# Hospital Advisory Committee

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

01/03/2021 01:30 PM - 04:00 PM

**APOLOGIES**

As at the time of publication, no apologies had been received.

**FOR INFORMATION/NOTING**

**Item:** **Interests Registers**

**Proposed by:** Jeanette Kloosterman, Board Secretary

**Meeting of:** Hospital Advisory Committee, 1 March 2021

## Recommendation

**That the Hospital Advisory Committee receive and note the Interests Registers.**

## Purpose

To disclose and manage interests as per statutory requirements and good practice.

## Changes to Interests Registers over the last month:

- Roger Jarrold – Fletcher Construction and Health Research Council interests updated
- Patrick Ng – entry for daughter updated

## Background

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).

## Appendice

- Board, Hospital Advisory Committee Appointees and Executive Leadership Team Interests Registers

**SOUTHERN DISTRICT HEALTH BOARD**
**INTERESTS REGISTER**

| Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB | Management Approach |
|---|---|---|---|---|
| **Pete Hodgson** (Board Chair) | 22.12.2020 | Trustee, Koputai Lodge Trust (unpaid) | Mental Health Provider | |
| | 22.12.2020 | Chair, Callaghan Innovation Board (paid) | | |
| | 22.12.2020 | Chair, Local Advisory Group, New Dunedin Hospital | | |
| | 22.12.2020 | Member, Steering Group, New Dunedin Hospital | | |
| | 22.12.2020 | Board Member, Otago Innovation Ltd | | |
| **David Perez** (Deputy 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 | |
| | 09.12.2019 | Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB | | |
| | 09.12.2019 | Daughter is employed as MRT, Dunedin Hospital | | |
| **Kaye Crowther** | 09.12.2019 | Life Member, Plunket Trust | Nil | |
| | 09.12.2019 | Trustee, No 10 Youth One Stop Shop | Possible conflict with funding requests. | |
| | 09.12.2019 | Employee, Findex NZ | | |
| | 14.01.2020 | Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust | | |
| | 14.01.2020 | Member, National Council of Women, Southland Branch | | |

**SOUTHERN DISTRICT HEALTH BOARD**
**INTERESTS REGISTER**

| Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB | Management Approach |
|---|---|---|---|---|
| | 07.10.2020 | Trustee, Southern Health Welfare Trust | Trust for Southland employees - owns holiday homes and makes educational grants. | |
| **Lyndell Kelly** | 09.12.2019 | Employed as Specialist, Radiation Oncology, Southern DHB | Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB. | |
| | 18.01.2020 | Honorary Senior Lecturer, Otago University School of Medicine | | |
| | 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 | | |
| | 12.01.2021 | Nga Kete Matauranga Pounamu Trust Board Member | | |
| **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 Otākou 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 | |
| | | | | |

**SOUTHERN DISTRICT HEALTH BOARD**
**INTERESTS REGISTER**

| Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB | Management Approach |
|---|---|---|---|---|
| **Moana Theodore** | 15.01.2019 | Employee, University of Otago | | |
| | 15.01.2019 | Co-director, National Centre for Lifecourse Research, University of Otago | | |
| | 15.01.2019 | Member, Royal Society Te Apārangi Council | | |
| | 15.01.2019 | ~~Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)~~ | Removed 07/09/2020 | |
| | 15.01.2019 | Shareholder, RST Ventures Limited | | |
| | 27.04.2020 | Nephew, Casual Mental Health Assistant, Southern DHB (Wakari) | | |
| | 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 (Updated 28.01.2021) | ~~CFO,~~ Advisor to Fletcher Construction Company Limited | Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade. | |
| | 16.01.2020 (Updated 28.01.2021) | ~~Member~~, Chair, Audit and Risk Committee, Health Research Council | | |
| | 16.01.2020 | Trustee, Auckland District Health Board A+ Charitable Trust | | |
| | 16.01.2020 | Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board | | |
| | 23.01.2020 | Nephew - Partner, Deloitte, Christchurch | | |
| | 16.08.2020 | Son - Auditor, PwC, Auckland | PwC periodically undertake work for SDHB, eg valuations | |
| | | | | |

**SOUTHERN DISTRICT HEALTH BOARD**
**INTERESTS REGISTER**
**EXECUTIVE LEADERSHIP TEAM**

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

| Employee Name | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern District Health Board |
|---|---|---|---|
| **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 | Director Otākou Healther Services Ltd | |
| | 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 |

**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 |
|---|---|---|---|
| | 10.02.2017 | Director & Shareholder, Carlisle Hobson Properties Ltd | Nil |
| | 26.10.2017 | Nephew, Tax Advisor, Treasury | |
| | 18.12.2017 | Ex-officio Member, Southern Partnership Group | |
| | 30.01.2018 | CostPro (costing tool) | Developer is a personal friend. |
| | 30.01.2018 | Francis Group | Sister is a consultant with the Francis Group. |
| | 20.02.2020 | Member, Otago Aero Club | Shares space with rescue helicopter. |
| | 23.09.2020 | Arvida Group (aged residential care provider) | Sister works for Arvida Group (North Island only) |
| **Lisa GESTRO** | 06.06.2018 | Lead GM National Travel and Accommodation Programme | This group works on behalf of all DHBs nationally and may not align with SDHB on occasions. |
| | 04.04.2019 | NASO Governance Group Member | This group works on behalf of all DHBs nationally and may not align with SDHB on occasions. |
| | 04.04.2019 | Lead GM Perinatal Pathology | This group works on behalf of all DHBs nationally and may not align with SDHB on occasions. |
| **Nigel MILLAR** | 04.07.2016 | Member of South Island IS Alliance group | This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions. |
| | 04.07.2016 | Fellow of the Royal Australasian College of Physicians | Obligations to the College may conflict on occasion where the college for example reviews training in services. |
| | 04.07.2016 | 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 |

**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 |
|---|---|---|---|
| **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~~ |
| | ~~18.12.2017~~ | ~~Daughter, medical student at Auckland University.~~ | |
| | 27.01.2021 | Daughter, is a junior doctor in Auckland and is involved in orthopedic and general surgery research and occasionally publishes papers | |
| | 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 | |
| | 28.01.2021 | Member, National FPIM Governance Board | |
| | 28.01.2021 | South Island representative on Banking and Insurance Special Project 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. |
| | 21.12.2020 | Te Whare Tukutuku | Te Whare Tukutuku is sponsored by the NZ Drug Foundation and Te Rau Ora. Programme is designed to increase education and awareness on Maori illicit drug use to primary care and in Maori communities funded by MoH Workforce NZ. |

**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 |
|---|---|---|---|
| **Gail THOMSON** | 19.10.2018 | Member Chartered Management Institute UK | Nil |
| | 22.11.2019 | Deputy Chair Otago Civil Defence Emergency Management Group, Coordinating Executive Group | |
| **Jane WILSON** | 16.08.2017 | Member of New Zealand Nurses Organisation (NZNO) | No perceived conflict. Member for the purposes of indemnity cover. |
| | 16.08.2017 | Member of College of Nurses Aotearoa (NZ) Inc. | Professional membership. |
| | 16.08.2017 | Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site. | Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues. |
| | 16.08.2017 | Member National Lead Directors of Nursing and Nurse Executives of New Zealand. | Nil |
| **Greer HARPER** | 24.08.2020 | Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs. | |

**SOUTHERN DISTRICT HEALTH BOARD**
**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~~ | Removed 22.12.2020 |
| | | ~~Moana Moko - Maori Art Gallery/Ta Moko Studio - looking at Whanau Ora funding and other funding in health setting~~ | ~~Nil~~ | Removed 22.12.2020 |
| | 22.12.2020 | Board Member - Healthier Lives National Science Challenge | Nil | |
| | 22.12.2020 | Member - Aukaha Design panel for the new Dunedin Hospital | Nil | |

# Southern District Health Board

## Minutes of the Hospital Advisory Committee Meeting held on Monday, 21 December 2020, commencing at 10.00 am in the Board Room, Level 2, Main Block, Wakari Hospital Campus

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

Apologies were received from Committee members, Dr John Chambers and Dr Moana Theodore and Crown Monitor, Mr Andrew Connolly.

### 3.0 PRESENTATION – FUTURE DIRECTION OF RADIOLOGY SERVICES

Mr Stephen Jenkins, Service Manager; Dr Ben Wilson, Consultant Radiologist and Ms Janine Cochrane, General Manager Surgical Services and Radiology, joined the meeting to present on the Southern DHB Radiology Service. A copy of the presentation was included in the agenda. The following key points were raised in discussion:

- The Committee requested comparative figures for other DHBs for the number of MRI exams per 10,000 population and comparative figures for Computed Tomography (CT) and Ultrasound (US).
- The Ministry of Health (MoH) published scorecard information in relation to MRI capacity indicates that Southern is doing 2,993 MRI scans per machine, over a year and the peer average is 2,549.
- To achieve better equity, the boundaries may potentially be changed to redirect the Clutha population to Southland for MRI scans.
- Ultrasound (US) is not a MoH target.
- There is a shortage of Sonographers across the district which is impacting the wait list.
- The Chair suggested the possibility of any new equipment primarily for elective work being off-site, e.g. in a Community Hub.

- Dr Ben Wilson advocated for the further development of Health Pathways, especially for Ultrasound.
- An update was provided on space at Southland Hospital for replacement of the CT.
- The challenges with recruitment were outlined, with all DHBs recruiting from a small pool of specialist staff.
- The triaging process was outlined. There are very few rejections with clinical appropriateness and timing being key.
- Concern was raised over the challenges with access to diagnostic services.
- The Chair summarised the discussion, noting the under-capacity issues identified by the team and he queried where future developments should be, i.e. Southland, Dunedin or community hubs.
- A request was made for management to provide a pro-forma radiology plan for the March 2021 HAC meeting, addressing the diagnostics and imaging issues, mitigation for the short term and planning with a timeline for the medium and long term, with a particular focus on Dunedin. It was acknowledged that the plan needs to be balanced against priorities in other areas.
- It was acknowledged that building work will be required when installing the new CT scanner for Southland.

***Mr Stephen Jenkins, Dr Ben Wilson and Ms Janine Cochrane left the meeting.***

***Ms Ilka Beekhuis left the meeting.***

## 4.0 VALUING PATIENT TIME UPDATE

Dr Hywel Lloyd, Medical Director, joined the meeting and presented with Mrs Jane Wilson on Valuing Patient Time. A copy of the presentation and one-page update was included in the agenda. The following key points were raised in discussion:

- An apology was noted from Dr Nigel Millar who was to present on escalation with Ms Megan Boivin. A formal presentation will be made to the meeting in March 2021.
- An update on the concepts of SAFER bundles, presented to the Committee in July 2020 and rapid rounds, presented in October 2020.
- All areas are to be assessed by the end of February 2021 to understand where they are with rolling out the SAFER bundle and all components. An action and support plan will be identified for each of the areas.
- There will be variability in how the plan is implemented in each area.
- Clinical criteria for discharge is a key area of focus. Dr Lloyd advised on how this can be measured and captured.
- The Hospital Escalation Plan will be implemented in the New Year and presented to the Committee in March 2021. It will then be rolled out at Southland Hospital.
- An update was provided on the components of the Escalation Plan in the wider hospital setting – having the visual tools more accessible and visible at a Ward level.

***Miss Lesley Soper left the meeting.***

- "In Hospital referrals" is not a component of the SAFER bundle, but is an important aspect for patient flow, especially the responsiveness of the sub-Specialty teams. This will be enhanced over time through use of hospital pathways.
- Inclusion of the IT team members in clinical discussions and planning to enhance their understanding of the IT issues being experienced and constraints in the system.
- Reviews to be undertaken three to four times per annum to understand the reasons why there is a delay in patients being discharged.

- Getting momentum and engagement so staff see the value of the plan and understand it is a key piece of work to improve flow through the system.
- The proposed next steps for the New Year were outlined.
- The challenges with the implementation of Care Capacity Demand Management (CCDM) and Valuing Patient Time were outlined.
- A request was made for a greater degree of urgency with implementation and for the outcomes to be included in the Valuing Patient Time Plan.
- The Chair requested a tabulation of progress by service for the HAC meeting in March 2021. Members noted the SAFER Bundle specific metrics on page 57 of the agenda.

***Dr Hywel Lloyd left the meeting.***

**5.0 DECLARATION OF INTERESTS**

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

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

**6.0 PREVIOUS MINUTES**

***It was resolved:***

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

D Perez /L Kelly

**7.0 MATTERS ARISING/REVIEW OF ACTION SHEET**

The Committee reviewed the action sheet (tab 5).

- Telehealth – the Chair commended management on the production of the TeleHealth newsletter. The CEO advised the need for 7-day Hospital to be re-labelled as 7-day services.
- Clinical Risk Dashboard – the Chief Medical Officer (CMO) and Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) are to provide an update for the HAC meeting in March 2021.

**8.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS**

**Executive Director of Specialist Services Report**

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

*Equity*

An update was provided on the setting up of an equity programme of work for Specialist Services. The initial focus will be on achieving equitable access and outcomes in the areas of respiratory and cardiology services. A programme of work to improve access to delivery will be developed in consultation with Primary and Community and with a focus on the different ethnic groups. The EDSS advised that he would take into account the data quality issues with the census figures. An update was provided by the Chief Māori Health Strategy and Improvement Officer

who reported on feedback from the Community Health Council and the need to engage appropriately with the Pasifika community.

*Surgical Performance*

The challenges for the month with bed block were outlined. Whilst on plan year-to-date, there has been a deterioration with delivery in November 2020, impacting the results going in to December 2020. A collective decision, based on verbal advice from the Clinical Council, has been made to defer elective surgery in the lead up to Christmas to alleviate pressure on the system and stress on staff. Members noted concern due to the risk and impact on patient waiting time and requested that the Clinical Council provide a written response to the Committee outlining the rationale for their recommendation based on the data received by them. The EDSS confirmed that 37 patients had been cancelled, worth 87 case weights. A deferral plan is being prepared for the first weeks in January 2021. Members also noted concern over the high number of ED presentations at Southland Hospital. The CEO advised that the unusual trend Southern is experiencing with the undue pressure on the Hospitals not showing in the figures is being experienced in DHBs across the country and may be a flow-on effect of COVID. The team are investigating and a report will be provided. The Chair advised that if the Escalation Plan Programme was fully implemented and in place, it would assist with rationalisation of the situation.

*Outpatient Performance ESPI 2*

An update was provided on progress made with reducing the number of ESPI 2 breaches post COVID. With limited access to recovery funding, efforts have been made to focus on the key risk areas outlined in the report. The Ministry of Health (MoH) Prioritisation Tool is being used to balance supply and demand.

*Inpatient Performance ESPI 5*

The total number of breaches has reduced. The ability to reduce waitlists by undertaking more surgery is tied in to Theatre capacity and what can be outsourced. The focus has been on patients waiting over 21 months. There is a detailed report that gives the details behind every case waiting over eight months. It is proposed to give Clinical Council members access to the report. Corrections are being made where data quality issues are detected.

***Mrs Jane Wilson left the meeting.***

The EDSS responded to a query relating to Sterile Services and whether there are any solutions that can be put in place to assist with the challenges for this service in Dunedin in the short term. A request was made to clarify the number of trays being rejected within the Sterile Services department at Dunedin Hospital.

Medical Imaging Diagnostics

With the shift to a new Radiology Information System (EASYRIS), reporting is still being worked on and should be available for the next HAC meeting in March 2021.

*Emergency Departments (ED)*

The new ambulatory area "fit to sit" was commissioned in mid-November 2020 and offers six to eight chairs, freeing up some space in the ED in Dunedin. An update was provided on progress with the Medical Assessment Unit (MAU) in Dunedin and challenges around the number of people accessing the ED at Southland Hospital. The concerns around access have been discussed with the WellSouth PHN. In depth discussion was held on the challenges with ED access in Southland. A suggestion

was made that the ED paperwork be modified to collect information on why people are presenting to ED.

*Oncology*

An update was provided on Oncology and the 31-day target. The EDSS provided an update on the current status for radiation treatment.

***Mr Roger Jarrold left the meeting.***

An update was provided on challenges with the 62-day target. Concerns related to the current reporting system are being investigated further.

*Gastroenterology*

The EDSS spoke to the progress made with improvements to management of colonoscopies as outlined in the report.

The Committee commended the EDSS on the work done and the format of his report.

**Financial Report**

The EDSS presented the Specialist Services financial results for the month of November and outlined the contributing factors to the unfavourable variance.

In discussion the EDSS advised that Neurosurgery costs are included in the Inter District Flows (IDF) for Canterbury DHB.

The CEO responded to a query, advising on the impact of Nurses working a double shift.

***It was resolved**:*

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

## 9.0 GENERAL BUSINESS

**Overlap of Strategy Issues between Advisory Committees**

The Chair advised that it is proposed to hold regular meetings of the Chairs and Deputy Chairs of Southern DHB's Advisory Committees in the New Year to discuss agenda setting, with a view to avoiding overlap of agenda content between the various Committees and identify areas of interest across committees.

**Resignation of David Perez, Acting Board Chair and HAC Chair**

The Chair advised that this was potentially his final HAC meeting. Discussions are being held regarding a replacement Chair for HAC, however, nothing has been finalised at the current time.

**Software for ICU/CCU**

The EDSS referred to correspondence received from Dr Craig Carr noting areas of concern and requesting the implementation of a software solution that better connects the ICU in Dunedin and the CCU in Southland. He advised that:

- With pending resignations within the district, it has been agreed that the software should be included on the CAPEX list for appropriate prioritisation as part of the budget process. With pending retirements in Southland, it is

foreseeable that there will potentially be a workforce challenge and the software will help mitigate that.

- Dr Carr has previously raised concerns relating to resourcing of the High Dependency Unit (HDU) in Dunedin, as it does not have the same consistency of clinical input, in the same way as the ICU does and there have been challenges with nursing staff flexing to cover HDU as well. Agreement has been reached for a slight increase in SMO (approximately 0.2 FTE) to make the system work better.
- A comprehensive update for the air handling solution for the ICU in Dunedin will be provided for the HAC meeting in March 2021.

Dr Lyndell Kelly proposed a formal vote of thanks to Mr David Perez for his efforts as Chair of the HAC and wished him well in retirement.

## 10.0 CONFIDENTIAL SESSION

**At 1.19pm it was resolved that the Hospital Advisory Committee move into committee to consider the previous public excluded meeting minutes.**

***It was resolved**:*

**"That the minutes of the public excluded session of the Hospital Advisory Committee meeting held on 2 November 2020 be approved and adopted as a true and correct record."**

L Kelly / J O'Callaghan

A closing karakia was provided by the Chief Māori Health Strategy and Improvement Officer and the meeting closed at 1.22pm.

Chair: _____

Date: _____

## 1.40 pm Urology Presentation

**Presenters:**

Alastair Hepburn, Urology Consultant
James Goodwin, Service Manager, Surgical Services and Radiology

5

## 2.00 pm Dunedin Hospital Escalation Pathway

**Presenters:**

Megan Boivin, General Manager – Operations
Dr Nigel Millar, Chief Medical Officer

**HOSPITAL ADVISORY COMMITTEE**

**ACTION SHEET**

**As at 15 February 2021**



| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| Nov 2020 | **EDSS Report: ESPI 5** (Minutes item 6) | Management to supply the analysis that was completed on long waiting patients (across the surgical inpatient wait list – ESPI 5) to the Clinical Council for their review.<br><br>Management to report back on the transfer of care approach outlining how patients will be cared for when they are removed from the inpatient wait list under the transfer of care approach. | EDSS<br><br>EDSS | Confirmed this has been emailed to the Clinical Council.<br><br>As noted in the Executive Director of Specialist Services report. | ~~December 2020~~<br>1 March 2021<br>Complete<br><br>Complete |
| Nov 2020 | **EDSS Report - Faster Cancer Treatment** (Minutes item 6) | An update will be provided on the improvements made to the wording of Radiation Oncology letters as part of the presentation on the letters improvement work from the EDQCGS service.<br><br>The HAC report is to include a section on the current wait lists for Radiation Oncology, | EDQ&CGS<br><br>EDSS | <br><br>As noted in the Executive Director of Specialist Services report. | ~~1 March 2021~~<br>03 May 2021<br><br>March 2021<br>Complete |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| | | Haematology and Medical Oncology, including the trend over time. | | | |
| Nov 2020 | **Clinical Risk Dashboard** (Minutes item 8) | EDQCGS to confirm that all available national benchmarks have been or will be added into the quality report.<br><br>An update to be provided by the Taskforce (lead by the CMO and Chief Nurse) on progress to date. | EDQ&CGS<br><br>CMO/ CN&MO | For inclusion in the FARC agenda.<br><br>A verbal update will be provided at the meeting. | 1 March 2021 Complete<br><br>Complete |
| Nov 2020 FAR 634 | **2021/22 Budget – Intervention Rates** (FAR Committee minutes item 6) | Standardised Intervention Rates to be published periodically as these become available to enable regular discussion on these. | CEO/ EDSS | | |
| Dec 2020 | **Radiology Services** (Minutes item 3) | Provide benchmark reporting which compares our CT scanning, MRI scanning and Ultrasound Scanning rates per 10,000 with the rest of the South Island and with Nationally if possible, split by Dunedin and Southland. (May).<br><br>Develop a proposed workplan for Radiology access over the next 10 | EDSS | | ~~1 March 2021~~<br>03 May 2021 |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| | | years with a particular emphasis on the key access issues Ultrasonography Southland and Dunedin, MRI Dunedin, CT Dunedin. (May).<br><br>An update on Dunedin CT procurement and implementation planning to be included in the March HAC report. | EDSS<br><br>EDSS | | 03 May 2021<br><br>03 May 2021 |
| Dec 2020 | **Valuing Patient Time** (Minutes item 4) | A presentation on escalation is to be provided by Dr Nigel Millar and Ms Megan Boivin for the March 2021 HAC meeting, noting that the Hospital Escalation Plan is to be implemented in the New Year.<br><br>All areas are to be assessed by the end of February 2021 to understand where departments are with roll out of the SAFER bundle and all components. An action and support plan is to be identified for each area and an update and tabulation of progress by service is to be provided to the HAC meeting in May 2021 as part of the VPT and Taskforce updates. | CMO/ GM Operations<br><br>CN&MO | A presentation will be provided at the meeting. | Complete<br><br>03 May 2021 |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| Dec 2020 | **EDSS Report** (Minutes item 8) | The Clinical Council is to provide a written response to the Committee outlining the rationale for their recommendation to defer elective surgery in the lead up to Christmas based on the data received by them. | EDQCGS/ Chair Clinical Council | An update is provided and attached to this action sheet. | Complete |
| Dec 2020 | **EDSS Report** (Minutes item 8) | GM Surgical to provide a brief report for March HAC outlining the rate of tray rejections in Dunedin sterile services and explain the mitigations in place to minimise this whilst we await the new build. | EDSS | An update is provided and attached to this action sheet. | Complete |
| Dec 2020 | **General Business** (Minutes item 9) | A presentation from our Building and Property team to be delivered in March outlining the key issues being managed and pathway forward with Air Handling for the ICU. | EDSS | Report to be submitted for inclusion in the FARC agenda. | Complete |
| Dec 2020 | **Actions that will require ongoing updates.** | Ethnicity (Minutes item 6 under EDSS – November 2020).<br><br>Future reporting on CT Performance is to be broken down specifically for Dunedin and Southland and the longest waiting times are to be recorded.<br><br>CT acute volumes completed within required timeframe to be | EDSS<br><br>EDSS<br><br>EDSS | These actions have been noted and will be included in future agendas as reports become available**.** | Complete<br><br>Complete<br><br>Complete |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| | | part of Radiology reporting going forward. | | | |

**Action**
Clarify the number of trays being rejected within the Sterile Services Department, Dunedin Hospital and include an update for the HAC meeting to be held on 1 March 2021.

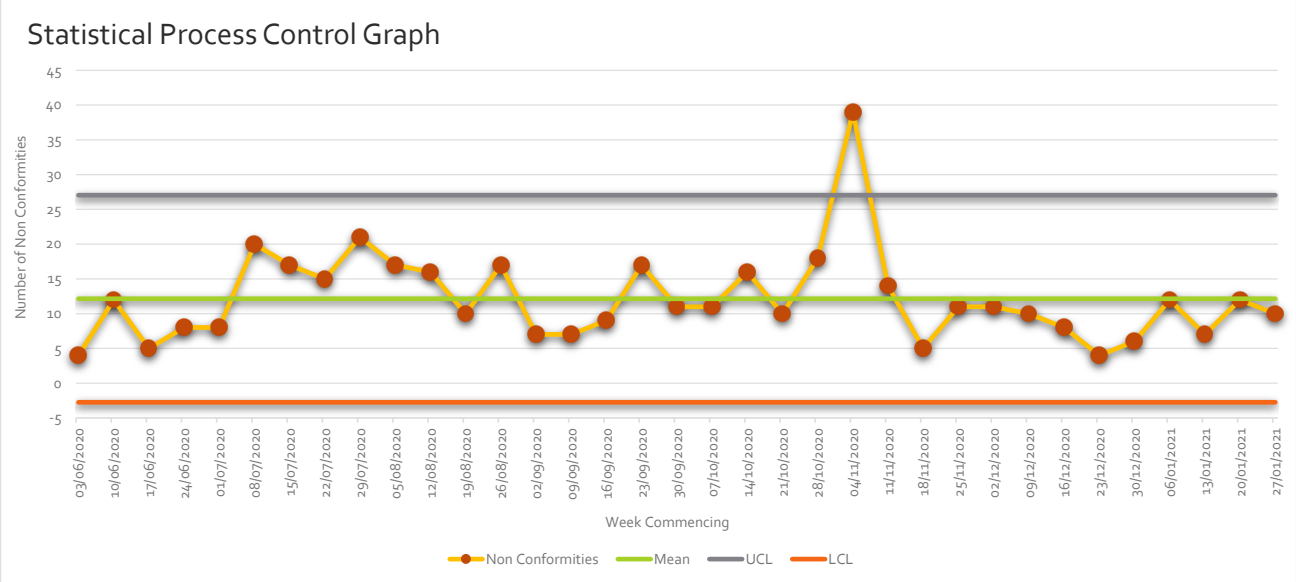
The solution to this problem is the new sterile services facility to which we are working hard to facilitate as soon as possible. In the interim, the mitigations are as noted below in points 1 – 6.

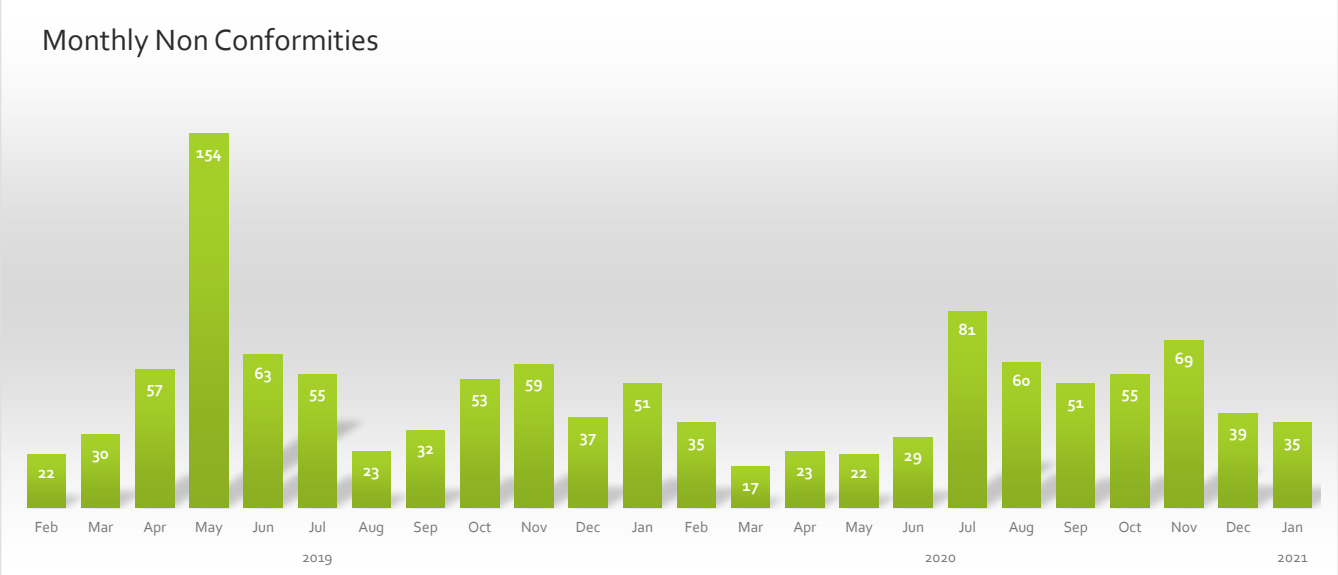
**Update**
A number of mitigations are in place to ensure that there is safe and efficient operating at Dunedin – please see weekly graphs attached outlining the type of non-conformity and contamination.

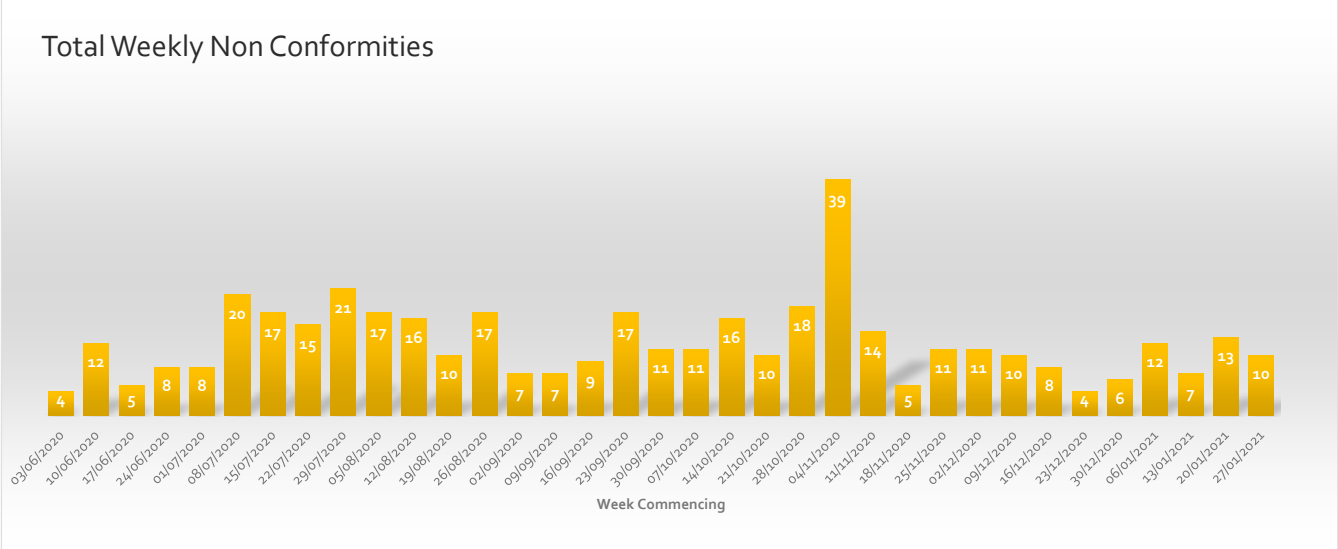
1. Monitoring and reporting is encouraged across all staff groups. Reporting is focussed on trends, investigate spikes, address issues –
   Sterile Service Unit (SSU)has implemented a quality group consisting of SSU manager, SSU coordinators, 2x SSU technicians, a theatre nurse and a person from quality team when required.
   We have implemented a Service Compromised system last year to support our focus and actions. A process to trace hair in packs has been implemented, University of Otago now undertake analysis of particles – which has improved the turnaround time for these. We will be creating a working group to look at managing loan sets. Loan set have a significant impact on to SSU as well as the theatre equipment coordinators (in terms of workload).
   The SSU quality group meetings are fortnightly, discusses non-conformity graphs; majority of issues reflect the environmental contamination.
   Non-conformities are discussed at every SSU staff meeting.
2. Introduction of a training role in Dunedin (not yet appointed) – have advertised role, received 3 applicants, one with appropriate experience, will be interviewing
3. On floor support and inspection from the Coordinator – monitoring of pre-cleaning and packing is continuing as is weekly product auditing
4. Movement of some work to CSSD (which has better environmental workflow from dirty to clean that Sterile Services). – loan trays are going into CSSD for cleaning.
5. Ongoing recruitment to ensure minimal vacancies and appropriate training.
6. Terminal cleaning schedule enhanced – daily cleaning enhanced with more regular terminal cleans throughout the year.

Janine Cochrane
General Manager, Surgical Services and Radiology

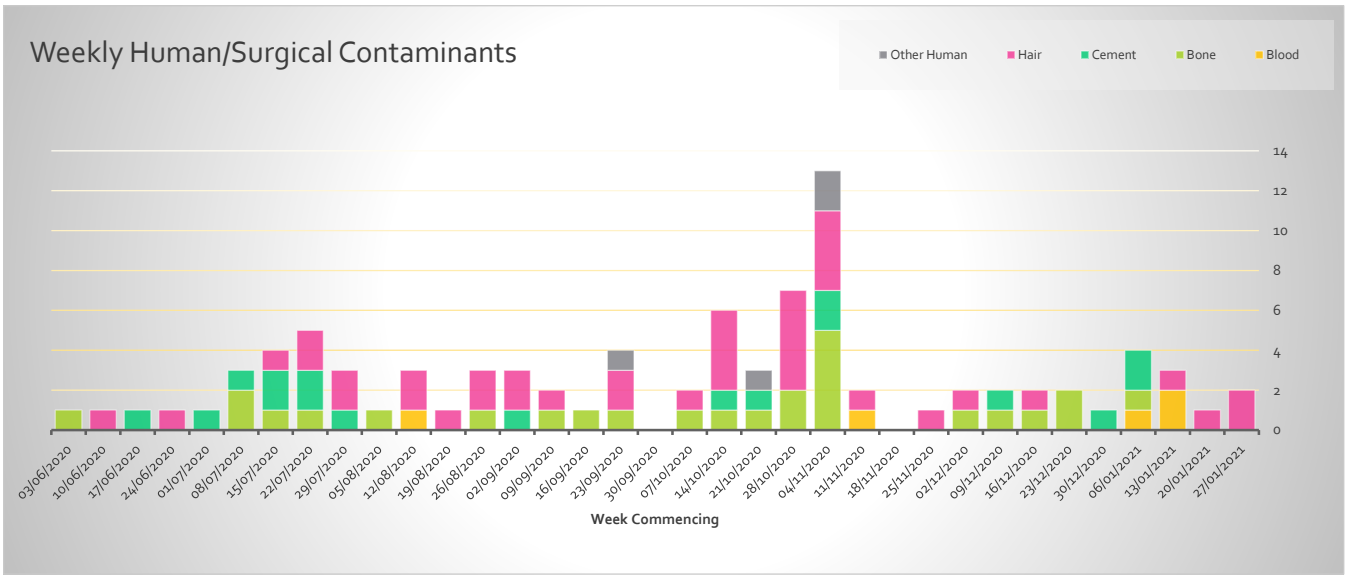
# Sterile Services Non-Conformities

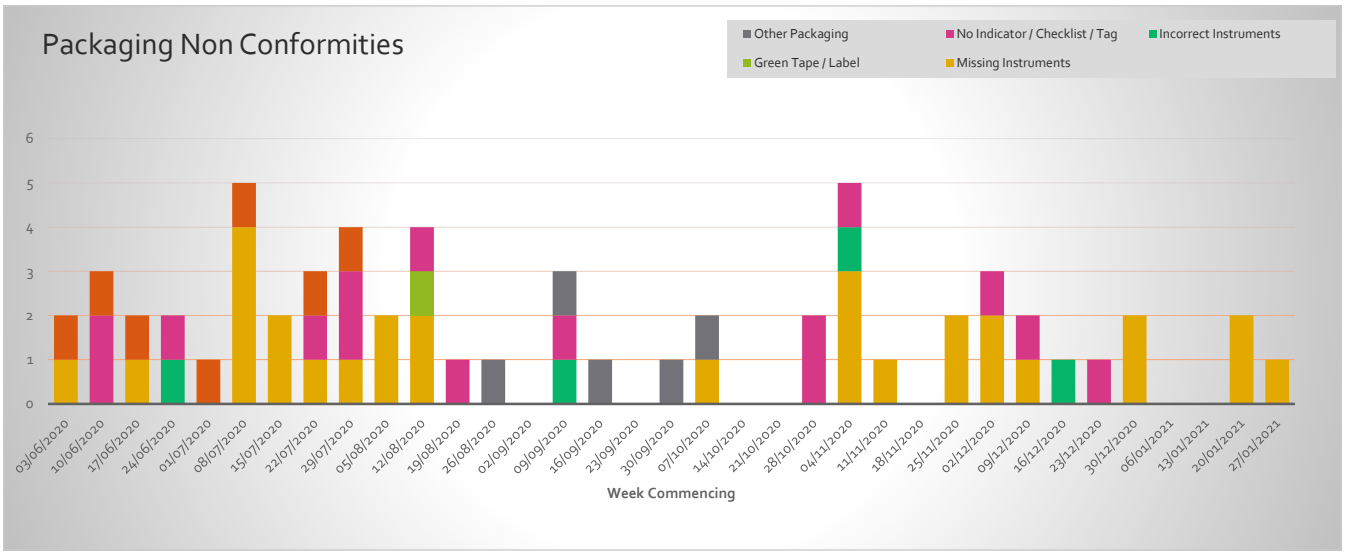


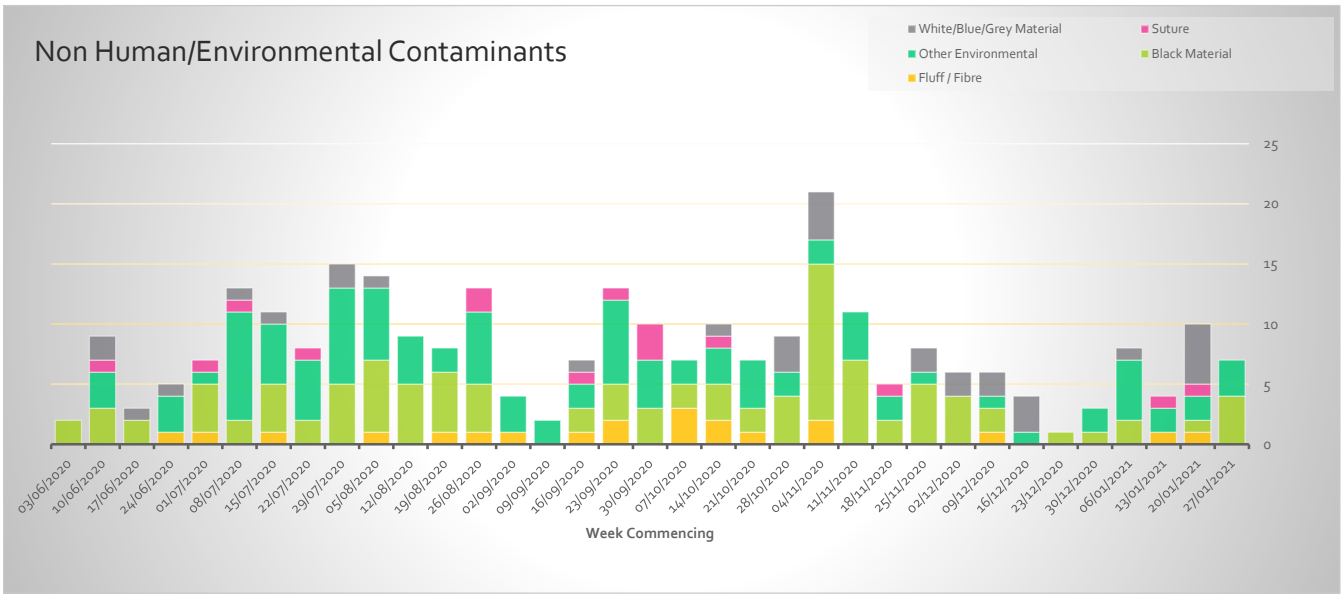



# Sterile Services Non-Conformities



Update in response to the action below

| | | | |
|---|---|---|---|
| Dec 2020 | EDSS Report<br><br>(Minutes item 8) | The Clinical Council is to provide a written response to the Committee outlining the rationale for their recommendation to defer elective surgery in the lead up to Christmas based on the data received by them. | EDQCGS/<br><br>Chair Clinical Council |

At the Clinical Council meeting 10 December 2020 members raised significant concern around constraints on service delivery and patient safety across the district, particular emphasis was noted at the Southland hospital site, but it was noted this is a district wide issue. Concerns were initially raised from the community by the Chair of the Community Health Council.

It was stated by Chair of the Community Health Council that the community was raising concerns that patients and whānau were waiting too long for acute services and sometimes in unsafe conditions whereby insufficient monitoring was occurring due to staff constraints. This was not a criticism of the staff but that the system was not adequately resourced to meet the demand of patients that are coming through the hospital doors.

Issues such as barriers to accessing primary care services, difficulty in recruiting qualified staff for the hospital and staff fatigue were raised by members. Clinical Council members accepted the issues raised which were further supported by challenges with recruitment and staff absence.

All Clinical Council members requested that this item be urgently elevated to the attention of the DHB CEO to ensure staff and patient wellbeing be prioritised as the highest priority for the organisation.

Council members met with the CEO, Executive Director of Specialist Services and the GM Surgery and Radiology. In the discussion it was concluded that one of the key immediate actions possible was to reduce elective surgery in the remaining 10 days leading into Christmas and this was subsequently actioned by the surgical directorate. The other actions ultimately led to the establishment of the Taskforce led by the Clinical Leaders on the Executive Team.

Gail Thomson, Executive Director Quality & Clinical Governance Solutions
Tim Mackay, Chair Clinical Council

**FOR INFORMATION**

**Item:** Theatre Utilisation in relation to outsources services

**Proposed by:** Patrick Ng, Executive Director of Specialist Services
Janine Cochrane, General Manager Surgical Services and Radiology

**Meeting of:** 01 March 2021

6

## Recommendation

**That the Hospital Advisory Board notes the update provided.**

## Purpose

1. The Board seeks clarification regarding differences between the waiting times for access to publicly funded private facilities (and procedure carried out in public hospitals).

## Specific Implications For Consideration

1. Equity

    - Ensuring that there is not an undue difference to waiting times between patients receiving treatment in public facilities and funded publicly but with treatment completed in private facilities.

## Background

2. There are two private facilities at Southern District Health Board. Mercy Hospital in Dunedin and Southern Cross Hospital at Invercargill.

3. Both Mercy (Dunedin) and Southern Cross (Invercargill) provide services for both outsourcing (full private) and outplacing (costs of theatre +/- theatre staff but surgeon provided by the DHB). In Southland Outplacing lists occur mostly on Wednesdays and Surgeons go to Southern Cross to undertake the surgery. In Dunedin Outplaced lists occur on a Tuesday and ½ day Friday (fortnightly).

4. Outsourced lists are arranged by individual surgeons at each of the hospitals.

## Discussion

5. The following represents the number of patients that have received public care through a private facility for the year to date.

    (from July 2020 – January 2021).

| Outsourced and Outplaced procedured, July - January 2021 | Dunedin | Invercargill |
|---|---|---|
| Cardiac | 5 | 0 |
| Endoscopy | 7 | 0 |
| ENT | 103 | 0 |
| General Surgery | 24 | 54 |
| Ortho | 116 | 58 |
| Plastics | 14 | 0 |
| Urology | 30 | 50 |
| Neuro | 2 | 0 |
| Ophthalmology | 255 | 121 |
| **Total** | **556** | **283** |

6. All Private Hospitals have restrictions on admission criteria for patients based on the severity of co-morbidities. For example, if someone has an underlying respiratory disease, they may score above 1 or 2 on the ASA Physical Status Classification System (the systems goes from ASA 1 (a normal health patient) to ASA 6. Most private hospitals will only accept patients assessed as 2 or below. This means that at times, some patients may be treated earlier (or out of turn) than others because they can be admitted to the private facility whereas others can only receive their surgery in a public facility.

7. At times, we send urgent cancers and other surgery to be done in private, too (for example many of the cases done on the outplaced lists at Southern Cross in Invercargill will be cancers). In terms of how patients are selected from our wait lists to receive surgery, this is done in a way that is careful not advantage any patient over another. Regular review of the waiting lists to ensure that the right patients are being selected has been introduced over the last year. Patients are selected according to the severity of their condition (e.g. urgent cancers), and according to how long they have been on the waiting list (e.g. conditions with low severity but long waits).

8. Overall, waiting times for public surgery that is completed in private are circa 30% longer than surgery completed publicly for Dunedin. For Invercargill publicly funded surgery completed in private has a waiting time that is circa 14% faster, as outlined in the following table.

| Average Waiting Time for procedures | Dunedin | Invercargi |
|---|---|---|
| Public | 167 | 152 |
| Private | 217 | 133 |

## Next Steps & Actions

The Surgical teams will continue to ensure that those cases selected for completion in private using public funding are prioritised, based either on the urgency of the condition, or the amount of time spent on the public wait list before progressing to surgery.

**FOR INFORMATION**

**Item:** Executive Director of Specialist Services (EDSS) – January 2021 report

**Proposed by:** Patrick Ng, EDSS

**Meeting of:** Hospital Advisory Committee, 01 March 2021



## Recommendation

**That the Hospital Advisory Committee notes the content of this report.**

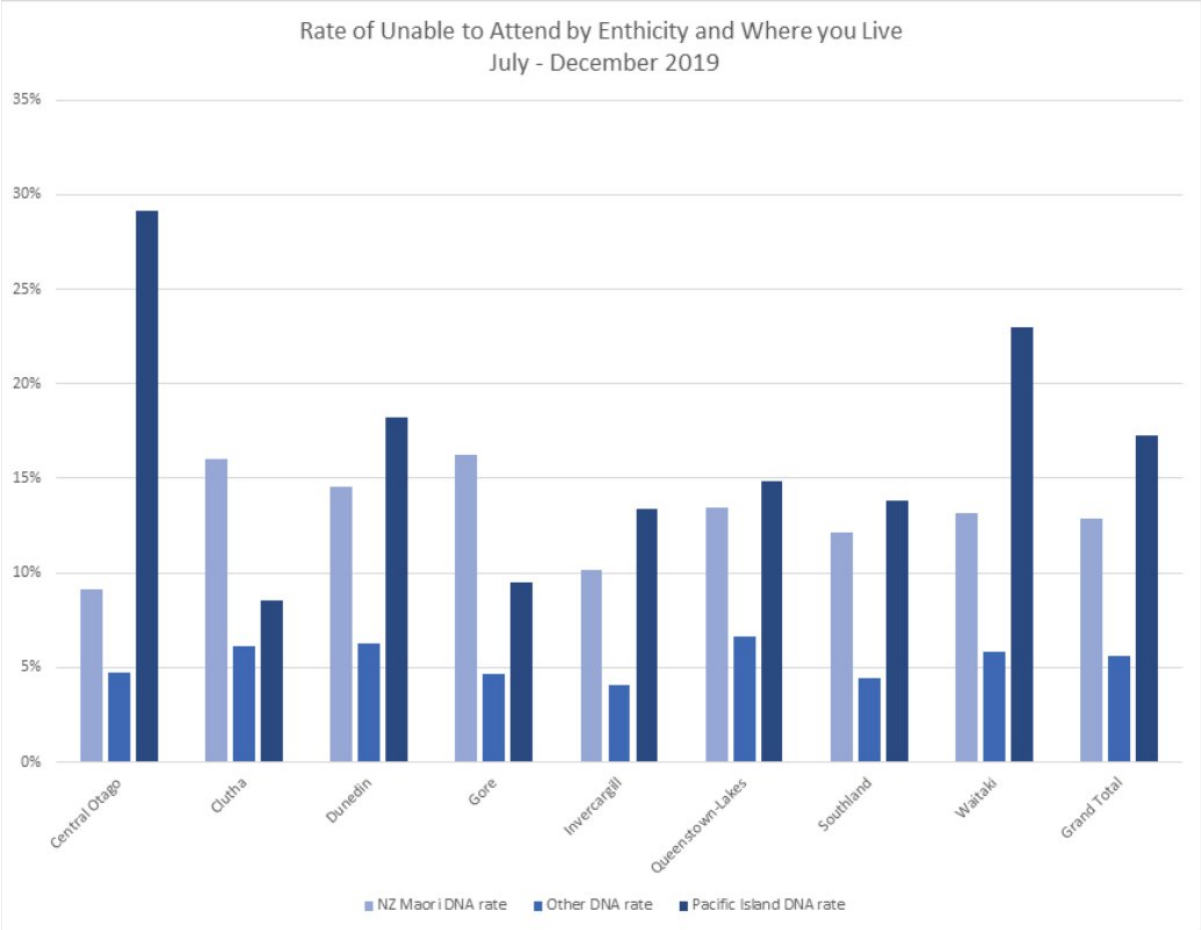
## Purpose

This report is to update the Hospital Advisory Committee on key activities and issues occurring within Specialist Services.

## 1. Equity

In a recent HAC meeting we noted our plans to develop a work programme over the course of the year which focuses on understanding and then trying to improve upon equity issues with may lead to inequitable access to specialist services. Our initial, rudimentary analysis indicated that Pasifika peoples appeared to gain less access to outpatient first specialist appointments as the rate at which we accepted FSA's for this ethnicity cohort was in the region of 1/3$^{rd}$ less than it would be if they accessed outpatient FSA's at the rate of the other ethnicities in our study. Subsequent to discussing this at HAC we then met with our Chief Maori Strategy and Improvement Officer to determine how we could work in partnership and where we should focus our initial efforts if we wanted to improve access for Pasifika and Maori populations. We concluded that we should focus our initial efforts on the Respiratory and Cardiology services due to the long term health impacts if these conditions are not well managed, and also due to the relatively high rates of *'unable to attend'* that we are seeing for Maori and Pasifika in these services. We also confirmed with our planning and funding team that these were good services to put an initial focus on.

The following chart shows the 'unable to attend' rates at all doctors' clinics by ethnicity, across Southern District Health Board. This information has also been shared with the rural hospitals. It shows that whilst there is fluctuation between different locations within Southern DHB, and whilst the Pasifika numbers may show more fluctuation in some cases because of low population numbers, overall there is a consistent pattern of high rates of 'unable to attend' for Pasifika and Maori, compared to relatively low rates of non-attendance by the remainder of the population. This appears to underscore non-attendance at appointments / clinics as a key issue that we must work on for these populations if we are to achieve notable improvements in equity of access.




For the respiratory and cardiology services which will be our main focus we note the following:

- Outpatient unable to attend (UAA) rates for cardiology (either first specialist appointments or follow up appointments) is 5% overall, but 13% for Maori, 7% for Pasifika and 4% for all other population groups.
- Outpatient unable to attend rates for respiratory (either first specialist appointments or follow up appointments) is 10% overall, but 22% for Maori, 26% for Pasifika, and 8% for all other population groups.

These rates of non-attendance give us an initial area to focus upon as we formulate a work plan to improve equity of access to our services. The GM Surgery and Radiology has been asked to form a working group as she has expressed a particular interest in improving equity of access. She will form a working group who will meet on a fortnightly basis to formulate a workplan and then monitor the delivery of the workplan. The Chief Maori Officer and Executive Director for Specialist Services will also be part of the regular working group in order to provide maximum support for this group and to ensure access to resources (e.g. for analysis) as required.

## 2. Surgical Performance – Case Weight Discharges

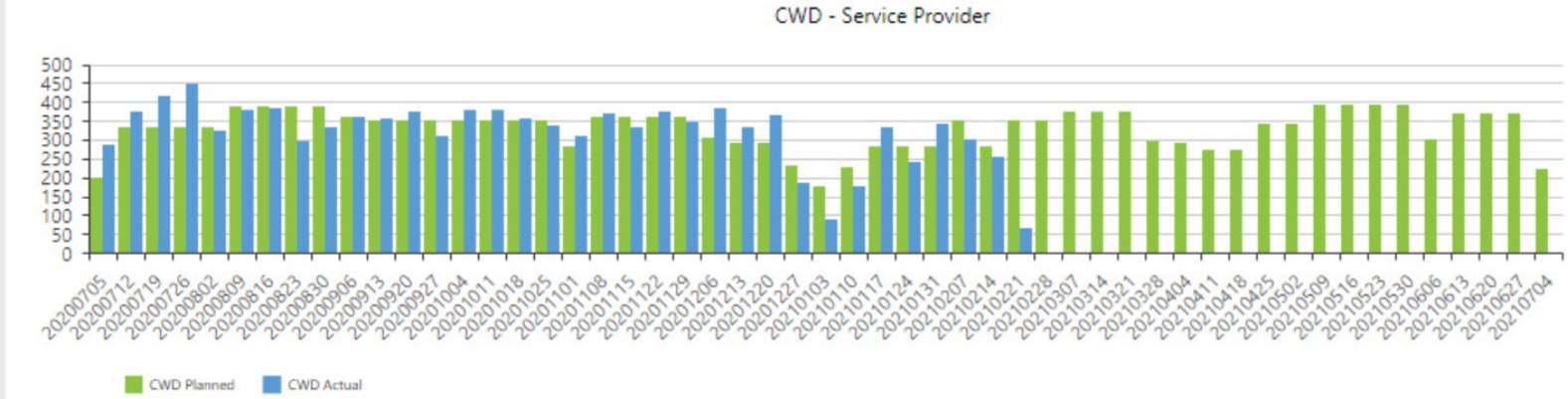
Despite the significant and ongoing challenges, we are facing with access to inpatient beds for elective surgery we were ahead of target for both the case weight discharges target for the service provider (+279.26 CWD per the highlighted yellow cell) and for the population view (+128.04 CWD per the highlighted yellow cell. Both results have deteriorated into February. We are currently only +5 CWD ahead for the population view.

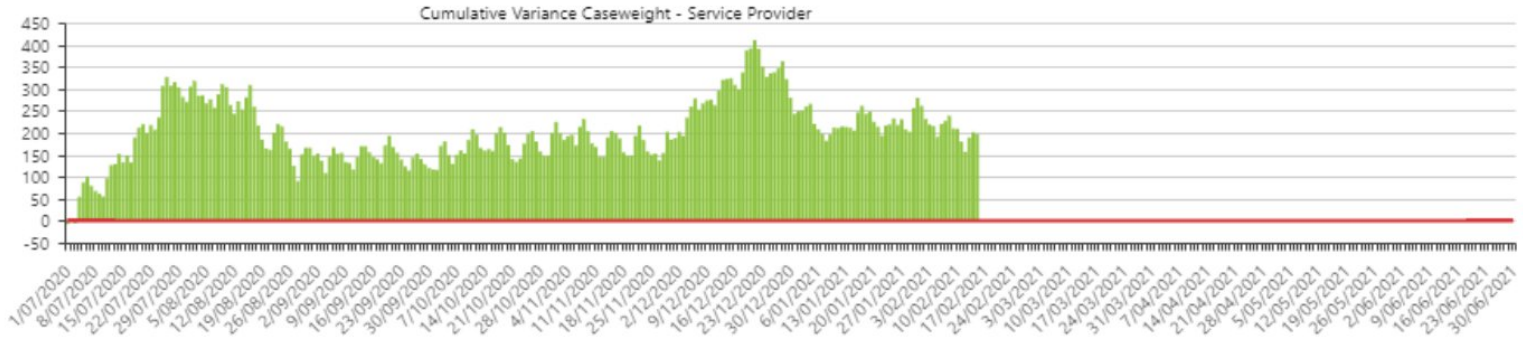
The service provider view reflects the target that is placed on the two hospitals. This is what the Surgical Directorate focuses on. It includes Southern DHB domiciled patients and out of district patients who are operated on in Southern District Health Board facilities (including outplacement and outsourcing done at Mercy in Dunedin and Southern Cross in Southland and paid for by SDHB).

The population view reflects the surgery done for our population and adjusts for inter district flows (adds our patients operated on at other district health boards such as CDHB and subtracts out of district patients operated on in our hospitals).

The fact that we are still ahead of plan despite (both for the hospitals' service provider view and the DHB's population view) despite the resourced beds and inpatient bed block challenges we have faced is good, but is incongruous with what we would expect and requires a bit of further clarification, as follows:

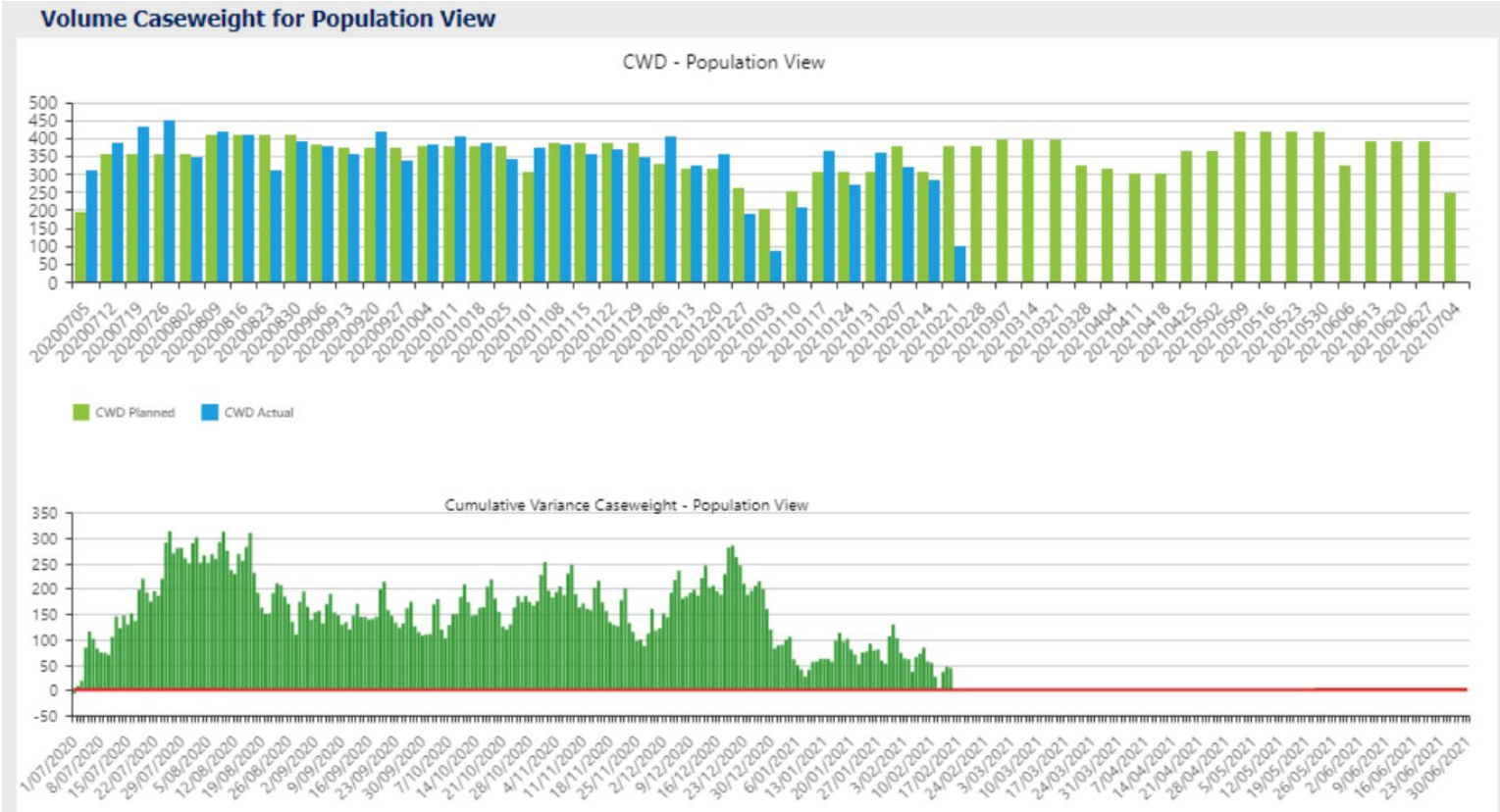
## Volume Caseweight for Service Provider




| Service Provider Date | Actual Internal CW | Actual O'Sourced CW | Total Actual CW | % CW Coded | Target CW | Weekly CW Variance | Average CW per patient | Cum. Actual Internal CW | Cum. Actual O'Sourced CW | Cum. Actual CW | Cum. Target CW | Cum. CW Variance | Cum. $ Value |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31/01/2021 | 23.25 | 0.00 | 23.25 | 100.00 | 0.00 | 23.25 | 3.32 | 9,154.23 | 1,099.11 | 10,253.34 | 9,974.12 | 279.23 | 1,412,323 |
| 1/02/2021 | 45.28 | 7.03 | 52.30 | 90.67 | 70.31 | -18.01 | 1.87 | 9,199.51 | 1,106.14 | 10,305.65 | 10,044.43 | 261.22 | 1,321,229 |

## Volume Caseweight for Population View




| 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 | Cum. Pop Adj Variance CW | Cum. Adj Variance $ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31/01/2021 | 23.25 | 0.00 | 0.00 | 23.25 | 100.00 | 0.00 | 270.60 | 228.91 | 41.69 | 836.37 | 945.09 | -108.72 | 10,818.30 | 10,690.30 | 128.01 | 128.01 | 647,450 |
| 1/02/2021 | 34.72 | 7.03 | 31.50 | 73.26 | 88.31 | 100.26 | 281.15 | 230.46 | 50.69 | 867.87 | 976.59 | -108.72 | 10,831.56 | 10,790.56 | 101.00 | 101.00 | 510,851 |

- The year to date performance includes 164 CWD of outsourced surgery > budgeted for. The majority of this is additional surgery that we did as part of 'Improvement Action Plan', (IAP), which was COVID recovery and effectively has been funded with additional COVID recovery funding. This additional work was primarily completed in July and August prior to us gaining clarity from the Ministry about how COVID recovery was going to work.
- Approximately 100 CWD is acute surgery completed for patients who were also on an elective waiting list. Our CEO has previously confirmed with the Ministry that it is valid to re-code these as elective surgery and we have organised for these to be re-coded accordingly and have processes in place to do a periodic 'sweep.'
- A high proportion of elective delivery over December (and we anticipate that this will also have been the case in January) was non-deferrable cancer work.

At a macro level the fact we have thus far stayed above target is positive, but at a service level it is not such a good picture. In particular, elective orthopaedic surgery came to a virtual standstill in Southland in late December and there has been little improvement during January. In Dunedin a lack of nursing resource in our main orthopaedic ward (3 SURG C) led to the Director of Nursing for that service advising that elective orthopaedic surgery needed to be scaled down from a maximum of 54 beds to 44 available beds and elective surgery had to be scaled accordingly. We were advised that the graduate intake in February would alleviate the resourced bed pressure in 3 SURG C (Dunedin) and had anticipated that there would be less nurse resourcing pressure during February as a consequence (in Dunedin in particular). However, we appear to have ongoing nurse roster gaps and we also appear to have nurse staffing issues that will prevent us from fully resourcing our HDU beds for another couple of months. A meeting to work through the data and gain an understanding of the extent to which we are short of nursing resources has been organised.

We remain dependent on acute and medical volumes returning to more normal levels, graduate nurses who have filled vacant roles becoming increasingly proficient and on the patient flow taskforce improving the rate of discharge (particularly for long stay patients) in order for our elective throughput to return to more normal levels.

In the meantime, we are conscious that orthopaedic surgery in particular needs to be able to move forward with cases that have now been waiting longer due to the challenges noted earlier. The GM Surgery and service managers in Dunedin and Southland are developing a proposal that will allow more of this surgery to be completed with outsourcing support (although not all of the long wait cases are suitable for outsourced surgery, we are looking at options for Southland in particular that involve leasing inpatient bed space from Southern Cross and doing some juggling so that more orthopaedic cases can be done). We hope to fund the additional work using the remainder of our unrecognised IAP funding for the year, but there may also be budget implications from the additional work that is required. This is being worked through carefully. Another option which we are working up with our South Canterbury colleagues is the possibility of completing some orthopaedic surgery at South Canterbury DHB (as they have surgical and inpatient bed capacity) but using our surgeon. This would use their spare capacity and would be at a lower cost than outsourcing the surgery.

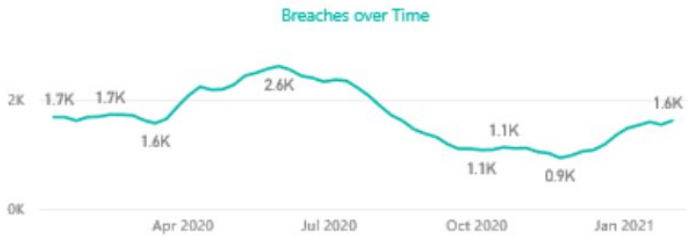
Although it is not completely clear to us why we faced such high acute pressure at the end of the calendar year and why the productivity numbers have not fully attested to the pressures that have been felt, two studies do point to potential indicators for why we have faced such inexplicable pressure over the last 5 or more months. The first is a study completed by our Planning and Funding team, which indicates that whilst average length of stay has not increased markedly overall, the mix of patients in our hospitals over the last half of the 2020 calendar year changed markedly. Whilst we

would normally have high numbers of respiratory patients those numbers were down significantly, and cancer volumes were notably up. A further study undertaken by the GM Surgery during January suggests that a number of cancers which would normally be detected and treated during the COVID lockdown appear to have been detected and treated subsequent to the lockdown, with a delay of up to circa 4 months. This appears to have effectively created a bubble of cancer cases moving through our system. It should be noted that we have yet to work this out quantitively, so these are at 'observation' level at this stage. However, if this does prove to be one of the key drivers of access related issues it gives us some hope that the inexplicable pressure this is causing us will dissipate in the coming months.

For the month of January, we delivered 260 case weight delivery (CWD) less acute surgery than for the same period last year and 149 more elective CWD for total volumes of -144 CWD when compared to last year. This now means that our year to date CWD is 209 CWD less acute surgery and 171 CWD more elective surgery than last year for a total of -38 CWD delivery year to date when compared to last year. In other words, overall, the total acute and elective CWD volumes are very similar to last year which further highlights that the inability to supply inpatient beds is not readily explained by acute pressure.

### 3. Outpatient Performance ESPI 2

ESPI 2 performance has seen some deterioration over December and January, as is usual for this time of year. FSA's for clinic are accepted at similar rates to the rest of the year but due to annual leave fewer clinics tend to be run during this period than normal. Overall, the number of ESPI 2 breaches has tracked up from pre-December levels per the following chart.



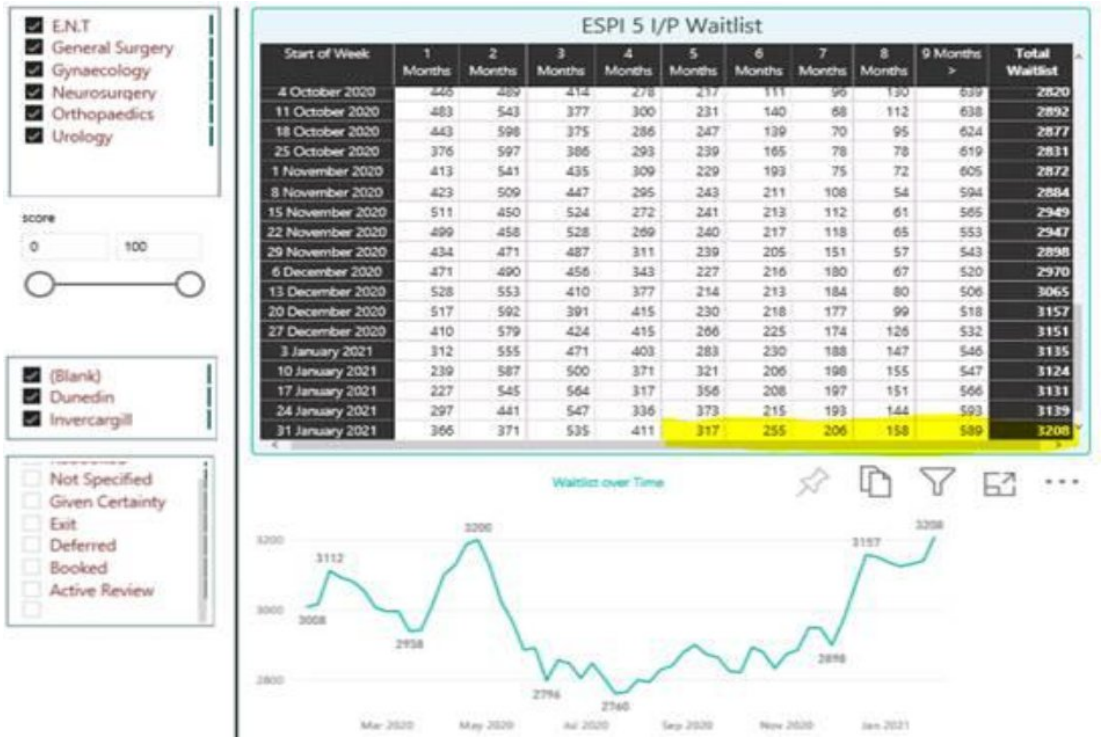

As noted in earlier reports, the key to us getting our services into balance (so that the number of referrals we accept for triage is in line with the underlying capacity in the service) is to use the Ministry of Health prioritisation tool to get the services into balance over time. We have been using the tool for this purpose for some time now in urology (Dunedin) and orthopaedics (Dunedin). The tool is in place in General Surgery (Dunedin and Southland). Discussion has been had with the ENT service (across district) about implementing the tool in this service too, and the Business Development Manager now needs to work with the Service Manager for that service to get this established. In Obstetrics & Gynaecology in Southland we believe that the overall volume of work coming into this service (which must be prioritised) may be higher than the service is resourced for. We are using the prioritisation tool to complete a brief study to show us (once referrals have been put into priority order) where we would need to draw the line to balance what is accepted with the

capacity within the service. We can then discuss the clinical appropriateness of where the line would need to be drawn with the clinicians and to the extent that it would be inappropriate to draw the line there, we can quantitatively work out the level of resource required compared to the level of resource we currently have. This would then be useful input for any future case proposing to prioritise investment into this service.

Circa $140k has been confirmed as part of the COIVD initiatives funding from the Ministry and we will work out how the business support team can best utilise this funding to increase the rate at which the prioritisation tool is rolled out across the remaining services.

## 4. Inpatient Performance ESPI 5

Unfortunately, the reduction in elective surgery for the reasons noted earlier has had a direct impact on long waiting ESPI 5 performance. The following chart shows the growth in the total wait list for our key specialities (noting that some smaller specialities are not included).




| Start of Week | 1 Months | 2 Months | 3 Months | 4 Months | 5 Months | 6 Months | 7 Months | 8 Months | 9 Months > | Total Waitlist |
|---|---|---|---|---|---|---|---|---|---|---|
| 4 October 2020 | 446 | 489 | 414 | 278 | 217 | 111 | 96 | 130 | 639 | 2820 |
| 11 October 2020 | 483 | 543 | 377 | 300 | 231 | 140 | 68 | 112 | 638 | 2892 |
| 18 October 2020 | 443 | 598 | 375 | 286 | 247 | 139 | 70 | 95 | 624 | 2877 |
| 25 October 2020 | 376 | 597 | 386 | 293 | 239 | 165 | 78 | 78 | 619 | 2831 |
| 1 November 2020 | 413 | 541 | 435 | 309 | 229 | 193 | 75 | 72 | 605 | 2872 |
| 8 November 2020 | 423 | 509 | 447 | 295 | 243 | 211 | 108 | 54 | 594 | 2884 |
| 15 November 2020 | 511 | 450 | 524 | 272 | 241 | 213 | 112 | 61 | 565 | 2949 |
| 22 November 2020 | 499 | 458 | 528 | 269 | 240 | 217 | 118 | 65 | 553 | 2947 |
| 29 November 2020 | 434 | 471 | 487 | 311 | 239 | 205 | 151 | 57 | 543 | 2898 |
| 6 December 2020 | 471 | 490 | 456 | 343 | 227 | 216 | 180 | 67 | 520 | 2970 |
| 13 December 2020 | 528 | 553 | 410 | 377 | 214 | 213 | 184 | 80 | 506 | 3065 |
| 20 December 2020 | 517 | 592 | 391 | 415 | 230 | 218 | 177 | 99 | 518 | 3157 |
| 27 December 2020 | 410 | 579 | 424 | 415 | 266 | 225 | 174 | 126 | 532 | 3151 |
| 3 January 2021 | 312 | 555 | 471 | 403 | 283 | 230 | 188 | 147 | 546 | 3135 |
| 10 January 2021 | 239 | 587 | 500 | 371 | 321 | 206 | 198 | 155 | 547 | 3124 |
| 17 January 2021 | 227 | 545 | 564 | 317 | 356 | 208 | 197 | 151 | 566 | 3131 |
| 24 January 2021 | 297 | 441 | 547 | 336 | 373 | 215 | 193 | 144 | 593 | 3139 |
| 31 January 2021 | 366 | 371 | 535 | 411 | 317 | 255 | 206 | 158 | 589 | 3208 |

Key observations are as follows:

- The total wait list is at a similar level (circa 3,200) to what it was during the midst of COVID in May.
- Post COVID, in the week beginning June 7th, we had 1,696 of our wait list at 5 months or greater in these key services on a total wait list of 2,796. This amounts to a breach ratio of 61%.

- By October 4th we had managed some improvement, with 1,193 breaches and a total wait list of 2,820. This amounts to a breach ratio of 42%.
- However, as of January 31st we have 1,317 breaches and a total wait list of 2,846. This amounts to a breach ratio of 56.5%.

In other words, our current challenges are causing our total inpatient wait list to grow and are leading to an increasing number of patients waiting 5 months or longer for their surgery. This helps to underscore the importance of acute volumes returning to manageable levels, getting good results from the taskforce and for nurse recruitment to translate into the ability to consistently resource more beds, all of which are key to allowing elective surgery to return to normal levels.

Some good pieces of work have been completed in the interests of optimally managing the longest waiting patients on our wait lists.

- All long waiting patients across all inpatient specialities have been analysed and where appropriate data corrections have been made. The analysed list has been shared with the Clinical Council so that they can form a clear view of the longest waiting patients and the nature of their condition/s.
- The Planned Care Manager has completed 'transfer of care' protocols for determining when care may appropriately be transferred from the inpatient wait list (e.g. when a requirement for surgery such as giving up smoking has not progressed). Per a previous HAC action a report has been developed for HAC to explain the protocols and how they will be used.
- Orthopaedics and General Surgery (our largest inpatient elective services) have systematically worked through all patients waiting > 21 months with the intention of booking them onto an elective surgical list where surgery is remains appropriate. However, the requirement to postpone elective surgery over the last few months has set back progress in this area.

## 5. Medical Imaging Diagnostics

The radiology service has confirmed that it has successfully implemented the following from the CT initiative that was signed off last year:

- They have recruited the additional Medical Imaging Technologist (MIT) and nursing staff required to run the evening shift.
- Radiology sessions are now starting at 7:30 rather than 8:30 allowing an additional 2 scans to occur per day.
- After 5pm is now a regular evening shift Monday to Thursday and we are getting an additional 5 elective scans completed each evening.
- We are completing more acute scans overnight than we had previously when we were using call back.
- A ½ day session for regular CT is being run on the Spec CT machine each Friday.

This should put meaningful capacity into the system and should see our CT performance improve in the coming months. Unfortunately, we had several long CT outages during December in Dunedin and our December and January performance have been impacted by this. There have also been implementation issues associated with the new 'Karisma' software which is believed to have led to some sessions being run light. And there is a seasonal performance dip in January as less sessions are completed due to leave. And we are still working through getting the reporting in the new Karisma system and cannot produce the graphs or the split by site yet (we are working with our IS colleagues to have this available as soon as possible). In the meantime, we have manually

calculated CT performance for December and January, which we believe to be 58% and 41% respectively, MRI performance of 50% and 39% respectively and Ultrasonography performance of 53% and 39% respectively.

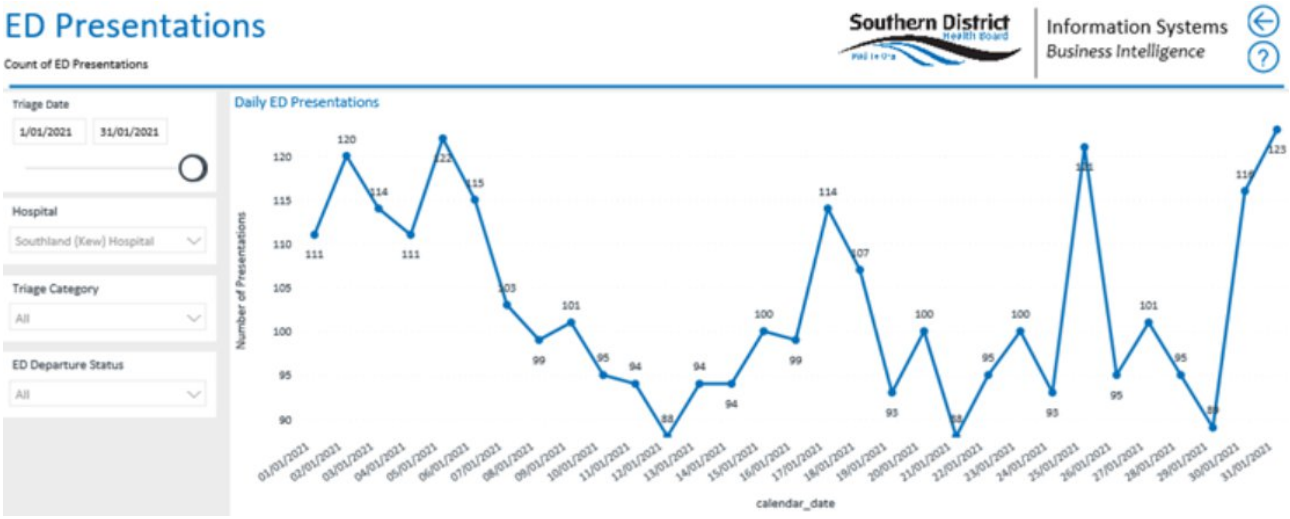
Key to improving access to medical imaging is the installation of the new CT scanner for Dunedin hospital. The location for the new CT was agreed by the Board in December last year (to be located in the Radiology Department). We have now completed the procurement for both this and the replacement of the existing CT machine and the Radiation Oncology CT machine. As noted previously, we have been having CT outages so it will be good to replace the existing CT machines with new ones. We are aiming to raise the capital request for the new machine within the next few days, and we have our Building and Property colleagues surveying the site for the new CT machine in the next few days as well. We have been told that the lead in time for the new CT will be circa 20 weeks and we hope to fit the building works within this timeframe which will lead to the 20-week timeframe becoming the critical path. We will gain clarity about whether this is possible once Building and Property have completed their inspection. In order to try to get the machine in as quickly as possible, we will go to all of government panel suppliers rather than running tender processes where suitable panel suppliers exist, and we will specify a pragmatic configuration which is focused on getting the machine in and into use as soon as we can.

For radiology more generally, we have commenced work on a broader, strategic review to determine what we believe our needs are for the next 5-10 years (in the lead up to the ambulatory and acute buildings being completed in Dunedin). Our key issues are access to CT and MRI in Dunedin (access to these modalities is good in Southland) and access to Ultrasonography in both locations. Our review will look at forecast growth in demand for all medical imaging modalities, the current age of our equipment and when it will need to be replaced and what we can do to provide improved access over the timeframe noted above. Once this review is completed it will be added to our HAC agenda and we are targeting the May HAC meeting to have this piece of work completed by.

## 6. Emergency Departments

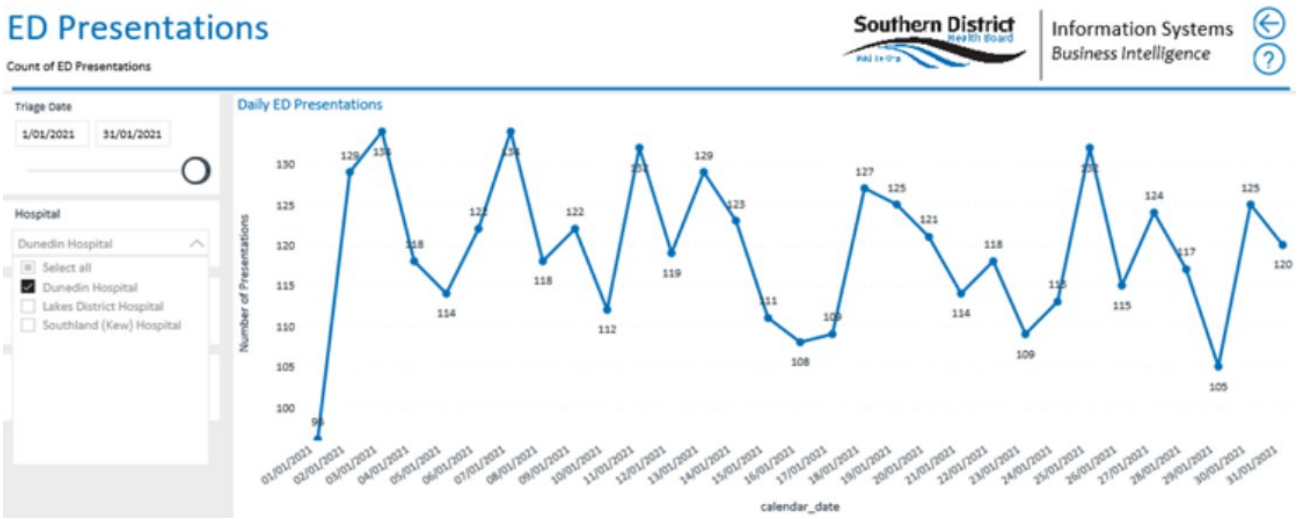
In the December HAC meeting we noted that average daily presentations in Invercargill were actually higher than Dunedin (despite a significantly lower population) for the first 2 weeks of December when they averaged 126 presentations per day. What we have found in January is that despite continuing to have high peaks, volumes have started to reduce, per the following chart, particularly between the 7$^{th}$ and 16$^{th}$ of January.

**Invercargill ED Presentations 1st of January 2021 to 31st of January 2021.**




Interestingly, Dunedin had a difference pattern with demand appearing to be relatively consistent all the way through January.

**Dunedin ED Presentations 1st of January 2021 to 31st of January 2021.**



Over the course of the full month, Invercargill ED presentations started to drop back down, and for the overall month Invercargill daily presentations averaged 103, compared to 119 for Dunedin, per the following table:

| Daily Average | Admit vs Non | | | |
|---|---|---|---|---|
| Location | Admitted | Non-Admitted | Total | % Admit |
| Dunedin | 35 | 85 | **119** | 29% |
| Invercargill | 22 | 81 | **103** | 21% |

As has previously been noted, presentations remain much higher for Invercargill relative to the size of the two populations.

For the purpose of benchmarking admissions and non-admitted presentations between Invercargill and Dunedin we have prepared the following tables. This benchmark is not completely reliable, as Dunedin is a semi-tertiary hospital, whilst Invercargill does provide support beyond the City where required (e.g. Central Lakes) but for the purpose of initial illustration this comparison is useful. The tables are summarised below.

| | |
|---|---|
| **Dunedin Population:** | **134,100** |
| **Invercargill Population:** | **56,200** |
| Invercargill as a % of Dunedin | 42% |
| Presentations % of Dunedin | 86% |

**Invercargill - Admissions:**

| | |
|---|---|
| Actual Admit | 22 |
| If proportional to population | 15 |
| Difference | 7 |
| **Difference %** | **52%** |

**Invercargill Non-Admissions:**

| | |
|---|---|
| Actual Non-Admit | 81 |
| If proportional to population | 35 |
| Difference | 45 |
| **Difference %** | **128%** |

**Invercargill Overall Presentations:**

| | |
|---|---|
| Admissions (over) | 7 |
| Non-Admissions (over) | 45 |
| Total (over) | 53 |
| Southland Actuals | 103 |
| Presentations Expected: | 50 |
| **Presentations over Expected:** | **106%** |

- Despite the Invercargill population being circa 42% of that of Dunedin, the Invercargill ED sees 86% of the patients that the Dunedin ED does.
- If Invercargill were to admit ED patients in proportion to their size, they would admit circa 15 per day, but they admit circa 22 per day, which is circa 52% more than Dunedin does *relative to population size.*
- Likewise, if Invercargill received non-admission patients in proportion to their size, they would receive circa 35 non-admitted patients per day, but they receive 81 non-admitted patients per day, which is circa 128% more than Dunedin does *relative to population size.*

- Overall, if the two hospitals are compared for district population size and Invercargill is benchmarked against Dunedin, it appears to have 106% of the presentations that it would do if it was proportional to Dunedin.



In the short to medium term, we have to act to address the pressure these volumes place on our ED staff and facilities. In the medium to longer term between ourselves and the Primary Health Organisation (PHO) we need to understand and solve the reasons for the disproportionately high presentation volumes at Invercargill hospital. A number of actions are underway in respect of this:

- The CEO has approved 4.8 additional nursing FTE for Invercargill ED so that the service can better cope with the high volumes it receives. These are being shuffled in and recruited into the ED service.
- A work programme is underway to develop a proposal for fit for purpose ED spaces and a potential expansion of ED beds at Invercargill. The proposed beds would either be additional ED beds or medical assessment unit beds. The proposed space for this development is the current fracture clinic space (the fracture clinic would be relocated) and once the fit for purpose spaces are accounted for an additional 4 beds could be provided. Scenario modelling has been run and is being written up. This appears to show that MAU beds would be well utilised throughout the day and may give better flow, too. These would also have an immediate and positive impact on the 95% target as patients would be discharged into the care of the medical teams when admitted into the medical assessment unit.
- Before additional beds can be agreed to, we need to collectively demonstrate that they are required relative to the ED presentations that Invercargill should be getting (rather than what they are currently getting). To help to validate what this number should be we are collecting information from a number of sources. This includes Nelson Hospital, South Canterbury Hospital and the future plans for the New Dunedin Hospital. We are also engaging with similar sized hospitals in mid central to try to get as comprehensive a picture as possible to tell us what the right number of beds to plan for is.

Key to getting the size of the ED right is gaining robust insights into why we are seeing such high presentation rates. A number of ideas have been raised such as Invercargill GP's not signing up for the free paediatric care initiative, inability to access medical imaging anywhere else within the district, inability to get timely access to GP's that patients are enrolled with and so on. However, to robustly understand what the issues are so that a work programme can be formulated which will systematically reduce presentations, we need greater and more comprehensive understanding of the data that is available to us. We have completed an initial set of work whereby we have cross referenced our radiology data with our ED presentation data. This has provided us with a view of total ED presentations requiring medical imaging, split by triage category, and we are working through this at the moment. It suggests that 38%-40% of Invercargill ED presentations require a medical image and 40-42% of Dunedin presentations.

However, the key to gaining maximum insight from the available data is to work closely with the PHO and we have agreed to work with the PHO CEO and his team by supplying relevant data from our data sets so that it can be cross referenced to the PHO's data sets. This will enable the PHO's 'Thelemas' business intelligence tool to be further developed so that we can start to get further insights into the available data, determine what is causing the high presentation numbers and determine what the most meaningful steps would be for any future work programme to return presentation rates to closer to national averages. This is work in progress, but we will provide regular updates as it is progressed. Ultimately, once we have a robust understanding about what is driving the high presentation rates options such as increasing primary care capacity and working together on providing access to medical imaging away from the main hospital are likely to be the

areas we need to focus on together if we are to meaningfully reduce the high presentations that are coming into the Invercargill ED.

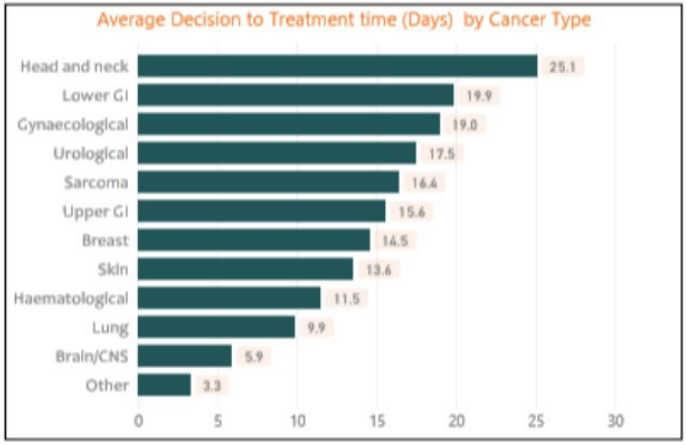
Performance against the ED 6-hour target continued to be challenging with an average of circa 80% achieved in Southland over the weeks during January. In Dunedin the performance was circa 74%.

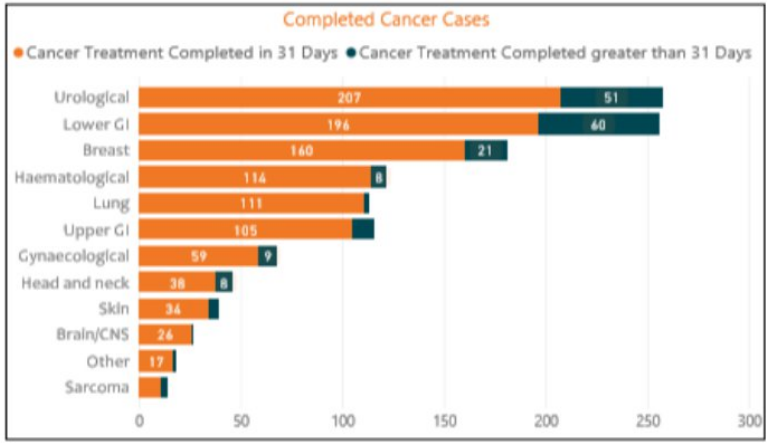


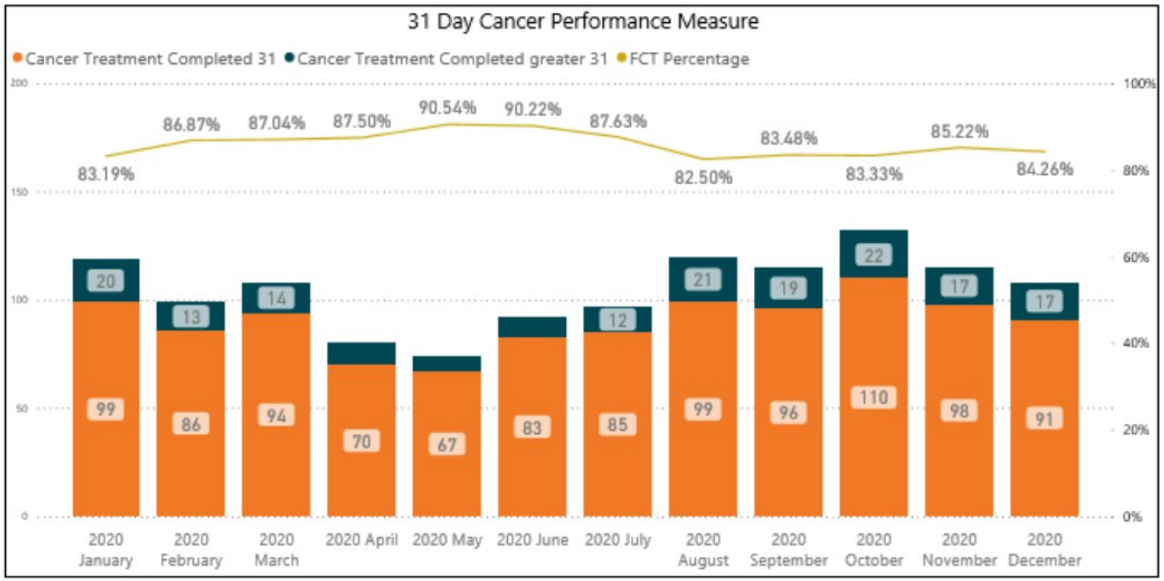
As noted earlier in Southland we are investigating the feasibility of incorporating a medical assessment unit with the ED and if the case is made successfully this, together with other work occurring on improving patient flow would make a meaningful difference to performance against target. In Dunedin a medical assessment unit has been approved and when incorporated with the changes to be implemented for Generalism we believe this will create a meaningful improvement against the target. Our Building and Property colleagues are currently working through options that will allow the space where the medical assessment unit will go to be cleared as soon as possible and this will then allow the space to be gutted, assessed and the building work to happen as soon as possible.

## 7. Oncology

We were marginally short of the 85% target in the last quarter with a result of 84,23% for the 31-day target which measures the time from diagnosis to first treatment.

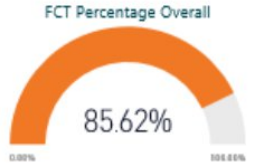

Average Decision to Treatment time (Days) by Cancer Type
Head and neck 25.1
Lower GI 19.9
Gynaecological 19.0
Urological 17.5
Sarcoma 16.4
Upper GI 15.6
Breast 14.5
Skin 13.6
Haematological 11.5
Lung 9.9
Brain/CNS 5.9
Other 3.3
0 5 10 15 20 25 30

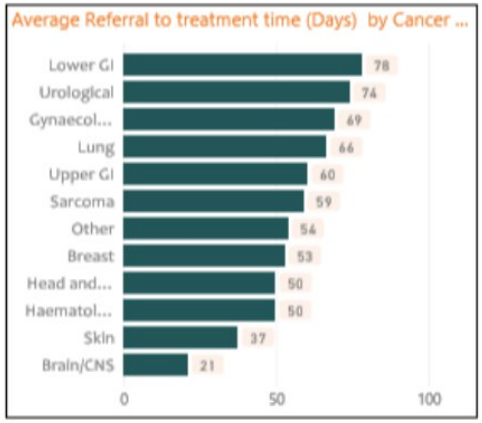

Completed Cancer Cases
Cancer Treatment Completed in 31 Days
Cancer Treatment Completed greater than 31 Days
Urological 207 51
Lower GI 196 40
Breast 160 21
Haematological 114 8
Lung 111
Upper GI 105
Gynaecological 59 9
Head and neck 38 8
Skin 34
Brain/CNS 24
Other 17
Sarcoma
0 50 100 150 200 250 300

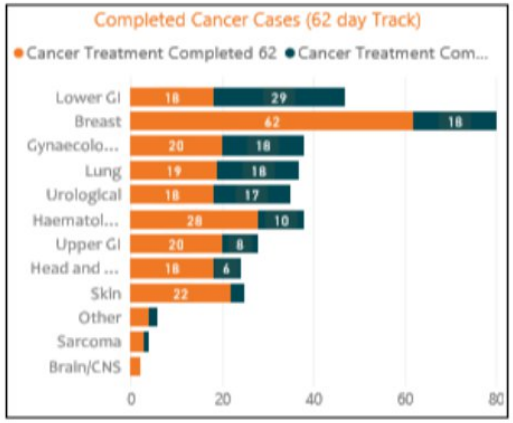

31 Day Cancer Performance Measure
Cancer Treatment Completed 31
Cancer Treatment Completed greater 31
FCT Percentage
83.19% 86.87% 87.04% 87.50% 90.54% 90.22% 87.63% 82.50% 83.48% 83.33% 85.22% 84.26%
100% 80% 60% 40% 20% 0%
20 13 14 12 21 19 22 17 17
99 86 94 70 67 83 85 99 96 110 98 91
2020 January
2020 February
2020 March
2020 April
2020 May
2020 June
2020 July
2020 August
2020 September
2020 October
2020 November
2020 December

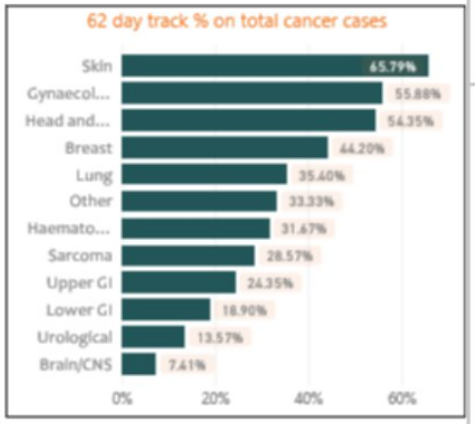

FCT Percentage Current Quarter
(Blank)

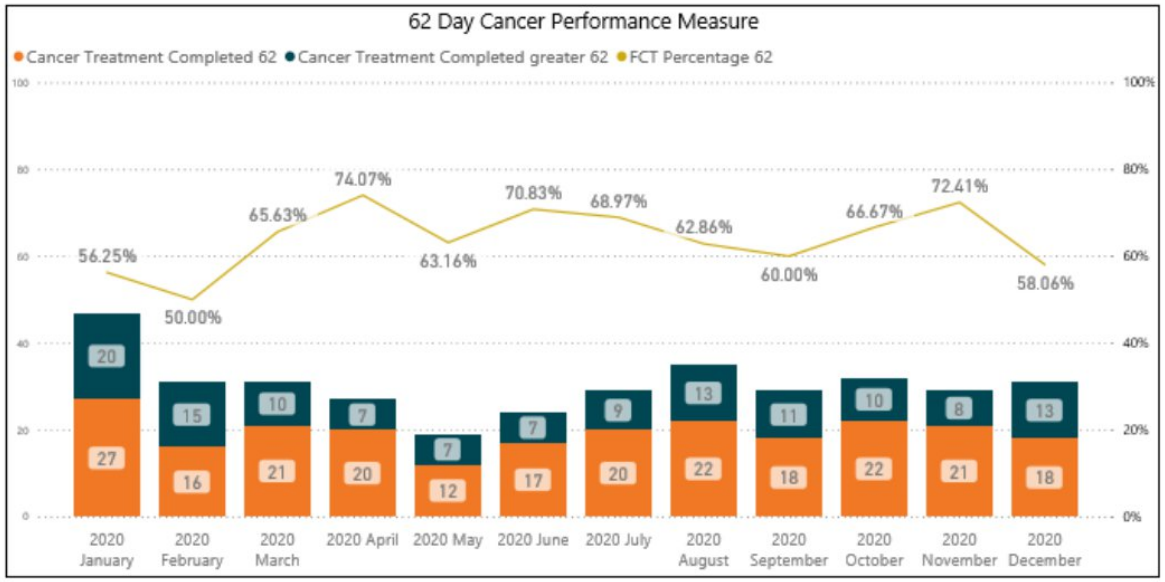

FCT Percentage Last Quarter
84.23%


FCT Percentage Overall
85.62%


Average Referral to treatment time (Days) by Cancer ...
Lower GI 78
Urological 74
Gynaecol... 69
Lung 66
Upper GI 60
Sarcoma 59
Other 54
Breast 53
Head and... 50
Haematol... 50
Skin 37
Brain/CNS 21
0
50
100

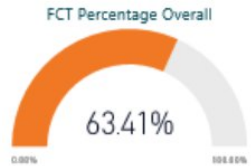

Completed Cancer Cases (62 day Track)
Cancer Treatment Completed 62
Cancer Treatment Com...
Lower GI 18 29
Breast 62 18
Gynaecolo... 20 18
Lung 19 18
Urological 18 17
Haematol... 28 10
Upper GI 20 8
Head and ... 18 6
Skin 22
Other
Sarcoma
Brain/CNS
0
20
40
60
80


62 day track % on total cancer cases
Skin 65.79%
Gynaecol... 55.88%
Head and... 54.35%
Breast 44.20%
Lung 35.40%
Other 33.33%
Haemato... 31.67%
Sarcoma 28.57%
Upper GI 24.35%
Lower GI 16.90%
Urological 13.57%
Brain/CNS 7.41%
0%
20%
40%
60%


62 Day Cancer Performance Measure
Cancer Treatment Completed 62
Cancer Treatment Completed greater 62
FCT Percentage 62
56.25%
50.00%
65.63%
74.07%
63.16%
70.83%
68.97%
62.86%
60.00%
66.67%
72.41%
58.06%
2020 January 20 27
2020 February 15 16
2020 March 10 21
2020 April 7 20
2020 May 7 12
2020 June 7 17
2020 July 9 20
2020 August 13 22
2020 September 11 18
2020 October 10 22
2020 November 8 21
2020 December 13 18
100%
80%
60%
40%
20%
0%


FCT Percentage Current Quarter
(Blank)


FCT Percentage Last Quarter
65.59%


FCT Percentage Overall
63.41%

In terms of the 62-day target, which measures the time from referral to first treatment our performance is less than the target. We believe that the manner in which we are recording our performance is inconsistent with other DHB's and we have commenced an exercise of replicating the CDHB logic for calculating the 62-day target. We anticipate that our performance may lift by as much as 10% if we were to calculate this more consistently with other DHBs. However, performance is still below the target and we considering what measures can be taken to improve performance against the 62-day measure.

Based on feedback from the previous HAC Chair we have also developed a quick report to show the wait list for each of the key oncology areas (haematology, oncology and radiation oncology) and to show how this is changing over time.

**FSA's Seen per Week and Wait List for Oncology Services**

Combined Monthly View

| | Specality desc | Haematology | | | Oncology | | | Radiation Oncology | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Year | Month | FSA Authorised (Demand) | FSA SEEN | Waitlist | FSA Authorised (Demand) | FSA SEEN | Waitlist | FSA Authorised (Demand) | FSA SEEN | Waitlist |
| ⊟ 2020 | July | 39 | 27 | 56 | 72 | 48 | 57 | 93 | 65 | 90 |
| | August | 37 | 34 | 57 | 59 | 64 | 62 | 113 | 94 | 117 |
| | September | 40 | 26 | 80 | 76 | 63 | 52 | 133 | 113 | 92 |
| | October | 31 | 32 | 68 | 60 | 39 | 76 | 93 | 88 | 116 |
| | November | 30 | 32 | 61 | 84 | 61 | 80 | 126 | 103 | 129 |
| | December | 28 | 17 | 80 | 67 | 51 | 96 | 116 | 97 | 147 |
| ⊟ 2021 | January | 20 | 28 | 77 | 38 | 36 | 77 | 80 | 65 | 118 |

Capacity Average/ Month

| Haematology | Oncology | Radiation Oncology |
|---|---|---|
| 28.00 | 51.71 | 89.29 |

Please note all Waitlist data is taken on Monday morning 9.00 am for the previous week and remains static However the referrals accepted and received gets updated for previous weeks during each refresh due to delays in triaging and entering the data. This prevents a linear relationship between weekly waitlist and received/authorized

- Based on average monthly FSA's seen of 28, the current Haematology wait list of 77 represents approximately 2.75 months' worth of workload.
- Based on average monthly FSA's seen of 51.71, the current Oncology wait list of 77 represents approximately 1.5 months' worth of workload.
- Based on average monthly FSA's seen of 89.29, the current Radiation Oncology wait list of 118 represents approximately 1.3 months' worth of workload.

At 118 the current Radiation Oncology wait list is higher than it has historically been. A 6$^{th}$ radiation oncologist from Singapore is currently being reference checked and a second Registered Medical Officer (RMO) will be starting soon. A radiation oncology clinical nurse specialist is also underway. The General Manager and Service Manager are currently quantifying the impact that these initiatives

are projected to have on the wait list and we will then consider whether this needs to be topped up with outsourcing some cases to St Georges in Christchurch to bring the wait list down to 70 which is more in line with where it has historically been.



## 8. Endoscopy

Our colonoscopy improvement programme continues to focus on the development of robust reporting, the roll out of the enhanced internal digital referral and ensuring we have referral pathways and a robust second review process for all colonoscopy referrals.

In terms of the enhanced digital referral this has been worked on by the project lead with input from a number of stakeholders. We are awaiting final amendments to be made by our IS colleagues and we can then programme this in to go live. The new referral will clearly identify when a GI Specialist has requested a referral through one of their junior staff (in which case the referral should automatically be accepted) as this (whether or not the GI Specialist has requested the referral or junior staff have requested it of their own accord) is currently creating a lack of clarity at times.

In terms of the referral pathway we need to ensure that when a colonoscopy referral is unable to be prioritised against access criteria by the nurse at triage there is a second review, and if either the triaging nurse, a gastroenterologist or a surgeon believe the referral needs to be progressed upon second review it needs to be accepted. This is working well in Dunedin but and we are working on how to make this process work as intended in Southland.

We are continuing to develop reports (some of these are still being validated) to give us an accurate picture of our capacity to complete colonoscopies, as well as to give us a sense of how well we continue to meet the Ministry of Health indicators and how long the wait times are for urgent, non-urgent and routine colonoscopies. A selection of these reports, together with further explanation, is as follows:

### Referrals Received and Accepted

We are working on a report that tells us how many referrals are received, accepted, declined or are awaiting prioritisation. This report needs an additional column, which is being worked on, to tell us what the net additions (or subtractions) from our wait list are on a weekly basis. Once the additional column is added we will be able to see what we have received versus what we have accepted and what has been accepted versus what we have scoped on a weekly basis to understand how our wait list is changing over time. The key information this will tell us is *'given the volumes we are currently receiving and accepting, is our current level of scoping staying on top of these, or are we adding to our wait list over time?'*

Once we have developed the extra column we will also develop an additional report to tell us by category (urgent, non-urgent, surveillance) what was received, accepted and scanned on a weekly basis so that we have an understanding by sub-category to what extent we are managing volumes on a weekly basis versus adding to our wait list. I.e. we will essentially report the same wait list information at sub-category level.

**Wait Time by Sub-Category**

Real time waitlist - combined

| Priority new | No of Waiting Patients | Average waiting time | Median Wait time | Longest Wait |
|---|---|---|---|---|
| Diag Urgent | 10 | 11.60 | 9.00 | 33 |
| Diag Non-Urgent | 107 | 29.24 | 21.00 | 204 |
| Diag Planned and Staged | 59 | 36.41 | 25.00 | 117 |
| NBSP | 44 | 14.00 | 13.00 | 82 |
| SURV | 562 | 115.42 | 100.00 | 363 |

Real time waitlist - by region

| Hospital | No of Waiting Patients | Average waiting time | Median Wait time | Longest Wait |
|---|---|---|---|---|
| **Dunedin** | | | | |
| Diag Urgent | 6 | 12.50 | 9.00 | 33 |
| Diag Non-Urgent | 66 | 26.27 | 15.00 | 204 |
| Diag Planned and Staged | 33 | 40.18 | 32.00 | 117 |
| NBSP | 32 | 14.00 | 13.00 | 82 |
| SURV | 217 | 74.87 | 73.00 | 363 |
| **Southland** | | | | |
| Diag Urgent | 4 | 10.25 | 10.50 | 14 |
| Diag Non-Urgent | 41 | 34.02 | 29.00 | 104 |
| Diag Planned and Staged | 26 | 31.62 | 15.00 | 104 |
| NBSP | 12 | 14.00 | 9.50 | 57 |
| SURV | 345 | 140.92 | 137.00 | 335 |

The above reports tell us the number of patients in each sub-category and the average, median and longest wait times, by sub-category. We are still undertaking some validation work on the surveillance times so these reports should be considered draft.

**Maximum Wait Time Breach Numbers and Non-Urgent Category Split by Wait Time Bands**

Maximum Wait time Breach

| Hospital | Urg >30 | Non urg >90 | SURV >120 | NBSP > 45 |
|---|---|---|---|---|
| Dunedin | | 1 | 37 | 1 |
| Southland | | 1 | 210 | 1 |
| **Total** | | **2** | **247** | **2** |

Non Urgent Waitlist Split

| Hospital | 42 days or lesser | 42 to 50 days | 50 to 60 days | 60 to 70 days | 70 to 80 days | 80 to 90 days | 90 days or greater | Total |
|---|---|---|---|---|---|---|---|---|
| Southland | 30 | 2 | 4 | | 4 | 2 | 1 | **43** |
| Dunedin | 55 | 1 | 2 | 4 | 3 | | 1 | **66** |
| **Total** | **85** | **3** | **6** | **4** | **7** | **2** | **2** | **109** |

The above reports (left hand side) tells us how many patients have breached the maximum wait times per category and (right hand side) the amount of time waiting (in time bands) for the non-urgent category. These results suggest that the wait times are mostly achieved for urgent and non-urgent patients, with only 2 non-urgent patients waiting longer than the 90-day target. Please note that this report is a 'live wait list report' so provides a breakdown of the wait list at the moment it is run (we ran this report on the 15th of February).

**Overall Performance Against Ministry Target by Month**

Performance on Ministry Targets - Region combined

| End of Month | Diag Urgent 14 days(90%) | Var Urgent | Non Urgent 42 days (70%) | Var Non Urgent | NBSP 45 Days (95%) | NBSP Var |
|---|---|---|---|---|---|---|
| 31 July 2020 | 91.23% | 1.23% | 68.95% | -1.05% | 97.78% | 2.78% |
| 31 August 2020 | 85.71% | -4.29% | 74.52% | 4.52% | 97.25% | 2.25% |
| 30 September 2020 | 89.80% | -0.20% | 82.79% | 12.79% | 97.25% | 2.25% |
| 31 October 2020 | 92.59% | 2.59% | 84.82% | 14.82% | 96.63% | 1.63% |
| 30 November 2020 | 100.00% | 10.00% | 78.82% | 8.82% | 100.00% | 5.00% |
| 31 December 2020 | 92.86% | 2.86% | 90.09% | 20.09% | 98.67% | 3.67% |
| 31 January 2021 | 81.08% | -8.92% | 63.43% | -6.57% | 98.08% | 3.08% |

The above report shows how we compare to the Ministry target on a month by month basis for urgent, non-urgent and bowel screening. It shows that our performance is generally very good (refer to the positive variances in green) and when we do drop below target (refer to negative variances in red) it is usually by a small percentage.

**Overall Performance Against Ministry Target by Month Split by Region**

Performance on Ministry Targets - by region

| Region | Dunedin | | | | | | Southland | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| End of Month | Diag Urgent 14 days (90%) | Var Urgent | Non Urgent 42 days (70%) | Var Non Urgent | NBSP 45 Days (95%) | NBSP Var | Diag Urgent 14 days (90%) | Var Urgent | Non Urgent 42 days (70%) | Var Non Urgent | NBSP 45 Days (95%) | NBSP Var |
| 31 July 2020 | 97.22% | 7.22% | 80.84% | 10.84% | 100.00% | 5.00% | 80.95% | -9.05% | 54.68% | -15.32% | 93.10% | -1.90% |
| 31 August 2020 | 85.71% | -4.29% | 75.78% | 5.78% | 97.22% | 2.22% | 85.71% | -4.29% | 72.55% | 2.55% | 97.30% | 2.30% |
| 30 September 2020 | 87.10% | -2.90% | 83.42% | 13.42% | 98.63% | 3.63% | 94.44% | 4.44% | 81.82% | 11.82% | 94.44% | -0.56% |
| 31 October 2020 | 94.59% | 4.59% | 83.33% | 13.33% | 96.49% | 1.49% | 88.24% | -1.76% | 88.00% | 18.00% | 96.88% | 1.88% |
| 30 November 2020 | 100.00% | 10.00% | 84.38% | 14.38% | 100.00% | 5.00% | 100.00% | 10.00% | 67.71% | -2.29% | 100.00% | 5.00% |
| 31 December 2020 | 100.00% | 10.00% | 89.10% | 19.10% | 98.11% | 3.11% | 83.33% | -6.67% | 92.42% | 22.42% | 100.00% | 5.00% |
| 31 January 2021 | 83.33% | -6.67% | 70.00% | 0.00% | 100.00% | 5.00% | 78.95% | -11.05% | 50.00% | -20.00% | 93.75% | -1.25% |

This report shows that there is a bit of variability between Otago and Southland, with Southland performance a little lower than Dunedin.

**Session Utilisation (based on Provation)**

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

| Location | Dunedin | | | | | | | southland | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Room | Blue Room | | | | Green Room | | | Endoscopy | | | | |
| Year | ilization schedule | Utilization by room | No of Procedures | Total Time | Utilization | Utilization by schedule | Utilization by room | No of Procedures | Total Time | Utilization | Utilization by schedule | Utilization by room |
| 2020 | 83.76% | 77.42% | 676 | 24268 | 65.66% | 72.23% | 38.30% | 1089 | 42571 | 66.68% | 98.54% | 67.19% |
| July | 86.80% | 86.80% | 106 | 3516 | 56.35% | 61.04% | 31.85% | 170 | 6573 | 62.24% | 88.35% | 59.54% |
| August | 91.99% | 87.61% | 101 | 3683 | 69.75% | 76.73% | 36.54% | 200 | 7590 | 65.89% | 98.83% | 75.30% |
| September | 79.68% | 72.43% | 107 | 3954 | 68.65% | 82.38% | 37.44% | 206 | 8061 | 69.97% | 101.78% | 76.34% |
| October | 90.82% | 82.57% | 77 | 2751 | 52.10% | 63.68% | 26.05% | 171 | 7221 | 71.64% | 103.75% | 68.38% |
| November | 76.76% | 76.76% | 160 | 5747 | 70.43% | 72.56% | 57.01% | 194 | 7454 | 67.52% | 100.19% | 73.95% |
| December | 75.60% | 59.17% | 125 | 4617 | 73.99% | 76.95% | 41.82% | 148 | 5672 | 62.19% | 98.47% | 51.38% |
| 2021 | 71.85% | 34.84% | 127 | 4462 | 66.40% | 71.51% | 28.17% | 122 | 4528 | 58.96% | 82.03% | 28.59% |
| January | 71.85% | 54.74% | 127 | 4462 | 66.40% | 71.51% | 44.27% | 122 | 4528 | 58.96% | 82.03% | 44.92% |
| Total | 82.38% | 68.90% | 803 | 28730 | 65.77% | 72.11% | 36.28% | 1211 | 47099 | 65.85% | 96.67% | 59.47% |

Drill on Rows

Notes

Utilization - This is calculated by assuming that any given day if at the least one scope was done then the availability was 480 Minutes for that room.

Utilization based on Schedule - This is based on general schedule by which a room is released for 480 Minutes or 240 Minutes. Eg Green room is scheduled only for 240 minutes on a Monday and Tuesday , whereas its scheduled for 480 Minutes on a Wednesday. This is mapped and utilization is calculated on it. Day to day utilization can be more than 100% as the actual schedule on the day could be different to the generic schedule

Utilization based on Room - This is based on the assumption that rooms are physically available for use for 480 minutes from Monday to Saturday. Utilization is measured on physical room

This report should be considered a *'first cut'* and explains how much session capacity exists in both Dunedin and Southland. This is important as if we want to achieve more scoping our first priority should be to maximise the utilisation of existing, resourced sessions, our second priority should be to complete as many sessions as possible within available resourcing and our final priority should be to resource additional sessions within the constraints of our physical capacity.

- Utilisation by schedule tells us how much of a session that was scheduled was used for case work. It is calculated on the following basis. The case time for the cases in the session is taken from 'Provation', which records the time the scope is in use. We have added an assumed 20 minutes for preparation and clean up for each case. Therefore, if a 4-hour session was scheduled on a Monday, 2 cases were completed and each took 40 minutes, the utilisation by schedule would be calculated as (40 minutes plus 20 minutes) X 2 cases equals 120 minutes used out of 240 minutes available (4 hours) equals a utilisation by schedule of 50%. This measure tells us how much of scheduled (and resourced) session time was used. Similar to operating theatres we would expect 80% or better. This measure does not, however, tell us how efficiently each case was completed and it does not tell us how many sessions were scheduled compared to the physical capacity that could be scheduled. This is captured in the next measure.

- Utilisation by room then tells us how much sessional capacity was used compared to how much could be booked in the room from Monday to Friday. For example, using the previous example, if the room was only resourced in the morning, but could have been booked for the whole day (8 hours) if we had sufficient resource to do so, the utilisation by room would be calculated at 120 minutes used versus 480 minutes available, reflecting only 25% utilisation.

Although we need to refine the reporting a bit further, what it tells us is that the sessions that are resourced and scheduled are used well (although we will need to look at the time spent per case to get a full picture for this in the future), but that there is a reasonable amount of additional capacity available in the rooms which is not currently resourced. The variability in utilisation by room in Southland is likely to also be driven by how much of the available session capacity has been picked up and used between gastroenterology and general surgery and we will drill into this further as we seek to enhance our understanding of utilisation. In Dunedin there is also the 'yellow' room, which is not currently resourced. Overall, the picture suggests that if we ultimately decide to resource more sessions to do more scoping there is facility capacity available for us to do this.

## 9. Caseweight, Discharges and Volumes

| | |
|---|---|
| **Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,518** | **7,140** Actual YTD vs 7,166 Plan YTD, as at January 2021 |

Note the above discharges is on the same basis i.e. being the Planned Care Interventions. Improvement Action Plan volumes are excluded.

Refer to page 24 - Caseweight and discharge volumes graph. (Board Action - Separated by site where possible).

| Jan-21 | | | | Jan-20 | YEAR ON YEAR | | YTD 2020/21 | | | | YTD Jan-20 | YEAR ON YEAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | % Variance | Actual | Monthly Variance | | Actual | Budget | Variance | % Variance | Actual | YTD Variance |
| | | | | | | **Medical Caseweights** | | | | | | |
| **1,435** | **1,344** | **91** | **7%** | **1,474** | **(39)** | **Acute** | **10,515** | **10,083** | **432** | **4%** | **10,850** | **(335)** |
| *931* | *887* | *44* | *5%* | 984 | (53) | Otago | 7,034 | 6,657 | 377 | 6% | 7,088 | (54) |
| *504* | *457* | *47* | *10%* | 490 | 14 | Southland | 3,481 | 3,426 | 55 | 2% | 3,762 | (281) |
| **327** | **243** | **84** | **35%** | **296** | **31** | **Elective** | **2,406** | **2,011** | **395** | **20%** | **2,257** | **149** |
| 291 | 211 | 80 | 38% | 269 | 22 | Otago | 2,129 | 1,766 | 363 | 21% | 2,000 | 129 |
| 36 | 32 | 4 | 13% | 27 | 9 | Southland | 277 | 245 | 32 | 13% | 257 | 20 |
| **1,762** | **1,587** | **175** | **11%** | **1,770** | **(8)** | **Total Medical Caseweights** | **12,921** | **12,094** | **827** | **7%** | **13,107** | **(186)** |
| | | | | | | **Surgical Caseweights** | | | | | | |
| **1,017** | **1,141** | **(124)** | **-11%** | **1,155** | **(138)** | **Acute** | **8,510** | **8,492** | **18** | **0%** | **8,326** | **184** |
| *677* | 797 | (120) | -15% | 769 | (92) | Otago | 5,926 | 5,924 | 2 | 0% | 5,896 | 30 |
| *340* | 344 | (4) | -1% | 385 | (45) | Southland | 2,584 | 2,568 | 16 | 1% | 2,429 | 155 |
| **1,070** | **998** | **72** | **7%** | **1,058** | **11** | **Elective** | **9,370** | **9,294** | **76** | **1%** | **9,397** | **(27)** |
| *752* | 738 | 14 | 2% | 786 | (34) | Otago | 6,955 | 6,765 | 190 | 3% | 6,894 | 61 |
| *318* | 260 | 58 | 22% | 272 | 46 | Southland | 2,415 | 2,529 | (114) | -5% | 2,502 | (87) |
| **2,087** | **2,139** | **(52)** | **-2%** | **2,213** | **(127)** | **Total Surgical Caseweights** | **17,881** | **17,786** | **94** | **1%** | **17,723** | **157** |
| | | | | | | **Maternity Caseweights** | | | | | | |
| **60** | **82** | **(22)** | **-27%** | **85** | **(25)** | **Acute** | **661** | **627** | **34** | **5%** | **728** | **(67)** |
| *54* | 60 | (6) | -10% | 55 | (1) | Otago | 475 | 457 | 18 | 4% | 516 | (41) |
| *6* | 22 | (16) | -73% | 30 | (24) | Southland | 186 | 170 | 16 | 9% | 212 | (26) |
| **403** | **331** | **72** | **22%** | **341** | **62** | **Elective** | **2,587** | **2,476** | **111** | **4%** | **2,431** | **156** |
| *228* | 198 | 30 | 15% | 188 | 40 | Otago | 1,598 | 1,484 | 114 | 8% | 1,451 | 147 |
| *175* | 133 | 42 | 32% | 152 | 23 | Southland | 989 | 992 | (3) | 0% | 980 | 9 |
| **463** | **413** | **50** | **12%** | **426** | **37** | **Total Maternity Caseweights** | **3,248** | **3,103** | **145** | **5%** | **3,159** | **89** |
| | | | | | | | | | | | | |
| | | | | | | **TOTALS** | | | | | | |
| **2,512** | **2,567** | **(55)** | **-2%** | **2,714** | **(202)** | **Acute** | **19,686** | **19,202** | **484** | **3%** | **19,904** | **(220)** |
| 1,662 | 1,744 | (82) | -5% | 1,808 | **(146)** | Otago | 13,435 | 13,038 | 397 | 3% | 13,500 | **(65)** |
| 850 | 823 | 27 | 3% | 906 | **(56)** | Southland | 6,251 | 6,164 | 87 | 1% | 6,403 | **(152)** |
| **1,800** | **1,572** | **228** | **15%** | **1,695** | **104** | **Elective** | **14,363** | **13,781** | **582** | **4%** | **14,085** | **278** |
| 1,271 | 1,147 | 124 | 11% | 1,244 | **27** | Otago | 10,682 | 10,015 | 667 | 7% | 10,345 | **337** |
| 529 | 425 | 104 | 24% | 451 | **78** | Southland | 3,681 | 3,766 | (85) | -2% | 3,739 | **(58)** |
| **4,312** | **4,139** | **173** | **4%** | **4,408** | **(97)** | **Total Caseweights** | **34,049** | **32,983** | **1,066** | **3%** | **33,989** | **60** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **TOTALS excl. Maternity** | | | | | | |
| **2,452** | **2,485** | **(33)** | **-1%** | **2,629** | **(177)** | **Acute** | **19,025** | **18,575** | **450** | **2%** | **19,176** | **(151)** |
| 1,608 | 1,684 | (76) | -5% | 1,753 | **(145)** | Otago | 12,960 | 12,581 | 379 | 3% | 12,984 | **(24)** |
| 844 | 801 | 43 | 5% | 875 | **(31)** | Southland | 6,065 | 5,994 | 71 | 1% | 6,191 | **(126)** |
| **1,397** | **1,241** | **156** | **13%** | **1,354** | **42** | **Elective** | **11,776** | **11,305** | **471** | **4%** | **11,654** | **122** |
| 1,043 | 949 | 94 | 10% | 1,055 | **(12)** | Otago | 9,084 | 8,531 | 553 | 6% | 8,894 | **190** |
| 354 | 292 | 62 | 21% | 299 | **55** | Southland | 2,692 | 2,774 | (82) | -3% | 2,759 | **(67)** |
| **3,849** | **3,726** | **123** | **3%** | **3,983** | **(135)** | **Total Caseweights excl. Maternity** | **30,801** | **29,880** | **921** | **3%** | **30,830** | **(29)** |

| Jan-21 | | | | Jan-20 | YEAR ON YEAR | Maternity Breakdown | YTD 2020/21 | | | | YTD Jan-20 | YEAR ON YEAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | % Variance | Actual | Monthly Variance | | Actual | Budget | Variance | % Variance | Actual | YTD Variance |
| **60** | **82** | **(22)** | **-27%** | **85** | **(25)** | **Acute** | **661** | **627** | **34** | **5%** | **728** | **(67)** |
| 39 | 61 | (22) | -35% | 60 | **(20)** | Specialist neonates | 432 | 463 | (31) | -7% | 536 | **(104)** |
| 21 | 21 | (0) | -2% | 25 | **(5)** | Maternity inpatient (DRGs) | 229 | 164 | 66 | 40% | 192 | **37** |
| **403** | **331** | **72** | **22%** | **341** | **62** | **Elective** | **2,587** | **2,476** | **111** | **4%** | **2,431** | **156** |
| 123 | 73 | 50 | 68% | 78 | **45** | Specialist neonates | 657 | 551 | 106 | 19% | 543 | **114** |
| 280 | 258 | 22 | 9% | 263 | **18** | Maternity inpatient (DRGs) | 1,929 | 1,925 | 4 | 0% | 1,888 | **42** |
| **463** | **413** | **50** | **12%** | **426** | **37** | **Total Maternity Caseweights** | **3,248** | **3,103** | **145** | **5%** | **3,159** | **89** |

**FOR APPROVAL/INFORMATION**

**Item:** Financial Report for the period ended 31 January 2021

**Proposed by:** Grant Paris, Management Accountant

Presented by: Patrick Ng, Executive Director of Specialist Services

**Meeting of:** 01 March 2021



## Recommendation

**That the Hospital Advisory Committee notes the Financial Report for the period ended 31 January 2021.**

## Purpose

1. To provide the Hospital Advisory Committee with the financial performance for the month and year to date ended 31 January 2021.

## Specific Implications for Consideration

2. Financial

- The historical financial performance impacts on the options for future investment by the organisation as unfavourable results reduce the resources available.

## Next Steps & Actions

The Finance team are continuing to refine and develop the presentation and content of the Financial Report to improve transparency and understanding of the financial performance and position of the organisation.

## Appendices

Appendix 1 Financial Report for the Hospital Advisory Committee

Appendix 1: Financial Report for the Hospital Advisory Committee



# SOUTHERN DHB FINANCIAL REPORT – Summary for HAC

**Financial Report for:** **January 2021**
**Report Prepared by:** **Grant Paris**
**Management Accountant**
**Date:** **19 February 2021**

## Overview

### Results Summary for Specialist Services

### *1.* January 2021 Result

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 | Budget | Variance | | Actual | Budget | Variance | Budget |
| $000 | $000 | $000 | | $000 | $000 | $000 | $000 |
| 44,660 | 45,061 | (401) | Revenue | 318,130 | 316,142 | 1,988 | 541,965 |
| 24,217 | 23,844 | (373) | Less Workforce Costs | 171,617 | 168,235 | (3,382) | 292,043 |
| 11,219 | 10,138 | (1,081) | Less Other Costs | 89,715 | 81,598 | (8,117) | 138,761 |
| **9,224** | **11,079** | **(1,855)** | **Net Surplus / (Deficit)** | **56,799** | **66,309** | **(9,510)** | **111,161** |

For January 2021, Specialist Services had a surplus of $9.2m, which is $1.9m unfavourable to budget.

### 2. Surgical Performance – Case Weights and Discharges

**Provider Activity View**

The Planned Care targets have now been agreed with the Ministry of Health. The elective caseweights for January 2021 are 104 more than January 2020 while the year to date elective caseweights are 278 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 half 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)

Appendix 1: Financial Report for the Hospital Advisory Committee

| Jan-21 | | | | Jan-20 | YEAR ON YEAR | | YTD 2020/21 | | | | YTD Jan-20 | YEAR ON YEAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | % Variance | Actual | Monthly Variance | | Actual | Budget | Variance | % Variance | Actual | YTD Variance |
| | | | | | | **Medical Caseweights** | | | | | | |
| **1,435** | **1,344** | **91** | **7%** | **1,474** | **(39)** | **Acute** | **10,515** | **10,083** | **432** | **4%** | **10,850** | **(335)** |
| *931* | *887* | *44* | *5%* | 984 | (53) | Otago | 7,034 | 6,657 | 377 | 6% | 7,088 | (54) |
| *504* | *457* | *47* | *10%* | 490 | 14 | Southland | 3,481 | 3,426 | 55 | 2% | 3,762 | (281) |
| **327** | **243** | **84** | **35%** | **296** | **31** | **Elective** | **2,406** | **2,011** | **395** | **20%** | **2,257** | **149** |
| 291 | 211 | 80 | 38% | 269 | 22 | Otago | 2,129 | 1,766 | 363 | 21% | 2,000 | 129 |
| 36 | 32 | 4 | 13% | 27 | 9 | Southland | 277 | 245 | 32 | 13% | 257 | 20 |
| **1,762** | **1,587** | **175** | **11%** | **1,770** | **(8)** | **Total Medical Caseweights** | **12,921** | **12,094** | **827** | **7%** | **13,107** | **(186)** |
| | | | | | | **Surgical Caseweights** | | | | | | |
| **1,017** | **1,141** | **(124)** | **-11%** | **1,155** | **(138)** | **Acute** | **8,510** | **8,492** | **18** | **0%** | **8,326** | **184** |
| *677* | 797 | (120) | -15% | 769 | (92) | Otago | 5,926 | 5,924 | 2 | 0% | 5,896 | 30 |
| *340* | 344 | (4) | -1% | 385 | (45) | Southland | 2,584 | 2,568 | 16 | 1% | 2,429 | 155 |
| **1,070** | **998** | **72** | **7%** | **1,058** | **11** | **Elective** | **9,370** | **9,294** | **76** | **1%** | **9,397** | **(27)** |
| *752* | 738 | 14 | 2% | 786 | (34) | Otago | 6,955 | 6,765 | 190 | 3% | 6,894 | 61 |
| *318* | 260 | 58 | 22% | 272 | 46 | Southland | 2,415 | 2,529 | (114) | -5% | 2,502 | (87) |
| **2,087** | **2,139** | **(52)** | **-2%** | **2,213** | **(127)** | **Total Surgical Caseweights** | **17,881** | **17,786** | **94** | **1%** | **17,723** | **157** |
| | | | | | | **Maternity Caseweights** | | | | | | |
| **60** | **82** | **(22)** | **-27%** | **85** | **(25)** | **Acute** | **661** | **627** | **34** | **5%** | **728** | **(67)** |
| *54* | 60 | (6) | -10% | 55 | (1) | Otago | 475 | 457 | 18 | 4% | 516 | (41) |
| *6* | 22 | (16) | -73% | 30 | (24) | Southland | 186 | 170 | 16 | 9% | 212 | (26) |
| **403** | **331** | **72** | **22%** | **341** | **62** | **Elective** | **2,587** | **2,476** | **111** | **4%** | **2,431** | **156** |
| *228* | 198 | 30 | 15% | 188 | 40 | Otago | 1,598 | 1,484 | 114 | 8% | 1,451 | 147 |
| *175* | 133 | 42 | 32% | 152 | 23 | Southland | 989 | 992 | (3) | 0% | 980 | 9 |
| **463** | **413** | **50** | **12%** | **426** | **37** | **Total Maternity Caseweights** | **3,248** | **3,103** | **145** | **5%** | **3,159** | **89** |
| | | | | | | | | | | | | |
| | | | | | | **TOTALS** | | | | | | |
| **2,512** | **2,567** | **(55)** | **-2%** | **2,714** | **(202)** | **Acute** | **19,686** | **19,202** | **484** | **3%** | **19,904** | **(220)** |
| 1,662 | 1,744 | (82) | -5% | 1,808 | (146) | Otago | 13,435 | 13,038 | 397 | 3% | 13,500 | (65) |
| 850 | 823 | 27 | 3% | 906 | (56) | Southland | 6,251 | 6,164 | 87 | 1% | 6,403 | (152) |
| **1,800** | **1,572** | **228** | **15%** | **1,695** | **104** | **Elective** | **14,363** | **13,781** | **582** | **4%** | **14,085** | **278** |
| 1,271 | 1,147 | 124 | 11% | 1,244 | 27 | Otago | 10,682 | 10,015 | 667 | 7% | 10,345 | 337 |
| 529 | 425 | 104 | 24% | 451 | 78 | Southland | 3,681 | 3,766 | (85) | -2% | 3,739 | (58) |
| **4,312** | **4,139** | **173** | **4%** | **4,408** | **(97)** | **Total Caseweights** | **34,049** | **32,983** | **1,066** | **3%** | **33,989** | **60** |
| | | | | | | | | | | | | |
| | | | | | | **TOTALS excl. Maternity** | | | | | | |
| **2,452** | **2,485** | **(33)** | **-1%** | **2,629** | **(177)** | **Acute** | **19,025** | **18,575** | **450** | **2%** | **19,176** | **(151)** |
| 1,608 | 1,684 | (76) | -5% | 1,753 | (145) | Otago | 12,960 | 12,581 | 379 | 3% | 12,984 | (24) |
| 844 | 801 | 43 | 5% | 875 | (31) | Southland | 6,065 | 5,994 | 71 | 1% | 6,191 | (126) |
| **1,397** | **1,241** | **156** | **13%** | **1,354** | **42** | **Elective** | **11,776** | **11,305** | **471** | **4%** | **11,654** | **122** |
| 1,043 | 949 | 94 | 10% | 1,055 | (12) | Otago | 9,084 | 8,531 | 553 | 6% | 8,894 | 190 |
| 354 | 292 | 62 | 21% | 299 | 55 | Southland | 2,692 | 2,774 | (82) | -3% | 2,759 | (67) |
| **3,849** | **3,726** | **123** | **3%** | **3,983** | **(135)** | **Total Caseweights excl. Maternity** | **30,801** | **29,880** | **921** | **3%** | **30,830** | **(29)** |

| Jan-21 | | | | Jan-20 | YEAR ON YEAR | Maternity Breakdown | YTD 2020/21 | | | | YTD Jan-20 | YEAR ON YEAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | % Variance | Actual | Monthly Variance | | Actual | Budget | Variance | % Variance | Actual | YTD Variance |
| **60** | **82** | **(22)** | **-27%** | **85** | **(25)** | **Acute** | **661** | **627** | **34** | **5%** | **728** | **(67)** |
| 39 | 61 | (22) | -35% | 60 | (20) | Specialist neonates | 432 | 463 | (31) | -7% | 536 | (104) |
| 21 | 21 | (0) | -2% | 25 | (5) | Maternity inpatient (DRGs) | 229 | 164 | 66 | 40% | 192 | 37 |
| **403** | **331** | **72** | **22%** | **341** | **62** | **Elective** | **2,587** | **2,476** | **111** | **4%** | **2,431** | **156** |
| 123 | 73 | 50 | 68% | 78 | 45 | Specialist neonates | 657 | 551 | 106 | 19% | 543 | 114 |
| 280 | 258 | 22 | 9% | 263 | 18 | Maternity inpatient (DRGs) | 1,929 | 1,925 | 4 | 0% | 1,888 | 42 |
| **463** | **413** | **50** | **12%** | **426** | **37** | **Total Maternity Caseweights** | **3,248** | **3,103** | **145** | **5%** | **3,159** | **89** |

## Recovery Plan

The Improvement Action Plan (Recovery Plan) covers five areas;

- First specialist appointments (FSA) and follow up appointments waitlists (ESPI 2)
- Inpatient surgical discharge waitlists (ESPI 5), including orthopaedics, general surgery, ophthalmology & urology waitlists
- Diagnostic procedures (MRI)
- Minor surgical procedures, being skin lesions
- Other procedures, being colonoscopies

We have recognised $1.01M for the year to date to January 2021 for the work delivered regarding inpatient surgical discharges and skin lesions. However there is risk around the delivery of the plan trajectory for the other plan items, and at this stage, no revenue has been recognised for FSAs and follow ups, diagnostic procedures or other procedures.

Appendix 1: Financial Report for the Hospital Advisory Committee

**SDHB Monthly HAC Statement of Financial Performance -January 2021**

| 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** | | | | | |
| 753 | 814 | (61) | | MoH Revenue | 5,728 | 5,695 | 33 | | 9,762 |
| 0 | 0 | 0 | | IDF Revenue | 0 | 0 | 0 | | 0 |
| 770 | 614 | 156 | | Other Government | 6,654 | 5,014 | 1,640 | | 8,603 |
| **1,523** | **1,428** | **95** | | **Total Government & Crown** | **12,382** | **10,709** | **1,673** | | **18,365** |
| | | | | **Non Government & Crown Agency Revenue** | | | | | |
| 92 | 184 | (92) | | Patient related | 777 | 1,291 | (514) | | 2,214 |
| 69 | 183 | (114) | | Other Income | 1,100 | 1,282 | (182) | | 2,197 |
| **161** | **368** | **(207)** | | **Total Non Government** | **1,877** | **2,573** | **(696)** | | **4,411** |
| 42,976 | 43,266 | (290) | | Internal Revenue | 303,871 | 302,860 | 1,011 | | 519,189 |
| **44,660** | **45,061** | **(401)** | | **TOTAL REVENUE** | **318,130** | **316,142** | **1,988** | | **541,965** |
| | | | | **EXPENSES** | | | | | |
| | | | | **Workforce** | | | | | |
| | | | | **Senior Medical Officers (SMO's)** | | | | | |
| 5,631 | 5,885 | 254 | 6 | Direct | 43,693 | 43,864 | 171 | 8 | 76,626 |
| 404 | 355 | (49) | | Indirect | 2,536 | 2,486 | (50) | | 4,262 |
| 221 | 135 | (86) | | Outsourced | 2,367 | 1,052 | (1,315) | | 1,777 |
| **6,256** | **6,375** | **119** | **6** | **Total SMO's** | **48,597** | **47,402** | **(1,195)** | **8** | **82,665** |
| | | | | **Registrars / House Officers (RMOs)** | | | | | |
| 4,132 | 3,942 | (190) | (16) | Direct | 27,613 | 27,572 | (41) | (3) | 48,299 |
| 331 | 230 | (101) | | Indirect | 1,316 | 1,607 | 291 | | 2,755 |
| 75 | 25 | (50) | | Outsourced | 315 | 195 | (120) | | 329 |
| **4,538** | **4,196** | **(342)** | **(16)** | **Total RMOs** | **29,244** | **29,374** | **130** | **(3)** | **51,383** |
| **10,794** | **10,571** | **(223)** | **(10)** | **Total Medical costs (incl outsourcing)** | **77,840** | **76,776** | **(1,064)** | **6** | **134,048** |
| | | | | **Nursing** | | | | | |
| 9,743 | 9,770 | 27 | (17) | Direct | 65,481 | 64,201 | (1,280) | (46) | 110,709 |
| 15 | 1 | (14) | | Indirect | 121 | 7 | (114) | | 12 |
| 15 | 3 | (12) | | Outsourced | 37 | 22 | (15) | | 37 |
| **9,773** | **9,775** | **2** | **(17)** | **Total Nursing** | **65,639** | **64,229** | **(1,410)** | **(46)** | **110,758** |
| | | | | **Allied Health** | | | | | |
| 1,997 | 1,914 | (83) | (14) | Direct | 15,424 | 14,949 | (475) | (9) | 25,827 |
| 51 | 25 | (26) | | Indirect | 244 | 176 | (68) | | 456 |
| 126 | 43 | (83) | | Outsourced | 819 | 297 | (522) | | 504 |
| **2,174** | **1,982** | **(192)** | **(14)** | **Total Allied Health** | **16,487** | **15,421** | **(1,066)** | **(9)** | **26,787** |
| | | | | **Support** | | | | | |
| 169 | 175 | 6 | 2 | Direct | 1,213 | 1,296 | 83 | 2 | 2,216 |
| 0 | 1 | 1 | | Indirect | 5 | 6 | 1 | | 11 |
| 0 | 0 | 0 | | Outsourced | 0 | 0 | 0 | | 0 |
| **168** | **176** | **8** | **2** | **Total Support** | **1,218** | **1,302** | **84** | **2** | **2,227** |
| | | | | **Management / Admin** | | | | | |
| 1,300 | 1,326 | 26 | 3 | Direct | 10,360 | 10,409 | 49 | (6) | 18,055 |
| 4 | 9 | 5 | | Indirect | 44 | 60 | 16 | | 102 |
| 2 | 6 | 4 | | Outsourced | 28 | 39 | 11 | | 66 |
| **1,307** | **1,340** | **33** | **3** | **Total Management / Admin** | **10,432** | **10,507** | **75** | **(6)** | **18,223** |
| | | | | | | | | | |
| **24,217** | **23,844** | **(373)** | **(35)** | **Total Workforce Expenses** | **171,617** | **168,235** | **(3,382)** | **(53)** | **292,043** |
| 2,782 | 2,501 | (281) | | **Outsourced Clinical Services** | 23,331 | 21,200 | (2,131) | | 36,350 |
| 0 | 0 | 0 | | **Outsourced Corporate / Governance Servic** | 0 | 0 | 0 | | 0 |
| 0 | 0 | 0 | | **Outsourced Funder Services** | 0 | 0 | 0 | | 0 |
| 6,780 | 5,923 | (857) | | **Clinical Supplies** | 53,859 | 48,656 | (5,203) | | 82,237 |
| 684 | 750 | 66 | | **Infrastructure & Non-Clinical Supplies** | 6,077 | 5,365 | (712) | | 9,075 |
| | | | | **Non Operating Expenses** | | | | | |
| 972 | 963 | (9) | | Depreciation | 6,448 | 6,377 | (71) | | 11,099 |
| 0 | 0 | 0 | | Capital charge | 0 | 0 | 0 | | 0 |
| 0 | 0 | 0 | | Interest | 0 | 0 | 0 | | 0 |
| **11,219** | **10,138** | **(1,081)** | | **Total Non Personnel Expenses** | **89,715** | **81,598** | **(8,117)** | | **138,761** |
| **35,436** | **33,982** | **(1,454)** | | **TOTAL EXPENSES** | **261,332** | **249,834** | **(11,498)** | | **430,804** |
| **9,224** | **11,079** | **(1,855)** | | **Net Surplus / (Deficit)** | **56,799** | **66,309** | **(9,510)** | | **111,161** |

Financial Report

Appendix 1: Financial Report for the Hospital Advisory Committee

## *3. Revenue*



### Ministry of Health (MoH) Revenue

MoH revenue was $0.06m unfavourable to budget for the month and $0.33m favourable year to date. The main contributors are detailed below:

| Category | Monthly Variance $000s | YTD Variance $000s | Comment |
|---|---|---|---|
| Personal Health-side contracts | (35) | (9) | The Jan variance is driven by Bowel Screening revenue less than budgeted and Cancer Psychologists and Support Services revenue contract which was budgeted separately and is part of PBFF in 2021. |
| Public Health-side contracts | (6) | 179 | 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 | (20) | (136) | Contracts have been reconciled to match eligible personnel to the delivery. |
| Other | | (1) | |
| **Total** | **(61)** | **33** | |

### Other Government Revenue

Other Government revenue was $0.16m favourable in January and $1.64m favourable year to date. The major drivers for this are shown below.

| Category | Monthly Variance $000s | YTD Variance $000s | Comment |
|---|---|---|---|
| Haemophiliac rebate | 212 | 1242 | Rebate reflecting increased cost and volume year to date. |
| ACC | 89 | 399 | Additional Orthopaedics ACC revenue |
| Dental school | (39) | (40) | Reduced activity in January |
| Other | (106) | 39 | |
| **Total** | **156** | **1,640** | |

### Patient related revenue

Patient related revenue was under budget for the month by $0.09m and $0.51m 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 $0.11m under budget in January and $0.18m 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.
- A YTD correction to South Island Alliance Programme Office (SIAPO) revenue for recovery of employee costs while seconded

Appendix 1: Financial Report for the Hospital Advisory Committee

**Internal Revenue**
Internal revenue is under budget for the month and $1.01m favourable year to date driven by the revenue booked for the recovery plan. (offset by costs)

## *4. Workforce Costs*



**Monthly result**
Workforce costs (personnel plus outsourcing) were $0.37m unfavourable to budget in January 2021 driven by Direct & Indirect RMO costs and Allied Health costs. Operationally full time equivalent (FTE) were 35 unfavourable to budget in January 2021

**FTE**
Monthly FTE is 35 over budget in January summarised in the following table. Nursing continues to be the main driver of the unfavourable year to date unfavourable variance, however the monthly overrun was less than normal.

| Staff Type | Actual FTE Jan21 | Budget FTE Jan21 | Monthly Variance | % | Actual FTE YTD Jan21 | Budget FTE YTD Jan21 | YTD Variance |
|---|---|---|---|---|---|---|---|
| SMO | 218 | 224 | 6 | 3% | 237 | 245 | 8 |
| RMO | 335 | 319 | (16) | (5%) | 316 | 314 | (3) |
| Nursing | 1,229 | 1,212 | (17) | (1%) | 1,197 | 1,151 | (46) |
| Allied | 268 | 254 | (14) | (6%) | 289 | 280 | (9) |
| Support | 35 | 38 | 2 | 7% | 36 | 38 | 2 |
| Mgmt / Admin | 247 | 251 | 3 | 1% | 278 | 272 | (6) |
| | **2,333** | **2,298** | **(35)** | **(2%)** | **2,353** | **2,300** | **(53)** |

**Senior Medical Officer (SMOs)**

SMOs were $0.12m favourable and 6 FTE favourable for the month. Year to date SMOs are $1.20m unfavourable, 8 FTE favourable.

Continued Vacancies are partially offset by additional allowance payments and overtime, which is driven by extra hours payments, additional radiologist reads and SMOs covering RMO roster gaps.

Outsourced costs are $0.09m unfavourable in a number of areas including Paediatric, General Surgery, Obstetrics & Gynaecology and ENT.

**RMOs**

RMOs were $0.34m unfavourable and 16 FTE unfavourable for the month. Year to date RMOs are $0.13m favourable and 3 FTE unfavourable to budget.

- The 16 FTE unfavourable for January variance has been driven by the annual changeover process, with overlaps in some services as team's transition. Unfavourable variance in overtime of 5FTE has been offset by favourable variances in training 5FTE, stat leave 7FTE and annual leave taken 9FTE.

  Annual leave taken continues to be significantly lower than budget with only 80% of budgeted leave taken in January and 59% taken year to date.

- Indirect favourable year to date expenditure relates to courses and conferences $0.36M favourable, although January month was $0.06M unfavourable. The year

to date is reduction in expenditure primarily reflecting overseas courses being avoided due to COVID. The courses and exams are now done online thereby reducing cost.



**Nursing**

Nursing was on budget and 16.5 FTE unfavourable for the month. Year to date Nursing was $1.41m and 46 FTE unfavourable.

1. Ordinary time variance was against the ytd unfavourable trend being 51FTE under budget and $392k favourable (December year to date trend of 9.5 FTE unfavourable and $230k over budget).

   This is due to the budget not reducing FTE sufficiently over the Christmas period to reflect reduced staffing for any "covered" areas over the Christmas breaks.

2. Stat leave was over budget by 57 FTE due to the budget understating the number of employees entitled to a stat day.

3. Continued FTE variances remain for;

   - 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 2,595 hours (16.2 FTE) which is partially offset by the HCA budget increase of 13.3 FTE in 2020/21.
   - Sick leave unfavourable by 5.5FTE, which is not unexpected as vigilance to the possible spread of any illness means those unwell stay home, this increase has been consistent ytd but has dropped in Jan

**Allied Health**

Allied Health was $0.19m and 14 FTE unfavourable to budget in January. Year to date Allied Health was $1.066m unfavourable and 9 FTE unfavourable.

MRTs and Sonographers are a further $0.05m unfavourable this month ($0.14m year to date) due to being 11 FTE over budget. They have recruited above budget to ensure adequate staffing coverage with graduates and resignation movements and the phasing of the budget to account for this annual cycle of recruitment needs to be improved in budget planning. Partially offsetting this were Technicians that were $0.02m favourable (4 FTE).

Outsourced Technicians are $0.1m unfavourable ($0.52m year to date) mainly across Anaesthesia Service (Dunedin), Ophthalmology and Audiology continuing to cover vacant roles.

**Support**

Support was on budgeted dollars for the month and 2 FTE favourable. Year to date Support was $0.08m favourable and 3 FTE favourable.

Annual leave taken is unfavourable for the month but favourable year to date.

Appendix 1: Financial Report for the Hospital Advisory Committee



**Management and Administration**

Management/Admin dollars were $0.03m and 3 FTE favourable for the month. Year to date Management/Admin costs are $0.8m favourable and 6 FTE unfavourable.

Annual leave taken is 2 FTE more than budget in the month resulting in decreased ordinary hours worked. (Year to date annual leave is 5 FTE less than budget, resulting in increased ordinary hours worked.)

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 $0.28m unfavourable in January and $2.13m unfavourable year to date as shown below.

| | Monthly Actual $000s | Monthly Budget $000s | Monthly Variance $000s | YTD Actual $000s | YTD Budget $000s | YTD Variance $000s | Annual Budget $ |
|---|---|---|---|---|---|---|---|
| Outsourced Surgical Services | 468 | 221 | (247) | 5,886 | 4,600 | (1,286) | 7,813 |
| Outsourced Clinical Services - Other | 430 | 351 | (79) | 3,009 | 2,641 | (368) | 4,550 |
| Radiology Service | 153 | 138 | (15) | 1,357 | 1,106 | (251) | 1,912 |
| Breast Screening | 95 | 86 | (9) | 803 | 691 | (112) | 1,196 |
| Other Radiology Procedures | 40 | 34 | (6) | 301 | 274 | (27) | 475 |
| Laboratory Service | 1,477 | 1,477 | | 10,340 | 10,342 | 2 | 17,728 |
| Laboratory Sendaway Tests | | | | | 3 | 3 | 5 |
| Laboratory O/P Tests | | | | 1 | | (1) | |
| Audiology | 2 | 2 | | 32 | 14 | (18) | 24 |
| Lithotripsy | | 6 | 6 | 30 | 44 | 14 | 77 |
| MRI Scans | 21 | 29 | 8 | 686 | 234 | (452) | 404 |
| Vascular Assessments | 58 | 66 | 8 | 496 | 528 | 32 | 913 |
| CT Scans | 34 | 52 | 18 | 351 | 414 | 63 | 716 |
| Ophthalmology | 3 | 39 | 36 | 40 | 309 | 269 | 535 |
| | 2,781 | 2,501 | (280) | 23,332 | 21,200 | (2,132) | 36,348 |

1) Other Outsourced clinical services is for additional urology and general surgery diagnostic procedures not available in Dunedin and additional orthopaedic and ophthalmology services in Southland.
2) Outsourced Surgical Services are $0.25m unfavourable to budget this month due to utilising additional sessions available for ophthalmology outplaced lists, and additional orthopaedic and ophthalmology outsourcing in Southland. The $1.29m unfavourable YTD, includes the January unfavourable variance plus the activity in prior months related to the Recovery Plan.

Appendix 1: Financial Report for the Hospital Advisory Committee



## *6. Clinical Supplies (excluding depreciation)*

Clinical supplies were unfavourable to budget by $0.86m in January 2021, 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 $ |
|---|---|---|---|---|---|---|---|
| Air Ambulance | 692 | 359 | (333) | 3,163 | 2,874 | (289) | 4,971 |
| Blood and Tissue Supplies | 840 | 569 | (271) | 6,182 | 4,434 | (1,748) | 7,490 |
| Pharmaceuticals | 1,719 | 1,555 | (164) | 12,875 | 12,219 | (656) | 19,725 |
| Patient Consumables | 247 | 121 | (126) | 2,172 | 1,592 | (580) | 2,207 |
| Pacemakers | 190 | 85 | (105) | 1,110 | 713 | (397) | 1,213 |
| Cardiac Implants | 110 | 43 | (67) | 1,294 | 883 | (411) | 1,420 |
| Renal Fluids & Supplies | 140 | 77 | (63) | 764 | 632 | (132) | 1,085 |
| Radioactive Supplies | 70 | 22 | (48) | 208 | 172 | (36) | 298 |
| Disposable Instruments | 198 | 164 | (34) | 1,864 | 1,436 | (428) | 2,507 |
| Implants and Prostheses - Other | 111 | 81 | (30) | 730 | 651 | (79) | 1,124 |
| Clinical Equipment - Operating Leases (non-financing | 41 | 19 | (22) | 196 | 35 | (161) | 127 |
| Staples & Accessories | 53 | 74 | 21 | 541 | 595 | 54 | 1,030 |
| Hip Prostheses | 141 | 171 | 30 | 1,562 | 1,639 | 77 | 3,053 |
| Sutures | 41 | 83 | 42 | 704 | 665 | (39) | 1,150 |
| Clinical Equipment - Service Contracts | 279 | 327 | 48 | 2,396 | 2,292 | (104) | 3,929 |
| Shunts and Stents | 85 | 156 | 71 | 1,126 | 1,250 | 124 | 2,162 |
| Knee Prostheses | 40 | 113 | 73 | 677 | 1,077 | 400 | 2,006 |
| Ambulance | 1 | 87 | 86 | 592 | 700 | 108 | 1,211 |
| Other | 1,782 | 1,817 | 35 | 15,703 | 14,797 | (906) | 25,529 |
| | 6,780 | 5,923 | (857) | 53,859 | 48,656 | (5,203) | 82,237 |

1) Air ambulance was $0.33m over budget for the month and $0.29m unfavourable ytd (majority of unfavourable variance has been driven by January results). In January there were 47 flights at average $15,350 per flight compared to ytd average of 34 flights at $13,877 per flight, this includes:

   - 5 neurosurgery flights for $65k
   - 2 PICU flights for $98k (plus rebate of $32k)
   - 7 x NICU flights $76k (very high)
   - 2 repatriation flights for people being on holiday

   Costs in the 19/20 year were also much higher in the January period compared to the rest of the months.

2) Pharmaceutical costs were $0.16m over budget for the month and $0.66m unfavourable year to date.

   With the exception of the Oncology wards, 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 | Monthly Budget | Monthly Variance | YTD Actual $000s | YTD Budget $000s | YTD Variance | Annual Budget $ |
|---|---|---|---|---|---|---|---|
| Oncology Ward | 360 | 270 | (90) | 2,367 | 2,349 | (18) | 3,651 |
| Gastroenterology 8th floor | 163 | 101 | (62) | 1,120 | 801 | (319) | 1,289 |
| Oncology & Haematology Outpatient Service | 509 | 450 | (59) | 3,661 | 3,932 | 271 | 6,098 |
| Rheumatology / Outpatients | 119 | 91 | (28) | 883 | 654 | (229) | 1,094 |
| General Medicine 8A | 33 | 19 | (14) | 197 | 135 | (62) | 226 |
| Dermatology | 14 | 2 | (12) | 67 | 10 | (57) | 18 |
| Main Operating Theatres Expenditure | 58 | 76 | 18 | 551 | 526 | (25) | 892 |
| Orthopaedic Trauma 3B | 15 | 34 | 19 | 218 | 239 | 21 | 405 |
| Oncology / Haematology 8C | 34 | 65 | 31 | 294 | 452 | 158 | 767 |
| | 1,305 | 1,108 | (197) | 9,358 | 9,098 | (260) | 14,440 |

3) Blood and Tissue Supplies
The majority of this variance is due to a $0.27m unfavourable variance reflecting the increased usage of Haemophiliac products. This is predominantly offset by the Haemophiliac rebate (Other Government revenue), although other blood products are $0.09m over budget due to price being higher than budgeted and acuity and patient requirements.

4) Pacemakers are $0.1m unfavourable for the month and $0.40m unfavourable year to date. Implantable Cardioverter Deflator (ICD) costs are $0.06m unfavourable for the month. 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 January with 4 additional procedures performed. Further work is required to bring activity to planned levels. Pacemakers (non ICD) were $0.04m unfavourable for the month due to high acute demand in January in the Cath Lab.

5) 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).

6) Disposable Instruments $0.04m over budget for the month and $0.43m over budget year to date, with an increase in volumes of products used in general surgery cancer and urology procedures.

7) Renal fluids and supplies was $0.06m over budget for the month and $0.13m unfavourable ytd.

8) Clinical equipment – operating leases are $0.02m over budget and $0.16m unfavourable ytd due to costs incurred for hiring bariatric equipment.

## *7. Infrastructure and Non-Clinical (excluding depreciation)*

These costs were $0.07m favourable to budget in January 2021 and $0.71m 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 | 304 | 429 | 125 | 3,159 | 2,982 | -177 | 5,057 |
| Facilities | 24 | 20 | -4 | 187 | 146 | -41 | 250 |
| Transport | 76 | 82 | 6 | 618 | 612 | -6 | 1,038 |
| IT Systems & Telecommunications | 105 | 86 | -19 | 751 | 601 | -150 | 1,034 |
| Professional Fees and Expenses | 46 | 24 | -22 | 230 | 170 | -60 | 292 |
| Other Operating Expenses | 131 | 108 | -23 | 1,132 | 853 | -279 | 1,405 |
| | 686 | 749 | 63 | 6,077 | 5,364 | -713 | 9,076 |

These costs are driven by the following;

Appendix 1: Financial Report for the Hospital Advisory Committee

| | Monthly Actual $000s | Monthly Budget $000s | Monthly Variance $000s | YTD Actual $000s | YTD Budget $000s | YTD Variance $000s | Annual Budget $ |
|---|---|---|---|---|---|---|---|
| Bureau and Outsourcing Fees | 17 | | (17) | 114 | | (114) | |
| Stock Adjustments | 15 | | (15) | 62 | | (62) | |
| Cost of Goods Sold | 13 | | (13) | 81 | | (81) | |
| Consultants Fees | 16 | 4 | (12) | 66 | 30 | (36) | 52 |
| Printing & Forms | 20 | 10 | (10) | 145 | 86 | (59) | 131 |
| Cleaning Supplies | 37 | 27 | (10) | 274 | 193 | (81) | 324 |
| Corporate Training | | 14 | 14 | | 95 | 95 | 163 |
| Patient Meals (Outsourced) | 309 | 345 | 36 | 2,447 | 2,392 | (55) | 4,061 |
| Cleaning (Outsourced) | (80) | 13 | 93 | 86 | 92 | 6 | 155 |
| Other | 339 | 337 | (2) | 2,799 | 2,476 | (323) | 4,189 |
| | 686 | 750 | 64 | 6,074 | 5,364 | (710) | 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) Cleaning (Outsourced) relates to a year to date correction to the allocation of the Cleaning Schedule

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.