sponsors	The change management approach is based on the principles of Agile, so that high staff engagement translates to swift change with a balanced approach to traditional project management processes. This approach is aimed to build momentum as clinicians see their SAFER changes translate into action. Contrasting with the rather onerous planning that is stifling before implementation can commence, leading to both frustration and disengagement. Critical to this work will be the mentoring, support and engagement of clinicians who have not been engaged to date or have become disillusioned, to lead a transformational change process in patient care. It is expected that usual teams including leaders, managers, clinical and support staff take an active role in leading or participating in this work and the SAFER bundle becomes embedded in Service Level Accountability. Engagement with Patient/Consumer Advisors and linkages with the Community Health and Clinical Councils is essential, as is engagement with unions and the wider sector and community.

EXECUTIVE SUMMARY

Value Proposition:	
Communications Plan	Effective multi-media communications are critical to keeping staff and our community engaged and up to date, showcasing initiatives and improvement outcomes. A refreshed Valuing Patients' Time communications plan will be developed building on the communications work to date. The core objectives of the Communications Plan are to - Articulate a clear vision for embedding the SAFER bundle - "Build the Will" by engaging and motivating clinicians from across all inpatient wards to become actively involved in embedding all components of the SAFER bundle - Build patient and the community confidence in SAFER systems and processes - Share the positive outcomes, challenges and continuous improvement opportunities
Training and Coaching requirements	• Education, training and coaching will need to be at all levels (Ward to Board) and delivered to different audiences with support from the Quality Improvement team. • The DHB 'improvement movement' is already enabling more and more staff to understand the science and art of improvement methodology
Reinforcement Plan/Performance Metrics	• An appropriate suite of metrics and balancing metrics – both qualitative and quantitative will be further developed and build on our existing outcome metrics • Detailed actions and expectations will be embedded as part of the Quality Framework and Service Level Accountability championed by the Clinical Council

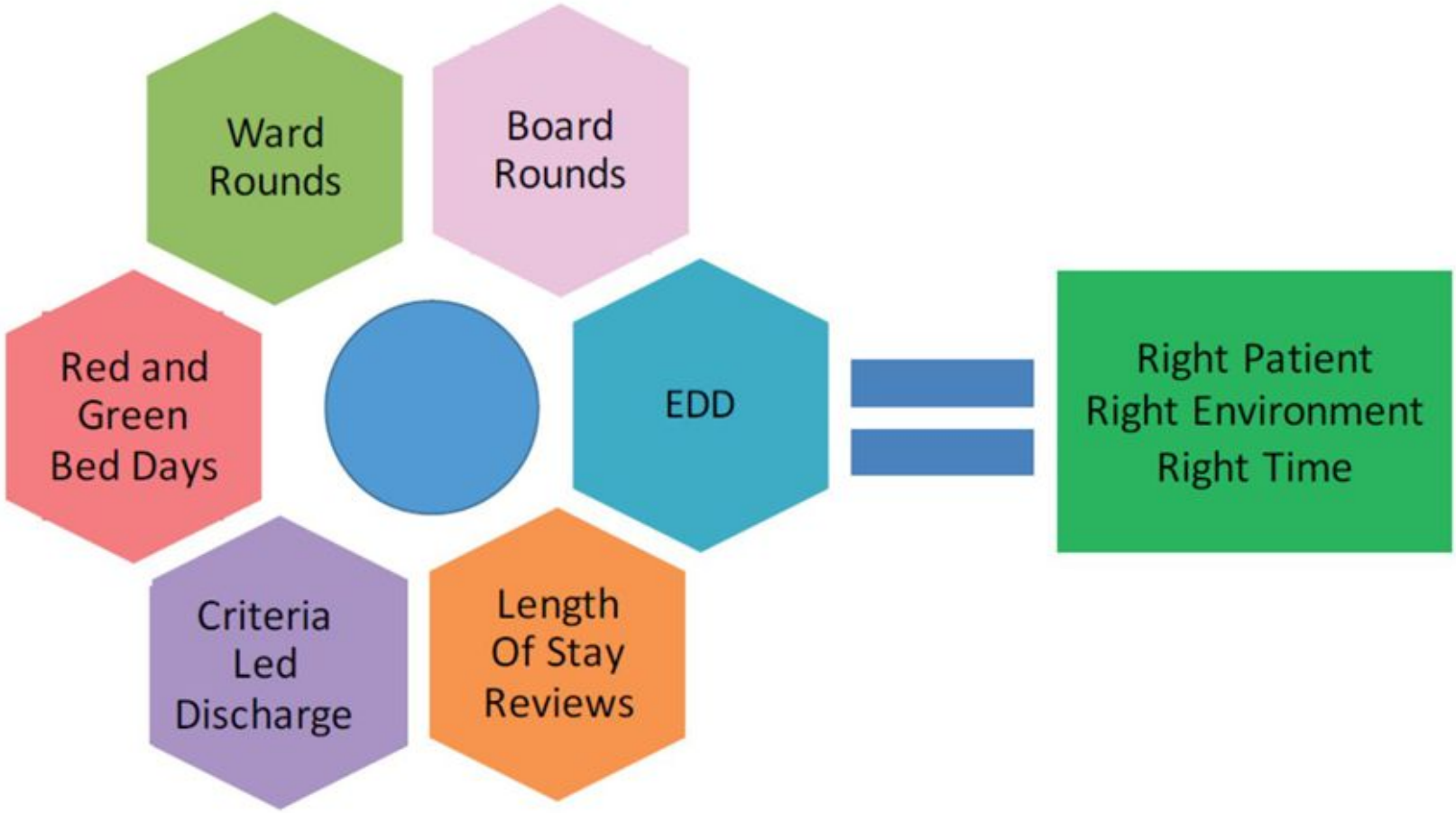
Patient Flow Intervention Model



OVERVIEW PLAN ON A PAGE

Work-stream	Changes, Objectives and Impacts	Sub-Workstreams/Concepts
SAFER **Patient Flow Bundle in all inpatient Adult Wards**	**Change concepts:** Improve efficiency of inpatient care planning and delivery using the SAFER patient flow bundle **Objective:** Delays to diagnosis, care delivery and discharge are reduced **Impact:** ↑ % discharged before noon, ↑weekend discharges, ↓ inpa ent LOS, ↓ arrival to departure in ED, ↓ stranded pa ents,	**S**enior Review – Rapid Rounds and Red2Green
		All patients -Expected Date of Discharge (EDD) and Clinical Criteria for Discharge (CCD)
		Flow from ED to inpatient wards
		Early Discharge Before noon
		Review of Stranded Patients
ED **Emergency Department**	**Change concepts:** Actively manage ED flow, improve situational awareness, match capacity to demand, design models to optimise flow **Objective:** Improve flow within ED and to inpatient wards, optimise variance response, align rosters to demand smoothing throughput, right time right place right clinician **Impact:** ↓ arrival to departure in ED, ↓ inpa ent LOS	Dunedin Fit to Sit Expansion
		Southland Primary Care ED Presentations
		Southland ED Capacity
GenMed **General Medicine**	**Change concepts:** Improve efficiency of inpatient care planning and delivery, improve discharge planning **Objective:** Delays to diagnosis, care delivery and discharge are reduced **Impact:** ↓ arrival to departure in ED, ↓ inpa ent LOS, ↑ % discharged before noon, ↓ % stranded pa ents	Enhanced Generalism Model of Care Reducing the number of referral points from ED
		Southland Hospital Discharge Lounge
Older People & Frailty	**Change Concepts:** A 'whole of system' approach to managing individuals with frailty across our health system. A Frailty Pathway **Objective:** Individuals receive the most appropriate care at the right place in a timely fashion with early CGA. Impact: ↓Reduced average ED wait for Frail older people, ↓Frailty presenta ons, ↓ Reduced Readmission rate	Frailty stratification and early identification
		Early Comprehensive Geriatric Assessment when frailty a component of presentation
		Model of Care - OPAL
		Investigate OPH capacity and reach to support frailty throughout the hospital

SAFER Patient Flow Bundle



PLAN 20/21 AND MILESTONE REPORTING (HIGH LEVEL)

	Focus Area	Baseline	Approach	Milestone 2020/21
SAFER Patient Flow bundle	**Sponsorship and Change Team**	Lack of clarity between sponsorship and operational accountabilities	Re-establish VPT Change Team with clear lines of accountability and reporting	Q2 ● Confirm Sponsorship model and change team responsible for overall programme accountability and reporting to Clinical Council, ELT and Board Q2 ● Confirm metrics and regular reporting requirements Q2 ● Add SAFER bundle to service level accountability document Q3 ● Service level accountability with SAFER bundle introduced
	Communications & Building the Will	Loss of momentum and VPT programme visibility	Create a SAFER 'social movement' re-invigorating the initial VPT Patient Flow programme involving leaders who are passionate about valuing patients' time	Q3 ● Develop a refreshed Communications Plan with compelling narratives that describe the link between implementing the SAFER patient flow bundle and improving patient care. Q3 Identify key supporters and clinical champions in each service to create a network for support and mentoring between teams Q3 Identify barriers and where in the organisation specific effort is required to get messaging/support/action and reinforcement – stakeholder analysis Q3 Identify Training and Coaching needs & develop support plan
	SAFER ward baseline self assessments	SDHB does not have the SAFER bundle implemented in all inpatient areas	Baseline assessments as part of Service Level Accountability and Service Planning	Q2 ● SAFER bundle self assessment stocktake completed for all inpatient adult wards (excludes ICU, CCU, maternity, day units and paediatrics) Q2 ● Rapid Round Baseline Assessment completed for all inpatient wards Q3 Baseline reports collated and analysed with recommendations identified to inform a detailed action plan Q3 SAFER implementation support plans developed for all inpatient services as part of service planning and service level accountability

On track	●	Caution	●	Critical/Overdue	●	Completed	●

PLAN 20/21

Focus Area	Description	Approach	Milestone 2020/21
SAFER Patient Flow bundle (cont.)	**S - Senior Review.** All patients will have a senior review before midday by a clinician able to make management and discharge decisions using Red2Green/Rapid Rounds	Expectation set with all inpatient adult services that SAFER patient flow bundle is embedded in Service Level Accountabilities as per the SAFER Bundle Rapid Improvement Guides	Q2 ● Identify electronic whiteboard system issues impacting on effective and timely input and extraction of data Q2 ● Determine and implement agreed actions to whiteboard address system issues Q4 All inpatient wards to repeat Rapid Round self assessment (6mths post baseline)
	A – All patients will have an expected discharge date(EDD) and clinical criteria for discharge (CCD).		Q2 ● Investigate solutions to capture and measure criteria led discharge, CCD – Hywel building the specifications Q3 EDD performance reporting in place for ward, specialty and by admitting clinician Q4 CCD performance metric reporting developed and implemented
	F – Flow of patients will commence at the earliest opportunity from ED & assessment units to inpatient wards.		Q2 ● Measure ward/specialty/clinician based metrics for reduced time from decision to admit to ward arrival. Q3 Introduce the concept of pull strategies to wards to improve patient flow Q4 Re-measure and share with wards/specialties/clinician
	E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.		Q3 Establish early discharge performance reporting visibility by ward, specialty and discharging clinician in addition to current organizational level reporting Q4 Identify plan for improving pre-midday D/C (incl link early discharge to pull model to improve patient flow)
	R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients')		Q3 ● Repeat the multidisciplinary Review of all stranded patients with a length of stay > 7 days identifying top constraints Q3 ● Repeat the multidisciplinary Review of all stranded patients with a length of stay > 21 days identifying top constraints Q3 Develop an action plan to address the constraints that will have the most impact on improving patient flow Q4 Repeat the multidisciplinary Review of all stranded patients with a length of stay > 7 days & > 21 days

	Focus Area	Description	Approach	Milestone 2020/21
Service Level Patient Flow initiatives	**ED Workstream**	Operational programmes of work that value patients time	Match capacity and demand in Dunedin and Southland EDs	Q2● Dunedin Fit2Sit unit completed Q2● Dunedin Hospital ED Escalation Plan final document completed and endorsed at Clinical Council Q3 Escalation Plan fully implemented
	General Medicine Workstream	Operational programmes of work that value patients time	Introduce an enhanced generalism Model of Care in Dunedin Hospital	Q2● Completion of Enhanced Generalism Model of Care Business Case to include SAFER bundle implementation Q2● Enhanced Generalism Model of Care approved by the Board
	Older People & Frailty	Operational programmes of work that value patients time	Early Identification of those presenting with frailty Early CGA & multidisciplinary approach	Q3 Develop frailty scoring & stratification for whole health system Q3 Quality dashboard metrics for Older People with frailty Q3 Investigate the capacity and reach of OPH to support frailty within the hospital and the community Q4 Commence CGA early in the assessment and admission process Q4 Review constraints for frail flow within the hospital
	Surgical Services and medical sub specialties	Operational programmes of work that value patients time	Implement SAFER Bundle	Q2● Undertake review as per SAFER bundle review Q3 Educate and inform to build buy in and hearts and minds across disciplines Q3 Develop detailed plan for surgical and med subspecialties baseline assessment of Bundle Activity & implement SAFER Bundle Q3 Repeat the multidisciplinary Review of all stranded patients with a length of stay > 21 days identifying top constraints Q3 Monitor progress using SAFER bundle metrics Q4 Repeat the multidisciplinary Review of all stranded patients with a length of stay > 7 days identifying top constraints

SAFER Bundle specific metrics –

Reporting available early 2021

Metric Description	Broken down by	Comments
Time from Decision to Admit to SMO review	By Specialty, by SMO, by Ward	This metric is achievable and available
Time from decision to admit to setting of EDD	By Specialty, by SMO, by Ward	This metric is achievable and available.
Percentage of Patients discharged on initial set EDD	By Specialty, by SMO, by Ward	iPM records initial EDD and the white board system holds updated EDD (ensure original iPM data not overridden)
Percentage Inpatients with no R2G process	By Specialty, by SMO, by Ward	Need to define R2G process: Count Green day and red day with constraint identified. If not one of the above present for 36 hour period Mon-Fri
Percentage Inpatients with R2G process > 80% of admit days	By Specialty, by SMO, by Ward	R2G process defined as above Includes Admit days Mon- Fri
Percentage of daily discharges occurring before 12 noon	By Specialty, by SMO, by Ward	Currently available and reported in Patient Flow metrics
Percentage of inpatient discharged on Sat & Sun	By Specialty, by SMO, by Ward	Taken from previous midnight census
Percentage of patient with CCD set within 24 hours of admission	By Specialty, by SMO, by Ward	Currently unavailable

NB: Patient Flow and Balancing Metrics reported monthly in Quality and Risk reporting

SOUTHERN DISTRICT HEALTH BOARD

7.1

Title:	**Executive Director of Specialist Services Report**
Report to:	Hospital Advisory Committee
Date of Meeting:	21 December 2020

Summary:

Considered in these papers are:

- November 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:** 07/12/2020	**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 – November 2020

Recommendation

That the Hospital Advisory Committee notes this report.

1. Equity

Further to our initial, rudimentary analysis of first specialists appoints which indicated that Pasifika patients appear to get almost 1/3rd less referrals accepted at triage relative to their share of the population we have organised a meeting with the Chief Māori Health Strategy and Improvement Officer to see how we can work with his team on starting to improve our understanding of why the referral and corresponding acceptance rate for our Pasifika population appears to be lower than other populations. Although willing to help us, his remit does not specifically cover the Pasifika population and we will now broaden our engagement on the issue and engage with our planning and funding colleagues, as we believe that a large proportion of the problem is likely to be at the primary care end where health literacy and GP enrolment are likely to be a factor in the under-representation we see for first specialist appointments in the hospital.

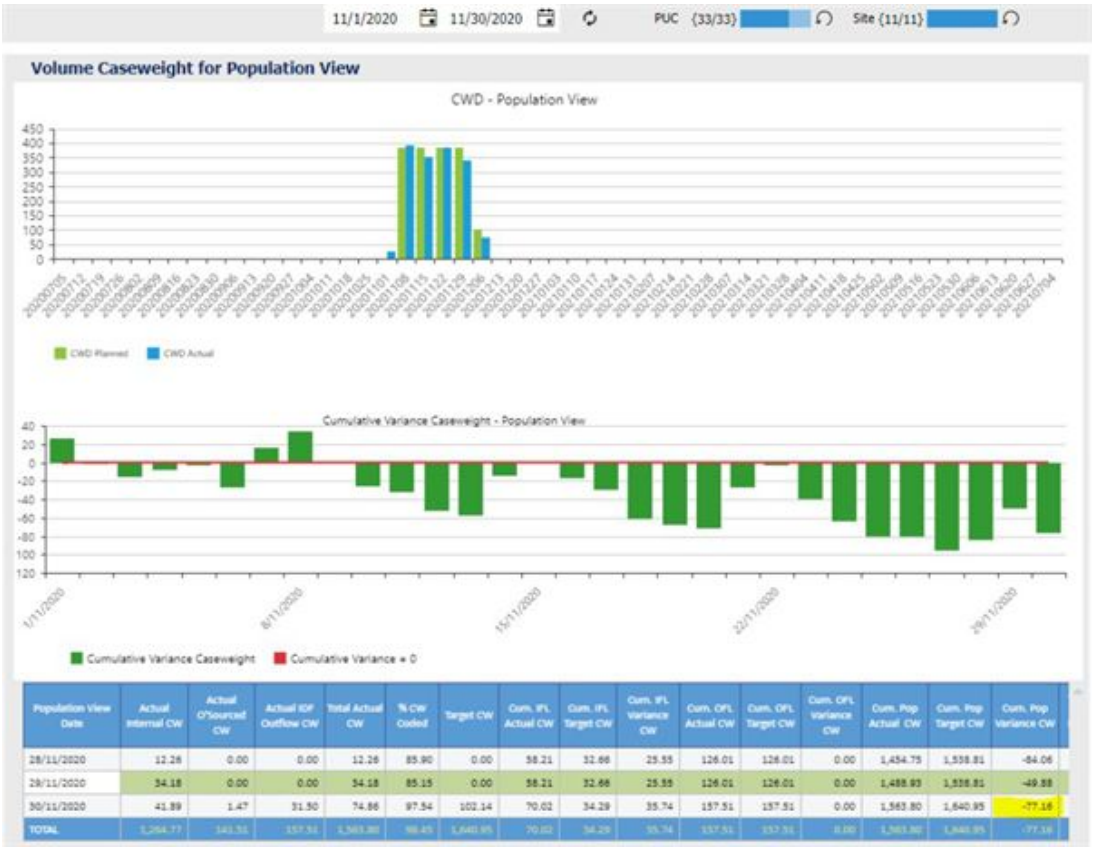
We have also agreed with our Chief Māori Health Strategy and Improvement Officer that we will start a programme of work to review both Māori and Pasifika access to our cardiology and respiratory services, relative to their share of the population. We have been advised that these are particularly good services to look at from the perspective of equitable access and equitable outcomes. Our GM Surgical and Radiology has expressed a particular interest in equity issues so we will ask her to take a lead on equity improvement work in the New Year and to involve the Executive Director of Specialist Services, Chief Māori Health Strategy and Improvement Officer, General Manager for Medicine Women and Children Services, Business Analyst – Demand and Capacity and others as relevant. As we start to systematically understand how referral and intervention rates compare, we will then start to engage on how to make improvements and we will provide regular updates in this section of our HAC report.

2. Surgical Performance – Case Weight Discharges

The pressures on elective surgery have persisted into November with the inability to provide inpatient ward beds to meet the overall demands on the hospital continuing to cause elective surgery to have to be cancelled.

The following charts show elective surgical performance in the month of November (for our 'population view' – which includes surgery for our patients at other DHBs).

On a year-to-date basis we are still slightly ahead of our elective surgical target, by 28.3 CWD (case weighted discharges). However, for the month of November we produced 77.16 CWD less than the November target (i.e. November's performance contributed negatively to our year-to-date performance against year-to-date plan).



Population View Date	Actual Internal CW	Actual O'Sourced CW	Actual IDF Outflow CW	Total Actual CW	% CW Coded	Target CW	Cum. IFL Actual CW	Cum. IFL Target CW	Cum. IFL Variance CW	Cum. OFL Actual CW	Cum. OFL Target CW	Cum. OFL Variance CW	Cum. Pop Actual CW	Cum. Pop Target CW	Cum. Pop Variance CW
28/11/2020	12.26	0.00	0.00	12.26	85.90	0.00	58.21	32.66	25.55	126.01	126.01	0.00	1,454.75	1,538.81	-84.06
29/11/2020	54.18	0.00	0.00	54.18	85.15	0.00	58.21	32.66	25.55	126.01	126.01	0.00	1,488.93	1,538.81	-49.88
30/11/2020	41.89	1.47	31.50	74.86	97.54	102.14	70.02	34.29	35.74	157.51	157.51	0.00	1,563.80	1,640.95	-77.16
TOTAL	1,264.77	141.51	157.51	1,563.80	98.45	1,640.95	70.02	34.29	35.74	157.51	157.51	0.00	1,563.80	1,640.95	-77.16

The following table (run on data out of our General Ledger) shows that overall, to achieve the performance that we have on a year-to-date basis, we have spent $417,000 more on outsourced surgery than we had budgeted for. At CWD prices with our providers of circa $5,000 and at circa 1.3 CWD per outsourced CWD this amounts to in the region of 64 more surgeries outsourced than planned for.

Outsourced Clinical Services (Surgery & Radiology) Year to Date

Outsourced Clinical Services	Nov YTD Actual	Nov YTD Budget	Act vs Budget
Audiology	-25	-10	-15
Breast screening	-616	-510	-105
CT Scans	-301	-306	4
Laboratory O/ P Tests	0	0	0
Laboratory Sendaway Tests	0	0	0
Lithotripsy	-28	-33	5
MRI Scans	-631	-172	-459
Ophthalmology	-33	-228	195
Other Radiology Procedures	-221	-203	-18
Outsourced Clinical Services - Other	-1,106	-969	-137
Radiology Service	-1,009	-816	-193
Surgical	-4,113	-3,833	-280
Vascular Assessments	-224	-267	43
Grand Total	**-8,308**	**-7,348**	**-960**
		Surgical O-Spend:	-417

Overall, this is a reasonably good position to be in when considering the amount of access block surgical cancellations that have occurred since August. However, bed access challenges have led to full Emergency Departments, particularly in Southland and

put enormous pressure on the system and our staff. We have collectively agreed to postpone deferrable elective surgery in the lead up to Christmas to alleviate this pressure and this will invariably lead to a deterioration against our elective surgical target.

The extent of our bed access issues continues to remain a bit of a puzzle for our organisation, as overall volumes do not appear to be up markedly. When the Chief Executive and Executive Director of Specialist Services did a cursory review of a preliminary data set we appeared to find that for the ward we investigated (which was a medical ward), admissions / discharges were down slightly year on year, length of stay was higher year on year and occupancy was up marginally as the impact from length of stay was slightly greater than the impact from reduced admissions / discharges.

Other DHBs are also reporting higher length of stay and that this is putting pressure on both elective surgical delivery and beds in hospitals. Anecdotally an issue that has been identified by others is access to aged residential care beds, but this needs to be validated and quantified.

As the Chief Executive noted in the Board meeting held in early December, a comprehensive analysis is required to understand this phenomenon better and the CEO has tasked a cross directorate team to provide analysis to develop an understanding of what is occurring.

We have proposed to this group an approach to conducting this analysis which includes quantitative, qualitative and empirical analysis along the following lines:

- Collect a data set for October and November 2019 and 2020 across relevant adult medical and surgical wards.
- Pivot analyse the data set to identify wards with outlier year on year average length of stay.
- For the outlier wards filter to select a valid year on year sample. For simplicity this could be a full month of data from each year for that ward.
- For a given disease type and age, compare the length of stay for patients last year versus this year.
- For those patients review the discharge notes and interview ward staff to determine what was required to finalise the discharge.
- Quantify the key determinants which led to prolonged discharge in 2020 versus 2019.

Once quantified in this manner we will then understand our phenomenon better and we will be able to formulate the right decision making (and determine where to provide the focus – e.g. primary care versus secondary care versus degrees of both) to reduce length of stay and improve our flow.

We look forward to understanding the challenges better – the sooner we can take positive steps towards addressing them the sooner we can improve the rate at which we

can complete our surgeries, and work to reduce the pressures being experienced by our staff.

3. Outpatient Performance ESPI 2

We are continuing to monitor our work programme which is focused on reducing the number of ESPI 2 breaches (patients who have had to wait > 120 days for an outpatient appointment). We achieved good performance in the period immediately after COVID, dropping from circa 2,600 breaches to circa 1,100 breaches from June-July to October. Per the chart below, progress continued into November and we are now breaching at circa 900 breaches across all specialities. This represents good post COVID performance but has had to be achieved with minimal access to recovery funding. We have now been advised by the Ministry of Health that the funding tagged to outpatients will now not be paid until the end of the financial year. Given the uncertainties that this is creating for us we are being deliberate to only invest recovery in our key risk areas for now, which we have identified as follows:

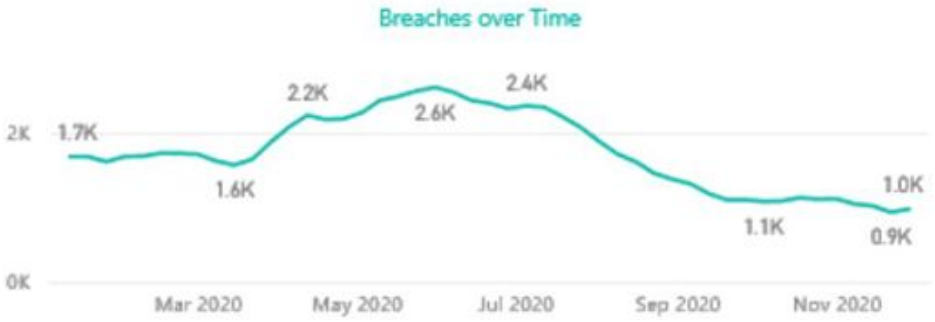
- Obstetrics & Gynaecology in Southland.
- Medical Oncology in Dunedin (district wide service).
- Radiation Oncology in Dunedin (district wide service).

For the above specialties we are taking deliberate steps to incur unbudgeted locum costs on the basis that we will fund those costs from the trajectory funding we will now not receive until the end of the financial year.

Our ESPI 2 recovery performance has been good up until the end of November but is now starting to tail off. Over the Christmas New Year period we traditionally accept referrals (based on need) at a higher rate than we can supply clinic services (due to relatively high rates of leave in late December, January and February). We are therefore anticipating a level of deterioration going into the New Year. Initiatives which are in place, underway or will be put in place once promised funding is made available are as follows:

- Use of the Ministry of Health prioritisation tool. The prioritisation tool continues to be used to ensure we safely match incoming demand with our ability to supply clinics in our Urology (Dunedin), Orthopaedics (Dunedin) and General Surgery (Southland) services. We have also rolled out the tool in General Surgery in Dunedin. As General Surgery in Southland has lost some capacity due to retirement, we will now review the acceptance threshold in that service so that we do not accept more referrals than we have capacity to see and therefore start to accumulate backlogs in that service.
- Obstetrics & Gynaecology in Southland have agreed to use the tool to enable us to gauge the extent to which we are under-staffed there (and therefore unable to complete colposcopies, follow-up clinics first specialist appointment clinics and accept FSAs at the rate at which we can see them in clinic without adding to backlog). This will be achieved by identifying the score at which we could safely and appropriately decline referrals and return them to the GP compared to the score we would have to apply to do so with the current incoming demand. The difference translates into our capacity deficit.

- Our Ear Nose and Throat (ENT) services have agreed to start trialling the prioritisation tool in these services as well.
- Once we have confirmed the funding the Ministry awarded us as part of the initiatives we successfully bid on, we will put further resource into the roll out of the prioritisation tool and seek to systematically apply it to all of our surgical specialties. The tool is important as it allows us to stratify (prioritise) all referrals, understand where we can safely draw the line and allows us to adjust our referral practices to respond to events such as resignations and vacancies which reduce the capacity available within the service.
- Our Planned Care Planning Manager has been to Southland and is systematically working across all specialities to ensure that we are booking our first specialist appointments on an 'acuity' basis. The acuity basis takes into account the severity of the condition and the amount of time waiting when compared to the clinically indicated date. This then produces a priority order which the booking teams can systematically book from which appropriately balances the severity of the condition with how long individual patients have been waiting for their appointment.



As our Medicine, Women and Children directorate is either at ESPI 2 compliance or close to it for most of its specialities now (with the exception of Obstetrics & Gynaecology in Southland) we will be progressing with a new approach in the New Year. At our weekly review meeting we will review every patient that has waited longer than the 4-month target and seek to take action to ensure that they are booked into the next available appointment slot. Surgical and Radiology are not yet at the point where we can apply this level of detail in our weekly meetings (as the overall number of breaches is still relatively high). However, as the prioritisation tool starts to bed in across all specialities in this service, we plan to apply a similar approach there, too.

4. Inpatient Performance ESPI 5

Total breaches for all specialties (excluding Obstetrics and Gynaecology) has seen some improvement since the breach backlog grew due to the cancellation of all deferrable elective surgery during the COVID lock down. Total breaches for this cohort (excluding O&G) were circa 2,000 on the 1st of July (the start of the financial year) and are now at circa 1,450 at the end of November. However, breach performance was circa 1,450 at

the start of November, so performance has not improved markedly in the month of November.

The inpatient wait list is dependent on our ability to provide surgery and as noted in an earlier section, we have had frequent cancellations in November due to bed block (inability to provide inpatient beds to complete the surgery). When this occurs, the urgent surgeries (acute or urgent elective cancers) take precedence and deferrable elective surgery gets cancelled. We have seen a number of deferrable surgeries (e.g. in orthopaedics) cancelled during the month of November and this has hindered our ability to complete more surgery on long waiting patients.

Notwithstanding this, we have been able to achieve the trajectories for a number of our inpatient recovery plans, and we earned circa $650k of trajectory revenue associated with inpatient surgery in the first quarter of the year (July to September). In our recovery trajectories we have signalled the ability to progress against our outpatient backlogs in year 1 and have signalled the difficulty of progressing with inpatient backlogs and we have deliberately spread recovery of inpatient backlogs over a multi-year period. We have recently been advised by the Ministry that the payment for the first quarter of inpatient surgery has been confirmed at $650k and that this will be paid to us on the 31st of December. We have accrued this revenue in the November month, so it has reduced the deteriorated financial performance in November but will effectively have already been recognised when the funding is released on the 31st of December.

Work has been progressing speciality by speciality on the longest waiting patients (e.g. patients waiting > 24 months). We are now down to a small handful of cases of patients who have waited > 21 months (which is where we have set the filter) who have no reason to still be waiting. Unfortunately, we have been hindered by some of the elective cancellations noted earlier (e.g. in orthopaedic surgery) but have nevertheless made good progress. We have also completed a proof of concept for a 'transfer of care' approach, whereby long waiting patients who would be more appropriately managed off the waitlist are provided with an alternative care pathway and taken off the long wait list. The process involves a call to the patient to understand their current status. In some cases this may identify that surgery has already occurred (e.g. privately), that they have left the district and are on another list, that they need assistance with meeting pre-requisites such as losing weight or quitting smoking, that they no longer want the surgery or that they are in fact ready for surgery (in which case rather than transferring care they would be booked as quickly as possible).

We are finding that as we look into specific cases the weekly meeting, we have established with all specialities to review ESPI performance and long waits is needing more and more time. However, this is a valuable meeting as it ensures that wait lists are being managed at a good level of detail and we will need to find a way to be able to extend the length of these meetings.

5. Medical Imaging Diagnostics

Both Dunedin and Southland are in the midst of moving to a new Radiology Information System (EASYRIS). This is a much more modern system and is an exciting move.

However, unfortunately the reporting is still being worked on and we are unable to provide accurate charts for this HAC meeting. This will be rectified by the next HAC meeting in the New Year.

Unfortunately, a further CT outage in Dunedin has negatively impacted on performance. However, the overall downtime was circa 24 hours rather than the extended outage we saw on our MRI machine a few months ago.

Advice from the Ministry of Health was that the Minister of Health was due to provide a final sign-off on the capital requested (and recently approved) for the additional Dunedin CT machine in mid-December. And as the Board have now approved our recommendation to locate the new CT machine in the Dunedin Radiology Service, we will commence planning early in the new calendar year to purchase and install the new machine as quickly as possible. This will require a reasonably substantial building project which we will seek to get going as quickly as we can.

As noted in an earlier HAC report, Dunedin Hospital's CT intervention rate has historically been circa 580 per 10,000, a much lower intervention rate than the circa 880 per 10,000 seen across the South Island overall.

As discussions progress in other areas it is becoming increasingly obvious that access to CT constrains a number of our other flows, e.g. from the ED, and for faster diagnosis, e.g. in some of our faster cancer streams. Anecdotally, access also contributes to bed block, when patients are admitted so that there is surety about them receiving a CT within a reasonable timeframe. As we complete the implementation of the CT initiatives that were agreed to be funded earlier this year and then complete the implementation of our additional CT machine at Dunedin hospital, we can reasonably expect to see positive improvements in flow and access to treatment across our hospital. It is therefore imperative that we implement the initiatives that will provide this added capacity as quickly as we can.

6. Emergency Departments

The new ambulatory area (formally known as 'fit to sit') was commissioned in mid-November, offering 6-8 chairs as a much needed initial expansion of the available ED facilities. Now that the medical assessment unit has been agreed to by the Board as part of the 'Enhanced Generalism plus Medical Assessment Unit' business case, it is now imperative that we implement this initiative as quickly as possible. As well as enabling us to maximise the benefits from enhanced generalism, the improved flow in the ED and rate of discharging that does not require an inpatient ward admission will enable us to reduce pressure on both our ED and our inpatient wards. We have had an initial meeting with our General Manager for Building and Property and our Procurement Manager. Early in the New Year we will establish a steering group to de-cant the medical assessment unit space as quickly as possible. We are also investigating procurement / construction contracting options that will allow us to rapidly gut the facility assess what is there (e.g. in terms of asbestos) and then quickly cycle through any containment and construction works that are required. We will keep you updated as we progress this in the New Year.

In Southland there is significant tension, presentations to ED are very high, amongst the highest per capita when looking at Health Round Table Benchmark information, and

admission rates according to the Health Round Table data is by far the lowest of all benchmarks. Some debate the data and this must be addressed, however it is clear that there is a very high per capita presentations, and many of these are primary care level presentations. There is confusion as many assume this relates to after hours services however the majority of primary care level presentations are indeed in hour presentations, addressing after hours along will not address the issue but it also requires the PHO to genuinely tackle access to timely affordable in hours primary care services. Staff are under significant pressure and with the volume of attendances there is hu1ge facility pressure creating bottlenecks and increasing risk. It is likely that the solutions required will need both change in primary care and potentially modifications to the ED physical space. We ran a workshop to determine what needs to be done to address chronic ED space issues, which included the Internal Medicine Clinical Leader and the ED Clinical Leader, together with key people who have formed our reference group to date. We concluded from the workshop that our first priority is suitable existing ED spaces, our second priority is a suitably sized medical assessment space and our third priority is additional ED space. Anything we propose will tackle the issues in this order. It should be noted that this prioritisation occurred without consideration of other space in the hospital. At a recent SMO meeting across the hospital opinion was divided as to whether the first priority should be to increase inpatient bed capacity, or increase ED capacity.

As noted earlier in this report, a significant amount of pressure has been felt in the ED recently with what has felt like high presentation rates, particularly in Southland.

The following pivot tables show data extracted from our Power BI data sets. They show that:

a. For the month (to date) in December, daily ED presentation rates in Southland have been 127. This compares with daily average presentation rates for the months from July to November of only 108, i.e. a notable uptick.

b. For the month (to date) in December, ED presentation rates in Dunedin have been 129. This compared with daily average presentation rates for the months of July to November of 126, so the uptick does not appear to have been as marked in Dunedin as for Southland.

Bearing in mind that we would normally expect to see daily presentation rates drop post winter, there appears to be ongoing demand on both our Emergency Departments and in the case of Southland, the December to date daily presentation rate is significantly up on the prior months and actually above the average monthly presentation rates for Dunedin for July to November, despite serving a population of half that of Dunedin.

Southland ED	Triage						
Average by Mont	1	2	3	4	5	6	Overall Avg
July	1	12	45	43	3	1	106
August	1	14	44	47	5		111
September	1	11	43	41	5		102
October	1	11	42	46	5		106
November	1	12	48	46	5		113
December	2	13	51	57	4		127
Grand Total	**1**	**12**	**45**	**45**	**5**	**1**	**111**

Dunedin ED	Triage					
Average by Mont	1	2	3	4	5	Overall Avg
July	2	20	47	51	7	127
August	2	19	48	54	8	131
September	2	19	45	51	9	125
October	2	20	47	49	6	124
November	3	21	44	50	8	125
December	4	24	41	51	9	129
Grand Total	**2**	**20**	**46**	**51**	**8**	**127**

During the month we also took the opportunity to invite the Primary Health Organisation (PHO) Chief Executive to discuss the data that he has in his own PHO Power BI dashboards with a group of Southland stakeholders and he has subsequently provided us

with access to the dashboards. The most significant observation is that it appears that only circa 60% of Southland patients are enrolled at a GP practice. This needs further validation as it is inconsistent with the PHO enrolment numbers based on population, but, on the assumption, that this is correct it helps to explain why we are seeing ED presentations that would reasonably be expected to be a primary care presentation in much greater numbers at Southland Hospital, it should be noted however that GPs are supposed to provide access to both enrolled and non enrolled patients. We have emphasised with our teams that it is important to work with our partners in primary care to reduce the number of people presenting and waiting on the waiting room side of our Emergency Department. However, if initiatives ultimately need to expand the supply of GP practices and then encourage sufficient GP enrolment rates these could take some time to land successfully. However, demand on our ED from the other side of the wall to the waiting room (i.e. more severely ill patients who arrive by ambulance) also remains very high.

7. Oncology

As discussed in our recent HAC meeting, we are now expanding our cancer treatment reporting to include both the 31-day target (which is in the Ministry 'MIF' dashboard), and we will now also start to report against the 62-day target.

31 Day Target

The following table shows current 31-day target performance (noting that this was downloaded on the 9th of December and November 2020 final performance will not be available until the 20th of December).

The following definition should help to explain what the 31-day target measures:

"The time elapsed from the decision to treat until the first treatment."

This measure does not include the initial external referral from primary care and is focused on how long it took until the first treatment occurred once a diagnosis was made which indicated that treatment was required. A brief discussion with our GM Surgery and Radiology (who was instrumental in developing the Faster Cancer Treatment reporting when in her previous role as GM for Internal Medicine, and still plays an active role in managing cancer co-ordination across surgical, medicine and women services), suggests that circa 75% of cancers are from non-GP referrals. These may be identified from screening; ED direct presentations or incidental findings and the key measure then becomes the 31 days from decision to treat until first treatment.

Although performance has deteriorated a little in November, the charts below suggest that we generally achieve the 31-day target of 85% or are close to it.


Treatment Date
1/01/2020
28/11/2020
Cancer Type
Brain/CNS
Breast
Gynaecological
Haematological
Head and neck
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urological
Treatment Type
Chemotherapy
Concurrent radiation therapy...
Non-intervention management
Other
Palliative care
Patient declined treatment
Patient died before treatment
Radiation therapy
Surgery
Targeted therapy
Average Decision to Treatment time (Days) by Cancer Type
Head and neck 25.9
Lower GI 19.6
Urological 18.2
Gynaecological 17.6
Sarcoma 17.1
Breast 15.7
Skin 13.1
Upper GI 12.9
Haematological 11.1
Lung 11.0
Brain/CNS 3.7
Other 1.5
0 5 10 15 20 25 30
Completed Cancer Cases
Cancer Treatment Completed in 31 Days
Cancer Treatment Completed greater than 31 Days
Lower GI 201 57
Urological 184 51
Breast 153 23
Lung 112
Upper GI 106 9
Haematological 107
Gynaecological 55
Head and neck 40
Skin 31
Brain/CNS 23
Other 17
Sarcoma
0 50 100 150 200 250 300
31 Day Cancer Performance Measure
Cancer Treatment Completed 31
Cancer Treatment Completed greater 31
FCT Percentage
83.74% 86.92% 86.89% 88.30% 87.91% 88.66% 87.62% 82.84% 84.00% 85.21% 79.49%
January 103 20
February 93 14
March 106 16
April 83 11
May 80 11
June 86 11
July 92 13
August 111 23
September 105 20
October 121 21
November 62 16
100% 80% 60% 40% 20% 0%
FCT Percentage Current Quarter
83.18%
FCT Percentage Last Quarter
84.62%
FCT Percentage Overall
85.55%

62 Day Target

The 62-day target encompasses the initial urgent referral from primary care to the decision to treat to first definitive treatment. In other words, this measure includes the same end point as the 31-day measure (first definitive treatment) but the measure starts from when the urgent referral was sent to the hospital.

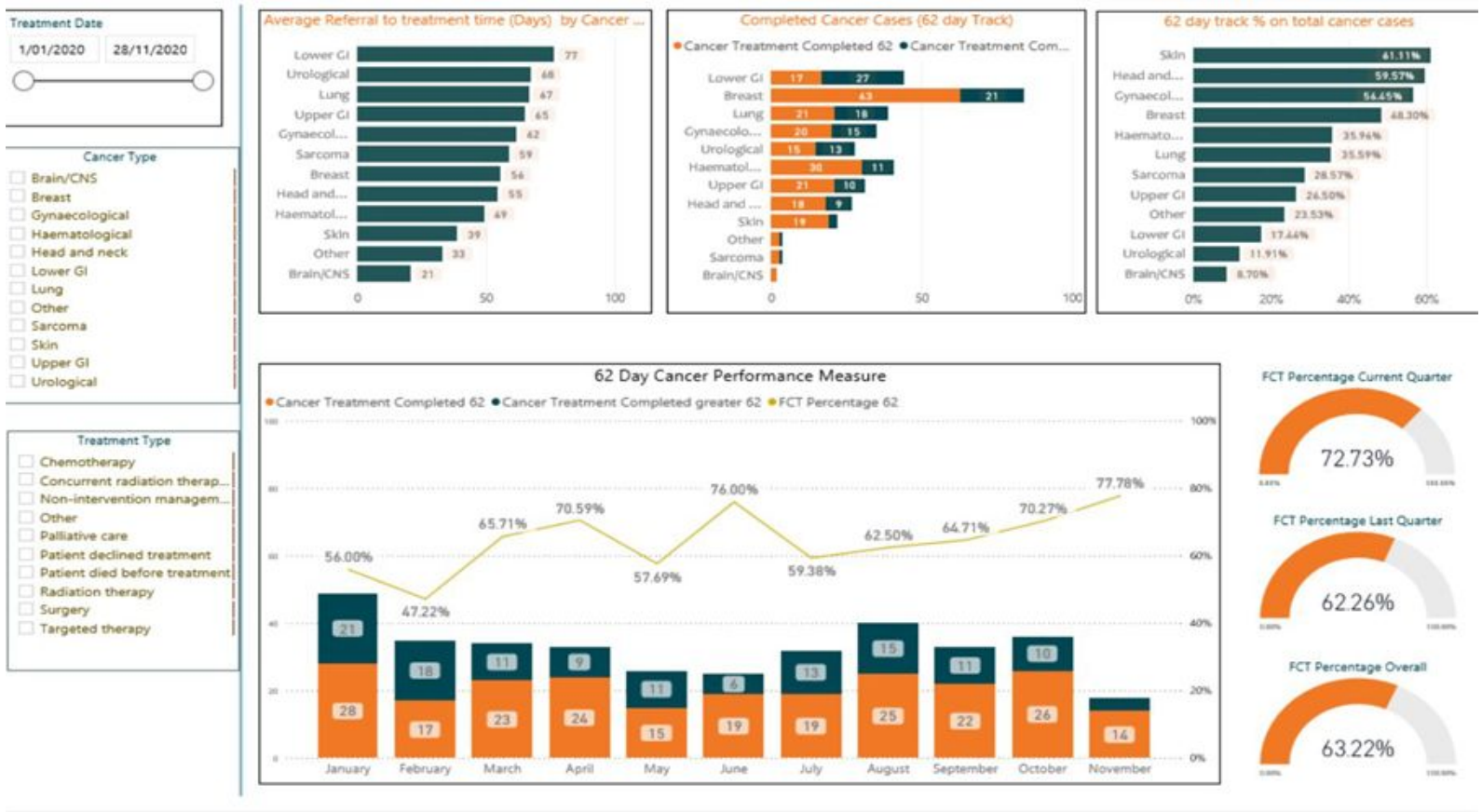
The reporting for Faster Cancer Treatment (FCT) is not extracted from our core patient administration system. Although patient administration system information is a component of the FCT reporting, a separate, DHB developed database is used to maintain FCT workflow and reporting (as the requirements were historically too complex to include in the patient administration system).

Our performance compared to other DHBs looks low at circa 74% against a target of 90%. However, there appear to be a number of anomolies in how we report our performance compared to how other DHBs report their performance. For example, the manner in which we report suggests that we have higher numbers of cancer than DHBs with much larger populations than ours and this does not appear to be correct.

We will now replicate the logic which Canterbury DHB uses to report its FCT 62-day performance and we anticipate that this may raise our FCT performance by circa 10%. We have advised the Cancer Control Agency that we are looking into this so that if our performance lists at this rate it will not be misconstrued as an underlying performance improvement but rather a correction to our reporting approach.

On the assumption that these reporting changes do lift our performance to this level it will put us closer to our peers and we will no longer be an outier to the extent that we currently are. However, our underlying performance will still be short of the target of 90%.

Our initial review of the data suggests that access to medical imaging diagnostics is one of the inhibitors to overall performance. Intuitively a medical imaging diagnostic such as a CT is often required before a definitive diganosis and decision to treat can therefore be made, so this would intuitively be a differentiator between performance once a decision is made to treat and performance from when an external referral has been received. Once we are comfortable with the 62 day calculations we will explore this in more detail. This underscores the importance of maximising access to medical imaging diagnostics and reinforces the importance of getting the additional CT machine and the CT initiative implemented as quickly as possible.


Treatment Date
1/01/2020
28/11/2020
Cancer Type
Brain/CNS
Breast
Gynaecological
Haematological
Head and neck
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urological
Treatment Type
Chemotherapy
Concurrent radiation therap...
Non-intervention managem...
Other
Palliative care
Patient declined treatment
Patient died before treatment
Radiation therapy
Surgery
Targeted therapy
Average Referral to treatment time (Days) by Cancer ...
Lower GI 77
Urological 68
Lung 67
Upper GI 65
Gynaecol... 62
Sarcoma 59
Breast 56
Head and... 55
Haematol... 49
Skin 39
Other 33
Brain/CNS 21
0
50
100
Completed Cancer Cases (62 day Track)
Cancer Treatment Completed 62
Cancer Treatment Com...
Lower GI 17 27
Breast 43 21
Lung 21 18
Gynaecolo... 20 15
Urological 15 13
Haematol... 30 11
Upper GI 21 10
Head and ... 18 9
Skin 19
Other
Sarcoma
Brain/CNS
0
50
100
62 day track % on total cancer cases
Skin 61.11%
Head and... 59.57%
Gynaecol... 54.45%
Breast 48.30%
Haemato... 35.94%
Lung 35.59%
Sarcoma 28.57%
Upper GI 26.50%
Other 23.53%
Lower GI 17.44%
Urological 11.91%
Brain/CNS 8.70%
0%
20%
40%
60%
62 Day Cancer Performance Measure
Cancer Treatment Completed 62
Cancer Treatment Completed greater 62
FCT Percentage 62
56.00%
47.22%
65.71%
70.59%
57.69%
76.00%
59.38%
62.50%
64.71%
70.27%
77.78%
January 21 28
February 18 17
March 11 23
April 9 24
May 11 15
June 6 19
July 13 19
August 15 25
September 11 22
October 10 26
November 14
100%
80%
60%
40%
20%
0%
FCT Percentage Current Quarter
72.73%
FCT Percentage Last Quarter
62.26%
FCT Percentage Overall
63.22%

8. Gastroenterology

Some good initial progress has been made as we focus our efforts on colonoscopies. These improvements can be summarised as:

- Endoscopy Oversight (Endoscopy Oversight Committee).
- Colonoscopy review processes.
- Colonoscopy reporting.
- Colonoscopy digital referral enhancements.

In terms of the Endoscopy Oversight Committee (EOG), having an external, impartial and reputable Chair has made a significant and important change in terms of aligning our GI Specialists and other stakeholders, and we have had good feedback from a number of these stakeholders about the direction these meetings are taking.

In terms of the colonoscopy review process we have now documented the process flows and are having initial meetings to establish how to strengthen these and understand the impact of any changes. Initial work has occurred to determine the role that a Referral User Group (RUG) would have in managing the second review process (which referrals are put through if they are initially declined during triage). Processes are already in place and appear to be working, and we may refine our thinking from requiring a RUG to ensuring that regular reporting is in place and reviewed to ensure that referrals are appropriately stepped through the second review process, and the final outcome for the referral is recorded in a manner that enables the history of the referral to be identified as required. We will discuss the concept of the RUG further at the Endoscopy Oversight Group and gain agreement on the way forward prior to making final decisions about the RUG and the role we need this to play in the future.

In terms of Colonoscopy reporting, a new code has been introduced for colonoscopies so that their wait list can be separately identified in our patient administration system. This will enable us to differentiate colonoscopies in a number of the reports we want to build over time.

A number of reports have now been constructed in our 'Power BI' dashboard reporting system and these can all be refreshed at the push of a button. There are some data integrity issues that we are still working on, so please bear this in mind when reviewing the following reports. We have attached some examples of the reports that we have built for information.

Real Time Wait List

This report has been developed to replace the five reports and manual process our General Manager Medicine, Women and Children previously had to work through in order to produce a report showing the status of our colonoscopy wait list. This can now be run at the touch of a button. Per previous reporting, it shows a breakdown of urgent, non-urgent and the other categories and shows the number of patients waiting, the average and median wait times, the shortest wait and the longest wait.

We have asked for the following enhancements to be made to this report:

- Remove the median and shortest wait rows to make the report easier to read.

There appears to be a data quality issue in the source data for the longest wait time for surveillance colonoscopies (highlighted in yellow). This is currently being worked on and the report will be enhanced to report this correctly. In some cases the wait time also reflects planning or patient requests for delays. We will investigate whether we can categorise these as planned in the future enhancements we make to this reporting so that the wait does not give the wrong impression about how long it has taken to complete the scope.

Overall the report gives us the ability to see the status of the colonoscopy wait list at a glance for each site. Reporting by site helps us to see whether there is variation in the service we are able to supply on each site and where there is a significant variance will enable us to target any future investment to where the need is greatest. We have been requested to provide a consolidated report as well and will include this in the next release.

Real time waitlist

Hospital	No of Waiting Patients	Average waiting time	Median Wait time	Shortest Wait	Longest Wait
Dunedin					
Diag Urgent	1	4.00	4.00	4	4
Diag Non-Urgent	82	19.41	14.00	1	95
Diag Planned and Staged	54	33.93	29.50	4	127
NBSP	15	11.47	4.00	1	99
SURV	315	93.45	84.00	-2	738
Southland					
Diag Urgent	2	4.00	4.00	1	7
Diag Non-Urgent	53	28.26	21.00	3	148
Diag Planned and Staged	25	32.36	25.00	2	137
NBSP	13	13.08	4.00	1	78
SURV	425	167.09	162.00	-2	875

Maximum Wait Time Breach

This report shows the number of patients waiting outside of the Ministry indicated timeframe for each category. As can be seen from the report, we have a high number of routine surveillance patients waiting outside of the timeframe due to the backlogs that developed when we stopped scoping during COVID. This is one of our focal areas in our recovery plan. We have been asked for trend reporting (to show the progress being made over time) and will look to include this enhancement in a future release. We have also been asked to investigate whether we can report on what the average length of the wait was for those patients who breached the indicated timeframes before they got a scope and will look at incorporating this in a future release, too.

Maximum Wait time Breach

Hospital	Urg >30	Non urg >90	SURV >120	NBSP > 45
Southland		2	255	1
Dunedin		1	94	1
Total		3	349	2

Referrals Received

This report tells us how many referrals have been received on a weekly basis (note that the colonoscopy / flexible sigmoidoscopy filters have been turned on for this report).

Referrals received

Start of Week	Dunedin	Southland
8 November 2020	17	13
15 November 2020	27	25
22 November 2020	21	15
29 November 2020	24	8
6 December 2020	3	1
Total	**92**	**62**

We have also produced a report which tells us how many scopes were seen / done on a weekly basis, as follows. We are in the process of enhancing these reports. Details of our planned enhancements are below.

Endoscopy Seen/ Done - Minus Surveillance

Hospital	Dunedin						Southland						Total
Start of Week	Diag Urgent	Diag Non-Urgent	Diag Planned and Staged	NBSP	SURV	Total	Diag Urgent	Diag Non-Urgent	Diag Planned and Staged	NBSP	SURV	Total	
28 June 2020	3	4	3	6	22	38	2	7	3	2		14	52
5 July 2020	5	17	12	4	28	66	4	13	1	3	6	27	93
12 July 2020	5	12	9	15	17	58	1	17		4		22	80
19 July 2020	5	29	2	5	13	54	1	18	10	3		32	86
26 July 2020	6	15	11	11	16	59	5	22	7	2		36	95
2 August 2020	4	29	7	7	10	57	4	15	6	7		32	89
9 August 2020	9	17	8	6	14	54	5	16	3	3	16	43	97
16 August 2020	8	13	13	8	13	55	2	6	9	7		24	79
23 August 2020	4	17	8	18	8	55	4	4	8	4		20	75
30 August 2020	9	14	11	8	20	62	2	15	5	4		26	88
6 September 2020	3	14	13	14	22	66	5	17	5	4	8	39	105
13 September 2020	4	14	11	9	11	49	8	12	4	4		26	75
20 September 2020	5	15	6	13	16	55	3	10	12	8		33	88
27 September 2020	6	23	6	13	8	56	1	7	8	8		24	80
4 October 2020	7	30	8	13	10	68	5	16	5	5	9	40	108
11 October 2020	1	17	5	7	23	53	3	9	12	5		29	82
18 October 2020	7	25	10	8	15	65	3	8	14	3		28	93
25 October 2020	6	9	5	9	12	41	2	3	3	4		12	53
1 November 2020	3	19	17	6	34	79	1	17	5	4		27	106
8 November 2020	3	32	8	9	20	72	4	14	2	4	13	37	109
15 November 2020	3	16	10	8	21	58	1	10	7	7	2	27	85
22 November 2020	2	21	5	8	30	66	3	14	5			22	88
29 November 2020	3	21	5	12	15	56	3	16	1	6		26	82
6 December 2020	4	20	11	13	20	68	1	2	2			5	73
Total	**115**	**443**	**204**	**230**	**418**	**1410**	**71**	**288**	**137**	**101**	**54**	**651**	**2061**

We are working on a single report which consolidates the above reports. We will then have a single report to tell us (on a weekly basis), how many we received, how many we scoped and therefore what the net addition to the wait list was for that week. This will become a key operational report which we can consolidate into a monthly view to explain our demand and supply situation on a weekly, monthly, quarterly and annual basis.

Performance Against Ministry Target

The following report demonstrates our monthly performance against the key Ministry targets for colonoscopy:

Performance on Ministry Targets

Region	Dunedin					Southland				
End of Month	Diag Urgent 14 days	Diag Urgent 30 Days	Non Urgent 42 days	Non Urgent 90 Days	NBSP	Diag Urgent 14 days	Diag Urgent 30 Days	Non Urgent 42 days	Non Urgent 90 Days	NBSP
Friday, 31 July 2020	94.59%	100.00%	82.22%	92.78%	96.67%	80.95%	100.00%	56.94%	61.11%	93.10%
Monday, 31 August 2020	86.11%	100.00%	78.82%	95.29%	97.26%	85.71%	95.24%	73.83%	88.79%	97.30%
Wednesday, 30 September 2020	87.88%	96.97%	83.33%	96.96%	97.22%	94.44%	100.00%	81.75%	97.62%	94.29%
Saturday, 31 October 2020	92.31%	100.00%	83.08%	98.01%	96.49%	88.24%	94.12%	86.52%	98.88%	96.88%
Monday, 30 November 2020	100.00%	100.00%	78.69%	99.18%	98.15%	100.00%	100.00%	45.90%	96.72%	100.00%
Thursday, 31 December 2020	100.00%	100.00%	82.86%	97.14%	95.65%	100.00%	100.00%	82.35%	100.00%	100.00%

We have requested the following enhancements to this report:

- Show the performance and the target and the variance (performance versus target).
- Show a consolidated picture (Dunedin and Southland) which reconciles with what we report to the Ministry.

Sessional Use Reporting

The following report shows the rate at which we are utilising our scoping room capacity in both Dunedin and Southland.

This report needs further refinement. Its intention is to show us how well we are using our available session capacity (both resourced and un-resourced). As a starting point we have taken the available session time. We have then taken the scoping time indicated by our Provation system and we have added an assumed preparation time and a post scoping time to each scope. This then allows us to calculate the percentage of the available time that was used in each session for actual session work – replicating the 'wheels in, wheels out' measures that we use to determine the utilisation of our operating theatres. We will then formulate a benchmark which will enable us to compare how much of available session time is being used for scoping activity and therefore give us an initial sense of how well we are using available session time. The benchmark we use for operating theatres is 85% utilisation. If these sessions were to use a comparable benchmark then there appears to be the opportunity to use more of our available session time for more scoping work, but as noted earlier this still needs validating against an appropriate benchmark.

In future enhancements to our reporting we will seek to include further information on cancellations (which lead to sub-optimal session utilisation) and the reasons for these. And we will seek to gain an understanding of why individual scope times may be outliers (e.g. because of teaching component etc.).

Provation Data on Session Analysis (20 Minute Session turn around time)

Location	Dunedin						southland		
Room	Blue Room			Green Room			Endoscopy		
Start of Week	No of Procedures	Total Time	Utilization	No of Procedures	Total Time	Utilization	No of Procedures	Total Time	Utilization
28 June 2020	32	1341	69.84%	13	388	40.42%	31	1162	60.52%
5 July 2020	61	2176	75.56%	23	726	50.42%	31	965	50.26%
12 July 2020	49	1919	79.96%	22	702	73.13%	27	1098	57.19%
19 July 2020	55	2007	83.63%	27	946	65.69%	41	1761	73.38%
26 July 2020	59	2140	89.17%	21	754	52.36%	41	1629	56.56%
2 August 2020	54	2074	86.42%	19	789	82.19%	46	1773	73.88%
9 August 2020	60	2154	74.79%	23	808	56.11%	55	1924	66.81%
16 August 2020	52	1990	82.92%	20	753	78.44%	41	1629	67.88%
23 August 2020	54	2092	87.17%	27	894	62.08%	51	2000	69.44%
30 August 2020	35	1422	98.75%	34	1233	85.63%	41	1559	64.96%
6 September 2020	30	1233	51.38%	48	1843	76.79%	56	2173	75.45%
13 September 2020	51	1955	81.46%	13	457	47.60%	39	1580	65.83%
20 September 2020	60	2451	85.10%	15	522	54.38%	54	1984	68.89%
27 September 2020	51	1840	76.67%	9	338	70.42%	34	1559	81.20%
4 October 2020	60	2214	92.25%	12	394	41.04%	52	1907	66.22%
11 October 2020	42	1789	93.18%	25	983	68.26%	41	1771	73.79%
18 October 2020	58	2395	83.16%	26	872	60.56%	42	1797	62.40%
25 October 2020	44	1590	66.25%	14	502	34.86%	24	1174	81.53%
1 November 2020	47	1965	81.88%	44	1583	82.45%	42	1559	64.96%
8 November 2020	49	1976	68.61%	38	1409	73.39%	55	2113	73.37%
15 November 2020	36	1404	48.75%	23	953	66.18%	53	2194	76.18%
22 November 2020	51	1907	79.46%	44	1405	58.54%	39	1311	54.63%
29 November 2020	38	1671	69.63%	31	1201	83.40%	43	1722	71.75%
6 December 2020	31	1489	77.55%	45	1384	72.08%	9	334	34.79%
Total	**1159**	**45194**	**77.81%**	**616**	**21839**	**65.00%**	**988**	**38678**	**67.15%**

Note that the core data is extracted from our regional 'Provation' system, which captures the timestamp for activities associated with the use of the scope. We have added an average preparation time and post scope time to each scope to make the percentages more realistic.

We have requested the following enhancement to this reporting:

- Enable roll up so that we can report session utilisation weekly, monthly.
- Show utilisation against resourced time (not all available sessions are resourced) and physical session available time.

As we refine this report, its value will be in demonstrating to us how much additional scoping we could do within existing facilities, e.g. if we expanded our resourcing to enable more scoping to be done.

As noted earlier, these reports are a work in progress and we are continuing to refine them, both to ensure that we have robust data integrity and to ensure that they are providing meaningful decision-making information. However, good progress has been made and we wanted to share the progress that has been made in this HAC report.

In terms of colonoscopy digital referral enhancements, we have been working with our IS colleagues, the triaging nurse specialist and some of our SMO colleagues to develop a colonoscopy-specific digital internal referral which has the necessary information on it in order to optimise referral outcomes. We are now close to finalising the digital referral and the roll out (together with appropriate change management) will occur early in the New Year. This should enable the service to receive the referral promptly (rather than as a letter or paper based referral in the internal mail as sometimes happens now).

Receiving it digitally with the correct information on it will enable the referral to be processed quickly.

There is still a lot of work to be done to determine the appropriate intervention rate for colonoscopy and how best to facilitate the receipt of appropriate referrals in support of this (and then how to address any capacity constraints). However, whilst the larger issues are worked through, some good initial progress has been made on relationships, reporting and process, as reported above.

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,518	**5,426** Actual YTD vs 5,504 Plan YTD, as at November 2020

Refer to page 21-22 - Caseweight and discharge volumes graph.

Appendix 1 – New 'Every Day' Initiatives

This section is a new addition to our regular HAC reporting. It is an opportunity to provide information around some of the patient centred initiatives that have been implemented by our respective specialist teams.

Intravitreal Packs

The Dunedin Ophthalmology service has recently implemented 'intravitreal Packs' for eye injections. Previously, our staff would need to open around eight separate items aseptically for each injection. Now, following working with procurement, we order the packs pre-made, with all of the required items pre-packaged.

This has resulted in the following benefits:

- Patient Safety - Pack tracking: Each pack is stickered enabling us to track the pack (with sterile information and expiring date) into the patient notes. This was not an option before.
- Infection control tracking – if a patient develops endophthalmitis (a vision threatening risk of injecting), we can analyse the risk factors faster as now all of the items are pre-packaged.
- Waste reduction – There is a recycling programme for the metal speculum item in the pack.
- Time saving – Opening one item rather than eight is saving our staff time.
- Space saving – These packs are also easier to store.

New Intravitreal Pack

Former supplies need for intravitreal injection

Southern District Health Board
Piki Te Ora

Hospital Advisory Committee KPI Summary - Discharges and CWD Volumes

Planned Care Interventions Inpatient Surgical Discharges - November 2020

Planned Care Interventions Inpatient Surgical Discharges - Southern DHB population

	November 2020				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB population treated in-house	765	861	(96)	(11%)	4,247	4,369	(122)	(3%)	10,080
SDHB population treated by other DHBs	50	50	0	%	239	221	18	8%	523
SDHB population outsourced	110	122	(12)	(10%)	650	612	38	6%	1,224
SURGICAL ELECTIVE DISCHARGES	925	1,034	(109)	(11%)	5,136	5,202	(66)	(1%)	11,827
Surgical Discharges from a Non-Surgical PUC	62	61	1	1%	290	302	(12)	(4%)	691
TOTAL DISCHARGES	987	1,095	(108)	(10%)	5,426	5,504	(78)	(1%)	12,519

Planned Care Interventions Inpatient Surgical CWD Volumes - November 2020

Planned Care Interventions Inpatient Surgical CWD Volumes - Southern DHB population

	November 2020				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB population treated in-house	1,117	1,225	(108)	(9%)	6,078	6,215	(137)	(2%)	14,310
SDHB population treated by other DHBs	99	99	0	%	442	434	9	2%	1,025
SDHB population outsourced	143	156	(12)	(8%)	867	779	87	11%	1,559
SURGICAL ELECTIVE DISCHARGES - CWD	1,359	1,480	(120)	(8%)	7,387	7,428	(41)	(1%)	16,893
Surgical Discharges from a Non-Surgical PUC	170	161	9	6%	777	777	0	%	1,787
TOTAL CWD VOLUMES	1,530	1,641	(111)	(7%)	8,164	8,204	(41)	(%)	18,681

(1) Actual IDF Outflow volumes for November are not available, and have been reported based on the planned numbers

Nov-20				Nov-19	YEAR ON YEAR		YTD 2020/21				YTD Nov-19	YEAR ON YEAR
Actual	Budget*	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,496	1,376	120	9%	1,396	100	Acute	7,478	7,424	54	1%	7,873	(395)
346	287	59	21%	387	(41)	Elective	1,755	1,502	253	17%	1,635	120
1,842	**1,663**	**179**	**11%**	**1,782**	**59**	**Total Medical Caseweights**	**9,233**	**8,926**	**306**	**3%**	**9,507**	**(275)**
						Surgical Caseweights						
1,110	1,241	(131)	-11%	1,260	(150)	Acute	6,026	6,195	(169)	-3%	6,039	(13)
1,405	1,414	(9)	-1%	1,369	35	Elective	7,127	7,155	(27)	0%	7,019	108
2,515	**2,655**	**(140)**	**-5%**	**2,629**	**(114)**	**Total Surgical Caseweights**	**13,153**	**13,350**	**(196)**	**-1%**	**13,058**	**96**
						Maternity Caseweights						
46	85	(39)	-46%	95	(49)	Acute	488	462	27	6%	478	10
354	336	18	5%	339	15	Elective	1,824	1,825	(1)	0%	1,768	56
400	**421**	**(20)**	**-5%**	**434**	**(34)**	**Total Maternity Caseweights**	**2,312**	**2,287**	**26**	**1%**	**2,246**	**66**
						TOTALS						
2,653	**2,702**	**(50)**	-2%	**2,751**	**(98)**	**Acute**	**13,993**	**14,081**	**(89)**	-1%	**14,390**	**(397)**
2,105	**2,037**	**68**	3%	**2,094**	**10**	**Elective**	**10,706**	**10,482**	**225**	2%	**10,421**	**285**
4,758	**4,739**	**19**	**0%**	**4,845**	**(88)**	**Total Caseweights**	**24,699**	**24,563**	**136**	**1%**	**24,811**	**(112)**
						TOTALS excl. Maternity						
2,606	**2,617**	**(11)**	0%	**2,655**	**(49)**	**Acute**	**13,504**	**13,619**	**(115)**	-1%	**13,911**	**(407)**
1,751	**1,701**	**50**	3%	**1,756**	**(6)**	**Elective**	**8,882**	**8,657**	**225**	3%	**8,654**	**228**
4,357	**4,318**	**39**	**1%**	**4,411**	**(55)**	**Total Caseweights excl. Maternity**	**22,386**	**22,276**	**110**	**0%**	**22,565**	**(179)**

SOUTHERN DISTRICT HEALTH BOARD

7.2

Title:	**FINANCIAL REPORT**
Report to:	Hospital Advisory Committee
Date of Meeting:	21 December 2020

SUMMARY:

The issues considered in this paper are:

- November 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:** 15/12/2020	**PRESENTED BY:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:
That the Hospital Advisory Committee note the report.

SOUTHERN DHB FINANCIAL REPORT – Summary for HAC

Financial Report for: **November 2020**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **15 December 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
45,155	45,196	(41)	Revenue	227,065	225,927	1,138	541,965
24,263	23,588	(675)	Less Workforce Costs	121,200	119,274	(1,926)	292,043
12,806	12,004	(802)	Less Other Costs	65,685	60,142	(5,543)	138,761
8,086	**9,604**	**(1,518)**	**Net Surplus / (Deficit)**	**40,180**	**46,511**	**(6,331)**	**111,161**

For November 2020, Specialist Services had a surplus of $8.1m, which is $1.5m unfavourable to budget.

2. *November 2020 Result*

Provider Activity View

The Planned Care targets have now been agreed with the Ministry of Health. The elective caseweights for November 2020 are just 10 more than November 2019 while the year to date elective caseweights are 285 higher than this time last year. The focus on delivery of delayed electives and planned care services arising from the COVID-19 lockdown in April and May 2020 dominated activity in the first quarter of the 2020/21 financial year.

Acute delivery offsets electives being both down on plan and down compared with prior years actuals.

(NB see section 9 for summarised explanation on methodology used to measure activity)

Nov-20				Nov-19	YEAR ON YEAR		YTD 2020/21				YTD Nov-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,496	1,376	120	9%	1,396	100	Acute	7,478	7,424	54	1%	7,873	(395)
346	287	59	21%	387	(41)	Elective	1,755	1,502	253	17%	1,635	120
1,842	**1,663**	**179**	**11%**	**1,830**	**60**	**Total Medical Caseweights**	**9,233**	**8,926**	**307**	**3%**	**5,880**	**(274)**
						Surgical Caseweights						
1,110	1,241	(131)	-11%	1,260	(150)	Acute	6,026	6,195	(169)	-3%	6,039	(13)
1,405	1,414	(9)	-1%	1,369	35	Elective	7,127	7,155	(28)	0%	7,019	108
2,515	**2,655**	**(140)**	**-5%**	**2,596**	**(115)**	**Total Surgical Caseweights**	**13,153**	**13,350**	**(197)**	**-1%**	**7,876**	**95**
						Maternity Caseweights						
46	85	(39)	-46%	95	(49)	Acute	488	462	26	6%	478	10
354	336	18	5%	339	15	Elective	1,824	1,825	(1)	0%	1,768	56
400	**421**	**(21)**	**-5%**	**386**	**(34)**	**Total Maternity Caseweights**	**2,312**	**2,287**	**25**	**1%**	**1,385**	**66**
						TOTALS						
2,652	**2,702**	**(50)**	-2%	**2,751**	**(99)**	**Acute**	**13,992**	**14,081**	**(89)**	-1%	**14,390**	**(398)**
2,105	**2,037**	**68**	3%	**2,094**	**10**	**Elective**	**10,706**	**10,482**	**224**	2%	**10,421**	**285**
4,757	**4,739**	**18**	**0%**	**4,845**	**(89)**	**Total Caseweights**	**24,698**	**24,563**	**135**	**1%**	**24,811**	**(113)**
						TOTALS excl. Maternity						
2,606	**2,617**	**(11)**	0%	**2,655**	**(49)**	**Acute**	**13,504**	**13,619**	**(115)**	-1%	**13,911**	**(407)**
1,751	**1,701**	**50**	3%	**1,756**	**(6)**	**Elective**	**8,882**	**8,657**	**225**	3%	**8,654**	**228**
4,357	**4,318**	**39**	**1%**	**4,411**	**(55)**	**Total Caseweights excl. Maternity**	**22,386**	**22,276**	**110**	**0%**	**22,565**	**(179)**

Recovery Plan

The Recovery Plan covers orthopaedics, general surgery & urology waitlists. We have recognised $650k for the first quarter revenue for this work, however there is risk around the delivery of the plan trajectory in relation to the revenue recognised. The elective target for the recovery plan has not been met YTD, therefore any revenue previously recognised for this has been removed.

Statement of Financial Performance

Monthly Actuals $000s	Monthly Budget $000s	Monthly Variance $000s	Monthly Variance FTE		Year to date Actuals $000s	Year to date Budget $000s	Year to date Variance $000s	Year to date Variance FTE	Annual Budget $000s
				REVENUE					
				Government & Crown Agency Sourced					
761	814	(53)		MoH Revenue	4,212	4,068	144		9,762
0	0	0		IDF Revenue	0	0	0		0
959	749	210		Other Government	4,751	3,692	1,059		8,603
1,720	**1,563**	**157**		**Total Government & Crown**	**8,963**	**7,760**	**1,203**		**18,365**
				Non Government & Crown Agency Revenue					
18	184	(166)		Patient related	569	922	(353)		2,214
151	183	(32)		Other Income	781	915	(134)		2,197
169	**368**	**(199)**		**Total Non Government**	**1,350**	**1,838**	**(488)**		**4,411**
43,266	43,266	0		Internal Revenue	216,752	216,329	423		519,189
45,155	**45,196**	**(41)**		**TOTAL REVENUE**	**227,065**	**225,927**	**1,138**		**541,965**
				EXPENSES					
				Workforce					
				Senior Medical Officers (SMO's)					
6,149	6,207	58	7	Direct	31,269	31,142	(127)	9	76,626
384	355	(29)		Indirect	1,764	1,776	12		4,262
345	149	(196)		Outsourced	1,755	768	(987)		1,777
6,878	**6,711**	**(167)**	**7**	**Total SMO's**	**34,788**	**33,686**	**(1,102)**	**9**	**82,665**
				Registrars / House Officers (RMOs)					
3,778	3,863	85	(5)	Direct	19,157	19,432	275	0	48,299
208	230	22		Indirect	807	1,148	341		2,755
66	28	(38)		Outsourced	199	142	(57)		329
4,051	**4,120**	**69**	**(5)**	**Total RMOs**	**20,162**	**20,722**	**560**	**0**	**51,383**
10,929	**10,832**	**(97)**	**2**	**Total Medical costs (incl outsourcing)**	**54,950**	**54,408**	**(542)**	**9**	**134,048**
				Nursing					
9,306	8,864	(442)	(73)	Direct	46,049	45,320	(729)	(46)	110,709
25	1	(24)		Indirect	27	5	(22)		12
3	3	0		Outsourced	16	15	(1)		37
9,335	**8,868**	**(467)**	**(73)**	**Total Nursing**	**46,091**	**45,340**	**(751)**	**(46)**	**110,758**
				Allied Health					
2,176	2,175	(1)	(9)	Direct	11,060	10,658	(402)	(9)	25,827
27	25	(2)		Indirect	167	126	(41)		456
144	41	(103)		Outsourced	541	211	(330)		504
2,347	**2,241**	**(106)**	**(9)**	**Total Allied Health**	**11,768**	**10,995**	**(773)**	**(9)**	**26,787**
				Support					
173	178	5	3	Direct	856	895	39	2	2,216
0	1	1		Indirect	1	5	4		11
0	0	0		Outsourced	0	0	0		0
173	**178**	**5**	**3**	**Total Support**	**857**	**900**	**43**	**2**	**2,227**
				Management / Admin					
1,477	1,455	(22)	(7)	Direct	7,471	7,561	90	(8)	18,055
1	9	8		Indirect	39	43	4		102
1	5	4		Outsourced	22	28	6		66
1,479	**1,469**	**(10)**	**(7)**	**Total Management / Admin**	**7,533**	**7,631**	**98**	**(8)**	**18,223**
24,263	**23,588**	**(675)**	**(84)**	**Total Workforce Expenses**	**121,200**	**119,274**	**(1,926)**	**(52)**	**292,043**
3,224	3,176	(48)		**Outsourced Clinical Services**	17,734	15,811	(1,923)		36,350
0	0	0		**Outsourced Corporate / Governance Servic**	0	0	0		0
0	0	0		**Outsourced Funder Services**	0	0	0		0
7,674	7,168	(506)		**Clinical Supplies**	39,022	36,027	(2,995)		82,237
957	753	(204)		**Infrastructure & Non-Clinical Supplies**	4,424	3,847	(577)		9,075
				Non Operating Expenses					
951	907	(44)		Depreciation	4,505	4,457	(48)		11,099
0	0	0		Capital charge	0	0	0		0
0	0	0		Interest	0	0	0		0
12,806	**12,004**	**(802)**		**Total Non Personnel Expenses**	**65,685**	**60,142**	**(5,543)**		**138,761**
37,069	**35,592**	**(1,477)**		**TOTAL EXPENSES**	**186,885**	**179,416**	**(7,469)**		**430,804**
8,086	**9,604**	**(1,518)**		**Net Surplus / (Deficit)**	**40,180**	**46,511**	**(6,331)**		**111,161**

3. Revenue

Ministry of Health (MoH) Revenue

MoH revenue was $0.05m unfavourable to budget for the month and $0.14m favourable year to date. The main contributors are detailed below:

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Personal Health-side contracts	(99)	54	Nov includes ytd correction to Cancer Psychologists and Support Services revenue contract which was budgeted separately and is part of PBFF in 2021. YTD favourable includes additional revenue of $0.21m from MoH for Covid catch-up extra CT and MRI scans
Public Health-side contracts	34	163	Revenue received for Cervical Screening during the COVID period agreed by MoH at 2018/19 volumes which had been invoiced at delivery volumes during COVID-19
Clinical Training	11	(71)	Contracts have been reconciled to match eligible personnel to the delivery.
Other		(2)	
Total	**(53)**	**144**	

Other Government Revenue

Other Government revenue was $0.21m favourable in November and $1.1m favourable year to date. The major drivers for this are shown below.

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Haemophiliac rebate	70	814	Rebate reflecting increased cost and volume year to date.
ACC	173	177	Additional Orthopaedics ACC revenue offsetting lower than budgeted High tech imaging revenue for MRI (Otago & Southland)
Radiology	17	75	Revenue from School of Dentistry for MITs not budgeted offset by cost.
Other	(50)	(7)	
Total	**210**	**1,059**	

Patient related revenue

Patient related revenue was under budget for the month by $0.17m and $0.35m year to date. This is driven by ineligible patient revenue reflecting the drop in acute activity from the overseas tourist sector.

Other Income

Other income is $0.03m under budget in November and $0.13m year to date. This is mainly due to shortfalls in cost recoveries (offset by reduced costs) such as;

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

Internal Revenue
Internal revenue is on budget for the month and $0.42m favourable year to date as revenue booked for the recovery plan.

4. Workforce Costs

Monthly result
Workforce costs (personnel plus outsourcing) were $0.67m unfavourable to budget in November 2020 driven by Direct Nursing costs and indirect SMO and Allied Health costs. Operationally full time equivalent (FTE) were 84 unfavourable to budget in November 2020.

FTE
Monthly FTE is 84 over budget in November 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	250	257	7	3%	239	248	9
RMO	323	318	(5)	(2%)	313	313	0
Nursing	1,235	1,162	(73)	(6%)	1,189	1,144	(46)
Allied	296	287	(9)	(3%)	293	284	(9)
Support	36	38	3	7%	36	38	2
Mgmt / Admin	287	280	(7)	(2%)	283	275	(8)
	2,427	**2,343**	**(84)**	**(4%)**	**2,355**	**2,303**	**(52)**

Senior Medical Officer (SMOs)

SMOs were $0.17m unfavourable and 7 FTE favourable for the month. Year to date SMOs are $1.10m unfavourable, 9 FTE favourable.

The outsourced costs contribute to the unfavourable variance by $0.19m for November in a number of areas, including General Medicine, Paediatric, General Surgery, ENT & Obstetrics and Gynaecology.

Overtime and allowances were $0.34m unfavourable to budget offset by lower levels of leave (training, sick, stat). This is due to;

- Additional $0.17m of allowances primarily for call hours and radiology payments for additional reads.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Obs and Gynae Medical Staff	74	36	(38)	245	169	(76)	447
General Surgery Medical staff	76	49	(27)	362	236	(126)	622
Orthopaedics Medical Staff	56	31	(25)	241	148	(93)	392
Radiology Medical Staff	82	63	(19)	336	295	(41)	780
Anaesthesia Medical Staff	79	61	(18)	358	302	(56)	803
Improvement Action Plan	15		(15)	32		(32)	
Anaesthesia Medical Staff	140	129	(11)	679	606	(73)	1,607
Plastic Surgery	25	14	(11)	158	65	(93)	171
General Medicine Medical staff	54	43	(11)	266	200	(66)	530

- Overtime was $0.17m unfavourable ($0.57m year to date) driven by
  - Extra hour's payments and call backs.
  - Vacancies
  - Radiologists extra reads completed outside clinical hours
  - SMOs covering RMO roster gaps.

RMOs

RMOs were $0.07m favourable and 5 FTE unfavourable for the month. Year to date RMOs are $0.56m favourable with FTE on budget.

- The FTE unfavourable variance is driven by Training which is 5 FTE over budget for November. Year to date remains 0.23 FTE favourable.

  Annual leave taken continues to be significantly lower than budget with only 64% of budgeted leave taken in November and 55% taken year to date.

- Indirect favourable expenditure largely relates to courses and conferences and is now $0.34m favourable year to date, this reduction primarily reflecting overseas courses being avoided due to COVID. The courses and exams are now done online thereby reducing cost.

Nursing

Nursing was $0.47m unfavourable and 73 FTE unfavourable for the month. Year to date Nursing was $0.75m unfavourable and 46 FTE unfavourable.

During November 2020 there was additional costs due to increased evening and additional shift activity for perioperative in Southland.

Nursing Sick and Accident leave has remained much higher than budgeted, along with significant overtime (patient watches). These all contribute to higher FTE and costs.

FTE
The majority of 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 4,128 hours (25.8 FTE) which were only partially offset by the HCA budget increase of 10.75 FTE in 2020/21.
- Sick leave unfavourable by 15FTE, which is not unexpected as vigilance to the possible spread of any illness means those unwell stay home, this has increased in November from the previous months.
- Stat leave over budget due to limitations in CBS ability to calculate stat entitlements on rotating rosters. For example, perioperative was 1 FTE over budget in the base number of staff who received an entitlement to a paid stat day. Stat leave in total was 15 FTE over budget.
- General busyness across ED and Wards that require rostering additional staff

Offset by:
- ICU 11.2 FTE favourable due to the ward not being fully recruited however full recruitment is expected by year end and this favourable variance is expected to be eroded.
- Newly approved positions that are currently vacant including Care Capacity Demand Management (8 FTE).
- Other vacant positions including PACU (2 FTE), Palliative care (2 FTE) and Southland Maternity (1 FTE)

Allied Health

Allied Health was $0.11m and 9 FTE unfavourable to budget in November. Year to date Allied Health was $0.77m unfavourable and 9 FTE favourable.

MRTs and Sonographers are a further $0.05m unfavourable this month ($0.21m year to date) due to being 7 FTE over budget. Partially offsetting this were Technicians that were $0.04m favourable (3 FTE).

Outsourced Technicians are $0.10m unfavourable ($0.33m year to date) mainly across Anaesthesia, Perioperative, and Ophthalmology & Audiology continuing to cover vacant roles.

Support

Support was on budgeted dollars for the month and 3 FTE favourable. Year to date Support was $0.04m favourable and 2 FTE favourable.

Annual leave taken is favourable both for the month and year to date.

Management and Administration

Management/Admin dollars were $0.01m and 7 FTE unfavourable for the month. Year to date Management/Admin costs are $0.1m favourable and 8 FTE unfavourable.

Annual leave taken is 5 FTE less than budget in the month resulting in increased ordinary hours worked (year to date follows a similar pattern)

The annual leave revaluation budget phasing in July 2020 delivered a favourable variance of $0.14m. This one-off favourable impact drives the year to date favourable variance combined with lower levels of sick leave and training leave compared to budget.

5. Outsourced Clinical Services Costs

Outsourced services were $0.05m unfavourable in November and $1.92m 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 $
Breast Screening	616	105	(511)	616	510	(106)	1,196
Outsourced Clinical Services - Other	501	390	(111)	2,161	1,921	(240)	4,550
MRI Scans	63	35	(28)	631	172	(459)	404
Radiology Service	188	167	(21)	1,009	816	(193)	1,912
Vascular Assessments	84	80	(4)	456	389	(67)	913
Lithotripsy	8	7	(1)	28	33	5	77
Audiology	3	2	(1)	25	10	(15)	24
Outsourced Surgical Services	746	761	15	4,867	3,833	(1,034)	7,813
Ophthalmology	22	47	25	33	228	195	535
CT Scans	(15)	63	78	301	306	5	716
Other Radiology Procedures	(468)	42	510	221	203	(18)	475
Laboratory Service	1,477	1,477		7,385	7,387	2	17,728
Laboratory Sendaway Tests					2	2	5
	3,225	**3,176**	**(49)**	**17,733**	**15,810**	**(1,923)**	**36,348**

1) The Breast Screening variance is due to a realignment of costs within account codes to provide better transparency of costs incurred. The offset of these costs are in Other Radiology Procedures.

2) Other Outsourced clinical services are for additional urology and general surgery diagnostic procedures not available in Dunedin and additional orthopaedic services in Southland.

3) Outsourced Surgical Services are on budget this month as expected although $1.03m unfavourable YTD, largely driven by the Recovery Plan activity in prior months.

6. *Clinical Supplies (excluding depreciation)*

Clinical supplies were unfavourable to budget by $0.51m in November 2020, monthly variances are summarised below:

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Pharmaceuticals	1,872	1,701	(171)	9,097	8,908	(189)	19,725
Blood and Tissue Supplies	738	629	(109)	4,285	3,236	(1,049)	7,490
Patient Consumables	297	227	(70)	1,569	1,271	(298)	2,207
Shunts and Stents	248	189	(59)	925	922	(3)	2,162
Disposable Instruments	273	216	(57)	1,343	1,055	(288)	2,507
Pacemakers	161	109	(52)	785	529	(256)	1,213
Dressings	162	114	(48)	692	554	(138)	1,278
Clinical Equipment - Operating Leases (non-financing	38	3	(35)	141	14	(127)	127
Catheters	215	192	(23)	1,013	936	(77)	2,142
Implants and Prostheses - Other	121	99	(22)	498	481	(17)	1,124
Clinical Equipment - Minor Purchases	81	104	23	568	507	(61)	1,209
Screws, nails and plates	215	240	25	1,115	1,167	52	2,747
Air Ambulance	406	435	29	2,084	2,120	36	4,971
Hip Prostheses	236	285	49	1,284	1,296	12	3,053
Knee Prostheses	123	188	65	586	852	266	2,006
Other	2,488	2,436	(52)	13,040	12,179	(861)	28,275
	7,674	**7,167**	**(507)**	**39,025**	**36,027**	**(2,998)**	**82,236**

1) Pharmaceutical costs were $0.17m over budget for the month and $0.19m unfavourable year to date.

   With the exception of the Oncology ward, as shown below the major drivers of this monthly variance have been consistently running similar variances all year. Budgets were based on the Pharmac Forecast on hand at the time however actual activity has varied from that forecast.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Oncology Ward	368	324	(44)	1,595	1,744	149	3,651
Gastroenterology 8th floor	124	98	(26)	755	599	(156)	1,289
Emergency Department	39	20	(19)	144	104	(40)	249
Surgical Ward	48	29	(19)	194	146	(48)	348
General Medicine 8A	34	18	(16)	131	97	(34)	226
Medical Specialties Outpatients	25	10	(15)	64	50	(14)	119
Rheumatology / Outpatients	101	88	(13)	643	472	(171)	1,094
Radiology	18	6	(12)	77	33	(44)	79
General Surgery 4C	23	13	(10)	116	67	(49)	159
Oncology / Haematology 8C	41	63	22	219	321	102	767
	821	**669**	**(152)**	**3,938**	**3,633**	**(305)**	**7,981**

2) Blood and Tissue Supplies
   The majority of this variance is due to an $0.07m unfavourable variance reflecting the increased usage of Haemophiliac products. This is predominantly offset by the Haemophiliac rebate (Other Government revenue).

3) Pacemakers

   Implantable Cardioverter Deflator (ICD) costs are $0.05m unfavourable for the month and $0.26mk unfavourable year to date. A review identified COVID-19 delays had contributed to the uplifted demand, although clinicians' expectation for volumes to align with budget did not eventuate in November with two additional procedures performed on 30 November 2020. Further work is required to bring activity to planned levels.

4) Patient consumables over budget driven by unmet clinical theatre supplies savings loaded from October onwards ($59k per month increasing to $114k from January and $175k from March 2021)

5) Shunts and stents associated with higher volume of major reconstructive vascular surgical procedures. These are on budget year to date.

6) Disposable Instruments $0.06m over budget for the month and $0.29m over budget year to date. We are reviewing this expenditure in detail, to report early in the new year to identify if this increase is due to;

   - New products previously not used
   - Increased volumes of products used
   - Increased price above budget
   - Products that have previously been / or still should be capitalised.

   The reason or mix of reasons will determine action to be taken.

7) Dressings – over budget due to bariatric patients in 3 Surg and Surgical Ward Southland, dressings associated with these patients are expensive. There is also greater usage of negative pressure dressings which result in better patient outcomes.

8) Clinical equipment – operating leases are $0.04m over budget in November due to a combination of:

   - $0.02m of costs incurred for hiring bariatric beds.
   - $0.02m of unmet procurement savings.

9) Air Ambulance was $0.03m favourable in November 2020. Contributing to this was a PICU rebate that was $0.05m under accrued and prior month invoices that were $0.06m over accrued. In November 2020 there were two neuro missions at a cost of $0.05m.

7. Infrastructure and Non-Clinical (excluding depreciation)

These costs were $0.20m unfavourable to budget in November 2020 and $0.58m 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	467	416	(51)	2,374	2,123	(251)	5,057
Facilities	30	21	(9)	117	106	(11)	250
Transport	106	88	(18)	443	443		1,038
IT Systems & Telecommunications	127	86	(41)	534	428	(106)	1,034
Professional Fees and Expenses	38	24	(14)	142	121	(21)	292
Other Operating Expenses	189	118	(71)	815	626	(189)	1,405
	957	**753**	**(204)**	**4,425**	**3,847**	**(578)**	**9,076**

These costs are driven by the following;

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Bureau and Outsourcing Fees	28		(28)	80		(80)	
Patient Meals (Outsourced)	358	334	(24)	1,774	1,702	(72)	4,061
Cost of Goods Sold	20		(20)	56		(56)	
Printing & Forms	32	12	(20)	80	64	(16)	131
Uniforms	28	14	(14)	108	70	(38)	168
Maintenance - Outsourced	23	9	(14)	71	45	(26)	107
Accreditation Audit	19	6	(13)	48	31	(17)	74
Stock Adjustments	13		(13)	37		(37)	
Postage, Courier & Freight	53	40	(13)	250	204	(46)	471
Staff Travel - Domestic	78	66	(12)	329	336	7	801
Stationery & Supplies	44	32	(12)	224	185	(39)	400
Taxis	15	4	(11)	31	22	(9)	53
Hardware - Minor Purchases	14	4	(10)	20	22	2	54
Corporate Training		14	14		68	68	163
Others	229	218	(11)	1,317	1,098	(219)	2,592
	954	**753**	**(201)**	**4,425**	**3,847**	**(578)**	**9,075**

1) Bureau fees are driven by unbudgeted costs relating to the new IMedX transcription service that has been implemented in Southland. The analysis of the business case is currently being reviewed to show the cost / benefit.

2) Patient meals have been consistently over budget, due mainly to unmet savings that were budgeted in this code. ($14k per month).

3) Cost of Goods sold relates to Pharmaceuticals and should be added to this variance. The coding of pharmacy transactions has changed with the implementation of ePharmacy hence there is no budget.

4) The other variances are spread over a number of cost centres and while some are within budget year to date, half reflect consistent monthly overspends that need to be managed over the remaining year.

8. Non-operating Expenses

These costs relate to depreciation charges for clinical equipment and were over budget this month due to the unbudgeted depreciation incurred on the $1.8m of Respiratory equipment donated by the MoH for COVID resurgence.

9. Explanation regarding methodology for measuring activity

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.

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.