Hospital Advisory Committee

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

05/07/2021 09:00 AM - 11:00 AM

APOLOGIES

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

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Joanne Fannin, Personal Assistant

Meeting of: Hospital Advisory Committee, 5 July 2021

Recommendation

That the Hospital Advisory Committee (HAC) 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:

- Peter Crampton – Executive of Medical Deans Australia and New Zealand Social Accountability Committee and Board of the National Science Challenge removed.
- Andrew Connolly – Currently seconded to Ministry of Health as Acting Chief Medical Officer and Clinical Advisor to the Board, Waikato DHB added.
- Roger Jarrold – Treasury: Health Reform Challenge Panel added.
- Tuari Potiki – Te Rau Ora Directorship and Needle Exchange Services Trust (NEST) Board added.

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).

Appendices

- HAC, Board 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 (paid)		
	25.02.2021	Board Member, Quitta Ltd (unpaid)	Nicotine replacement therapy under development.	
Peter Crampton (Deputy Board Chair)	16.04.2021	Employment: Professor, Kōhatu Centre for Hauora Māori, University of Otago (appointed July 2018)		
	16.04.2021	Member, Health Quality and Safety Commission Board (appointed April 2020)		
	16.04.2021	Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)		
	16.04.2021	Honorary Fellow, Royal New Zealand College of General Practitioners		
	16.04.2021	Fellow, New Zealand College of Public Health Medicine		
	16.04.2021	Wife, Alison Douglass, is a member of the Health Practitioners Disciplinary Tribunal		
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	Member, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company).	
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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.	
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	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	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	
Tuari Potiki	09.12.2019	Employee, University of Otago		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil, does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.123.2019	*Shareholder in Te Kaika		
	24.06.2021	Te Rau Ora Directorship		
	24.06.2021	Needle Exchange Services Trust (NEST) member		
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)		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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	Corporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	17.08.2020	Health Research Council Fellow		
Andrew Connolly (Advisor)	21.01.2020 (updated 02.06.2021)	Employee, Counties Manukau DHB. Currently seconded to Ministry of Health as Acting Chief Medical Officer		
	21.01.2020 (updated 02.06.2021)	Clinical Advisor to the Board, Waikato DHB		
	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)	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)	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	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		
	18.06.2021	Treasury: Health Reform Challenge Panel		

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	25.02.2021	Portobello Maintenance Company	Nil, Body Corporate for residential area.
Kaye CHEETHAM		Nil	
Rory DOWDING	18.01.2021	Change Quest Ltd	Stepfather (Ross Hanson) and his trading entity (Change Quest Ltd) are at times employed as a contractor to SDHB HR Directorate
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 Health 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	

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, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
Hywel LLOYD	16.06.2021	GP, Mosgiel Health Centre	
	16.0.2021	Wife, Nurse, Paediatric Outpatients	
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
	27.01.2021	Daughter, is a junior doctor in Auckland and is involved in orthopaedic and general surgery research and occasionally publishes papers	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
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.
Nigel TRAINOR	17.05.2021	Daughter, Sonographer (works part-time for Dunstan Hospital)	
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

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
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	
	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, 3 May 2021, commencing at 9.00 am in the Board Room, Level 2, Main Block, Wakari Hospital Campus, Dunedin

Present:	Mrs Jean O'Callaghan	Chair
	Dr John Chambers	Committee Member
	Hon Pete Hodgson	Board Chair and Committee Member
	Dr Lyndell Kelly	Committee Member *by zoom*
	Miss Lesley Soper	Committee Member
	Dr Moana Theodore	Committee Member
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mrs Kaye Crowther	Board Member *by phone zoom*
	Mr Terry King	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Nigel Trainor	Chief Finance, Procurement & Facilities Officer
	Mr Gilbert Taurua	Chief Māori Health Strategy & Improvement Officer and Interim Executive Director Mental Health
	Mr Patrick Ng	Executive Director Specialist Services
	Dr Nigel Millar	Chief Medical Officer
	Ms Kaye Cheetham	Chief Allied Health Scientific and Technical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mr Rory Dowding	Interim Executive Director Strategy, Primary and Community
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

A Mihi Whakatau led by Mr Matapura Ellison was held for the newly appointed Executive Director Finance, Procurement and Facilities, Mr Nigel Trainor, followed by Whanaungatanga. Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from HAC Member, Ms Justine Camp and Board Members, Mr Tuari Potiki and Ms Ilka Beekhuis.

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

***It was resolved**:*

"That the minutes of the meeting held on 1 March 2021 be approved and adopted as a true and correct record with a change to the final sentence on page seven of the minutes to read "The EDSS advised that the rate at which the number of Tavis being done is not budgeted for."

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet and in discussion the following was noted:

- Management is to provide the number of resourced and physical bed numbers for Dunedin Hospital.
- Members noted that all other actions had been completed and the CEO confirmed that a letter had gone to the Sole Urologist as indicated on page three of the minutes.

Ms Gail Thomson, Executive Director, Quality and Clinical Governance Solutions and Mr Patrick O'Connor, Quality and Performance Improvement Manager joined the meeting.

6.0 LETTER IMPROVEMENT PRESENTATION

The Committee considered the presentation (included with the agenda as tab 4) by Ms Thomson and Mr O'Connor and in discussion the following was highlighted:

- The complexity and challenges of the system with the volume (350,000 letters forward in the last year, approximately 1,000 letter templates and 12 different systems producing letters).
- The areas of concern and the proposed steps to improve the letters process.
- The lessons learned from the Canterbury DHB, who moved to 20 templates only after undertaking a similar exercise. The CMO clarified that the process was part of the South Island Patient Information Care System (SI PICS).
- Following discussion the HAC Chair advised that this was a key issue for the Committee and the Board and requested that:
  - The letter improvement work be fast tracked, using the learnings from the SI PICS work implemented by Canterbury DHB and ensuring there is an equity lens across the process.
  - Text and e-mail correspondence is to be a part of the solution and the work is to be carried out with i-medics in mind.
  - A clear action plan with a timeline and benchmarks is to be provided for the July 2021 HAC meeting.
  - The confusion currently caused by the use of different letterheads is to be addressed more quickly through a communications strategy.

Ms Gail Thomson and Mr Patrick O'Connor left the meeting.

7.0 REVIEW OF ACTION SHEET – INFORMATION PAPERS

The Committee considered the information papers attached to the Action Sheet.

Standardised Intervention Rates (tab 5.1)

The report was taken as read and a verbal update was provided by the Executive Director of Specialist Services (EDSS), Patrick Ng.

- A summary of the next actions was provided:
  - Initiatives are to continue to lift Ophthalmology rates.
  - Work is to be done to prioritise knee replacements over other large Orthopaedic procedures.
  - Review opportunities to lift plastic surgery intervention rates, including allocating more bed capacity for this.

In response to concerns raised by the Committee concerning historical under and oversupply in specialty areas, management advised:

- On the challenges with recruitment in some areas, e.g. Ophthalmology and the recent success in recruiting in to positions.
- The Board's prioritisation process should be influenced by the information on actions taken by management, using the information as a catalyst to improve, e.g. increased number of cataracts done.
- The information provided shows public intervention rates only and does not include what is being provided privately. Consideration is being given at a national level as to whether the private rates should be published.

The Committee acknowledged the impact of the inability to recruit to long term vacancies and requested:

- An update on recruitment to long term vacancies, including information on how early we start the recruitment process and whether we recruit to what has been there historically or what is needed now.
- Clarification on how available theatre lists are allocated to the specialties. This will be supplied for a future HAC meeting.
- A funder plan with recommendations on adjustments required.
- An update on hospital referral arrangements with South Canterbury and possible arrangements with any other DHB to meet the needs of the Southern DHB population.

Radiology Strategy (tab 5.2)

The Committee considered the draft strategy included in the agenda and the verbal update from the EDSS, who acknowledged that the document was very secondary care focussed. He advised that there was an error with the calculations for the MRI Modelling. Key points within the draft strategy were highlighted, including staffing challenges and the short term, medium term and long term initiatives. Robust discussion was held on the placement of the MRI machine in Dunedin and access to CT and MRI scanning. The Committee noted the error in the calculations on page 10 of the draft strategy document and requested that the figures be recalculated and resubmitted for consideration by members. The Committee requested more urgency be given to progress on the strategy, particularly concerning the second MRI for Dunedin, noting it was not acceptable to wait until December 2021 for a business case for a second MRI machine. The EDSS is to provide the updated figures for discussion at the Board meeting on 4 May 2021. The Committee and Board are to consider the priority of the MRI as part of a wider prioritisation process. The Committee advised the need to have the right diagnostics in place to meet population based need and to progress this with urgency. The discussion was deferred until the Board meeting on 4 May 2021.

Enhanced Generalism Dunedin Hospital (tab 5.3)

The Committee considered the enhanced generalism/Medical Assessment Unit (MAU) Dunedin Hospital quarterly update and the EDSS advised on:

- Progress made with recruitment since the business case was approved in December 2020.
- The General Medicine Team acceptance of sub-specialty referrals.
- The Project Plan and pro-forma Benefits Realisation Plan and Risk Register.
- The full benefits of enhanced generalism in the MAU will not be realised until the MAU is built.
- Progress with the build being led by the Building and Property team. Decanting is required to enable the demolition to progress.
- The CEO advised the need to seek Board approval for funding for the decanting to enable the design work to get underway.
- The Committee acknowledged the progress made as outlined in the report and requested a greater sense of urgency to progress the decanting work to enable the MAU build and requested that update reports be provided for every HAC meeting.

8.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director of Specialist Services Report

The EDSS monthly report (tab 6.1) 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 work being done to improve reporting on equity issues. The Chief Māori Health Strategy and Improvement Officer has made contact with a colleague in Auckland and a meeting is to be held to assist with progressing the work. Committee member, Moana Theodore, commended management on the progress being made to improve equity reporting.

Surgical Performance – Case Weights Discharges

An update was provided on the deterioration against the year-to-date plan for case weight discharge elective surgery and the initiatives underway to improve performance. Orthopaedics is the specialty most impacted and arrangements have been made to utilise spare capacity at Timaru Hospital to provide operations for Southern's population. Work is being done to determine the amount of acute surgical capacity needed. The report is due back to the EDSS prior to 7 May 2021 and it is expected that the surgery will pay for itself from the revenue generated by the Elective case weight surgery. Work is progressing to determine what can be done from an outsourced surgical point of view. Management are hopeful that the Ministry of Health (MoH) may flex the funding rules this year as there are a number of DHBs struggling to meet their elective targets. The EDSS is working with the Executive Director of Finance, Procurement and Facilities (EDFPF) to establish a high level forecast for the year-end position for Specialist Services. It is expected that this will be discussed at the Finance Audit and Risk Committee (FARC) meeting to be held on 5 May 2021.

The Crown Monitor expressed concern around the Code Black decision made in March 2021 that impacted patients and the budget and discussion was held on who has the authority to close beds. An update was provided by the Chief Nursing and

Midwifery Officer and the Committee was advised that the reporting is being enhanced and future reporting will show the reasons for bed closures. This matter will be discussed at the FARC meeting on 5 May 2021.

Oncology

An update was provided on the deterioration in the 31-day and 62-day target for Faster Cancer Treatment for the last quarter and actions required as part of the recovery plan. The EDSS advised on the actions required, i.e. recruiting a sixth Radiation Oncologist or a Locum Radiation Oncologist. Outsourcing is also underway to St Georges and a tender process is underway to achieve the best outsourcing solution at the lowest cost possible. HAC Committee member, Lyndell Kelly, commented on the challenges with recruitment and the waiting times. Options for a collaborative approach are being explored with Canterbury DHB. Accuracy is required when labelling graphs, e.g. the graph on page 12 of the report showed "completed cancer cases" it should be "cancer cases commenced". More urgency is required when addressing issues, in particular referencing the advertising for a locum in Australia. An update was provided on scanning requirements for cancer patients and a request was made for the Interim Executive Director of Strategy, Primary and Community (EDSPC) to obtain the PET scanning volumes from Canterbury DHB. A request was made for further information to be provided for the recent increase in the waiting list for haematology.

Endoscopy

An update was provided on Endoscopy with colonoscopy performance and the requirement for surveillance scopes at Southland Hospital highlighted as a key area of focus. Southland patients are being offered treatment at Dunedin Hospital. Enhancements have been made to reporting with the use of additional codes within the Inpatient Management (IPM) Administration System, which allows information to be captured on why a procedure has been declined.

Emergency Department (ED)

Management responded to queries around the ED in Southland and advised the importance of benchmarking and working with primary care to reduce the primary care presentations. A recent snapshot of presentations to the Southland Hospital ED identified that 35% of the presentations were from outside of the Invercargill area.

Financial Performance Summary

The EDSS presented the Specialist Services financial results (tab 6.2) for the month of March 2021, outlined the contributing factors to the adverse $3.2M variance for the month and responded to members' queries.

The Interim EDSPC advised on the adverse pharmaceuticals result, noting the impact of high cost drugs. The change to the Pharmac Schedule advising of the change was received after the budget had been set.

***It was resolved**:*

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

CONFIDENTIAL SESSION

At 11.28am it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Executive Director of Specialist Services Report: **1. Planned Care Outpatient Recovery Targets** **2. Faster Cancer Treatment**	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage. Feedback is provided in confidence.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act. Section 9(2)(ba) protect information which is subject to an obligation of confidence and making available of the information would be likely to prejudice the supply of similar information.

Confirmed as a true and correct record:

Chair: _____

Date: _____

HOSPITAL ADVISORY COMMITTEE

ACTION SHEET

As at 28 June 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
May 2021	**Review of Action Sheet**	HAC to be provided with the number of resourced and physical bed numbers for Dunedin Hospital.	EDSS	As appended to the action sheet. 5.1	5 July 2021 **Action complete**
May 2021	**Letter Improvement Presentation** (Minute item 6.0)	• The letter improvement work is to be fast tracked, using the learnings from the SI PICS work implemented by CDHB and ensuring there is an equity lens across the process. • Text and e-mail correspondence is to be a part of the solution and the work is to be carried out with i-medics in mind. • A clear action plan with a timeline and benchmarks is to be provided for the July 2021 HAC meeting. • The confusion currently caused by the use of different letterheads is to be addressed more quickly	EDCG&S	As appended to the action sheet. 5.2	5 July 2021 **Action complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		through a communications strategy.			
May 2021	**Review of Action Sheet – Information papers** (Minutes item 7.0)	• An update on recruitment to long-term vacancies, including information on how early we start the recruitment process and whether we recruit to what has been there historically or what is needed now. • Clarification of what theatre time is allocated to the different surgical specialities. • An update on hospital referral arrangements with South Canterbury and possible arrange-ments with any other DHB to meet the needs of the Southern DHB population.	EDSS	As appended to the action sheet. 5.3 The South Canterbury orthopaedic surgery solution has been implemented successfully and has been in place since May with 3 joints per week being completed for Southern District Health Board by a combination of the private provider in Timaru (Bidwell), combined with an inpatient bed stay at Timaru hospital. Despite a concerted effort by our teams to get orthopaedic surgery completed at Southern Cross Hospital in Christchurch during June we were ultimately unsuccessful when the Christchurch orthopaedic	5 July 2021 **Action complete** **Action complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				surgeons pulled out. However, the overall outsourcing that we have been able to complete across our own district during June has been sufficient for us to remain on track to achieve the hospital provider forecast that we developed in April, despite the nursing strike not being included in the forecast as the strike notice had not been issued at the time the forecast was developed.	
May 2021	**Review of Action Sheet – Information papers** (Minutes item 7.0)	• The figures on page 10 of the draft strategy are to be re-worked and provided for discussion at the Board meeting on 4 May 2021. • The requirements for the radiology strategy CT and MRI staffing and investment in a second CT machine are to be urgently prioritised as part of budget planning for 2021/22.	EDSS	• The figures were updated and provided for discussion at the Board meeting on 4 May 2021. • Confirmation this has been prioritised and included as part of the budget planning for 2021/22.	**Action complete** 5 July 2021 **Action Complete**
	Review of Action Sheet – Information papers (Minutes item 7.0)	• The Committee requested a greater sense of urgency to progress the decanting work to enable the MAU build and that reports are	EDSS	• As appended to the action sheet. 5.4	5 July 2021 **Action Complete**

<table>
<tr><th>DATE</th><th>SUBJECT</th><th>ACTION REQUIRED</th><th>BY</th><th>STATUS</th><th>EXPECTED COMPLETION DATE</th></tr>
<tr><td></td><td></td><td>provided for every HAC meeting.
• Board approval to be sought for funding for the decanting to enable the design work for the MAU to get underway.</td><td></td><td>Paper included in the Board agenda.</td><td>Action Complete</td></tr>
<tr><td>May 2021</td><td>EDSS Report
(Minutes item 8.0)</td><td>• Ensure accuracy of labelling of graphs, e.g. Completed Cancer Cases should read Cancer Cases Commenced.

• Provide an update on the PET scanning volumes from Canterbury DHB.

• An update is to be provided on the waiting list for haematology.</td><td>EDSS

Interim EDSPC</td><td>• This was actioned on the day of the meeting.

PET CT services are provided by Pacific Radiology in Christchurch. SDHB volumes and percentage growth per the EDSPC team are noted below.

PET CT Volumes and Growth 2016 - 2020
<table><tr><th>Year</th><th>SDHB</th><th>Growth</th><th>% Growth</th></tr><tr><td>2016</td><td>216</td><td>0</td><td>0%</td></tr><tr><td>2017</td><td>268</td><td>52</td><td>24%</td></tr><tr><td>2018</td><td>268</td><td>0</td><td>0%</td></tr><tr><td>2019</td><td>316</td><td>48</td><td>18%</td></tr><tr><td>2020</td><td>385</td><td>69</td><td>22%</td></tr></table>Average Volumes (annual): 291
Average Growth (2016 to 2020): 16%
• As noted in the EDSS report.</td><td>Action complete

5 July 2021
Action Complete

Action Complete</td></tr>
</table>

HAC Action

HAC to be provided with the number of resourced and physical bed numbers for Dunedin Hospital.

Below is the data as of 07 May. This indicates both the resourced and physical beds within Dunedin hospital.

Dunedin Hospital Resourced and Physical Beds

Child & Maternity Wards	**Specialty**	**Physical Beds**	**Resourced Beds**	**Resourced %**
Childrens Ward	Paediatrics	22	16	73%
Neonatal Intensive Care (NICU)	NICU	22	16	73%
Queen Mary - Delivery	Maternity	7	7	100%
Queen Mary - Antenatal	Maternity	10	10	100%
Queen Mary - Postnatal	Maternity	26	22	85%
Total for Child & Maternity		**87**	**71**	**82%**

Adult Inpatient Wards	**Speciality**	**Physical Beds**	**Resourced Beds**	**Resourced %**
Surgical (3Surg)	orthopaedic	54	54	100%
Surgical (4a)	General surgery	24	24	100%
Surgical (4HDU)	Surgical High Dependency Unit (HDU)	6	6	100%
Day Of Surgery Admittance (4b)	DOSA - All	12	0	0%
Surgical (4c)	Gen surgery/ vascular / urology	30	25	83%
Day Unit (4Day)	Day surgery	4	5	125%
Intensive Care Unit (ICU)	ICU / Neurosurgery HDU	12	10	83%
Assessment, Treatment, Rehabilitation (6 ATR)	Older Persons Health	36	17	47%
Older Persons Assessment Liasion (OPAL)	Older Persons Health	8	7	88%
Mental Health (6c)	Mental Health Older Persons	16	12	75%
Cardiac & Respiratory (7a)	Cardiac / Respiratory	24	24	100%
Critical Care Unit (7b)	Critical Care Unit (CCU)	10	8	80%
Cardiology & Renal (7c)	Cardiology / Renal	16	16	100%
Medical Assessment Unit (IMAU)	MAU (internal medicine)	8	8	100%
Day Unit (7DU)	Day unit	8	6	75%
Inernal Medicine (8 Med)	Internal Medicine / Gastro	40	40	100%
Stroke unit	Stroke	8	6	75%
Oncology (8c)	Oncology/Haematology	16	14	88%
Total for Adult Inpatient Wards		**332**	**282**	**85%**

FOR INFORMATION

Item: SDHB Letters Process Update

Proposed by: Hywel Lloyd, Executive Director Clinical Governance and Quality (Acting)

Patrick O'Connor, Quality and Performance Improvement Manager

Meeting of: 5 July 2021

Recommendation

That the HAC notes the update to the SDHB letters process.

Purpose

1. To provide the Committee with an update on the SDHB letters review and proposed actions.

Specific Implications For Consideration

2. Quality and Patient Safety

    - Patient letters from our major systems to be standardised with the number of templates significantly reduced.

3. Equity

    - Patient Letters need to be reviewed from an equity perspective.

Background

4. A review of the letters process was commissioned by Gail Thomson, Executive Director for Quality & Governance, and Patrick Ng, Executive Director, Specialist Services. This review was completed by the Quality & Performance Improvement Team and presented to ELT in November 2020.

5. Given the scale of the letters process (350,000 letters sent last year or circa 1800 items per day) the review was deliberately broad in scope and aimed to uncover the major areas of concern within the letters process.

6. The major areas of concern are:

    - Variation of process across Specialities and Directorates, we lack common standards and approaches across the letters processes.

    - Timeliness of letters, concerns remain that letters are not delivered in a timely fashion.

    - Multiple systems producing letters, at last count we have 12 systems that produce letters. The majority of letters come out of our two In Patient Management systems. IT estimate that we have approximately 1,000 templates sitting in our systems at the moment. It is thought that these templates are often subtle variations of the same letters with slightly different logos or wording.

    - No clear channel strategy for communication to consumers.

- Most of what is measured is financial rather than related to quality.
- Letter wording and tone is sometimes in-appropriate. This is no surprise given the disparate and fragmented nature of the process.
- Equity, while the equitable aspect of letters has not been a focus of this investigation it does underlie all aspects of communication to patients. This requires further investigation.

7. These issues add up to a disparate, fractured and siloed letters process. This results in an inconsistent experience for patients and whanau which can express itself as inappropriate wording, late delivery of letters and communication channels which cater for the majority but are not suitable all groups.

8. The first step in improving the letters process was to rationalise the letters in our IPM systems. IT estimate that there are 1000+ letter templates sitting in our systems. We would be able to do this as part of the PICS project and align ourselves with the letters used by the Canterbury DHB. HAC asked that this be bought forward. If this is not possible the PICS project estimate this work can be done later this year or early next year as part of the PICS project.

Discussion

9. The technical feasibility assessment of using the Canterbury templates in our current IPM systems has not been completed by IT. This is due to higher priorities and limited resource who can complete this work.

10. If we can bring the implementation of the Canterbury templates forward this will likely require additional IT resource. We will consult with IT as to where this resource will be found and when they may be available to complete this work.

Next Steps & Actions

- Review, rationalise, and implement a new suite of templates into the IPM or PICs system. Introduce a gating system to stop the number of templates growing again.
- Quality & Clinical Governance are working closely with IT to formulate a definitive plan and approximate timeline to move this important piece of work forward.

An update on recruitment to long-term vacancies, including information on how early we start the recruitment process and whether we recruit to what has been there historically or what is needed now.

Background

This brief paper focuses on the status of Senior Medical Officer (SMO) recruitment, which is the workforce with the majority of our long-term vacancies. Whilst the focus of this paper is on SMO vacancies, we are also experiencing difficulties recruiting into key nursing and allied health vacancies and these are also covered in this paper. The relevant General Managers, Chief Medical Officer, Directors of Nursing and Allied Health and the General Manager of Human Resources have also provided their input into this paper.

Senior Medical Officers

These roles tend to have long lead in times from the start of recruitment to commencement. Available data indicates that the average 'time to hire', measured from the date that the request for recruitment (RFR) is approved until the commencement date of the new hire is 190 days (i.e., circa 6 months). Many of our SMO hires are from overseas and require medical council approval which can be a lengthy process. The changes and fluidity around immigration processes has added further complexity, uncertainty and delays as has the current managed isolation process.

Generally, an SMO vacancy tends to be replaced on a *'like for like'* basis as most services have backlogs rather than excess capacity in their outpatient appointments, follow up volumes and inpatient surgical wait lists.

Historically, roles that have been particularly difficult to recruit into have been:

- Radiologists, particularly in Dunedin.
- Orthopaedic surgeons, particularly in Southland.
- Diabetologists, particularly in Southland.
- Gynaecologists, particularly in Southland.
- Neonatologists in Dunedin.
- Radiation oncologists.
- Medical oncologists.
- Neurosurgeons

In a COVID-19 affected world, New Zealand appears to be an attractive destination and our ability to recruit into SMO vacancies appears to have improved. Recruitment data suggests that the Surgical and Radiology Directorate and the Medicine, Women & Children's' Directorate have both seen a reduction in vacancies since the start of this calendar year.

The data also suggests that key recruitment currently underway in the directorates is as follows:

Surgical & Radiology recruitment underway:

- Radiologist being advertised in Southland.
- Anaesthetist being advertised in Southland.
- Radiologist being reference checked in Southland.
- An offer has been made to a neurosurgeon in Dunedin.
- An Ear, Nose & throat surgeon is being reference checked in Dunedin.

I.e., 5 surgical and radiology SMO roles are currently being recruited into.

Pleasingly there has been recent success with two ENT surgeon appointments in Southland. This is a service which has had vacancies for some time and the two new surgical hires will allow the outpatient wait list to be brought back to compliance.

Recent successful recruitment includes the following (which are a combination of fixed term and permanent positions):

- Two permanent ENT roles waiting to start in Southland.
- Two anaesthesia roles waiting to start in Southland.
- A radiologist role waiting to start in Southland.
- A general surgeon role has started in Southland.
- An intensivist role is waiting to start in Dunedin.
- An anaesthetist – intensivist has started in Dunedin.
- Two general surgeons have started in Dunedin.
- An intensivist has started in Dunedin.
- A radiologist has started in Dunedin.

I.e., 11 surgical and radiology SMO roles have recently been recruited into with candidates that are either about to start or have already started.

Medicine, Women & Children recruitment underway:

- An obstetrics & gynaecology candidate is being reference checked in Southland.
- Another obstetrics & gynaecology candidate has received an offer in Southland.
- A radiation oncologist role is being recruited into in Dunedin.
- An internal medicine physician role is being recruited into in Dunedin.
- A medical oncologist has received an offer in Dunedin.
- A rheumatologist is being recruited into in Dunedin.
- Three internal medicine physicians have received offers in Dunedin.
- Two emergency physicians have received offers in Dunedin.
- Two emergency medicine SMO in Southland.

Recent successful recruitment includes the following (which are a combination of fixed term and permanent positions):

- An obstetrics and gynaecology candidate is waiting to start in Southland.
- A paediatrician is waiting to start in Southland.
- A general medicine physician is waiting to start in Southland.
- Another obstetrics & gynaecology candidate has started in Southland.
- A paediatrician and a neonatologist have started in Dunedin.
- A gastroenterologist has started in Dunedin.
- A haematologist is waiting to start in Dunedin (to cover planned sabbaticals).
- An obstetrics & gynaecology SMO has started in Dunedin.
- A neurologist is waiting to start in Dunedin.

I.e., 9 medicine, women and children roles have recently been recruited into with candidates that are either about to start or have already started.

Pleasingly, there has been recent success in recruiting a fixed term role into Haematology. Neonatology is a discipline which has carried vacancies for a number of years and now appears to have recruited to all their permanent roles.

Recently, we also appear to have had some success with Radiation Oncology. We have an offer out to a junior SMO, who will be offered an SMO role contingent on passing their final exams (with an anticipated start date of January 2022).

Overall, we have had a number of recent successes in the recruitment of SMO roles. In the coming months we will be recruiting for additional medical oncologist and haematologist roles and these will become part of the overall recruitment and marketing campaign which we are developing for our 3 oncology services. As the 'sales and marketing' aspects of this campaign can be re-used across other difficult to recruit to roles we will ask the recruitment team to apply the same collateral created for this campaign to all difficult to recruit to SMO roles going forward.

Nursing

Nursing is not enjoying the same success that we have seen in senior doctor recruitment. We are currently carrying 6.7 full-time equivalent (FTE) nursing vacancies in our inpatient wards in Southland compared to 1.7 FTE vacancies in March 2020. Vacancies in Southland have proven very difficult to recruit into. We currently have 27.0 FTE inpatient nursing vacancies in Dunedin compared to 15.4 FTE in March 2020.

We believe that better salaries, terms and conditions are attracting a number of nurses to Australia, which is harming our ability to recruit locally. In addition to this, the higher demand around the country for nursing staff in relation to the Ministry's response to COVID-19 with the development of surge and immunisation workforces, has created opportunities for nurses to reduce FTE and have a better work-life balance rather than returning to an environment which is perceived to be under-resourced. The number of vacancies being carried by Southern is higher than it has been in previous years and roster gaps in Dunedin led to closed beds and reduced surgery earlier in the calendar year. In addition to these challenges, the aged residential care sector has provided feedback that the DHB demand for nurses is stripping out their staffing with higher wage offers and is creating a workforce risk for their sector as well. This risks inadvertently adding to the DHB's burden, as when ARC cannot provide the service these patients will end up within the DHB service. It is therefore critical that a comprehensive approach is applied across the sector to address nursing workforce shortages.

The answer appears to be increasing our efforts to attract nurses from overseas. Historically, we have had success in attracting nurses from the Philippines, Singapore and from the United Kingdom. Successful nursing recruitment will become increasingly urgent as we seek to meet our Care Capacity Demand Management (CCDM) obligations which will require us to increase nursing numbers by circa 100 full time equivalent (FTE) nurses. It should be noted that the National Health System (NHS) in the UK has approached KiwiHealth Jobs (the DHB recruitment portal through which our clinical roles are advertised) requesting that we tone down our recruitment campaign in the UK as they are severely impacted by the COVID-19 pandemic and the nursing workforce in particular is under pressure. In response to this the DHBs have agreed to soften their approach in the UK for an interim period (we are still permitted to attract from the UK but a softer approach will be required).

In the last 3 years we have run a targeted campaign for specialist Intensive Care (ICU) nurses and we have successfully grown our ICU nursing workforce from 61.85 to 81.25. This campaign was primarily targeted at overseas candidates with the majority coming from the United Kingdom. A smaller overarching campaign for regular nursing roles has been in place since the beginning of the year for regular nursing, particularly in support of the gaps in Southland. As noted earlier, there are good synergies with the campaign we are about to launch to attract multi-disciplinary oncology roles and we will also be seeking to leverage the collateral that is developed across nursing recruitment as well.

Overall, we face growing risks with nursing recruitment and the two operational General Managers, Director of Nursing, Executive Director Specialist Services and the General Manager Human for Resources will work together to enhance and refresh our recruitment strategy to improve our chances of attracting the workforce that we need. It is evident that we cannot continue to rely only on recruitment. The "post and pray" approach in a COVID-19 world will not yield the results required and a longer-term sourcing and talent management approach is required.

Allied Health

Historically we have had challenges recruiting into Medical Physicist, Sonographer, Anaesthetic Technicians, Medical Imaging Technologists and Physiotherapist roles. We are currently actively recruiting to fill the following Allied Health roles:

- Two Medical physics roles.
- Two Sonographer roles.
- Approximately 5 Anaesthetic Technician roles.
- Approximately 5 Medical Imaging Technologist roles.
- Approximately 8 Physiotherapy roles.

Noting the difficulty in recruiting Sonographers we have recently given the go ahead to double the size of the training programme over the next 3 years from 3 trainees to circa 6 trainees. We have had recent success with graduates from the programme recently qualifying. Anaesthetic Technician vacancies continue to be problematic at both Dunedin and Southland and other DHBs are also reporting critical shortages. Very occasionally we have had to postpone elective theatre lists at Southland hospital due to a lack of Anaesthetic Technicians, which amplifies the significance of successfully recruiting into vacant roles. We are continuing to train Anaesthetic Technicians with trainees at both Dunedin and Southland sites. In a similar manner to nursing, we need to enhance our campaigning for these difficult to recruit to roles.

Oncology Services

Per the recent Board request to make meaningful progress in improving oncology resourcing we have worked with the clinical leaders to prioritise an initial investment of $2m in growing this workforce. In partnership with the clinical leaders, we have identified 16 initial roles across senior doctors, junior doctors, nursing, radiation therapy and physics roles. Resident Medical Officers (RMOs), or *'trainee doctors'*, were identified as a particular focus for all 3 services, in order to follow a *'grow your own'* approach that has proven successful in other DHBs. This will improve our chances of having doctors in place to replace pending retirements in the coming years. Other key focal areas for prioritisation were more senior doctors, more nursing and several additional physicists where it is considered that we are particularly lean.

To attract good applicants for all these roles we have commenced the development of a recruitment and marketing / media campaign with Haines Attract. As noted earlier, the initial collateral developed by Haines Attract can be recycled across other recruitment campaigns so we will ask our recruitment team to use these campaign materials to create similar campaigns and synergies for the other hard to recruit to roles identified earlier in this paper. It is also appropriate to consider longer-term workforce planning and talent management approaches in order to ensure a sustainable and longer term solution to the current workforce challenges we are facing.

FOR INFORMATION

5.4

Item: Enhanced Generalism/Medical Assessment Unit (MAU) Bi-Monthly Update

Proposed by: Patrick Ng, Executive Director Specialist Services

Meeting of: 05 July 2021

Recommendation

That the Board notes the progress to date on the planning and implementation of the Enhanced Generalism/MAU project which was approved on the 20th of December 2020.

Purpose

This brief paper summarises the progress that has been made since the last report. The project reporting has also been updated and is attached for information. Appendix 1-5.

Specific Implications for Consideration

Progress on the project from the previous report is as follows:

Enhanced Generalism

- Two of the additional SMOs have accepted offers and a third is in progress with anticipated start dates of August/September 2021.
- A 0.6 full time equivalent (FTE) Allied Health resource in Occupational Therapy (OT) has been appointed with an anticipated start date for this role of July 2021.
- Sub-specialty referrals are now being accepted by the General Medicine team.
- All Service Level Agreements will be in place by the end of June 2021.
- The appropriate socialisation and training for staff is occurring.
- An Informational Session recording is scheduled as part of the next phase in the Communication plan.

The required actions to initiate the generalist model of care are therefore well underway and are on track in terms of the attached project update and milestone plan. Work is still required to implement the benefit realisation metrics and record performance. This activity is scheduled to be initiated when the medicine team is fully staffed and can work the full SMO roster in December 2021 with further benefits will be realised when the MAU is open which is targeted for August 2022. In parallel to the 'onboarding' of the SMO team we are working with the IT Data Analytics team to create the required dashboards and the metrics for those dashboards. Mock-ups of the dashboards will be supplied as part of future project updates.

The project's focus now needs to move from Enhanced Generalism to the Medical Assessment Unit (MAU) decant and build process. To move forward with the MAU opening, we need to accomplish:

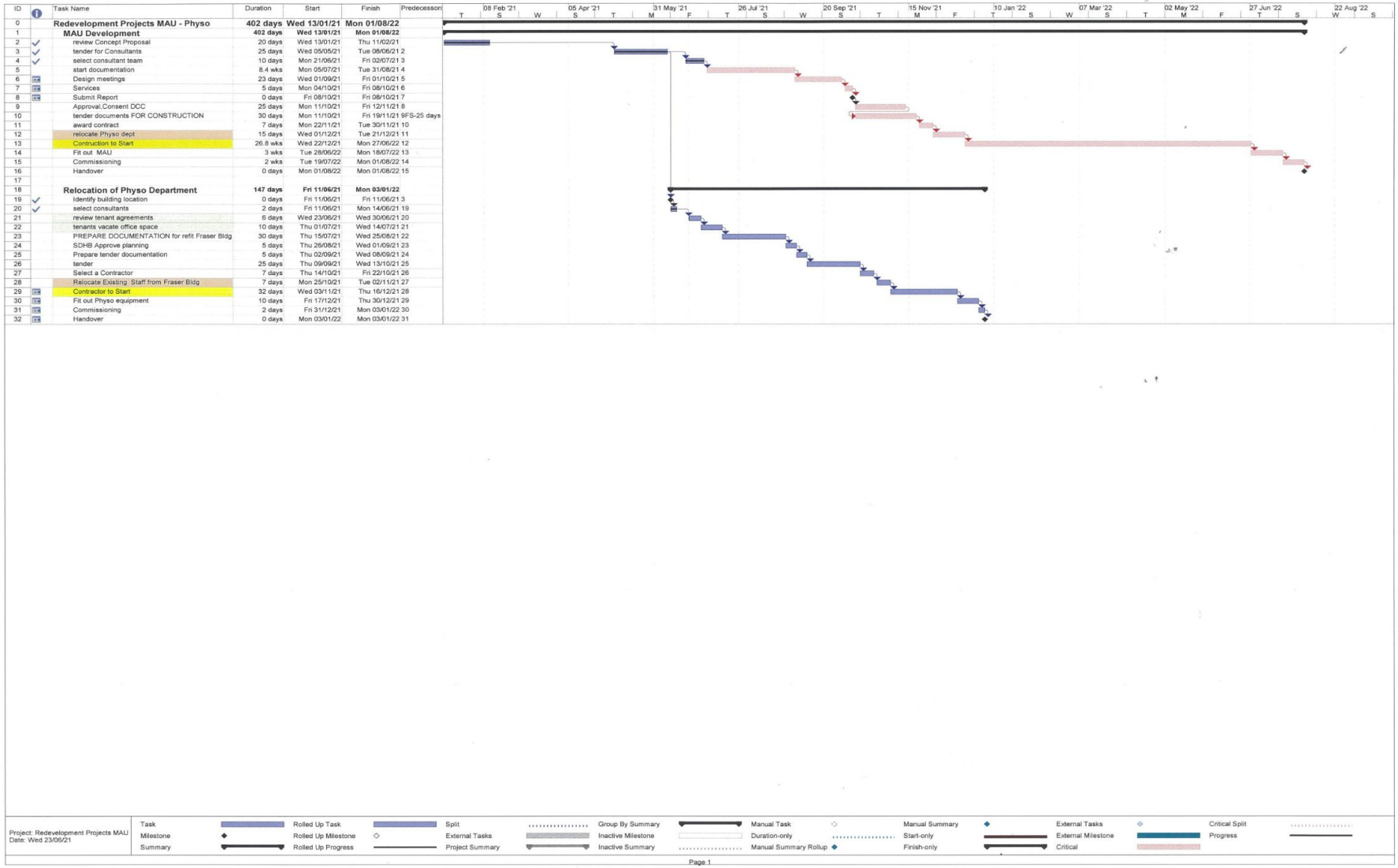
- A reconfiguration of the selected Physiology/Rheumatology/Pain area in the Fraser Building to meet the clinical standards for the services being provided.

- The decant of the Physiology and Rheumatology area next to the ED.
    - There are several dependencies involving the movement of staff in other departments (e.g., Oncology, Sterile Services, and Administration Staff) that are delaying the start of this decant process. Building & Property are working to address these concerns.

- Awarding the contract to finalise design of the MAU and associated costs. A brief paper has been prepared for the Board to request the necessary capital.

The decanting of the future medical assessment unit space is the highest priority in order for the medical assessment unit to be built as quickly as possible. The Executive Director Finance, Facilities and Procurement and the Executive Director Specialist Services have jointly asked that this is progressed as a top priority. A work breakdown structure outlining the current planning timeframes for decanting, construction and completion of the medical assessment unit is attached for information on the following page.

5.4

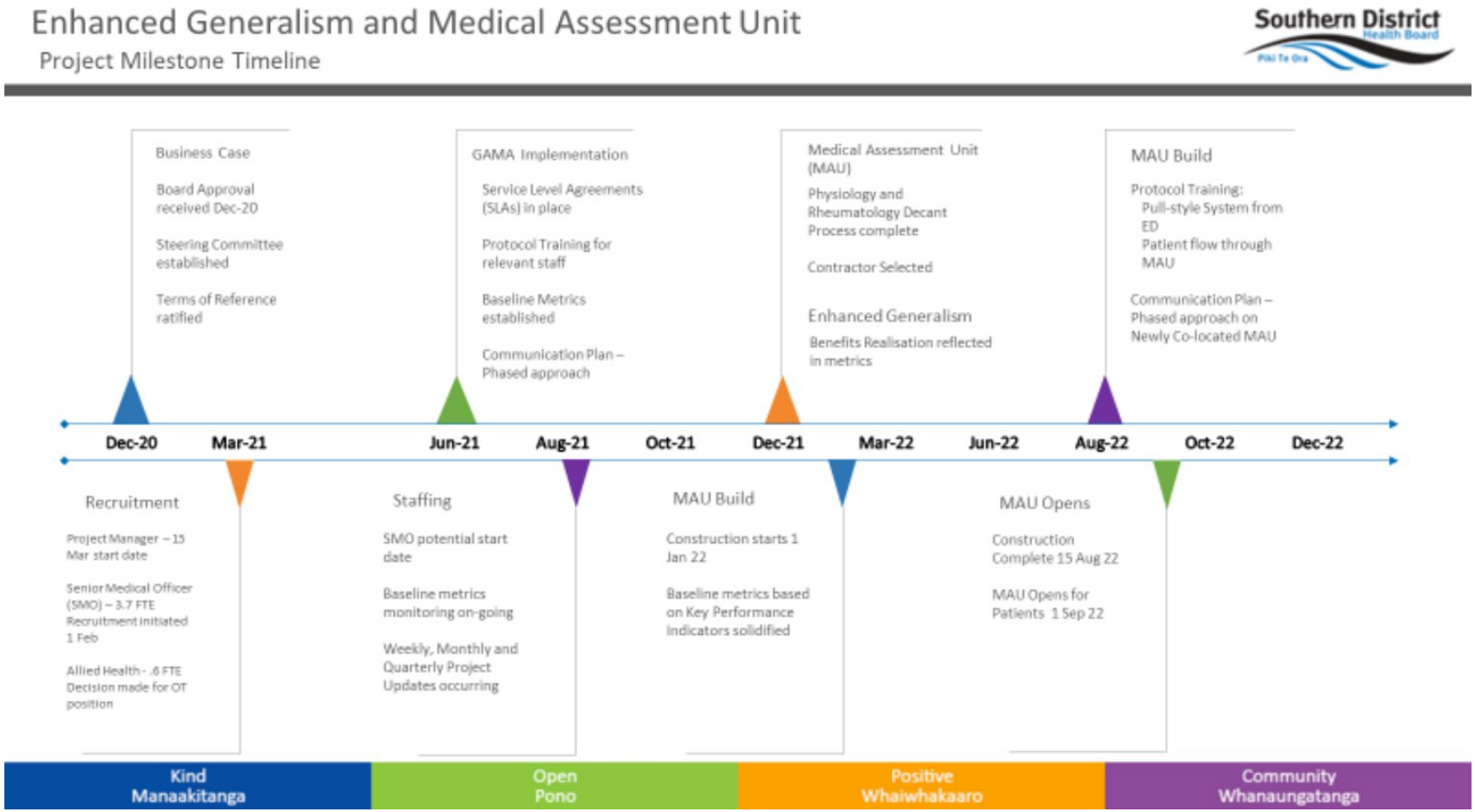


ID	Task Name	Duration	Start	Finish	Predecessors
0	**Redevelopment Projects MAU - Physo**	**402 days**	**Wed 13/01/21**	**Mon 01/08/22**	
1	**MAU Development**	**402 days**	**Wed 13/01/21**	**Mon 01/08/22**	
2	review Concept Proposal	20 days	Wed 13/01/21	Thu 11/02/21	
3	tender for Consultants	25 days	Wed 05/05/21	Tue 08/06/21	2
4	select consultant team	10 days	Mon 21/06/21	Fri 02/07/21	3
5	start documentation	8.4 wks	Mon 05/07/21	Tue 31/08/21	4
6	Design meetings	23 days	Wed 01/09/21	Fri 01/10/21	5
7	Services	5 days	Mon 04/10/21	Fri 08/10/21	6
8	Submit Report	0 days	Fri 08/10/21	Fri 08/10/21	7
9	Approval,Consent DCC	25 days	Mon 11/10/21	Fri 12/11/21	8
10	tender documents FOR CONSTRUCTION	30 days	Mon 11/10/21	Fri 19/11/21	9FS-25 days
11	award contract	7 days	Mon 22/11/21	Tue 30/11/21	10
12	relocate Physo dept	15 days	Wed 01/12/21	Tue 21/12/21	11
13	Contruction to Start	26.8 wks	Wed 22/12/21	Mon 27/06/22	12
14	Fit out MAU	3 wks	Tue 28/06/22	Mon 18/07/22	13
15	Commissioning	2 wks	Tue 19/07/22	Mon 01/08/22	14
16	Handover	0 days	Mon 01/08/22	Mon 01/08/22	15
17					
18	**Relocation of Physo Department**	**147 days**	**Fri 11/06/21**	**Mon 03/01/22**	
19	Identify building location	0 days	Fri 11/06/21	Fri 11/06/21	3
20	select consultants	2 days	Fri 11/06/21	Mon 14/06/21	19
21	review tenant agreements	6 days	Wed 23/06/21	Wed 30/06/21	20
22	tenants vacate office space	10 days	Thu 01/07/21	Wed 14/07/21	21
23	PREPARE DOCUMENTATION for refit Fraser Bldg	30 days	Thu 15/07/21	Wed 25/08/21	22
24	SDHB Approve planning	5 days	Thu 26/08/21	Wed 01/09/21	23
25	Prepare tender documentation	5 days	Thu 02/09/21	Wed 08/09/21	24
26	tender	25 days	Thu 09/09/21	Wed 13/10/21	25
27	Select a Contractor	7 days	Thu 14/10/21	Fri 22/10/21	26
28	Relocate Existing Staff from Fraser Bldg	7 days	Mon 25/10/21	Tue 02/11/21	27
29	Contractor to Start	32 days	Wed 03/11/21	Thu 16/12/21	28
30	Fit out Physo equipment	10 days	Fri 17/12/21	Thu 30/12/21	29
31	Commissioning	2 days	Fri 31/12/21	Mon 03/01/22	30
32	Handover	0 days	Mon 03/01/22	Mon 03/01/22	31

Appendices

Appendix 1	Project Milestone Timeline Chart
Appendix 2	Project Plan with WBS and GANTT
Appendix 3	Benefits Realisation Plan Register
Appendix 4	Project Risk Register
Appendix 5	Enhanced Generalism/MAU Project Dashboard

Appendix 1


Enhanced Generalism and Medical Assessment Unit
Project Milestone Timeline
Southern District Health Board
Piki Te Ora
Business Case
Board Approval received Dec-20
Steering Committee established
Terms of Reference ratified
GAMA Implementation
Service Level Agreements (SLAs) in place
Protocol Training for relevant staff
Baseline Metrics established
Communication Plan – Phased approach
Medical Assessment Unit (MAU)
Physiology and Rheumatology Decant Process complete
Contractor Selected
Enhanced Generalism
Benefits Realisation reflected in metrics
MAU Build
Protocol Training:
Pull-style System from ED
Patient flow through MAU
Communication Plan – Phased approach on Newly Co-located MAU
Dec-20
Mar-21
Jun-21
Aug-21
Oct-21
Dec-21
Mar-22
Jun-22
Aug-22
Oct-22
Dec-22
Recruitment
Project Manager – 15 Mar start date
Senior Medical Officer (SMO) – 3.7 FTE Recruitment initiated 1 Feb
Allied Health - .6 FTE Decision made for OT position
Staffing
SMO potential start date
Baseline metrics monitoring on-going
Weekly, Monthly and Quarterly Project Updates occurring
MAU Build
Construction starts 1 Jan 22
Baseline metrics based on Key Performance Indicators solidified
MAU Opens
Construction Complete 15 Aug 22
MAU Opens for Patients 1 Sep 22
Kind Manaakitanga
Open Pono
Positive Whaiwhakaaro
Community Whanaungatanga

Appendix 2
Separate document.

Appendix 3

Enhanced Generalism Benefits Realisation Register							
Item #	Benefit (Description)	Assumptions	KPIs	Associated Metric	Benefit Owner	Transition to Operational State	Sustainment/Closure Plan
B-1	Reduction in average LOS for General Medicine patients	Wholistic approach Reduces avoidable investigations; Prompt access to diagnostics; Accurate Patient List Reports; Fully rostered staff	Reduced LOS Reduced # Stranded Patients Reduced # Super Stranded Patients	Avg LOS (days) Number of patients >10 days		Full implementation of Enhanced Generalism Model of Care	Sustained gains in reducing average LOS for GenMed patients
B-2	Improvement in overall SSED performance (3-5%)	MAU co-location with ED Timeliness of patient move from ED to MAU	ED performance to target Establish timeframe goals for move from ED to MAU	95% Target - ED Performance SSED performance Specialties vs General Medicine To be established		Co-located MAU with ED	Sustained gains in meeting ED target
B-3	Reduction in the number of re-admissions	Improved outcomes for patients Greater continuity of patient care	Reduced # re-admissions	Number of re-admissions for GM patients		Inherent to process	Sustained gains in low re-admission rates
B-4	Reduction in stranded patients	Reduction in avg LOS Greater continuity of patient care Prompt access to diagnostics	Reduced LOS Reduced # Stranded Patients	Avg LOS (days) Number of patients >10 days		Full implementation of Enhanced Generalism Model of Care	Sustained gains in reducing number of patients >10 days
B-5	Reduction in super stranded patients	Reduction in avg LOS Greater continuity of patient care Prompt access to diagnostics	Reduced LOS Reduced # Super Stranded Patients	Avg LOS (days) Number of patients >21 days		Full implementation of Enhanced Generalism Model of Care	Sustained gains in reducing number of patients >21 days
	NOTE: The Benefits Realisation register is a working document and will evolve as the project is implemented and matures. Benefits may be modified, added, or redefined to reflect changes in business processes or as additional benefits are identified.						

Appendix 4

Southern District Health Board
Pihi Te Ora

MAU Project
Risk Register

Risk No.	Risk Description	*Risk Level	Risk Owner	**Status (RAG)	RIP (Risk Impact to Project)	Risk Mitigation
MR-1	Detailed Design	2	Building & Property		tendering process underway	Decant process needs to be complete by end of November at the latest
MR-2	Decant Process	2	Building & Property		Not a quick process, several steps to be accomplished - Can't begin build until complete	Authorization to begin has been received
MR-3	Relocation of Physio/Rheum	2	Building & Property		Timing of move to Fraser Bldg dependent on movement by other projects. Plan sent to ELT for approval from B&P	B&P have been authorized to move forward with decant processes.
MR-4	MAU construction	3	Building & Property		Risks MR-1 thru MR-3 must be completed before MR-4 can begin	Will not be able to proceed until Decant process is complete. Still working the plan to be ready to go when that happens.

	*Risk Levels:			**Status:		
	1 - low			Red - Plan at risk		
	2 - medium			Amber - Plan off track, but being worked		
	3 - high			Green - Plan on track, no longer at risk		

Appendix 5

Enhanced Generalism/MAU Project Dashboard

Southern District Health Board
Pīki Te Ora

Item	Status	% Complete	Notes/Help Needed
Enhanced Generalism			
SLA/Referral Guidelines		80%	All meeting have taken place and moving into final stages
ED			ED referral guidelines will be developed from SLAs and are in work
Neurology			
Cardiology			
Gastroenterology			
Respiratory			
Communication Plan		80%	Initial Communication sent out 18/5 – will be on-going
Informational sessions		75%	Informational Session presentation to be recorded tbc
GAMA Implementation		80%	GAMA implementation underway – next phase Ward Configuration
Recruitment		85%	Two offers accepted and a further offer made. AH position – reference checks
Office Space		75%	Spaces identified; one of two desks placed in identified space
MAU			
MAU Design		50%	Feasibility design complete; need final design approval
Decant Process		5%	Authorization to begin decant processes received, dependencies on other projects
MAU Build		0%	Decant and Procurement processes need to complete prior to start

Red Project has not started or cannot move forward due to roadblocks (help needed) Amber Project has a plan, but is off-track, issues being addressed Green Project has a plan and is on track

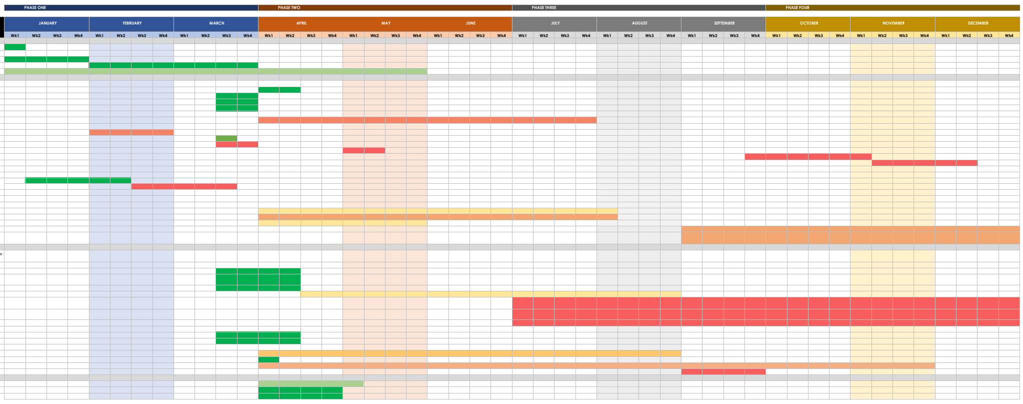
Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

5.4

WBS WITH GANTT CHART

PR OJE	MAU - Co-location with ED
PR OJE	Kathy Orr
CO MP	Dunedin Hospital/SDHB
DAT	15/12/2020

WBS NUMBER	TASK TITLE	TASK OWNER	START DATE	DUE DATE	DURATION (days)	% OF TASKS COMPLETE	NOTES
1	Business Case (Leadership)						
1.1 ◊	Board Approval	PN	8/12/2020	8/12/2020	0	100%	
1.2	Steering Committee	SD/SK				100%	
1.2.1	Membership Confirmed	SD/SK	1/12/2020	31/01/2021	60	100%	
1.2.2	ToR drawn up and	SD/SK	1/02/2021	31/03/2021	60	100%	
1.3	Project Plan and Initiation	KO	1/12/2020	30/05/2021	179	80%	
2	Project Definition & Planning						
2.1	Project Schedule creation						
2.1.1	WBS with Gantt	KO	1/04/2021	13/04/2021	12	100%	
2.1.2	Project Status Report	KO	15/03/2021	31/03/2021	16	100%	
2.1.3	Risk Register	KO	15/03/2021	31/03/2021	16	100%	
2.1.4	Project Dashboard	KO	15/03/2021	31/03/2021	16	100%	
2.2 ◊	Referral Guidelines						
2.2.1	ED and MAU	DA/KO	1/04/2021	1/08/2021	120	10%	
2.3 ◊	MAU Decant Process						
2.3.1	Physio/Rheumatology	B&P	1/02/2021	1/03/2021	30	10%	
2.3.1.1	Select Move	B&P	18/03/2021	18/03/2021	0	90%	
2.3.2	RFP for Consultants issued	B&P	19/03/2021	1/04/2021	12	0%	
2.3.2.1	Consultants	B&P	30/04/2021	13/05/2021	13	0%	
2.3.4	RFP for Contractor issued	B&P	24/09/2021	4/11/2021	40	0%	
2.3.4.1	Contractor	B&P	5/11/2021	9/12/2021	34	0%	
2.3.4.2	Contractor Starts	B&P	1/02/2022	6/05/2022	95	0%	
2.4 ◊	MAU Development						
2.4.1	MAU detailed design	B&P	13/01/2021	11/02/2021	28	100%	
2.4.2	Tender for Consultants	B&P	12/02/2021	25/03/2021	43	0%	
2.4.3	Award Contract	B&P	7/01/2022	20/01/2022	13	0%	
2.4.4	Contractor to Start	B&P	1/02/2022	3/10/2022	242	0%	
2.4.5 ◊	Construction Complete	B&P	9/12/2022	9/12/2022	0	0%	
2.5	Establish plan for MAU patient flow	DA/KO	1/04/2021	1/08/2021	120	50%	feasability design approved
2.6	IT Reporting/Metrics Support	KO	1/04/2021	1/08/2021	120	25%	
2.7	Finance/Budget updates/reporting	MV/B&P	1/04/2021	1/06/2021	60	50%	
2.8	Communication Plan	MG/KO	1/09/2021	1/07/2022	300	25%	initial meeting held; on-going plan
2.9	Change Management Plan	KO	1/09/2021	1/07/2022	300	25%	meetings to be scheduled with relevant teams
3	Project Launch & Execution						
3.1 ◊	Co-located MAU opens		9/12/2022	9/12/2022		0%	Decant and Construction must happen first
3.2	KPIs/Metrics Identified	KO					
3.2.1	Baseline metrics	KO	15/03/2021	15/04/2021	30	100%	
3.2.1.1	Improvement in overall SSED	KO	15/03/2021	15/04/2021	30	100%	identified and metric in place
3.2.1.2	Reduction in	KO	1/09/2021	1/04/2022	210	0%	baseline needs established
3.2.2	On-going data collection	KO	1/09/2021	1/04/2022	210	50%	meeting/discussion on-going
3.2.3	Monitoring metrics	KO	1/07/2022	31/12/2022	180	0%	Will begin after Co-located MAU opens
3.2.3.1	Improvement in overall SSED	KO	1/07/2022	31/12/2022	180	0%	on-going
3.2.3.2	Reduction in	KO	1/07/2022	31/12/2022	180	0%	on-going
3.3	Project Updates						
3.3.1	Schedule Updates	KO	15/03/2021	15/04/2021	30	100%	on-going
3.3.2	Chart Updates	KO	15/03/2021	15/04/2021	30	100%	on-going
3.4	Business Realisation Plan						
3.4.1	BRP developed	KO	1/04/2021	1/09/2021	150	40%	
3.4.2	BRP Register	KO	1/04/2021	8/04/2021	7	80%	
3.4.3	BRP Risks	KO	1/04/2021	1/12/2021	240	25%	on-going updates
3.4.4	Identify Benefits Owners	SK/SD	1/09/2021	30/09/2021	29	0%	
4	Project Performance / Monitoring						
4.1	Quarterly Board Reports	KO	31/03/2021	3/05/2021	33	75%	on-going
4.2	Monthly Status Reports	KO	31/03/2021	1/05/2021	31	100%	on-going
4.3	Weekly Project Status Reports	KO	15/03/2021	22/03/2021	7	100%	on-going



FOR INFORMATION

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

Proposed by: Patrick Ng, EDSS

Meeting of: Hospital Advisory Committee, 05 July 2021

6

Recommendation

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

Purpose

This report is for the purpose of updating the Hospital Advisory Committee on key activities and issues occurring within Specialist Services.

1. Equity

The equity working group continues to meet and develop a work plan to improve our understanding, reporting and action on equity. The group is chaired by our General Manager Surgery & Radiology and includes our Chief Maori Health Strategy & Improvement Officer and the EDSS reporting analyst, together with the Planned Care Manager. The GM Surgery & Radiology has been undertaking studies in Maori Culture at Otago University to provide her with as broad an understanding of the inhibitors to equitable access as possible.

The working group remains broadly on track in terms of the workplan, which is as follows, with updates underneath the table.

Quarter 4 and Quarter 1 of the new financial year (2021/22)	Equity in Outpatients and Radiology group established and meeting 2 weekly. Analysis of adult Cardiology, Respiratory and Radiology suite of equity measures completed (including intervention, referral and waiting time rates by location, ethnicity and decile. Results conveyed to operational staff as part of an education package. Establish other high risk groups that we could include in the work going forward (e.g. Ophthalmology).
Quarter 2	Develop a range of interventions with stakeholders and operational staff. Start using a modified version of the Equity Application developed for Oncology which can be used with interventions.
Quarter 3	Trial a range of interventions – measure effectiveness.
Quarter 4	Maintain the most effective interventions. Monitor.
onwards	Determine best way to move effective interventions to other services.

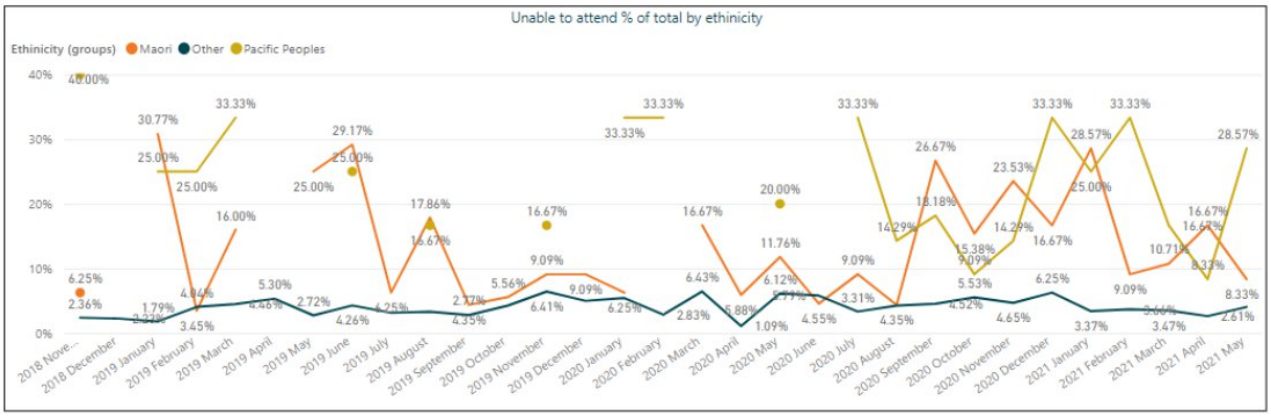
Progress against this work plan in the current month is as follows:

- We have had the PowerBI tool built to monitor 'Unable to Attend' rates in outpatients and waiting times for First Specialist assessment in our focal areas of Cardiology and Respiratory (see below). The purpose of this is to establish monitoring and to develop a baseline to improve from. The dashboard is included below.
- A draft education package has been completed for schedulers, which is initially focussed on Cardiology and Respiratory. We plan to run a workshop with staff to discuss equity issues and to determine actions in scheduling and outpatients over the next 4 weeks. This is likely to include changes to engagement, staff education, processes, the environment, and cultural support. These workshops will be a prototype for ongoing cultural education and development of processes and systems. The draft education package has been included in HAC materials and we would welcome feedback on it.
- Our Information System team colleagues have confirmed that the role for an equity Business Analysist has been approved and is being advertised.

The following tables are taken from our newly developed Equity Dashboard.

The first table shows the *'unable to attend'* rates for Cardiology Follow Up appointments.

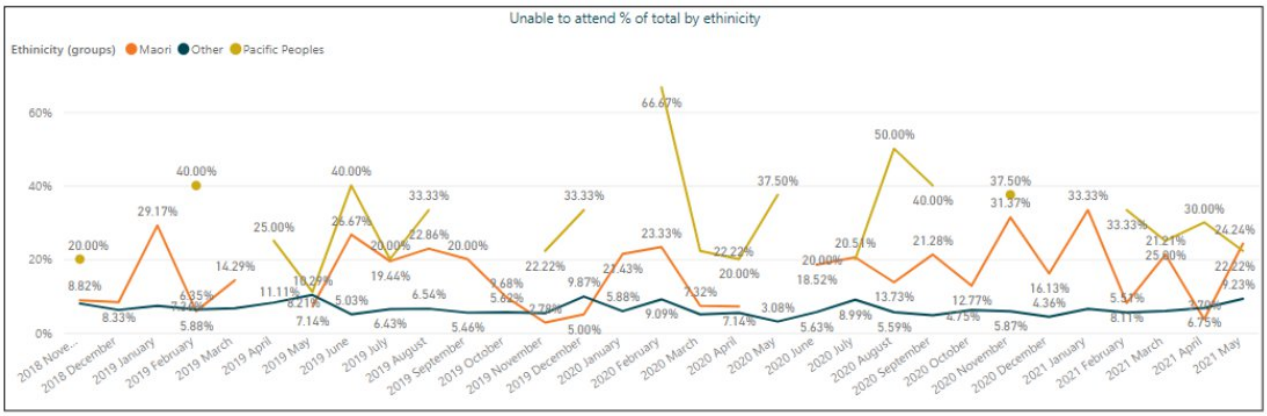
Cardiology Unable to Attend – Percentage by Ethnicity



The table shows that over a long time series (dating back to November 2018), Maori Unable to Attend (UTA) rates have been consistently higher than non-Maori. Pacific peoples are higher still, but very low numbers.

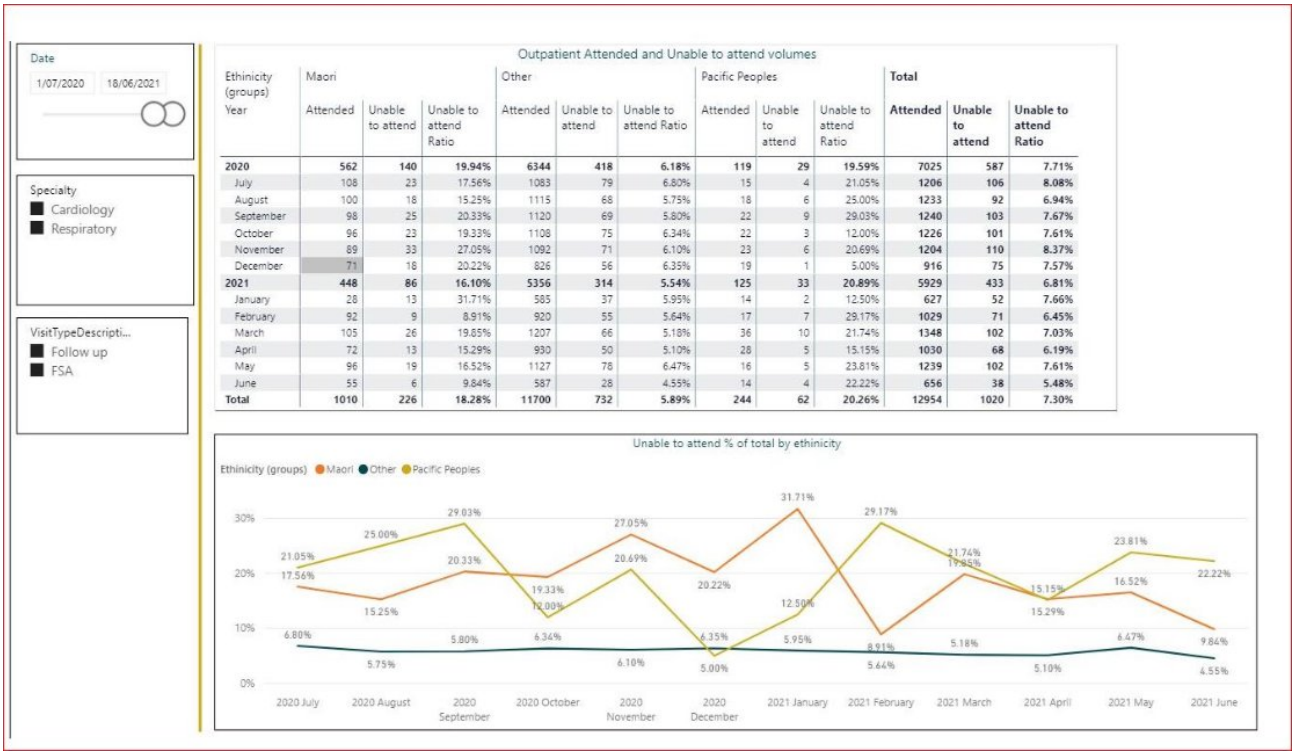
The Respiratory data shows a similar pattern of high unable to attend rates for follow-ups for Maori and Pasifika.

Respiratory Unable to Attend – Percentage by Ethnicity



And the following table, taken from our dashboard shows the overall UAA rates for Maori, non-Maori and Pasifika as a percentage of total appointments for FSA and Follow Up for the Cardiology and Respiratory services combined from the start of the current financial year.

Overall Unable to Attend Rates by Ethnicity – Cardiology and Respiratory Services



Ethinicity (groups)	Maori			Other			Pacific Peoples			Total		
Year	Attended	Unable to attend	Unable to attend Ratio	Attended	Unable to attend	Unable to attend Ratio	Attended	Unable to attend	Unable to attend Ratio	Attended	Unable to attend	Unable to attend Ratio
2020	**562**	**140**	**19.94%**	**6344**	**418**	**6.18%**	**119**	**29**	**19.59%**	**7025**	**587**	**7.71%**
July	108	23	17.56%	1083	79	6.80%	15	4	21.05%	**1206**	**106**	**8.08%**
August	100	18	15.25%	1115	68	5.75%	18	6	25.00%	**1233**	**92**	**6.94%**
September	98	25	20.33%	1120	69	5.80%	22	9	29.03%	**1240**	**103**	**7.67%**
October	96	23	19.33%	1108	75	6.34%	22	3	12.00%	**1226**	**101**	**7.61%**
November	89	33	27.05%	1092	71	6.10%	23	6	20.69%	**1204**	**110**	**8.37%**
December	71	18	20.22%	826	56	6.35%	19	1	5.00%	**916**	**75**	**7.57%**
2021	**448**	**86**	**16.10%**	**5356**	**314**	**5.54%**	**125**	**33**	**20.89%**	**5929**	**433**	**6.81%**
January	28	13	31.71%	585	37	5.95%	14	2	12.50%	**627**	**52**	**7.66%**
February	92	9	8.91%	920	55	5.64%	17	7	29.17%	**1029**	**71**	**6.45%**
March	105	26	19.65%	1207	66	5.18%	36	10	21.74%	**1348**	**102**	**7.03%**
April	72	13	15.29%	930	50	5.10%	28	5	15.15%	**1030**	**68**	**6.19%**
May	96	19	16.52%	1127	78	6.47%	16	5	23.81%	**1239**	**102**	**7.61%**
June	55	6	9.84%	587	28	4.55%	14	4	22.22%	**656**	**38**	**5.48%**
Total	**1010**	**226**	**18.28%**	**11700**	**732**	**5.89%**	**244**	**62**	**20.26%**	**12954**	**1020**	**7.30%**

With UAA rates of 18.28% for Maori and 20.26% for Pasifika peoples, compared to 5.89% for the remainder of the population this provides a clear focus for our improvement programme and the dashboard will enable us to see whether we are improving these rates over time.

In future HAC meetings we will also show the average wait time for appointments by ethnicity, and we plan to develop reports which will enable us to see intervention rates by ethnicity and geography.

As noted in our previous HAC meeting we want to meet with the Auckland DHB's equity and reporting teams to learn as much as we can about what additional data elements they have started collecting and how this is shaping their equity reporting. Our Chief Maori Health Strategy and Improvement Officer has supplied details of contacts that he has in this DHB. We have now been in touch so that we can establish an initial meeting. We will continue to progress this.

We also want to 'normalise' equity reporting by including information on access to services by ethnicity for each of the sections in our HAC report. A key staff member has been away due to a family illness but now that they are back we will prioritise the development of this for future HAC reporting.

Refer to appendix A, Powerpoints presentation - Equity in outpatients and radiology.

2. Surgical Performance – Case Weight Discharges

The following table outlines our case weight discharge (CWD) performance year to date compared to our elective plan.

YTD CASEWEIGHTS (with year on year comparison)

	YTD Service Provider View			- YTD IFL			+ YTD OFL			YTD Population View			Previous FYTD Service Provider View		Previous FYTD Population View	
PUC	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Year on Year Variance	Actuals	Year on Year Variance
Non Surgical PUC																
Non Surgical PUC with Surgical DRG	1,152.0	981.8	170.2	18.0	23.3	-5.4	391.4	511.4	-120.0	1,525.4	1,469.9	55.5	1,121.3	30.7	1,562.0	-36.6
PUC Total	**1,152.0**	**981.8**	**170.2**	**18.0**	**23.3**	**-5.4**	**391.4**	**511.4**	**-120.0**	**1,525.4**	**1,469.9**	**55.5**	**1,121.3**	**30.7**	**1,562.0**	**-36.6**
Surgical PUC																
S00.01 General Surgery	2,794.3	2,482.8	311.5	14.3	2.2	12.1	159.6	202.5	-42.8	2,939.6	2,683.1	256.5	2,563.0	231.3	2,642.6	297.0
S05.01 Anaesthesia Services	8.5	0.0	8.5		0.0	0.0	0.0	0.0	0.0	8.5	0.0	8.5	12.1	-3.6	12.3	-3.9
S15.01 Cardiothoracic	1,176.6	1,172.5	4.1	18.0	16.0	2.0	27.4	19.0	8.4	1,186.0	1,175.5	10.5	1,253.3	-76.7	1,250.3	-64.3
S25.01 Ear Nose and Throat	1,080.9	1,127.5	-46.6	5.3	1.3	4.0	21.6	17.3	4.3	1,097.2	1,143.5	-46.3	947.4	133.5	976.1	121.1
S30.01 Gynaecology	859.7	933.7	-74.0	6.4	1.3	5.1	156.2	78.6	77.6	1,009.5	1,010.9	-1.4	761.0	98.7	850.3	159.2
S35.01 Neurosurgery	352.6	307.9	44.7	28.0	34.4	-6.4	161.5	146.7	14.7	486.1	420.2	65.9	323.5	29.1	474.8	11.3
S40.01 Ophthalmology	825.0	1,006.1	-181.1	2.5	0.6	1.9	14.9	5.7	9.1	837.4	1,011.3	-173.9	702.1	122.9	711.0	126.4
S45.01 Orthopaedics	3,510.9	3,894.6	-383.7	268.4	239.6	28.7	74.6	98.2	-23.6	3,317.1	3,753.2	-436.1	3,762.1	-251.2	3,604.5	-287.4
S55.01 Paediatric Surgical Services	107.4	155.8	-48.3		0.0	0.0	121.3	69.2	52.1	228.8	224.9	3.8	88.2	19.2	284.5	-55.7
S60.01 Plastic & Burns	462.4	552.3	-89.9	1.3	2.1	-0.8	54.2	161.1	-106.8	515.3	711.3	-196.0	426.4	36.0	458.6	56.7
S70.01 Urology	990.2	907.6	82.5	4.5	2.2	2.3	32.8	31.3	1.4	1,018.4	936.7	81.7	797.7	192.5	832.6	185.8
S75.01 Vascular Surgery	664.2	721.4	-57.3	0.2	9.2	-9.0	12.4	24.8	-12.3	676.4	737.0	-60.6	596.1	68.1	599.4	77.0
PUC Total	**12,832.7**	**13,262.3**	**-429.6**	**348.9**	**309.0**	**40.0**	**836.5**	**854.2**	**-17.7**	**13,320.3**	**13,807.6**	**-487.3**	**12,232.9**	**599.8**	**12,697.1**	**623.2**
PUC Total	**13,984.7**	**14,244.1**	**-259.4**	**366.9**	**332.3**	**34.6**	**1,227.9**	**1,365.7**	**-137.8**	**14,845.7**	**15,277.5**	**-431.8**	**13,354.3**	**630.5**	**14,259.1**	**586.6**

In our previous HAC meeting it was requested that discharge numbers are also supplied. The following table shows the discharge view by specialty.

YTD DISCHARGES

	YTD Service Provider View			- YTD IFL			+ YTD OFL			YTD Population View		
PUC	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance
Non Surgical PUC												
Non Surgical PUC with Surgical DRG	496	504	-8	11	7	4	108	135	-27	593	632	-39
PUC Total	**496**	**504**	**-8**	**11**	**7**	**4**	**108**	**135**	**-27**	**593**	**632**	**-39**
Surgical PUC												
S00.01 General Surgery	1,693	1,590	103	9	7	2	67	82	-15	1,751	1,665	86
S05.01 Anaesthesia Services	24	0	24		0	0	0	0	0	24	0	24
S15.01 Cardiothoracic	204	225	-21	3	3	0	6	5	1	207	213	-6
S25.01 Ear Nose and Throat	1,252	1,496	-244	9	2	7	29	28	1	1,272	1,522	-250
S30.01 Gynaecology	1,100	996	104	10	3	7	79	46	33	1,169	1,040	129
S35.01 Neurosurgery	126	104	22	8	11	-3	46	55	-9	164	148	16
S40.01 Ophthalmology	1,696	2,072	-376	6	1	5	25	6	19	1,715	2,078	-363
S45.01 Orthopaedics	1,710	1,859	-149	43	37	6	66	83	-17	1,733	1,906	-173
S55.01 Paediatric Surgical Services	175	183	-8		0	0	107	72	35	282	255	27
S60.01 Plastic & Burns	541	598	-57	5	2	3	42	76	-34	578	673	-95
S70.01 Urology	976	937	39	5	4	1	15	22	-7	986	956	30
S75.01 Vascular Surgery	381	322	59	1	5	-4	4	4	0	384	320	64
PUC Total	**9,878**	**10,384**	**-506**	**99**	**74**	**25**	**486**	**479**	**7**	**10,265**	**10,775**	**-510**
PUC Total	**10,374**	**10,888**	**-514**	**110**	**81**	**29**	**594**	**614**	**-20**	**10,858**	**11,407**	**-549**

The 'service provider' view in the case weight discharge (CWD) table is the target set for the hospital. This is what the hospitals are focused on delivering and we are -259.4 CWD behind plan for May year to date against a May YTD target of 14,244 CWD per the first circle in the first table.

The 'population' view in the case weight discharge (CWD) table is a planners' target which includes both the hospital delivered CWD and the net CWD delivered by other DHBs for our population (delivery is primarily in CDHB). It is the service provider target minus inter district inflows plus inter district outflows. The second circle shows that we are -431.8 CWD against this target year to date which reflects that less of our population has been served in other DHBs than historically (the target is based on historic volumes). As our services have no way to influence the population target, they are focused on achieving the 'service provider' hospital target. However, the population target is important as the total elective revenue earned is based on the population view target and noting that the lost revenue for patients treated out of the district is offset by not having to pay the inter district flow costs for the treatment of these patients

As noted in previous reports, we are behind on the hospitals' 'service provider' target which is due to the nurse staffing and acute surgery pressures we experienced earlier in the year. Other large centres have faced similar pressures, although our staffing issues appear to have been potentially more significant than others. The staffing issues for Dunedin have improved since earlier in the year but we are continuing to hear of staffing challenges, most recently on the 4th floor in Dunedin. We have provided the relevant Director of Nursing with latitude within CCDM budget to address these issues to avoid compromising surgery, noting that the actions she takes will impact from the 2021/22 financial year onwards and we have CCDM budget in that year. It continues to remain problematic to deliver elective and acute surgical volumes at peak times and we continue to balance keeping elective lists full, with having to cancel elective cases when there is acute pressure. A piece of work is underway to propose a permanent solution which would provide additional acute capacity both during the week and an additional acute list on Saturdays (we have run an additional elective list on Sundays for several years now and this has been an effective way to prevent acute pressures accumulating and elective cancellations occurring early in the week).

The key to getting the additional acute capacity working effectively is to ensure that the additional capacity is consistently used at the same utilisation levels as current capacity is. This is likely to require us to have a robust short notice elective case process working alongside, so that during periods where acute capacity is not required the sessions will continue to be productively used. On the assumption that we can utilise the additional session time productively in this manner, the additional cost of staffing the sessions should take care of itself. We are obliged to deliver acute surgery and we receive funding for elective surgery (above our 'base' elective target). The marginal cost of an additional elective surgery delivered internally is in the region of 1/3rd of the cost of outsourced surgery. If acute + elective demand forces us to consistently utilise more outsourced surgery this will come at a greater cost than delivering more acute + elective surgery internally. The

other key to getting this capacity working effectively is to staff it at the right levels as additional shifts, rather than paying existing staff additional to deliver additional activity. This will make the solution more sustainable and has been requested by our ASMS colleagues in particular. Our GM Surgery and Radiology is working with our ASMS colleagues on how this would work and the GM Surgery and Radiology and EDSS will work together on how the overall model would work (including the self-funding aspect of how this would be established).

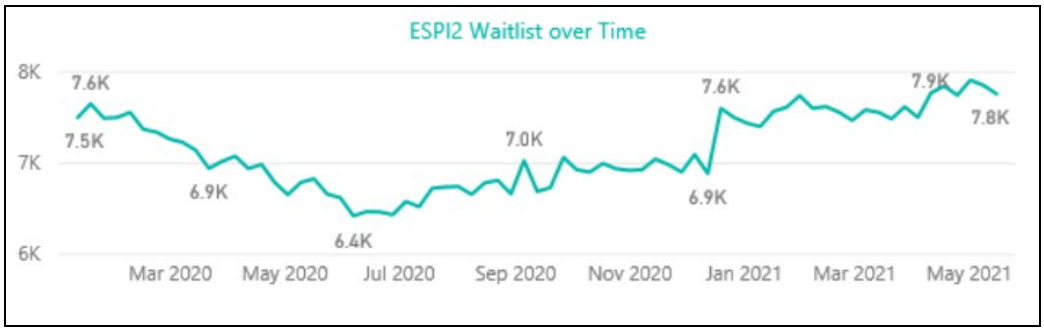
Southland hospital continues to experience difficulties with recruiting to cover all of its nursing and perioperative vacancies. Perioperative gaps have at times led to one of the perioperative managers 'scrubbing in' and personally participating in operations (she is also a qualified and experienced perioperative nurse). As we are about to undertake a significant oncology recruitment campaign, we will look at what synergies may exist for further recruitment into key vacancies in perioperative and inpatient nursing in Southland.

Despite the challenges, elective delivery for the month of May was good, exceeding the elective forecast that we developed. This was primarily due to a couple of unanticipated discharges with high case weights. In particular, there was a 100 CWD patient discharged on the 31st of May and this is unprecedented. We have not seen such a high CWD for a single patient previously. May's higher than expected performance has provided a partial offset for the impact of the nursing strike which had not been announced and therefore provided for when the forecast was constructed. June CWD performance (with the exception of the strike) has been close to forecast with higher rates of outsourcing being achieved in June. As at mid-June we appear to be close to achieving our forecast of being -500 CWD adverse to our full year provider CWD target of 17,500 CWD by June 30th.

3. Outpatient Performance ESPI 2

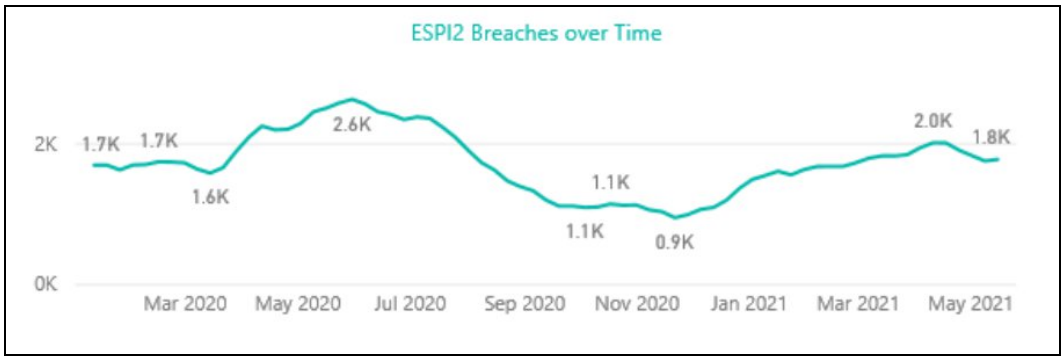
The outpatient waitlist was 7,902 patients in the first week of May but had decreased by 152 to be 7,750 in the last week of May.

Outpatient waitlist



In early April, the number of ESPI 2 breaches were 2,005 by the last week of May this had decreased by 236 to 1,769. This is shown in the following graph.

ESPI 2 breaches as sub-set of the outpatient waitlist



A break down of our key breach areas is per the following table. Please note that this table is taken from latest available Ministry data showing April performance (which is a snapshot), so the total in this table is different to the total as at the end of May.

The services with the largest number of breaches are highlighted in red and further commentary is provided below. Together they make up 2/3rd of the total breaches.

ESPI 2 Breaches by Speciality and Directorate

All Specialties		
Neuro Surgery	102	5%
Orthopaedics	**434**	**23%**
Haematology	42	2%
Gynaecology	**252**	**13%**
Vascular	65	3%
Cardiology	93	5%
ENT	**390**	**21%**
Plastics	59	3%
Respiratory	33	2%
General Surgery	**206**	**11%**
Dermatology	22	1%
Renal Medicine	6	0%
Neurology	81	4%
Diabetes	3	0%
Opthalmology	77	4%
General Medicine	9	0%
Rheumatology	12	1%
Total	**1,886**	

Surgery	
Neuro Surgery	102
Orthopaedics	434
Vascular	65
ENT	390
Plastics	59
General Surgery	206
Opthalmology	77
General Medicine	9
Total	**1342**
Breach Share	71%

Medicine	
Haematology	42
Gynaecology	252
Cardiology	93
Respiratory	33
Dermatology	22
Renal Medicine	6
Neurology	81
Diabetes	3
Rheumatology	12
Total	**544**
Breach Share	29%

Orthopaedic ESPI 2 Breaches

Orthopaedic ESPI 2 breaches have returned to pre-COVID levels per the following chart. The peak in May reflects the accumulation of long waiting patients during the COVID lock down. The reduction from July 2020 until November 2020 reflects lower volumes post COVID, effective use of the prioritisation tool in Dunedin and improved access to outpatient clinics in the rural hospitals which was worked on by the Orthopaedic Service Manager. A phenomenon of higher volumes was then experienced in Dunedin earlier in this calendar year. In Southland, the ESPI 2 breaches has remained relatively static at circa 200-250 (i.e., over half of the total orthopaedic breaches and disproportionately higher than Dunedin). Historically, Southland has carried orthopaedic vacancies for long periods of time and has applied very strict access criteria because of their limited capacity.

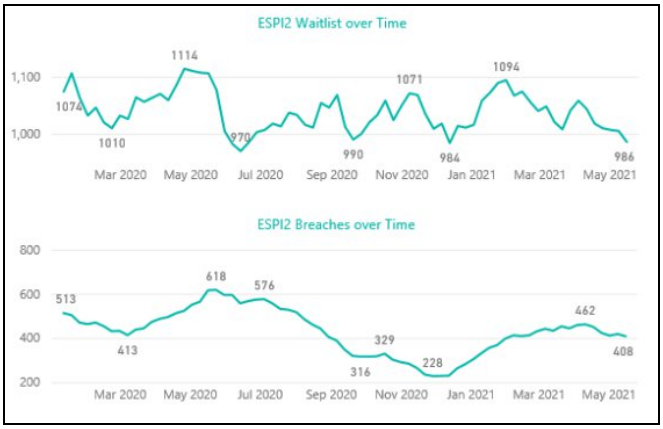
Orthopaedics in Dunedin has enjoyed recent success with volumes returning to manageable levels and continued application of the prioritisation tool to restrict referrals received. Breaches dropped from circa 240 in mid-April to 152 by the end of May for Dunedin. We continue to use the Ministry of Health (MoH) prioritisation tool with a key focus on trying to get the ESPI breaches down as quickly as possible.

Orthopaedics in Southland has a number of paediatric clinics planned in July which will help to remove a number of long waiting patients from the wait list. They have also undertaken a recent data cleansing exercise to ensure that the wait list is accurate, and we are asking them to complete this review periodically.

It has been suggested to us that we 'close' the wait list for a period of time which is an approach that other DHBs have applied when their wait list has been high. However, we are resistant to this idea as we believe it will lead to an accumulation of disability in the community that will prove hard to manage when we open the wait list again in the future. Our preference is to continue to use the MoH prioritisation tool to slowly but systematically reduce the wait list over time by ensuring that the capacity available to see patients in clinic is maintained at a higher rate than the rate at which referrals are accepted.

Orthopaedic ESPI 2 Breaches Over Time

The following table shows how orthopaedic ESPI breaches have tracked over time.



Gynaecology ESPI 2 Breaches

ESPI 2 breaches for the gynaecology service have been primarily driven by vacancies in Southland. We have provided funding for an additional locum in Southland as part of COVID recovery but have had challenges consistently covering our services. The team has also commenced a study using our prioritisation tool so that we can establish at what level / score we would need to cut off our first specialist appointments in order to match demand to capacity and what level of clinical risk this would create. We will now check that we have sufficient information and we will review this study in the coming months. New SMO will be commencing in the coming months but in the meantime weekend clinics have been organised to assist us to recover our volumes.

Gynaecology ESPI 2 breaches over time

ENT outpatient waitlist and ESPI 2 breaches

ENT remains a challenge with only a small decrease in the waitlist and number of breaches. Although a new surgeon has been employed in Southland they remain under supervision and will be unable to work independently for several months.

Our ENT service is above pre-COVID levels due to a large number of breaches in Southland.

We have carried vacancies in Southland since last year and have only been able to get occasional locum support to run outpatient clinics there.

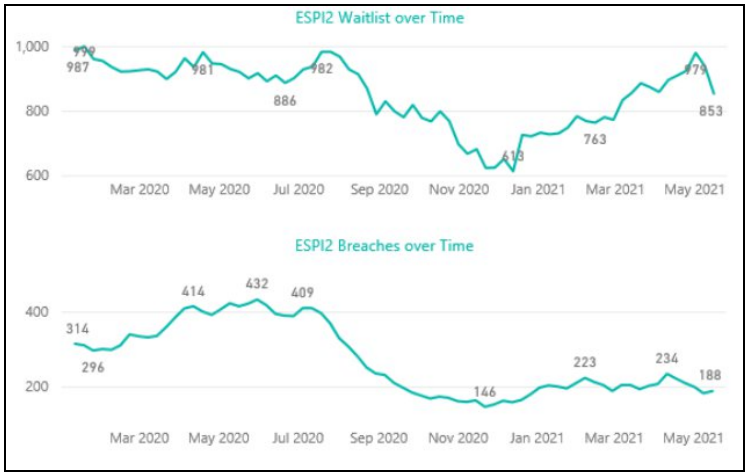
Whereas the Dunedin service is now within 13 FSA's of clearing their entire ESPI 2 backlog, Southland has accumulated a large backlog. Southland has recently employed a permanent SMO and another SMO will arrive in the coming months, so they will have enough capacity going forward to match the demand on the service. However, in the short term the new SMO is required to have supervision from the Dunedin team. Now that Dunedin have materially achieved compliance the Dunedin service (who triage referrals for the whole district) will be asked whether they can see Southland referrals in Dunedin or travel to Invercargill to ensure that the long waiting patients in Southland are seen in clinic.

General Surgery had a waitlist of 979 at the beginning of May and in the last week of May this has decreased to 853. Southland has employed a new SMO and she has been most effective. The

introduction of per bleed (PR) bleed clinics on the Dunedin site has helped reduce the number of long wait patients with this condition. The Service Manager will reduce the number of these clinics as the demand has reduced, and in their stead commence a functional bowel clinic which will focus on the other large group of long wait patients.

General Surgery outpatient waitlist and ESPI 2 breaches

General Surgery has seen a reduction in ESPI 2 breaches which are now lower than pre-COVID levels.



Southland General Surgery lost a very productive and experienced SMO to retirement late last year. However, they have now replaced this role with a new hire who has put a good level of capacity back into the service. They implemented the prioritisation tool sometime ago and the pattern of referrals accepted and seen in clinic each week is reasonably stable.

In Dunedin, the introduction of a PR clinic in Dunedin has enabled us to work through long waiting patients who had this condition. We will reduce the number of these clinics now that we have successfully worked through the long waiting patients and will commence with functional bowel clinics as a number of the long waiting patients left on the wait list have this condition. Dunedin has also had the prioritisation tool in place for some time now.

4. Inpatient Performance ESPI 5

The overall inpatient waitlist has plateaued since the end of March however we have seen a slight decrease in the number of ESPI 5 breaches.

ESPI 5 breaches as a sub-set of inpatient wait list

A breakdown of where the largest breaches are as per the following table.

ESPI 5 Breaches by Speciality

All Specialties - ESPI 5		
Vascular	68	4%
Orthopaedics	684	38%
Neurosurgery	25	1%
General Surgery	217	12%
ENT	421	24%
Paediatric Surgery	19	1%
Plastics	65	4%
Urology	81	5%
Cardiothoracic	8	0%
Opthalmology	141	8%
Gynaecology	28	2%
Dental	21	1%
Cardiology	3	0%
	1,781	

Orthopaedic ESPI 5 Breaches

Two thirds of our breaches are in three specialties highlighted in red, above. The large number of breaches in the orthopaedics service reflects the impact of high demand, the nursing crisis which led to bed closures earlier in the calendar year and the impact of high acute demand (also earlier in the calendar year). The Timaru hospital initiative has led to three orthopaedic patients per week

receiving their operation at Timaru hospital and we are looking to continue that initiative throughout 2021/22. The recovery plan for surgery for 2020/21 has focused on orthopaedic surgery and a high number of outsourced surgeries are occurring in the month of June. As we move into the 2021/22 financial year, we are planning to bias our outsourcing and recovery funding budgets towards orthopaedic surgery and will shortly commence discussions with the orthopaedic surgery team and Mercy hospital about the level of regular outsourcing work that can be completed at Mercy hospital. A similar conversation will be initiated with the surgeons and Southern Cross hospital in Southland.

Overall, we are exploring a plan next year whereby we will phase the outsourcing budget towards the first 6 months of the year to allow as high volumes as possible to be outsourced in the first half of the year. We will then re-deploy recovery money as it is earned (across all services) with a bias towards orthopaedic surgery to allow a continuation of outsourced volumes into the second half of the year.

Other initiatives we are exploring are whether we can establish more outplaced surgical capacity at the private hospitals so that this service is less impacted by future nursing or acute demand driven bed pressures, and whether patients who live close to the rural hospitals can be transferred to the rural hospitals for a proportion of their care so that their length of stay in the main hospitals is reduced, ultimately leading to better throughput and less cancellations.

General Surgery ESPI 5 Breaches

We now believe we are on top of our more urgent cases and from September of this year one of the General Surgeons in Dunedin will be focused on benign cases (on a 3 month rotation). This will allow us to systematically work through our longest waiting cases and appropriately have them incorporated into our available theatre lists so that they can be systematically worked off our waiting list.

ENT ESPI 5 Breaches

The ENT breaches are now higher than they have been historically. An initiative which will reduce the number of breaches is the completion of procedures that can be undertaken by a GP with a special interest (GPSI) in a GP setting. In partnership with our Planning & Funding colleagues we have recently confirmed that these can be funded to be completed in primary care and the GM Surgery & Radiology and the Service Manager are reviewing the waiting list to see what can be re-directed to primary care. Once we have clarity about what is left on the long wait list, we will then need to consider how we can provide additional theatre capacity to the ENT service to get the long waiting patients attended to.

As we appear to have worked through the crises from earlier in the year and our elective surgery is stabilising again, we will commence actively reviewing all long waiting patients on our ESPI 5 waiting lists with the objective of systematically bringing the longest wait down to under 1 year. This will be achieved by prioritising them onto outsourced surgical lists, in house surgical lists, clearing data quality errors on the wait list (e.g., patient has left the district) and where appropriate, returning patients to their GP, e.g., if they have been placed on the wait list, need to meet conditions such as weight loss or to quit smoking before being deemed suitable for surgery and there is no progress being made.

5. Emergency Departments

Per the following tables, the ED presentations and admissions in the month of May were in line with year to date presentations and admissions, although average presentation numbers were slightly higher for Southland.

ED Presentations and Admissions May 2021

May 2021	Admit	Non-Admit	Admit %	Total Presentations	Average Presentation
Southland	700	2,698	25.95	3,398	109.61
Dunedin	1,060	2,840	37.32	3,900	125.81

ED Presentations and Admissions Year to Date 2021

Calendar Year to May 2021	Admit	Non-Admit	Admit %	Total Presentations	Average Presentation
Southland	3,296	12,961	25.40	16,257	107.61
Dunedin	5,206	13,768	37.81	18,974	125.66

Within the month the minimum number of presentations at Dunedin during the month of May was 99 in a day and the maximum number was 143. The minimum number in Southland was 91 and the maximum was 136.

Performance against the 95% target in May averaged circa 77% per week in Dunedin and circa 84% per week in Southland.

Key to improving ED performance in Dunedin is the development of the medical assessment unit next to the Emergency Department. Creating the 'de-cant' space in the Fraser building for the existing services next to the ED so that they can move is the key holdup and we have been working with our building and property colleagues to try to get faster progress with this. The EDSS has proposed that a regular meeting is established with the EDFP&F and the GM Building and Property. The current tenants in the Fraser Building are from a number of different directorates and it essential that we have the directorates working together to get this vital initiative moving as quickly as possible.

Good progress has been made on the Southland Business Case which is focused on creating fit for purpose ED facilities for Southland Hospital.

At our request, the Ministry have provided us with assistance via Ernst & Young to benchmark the population we serve at Southland hospital. Their modelling has landed on a population of circa 93,500 served which is very close to what we had concluded. The population served is the Invercargill City district, Southland district, a proportion of Gore and a smaller proportion of Clutha. In the normal course of events an overseas population of circa 1,500 is served per annum. This benchmarking has been lifted directly into the strategic section of our business case.

We then asked for another component to be benchmarked, which is how many treatment spaces other hospitals have, both per population served and per presentations. To achieve this benchmarking, we asked Ernst & Young to determine the actual population served for each of the benchmark hospitals so that a valid 'like for like' comparison could be made. They have now completed this work (they are writing it up) and we will review our plans in line with this benchmarking.

The final piece of benchmarking information that we have asked them for is to compare our 'triage 3' patients and our 'triage 4' patients against our peer hospitals and to tell us to what extent we have excess presentations. The triage 3 presentations are a reasonable proxy for *'ambulatory sensitive hospitalisations'* (ASH), which are considered reducible if there is good care provided in a primary care setting, whereas the triage 4 excess presentations will enable us to establish targets for our joint programme of work with primary care which will aim to reduce excess presentations into the ED. These findings are currently being written up.

Once we have this information, we can then engage with the primary health organisation (PHO) on the ASH results – this is likely to lead to a broader conversation about care provided in a primary care setting, and we can have a separate conversation about the excess triage 4's. The excess presentations logically drive a more immediate combined programme of work for which initiatives such as 'Emergency Q' (re-direction of appropriate ED presentations to primary care) and the establishment of plan film imaging in a future health hub would lead to reduced presentations.

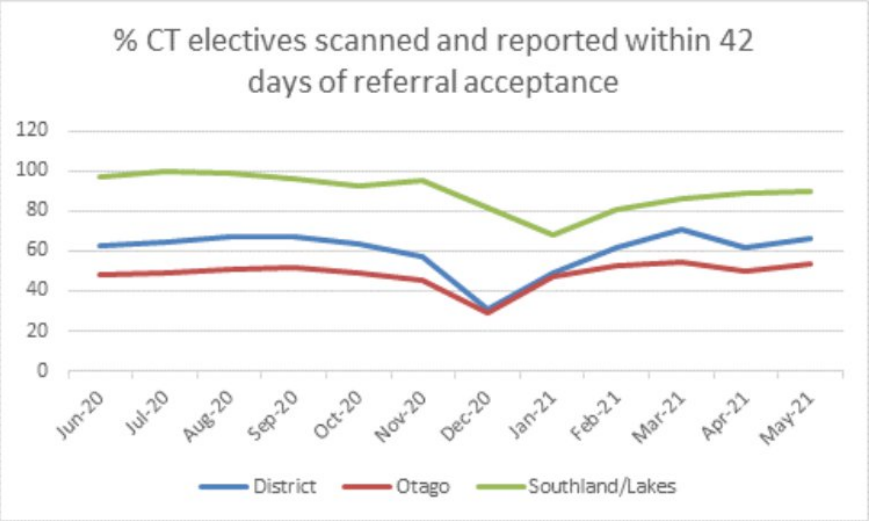
We have also had an initial meeting with the PHO's project manager, Helen Telford, who has met with our ED reference group and has run a mini-workshop on what the inhibitors are to reducing primary care suitable presentations into the ED. Helen is working on the PHO's business case for improving the after hours service and increasing access in Southland, and will work with both them and us in the establishment of a joint programme of work aimed at reducing the number of primary care suitable ED presentations into Southland hospital.

To complete the business case, we will need the plans worked up to a concept level with high level Quantity Surveyor input. We are working with the Building and Property team to have this completed and once completed the business case can be finalised.

Another focus at both sites has been increasing our planning and preparedness at both hospitals in the lead up to long weekends. The 'Mondayisation' of public holidays has meant that we have had a number of long weekends in recent months that we have needed to be prepared for. Ahead of the long weekends we have held meetings to look at the key indicators going into the long weekend (hours on the acute surgery board, adult inpatient bed occupancy, numbers in the ED waiting for a bed, roster gaps, e.g., due to illness). We have then made decisions about whether more acute lists need to be run, more junior doctors need to be rostered, the manner in which communication on allied health needs to be delivered, whether more medical imaging is required and so on. An escalation plan has been implemented at Dunedin alongside a status system which indicates whether the hospital is in green, yellow, orange or red based on a points system. In Dunedin, an e-texting system has been implemented, which means that the duty clinicians and key managers get notified if the status of the hospital changes. Based on notification on the status of the hospital the GM Operations and the EDSS can now use the text as the basis for dialogue, and for the EDSS to keep the CEO up to date. We do not yet have an e-text solution in place in Southland, but the acting GM and Duty Manager are providing manual text updates to the EDSS which is leading to a phone conversation if required and the EDSS can then keep the CEO up to date. For the most recent long weekend Southland was at times under pressure due to ongoing staffing issues / staffing gaps and sickness for both patients and staff caused by a gastro bug. This led to a couple of conversations between the acting GM, EDSS and DON over the weekend. However, the situation self-corrected and the flow of patients was able to be maintained.

6. Radiology

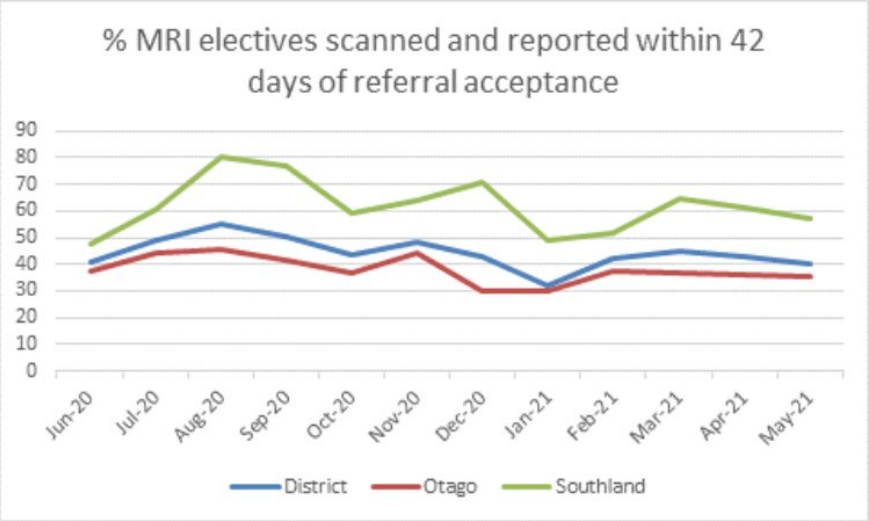
CT Performance (The target is that 95% of planned CT's are completed within 42 days).



Unfortunately, we are currently facing capacity issues across the district. Southland CT performance has deteriorated from recent performance of circa 90% against the 42 target to circa 85%. We believe this will self-correct as there has not been a change in staffing and capacity at Southland. Oamaru has advised us that the additional CT capacity they have previously provided to us will not be available going forward which would have an impact on our CT scanning capacity of circa 415 scans per annum. This is because they can no longer staff the additional sessions they were providing to us. Both of these challenges underscore the importance of implementing the second CT scanner in Dunedin to increase capacity and to boost our overall scanning performance. Overall performance of the district is circa 62%.

Good progress has been made on the implementation of the second CT scanner. The scanner is now expected in the country on the 30th of July. Building work has been occurring as quickly as possible in anticipation of the arrival of the scanner with a new reporting room established for the radiologists allowing work to progress on the scanner suite. Installation is programmed in for mid-August. Recruitment requests have also been raised in parallel in anticipation that this operating cost will be in the 2021/22 operating budget and following a week of training for the initial staffing, we are anticipating ramping up the use of the scanner from late August / early September.

MRI Performance (The target is that 85% of planned MRI's are completed within 42 days).



Southland performance against the 42 day target is circa 60% whilst Dunedin performance is at circa 35% with an overall result for the district in May of 42%.

High acute volumes are being reported by the service whilst there is a limited budget for the outsourcing of scans.

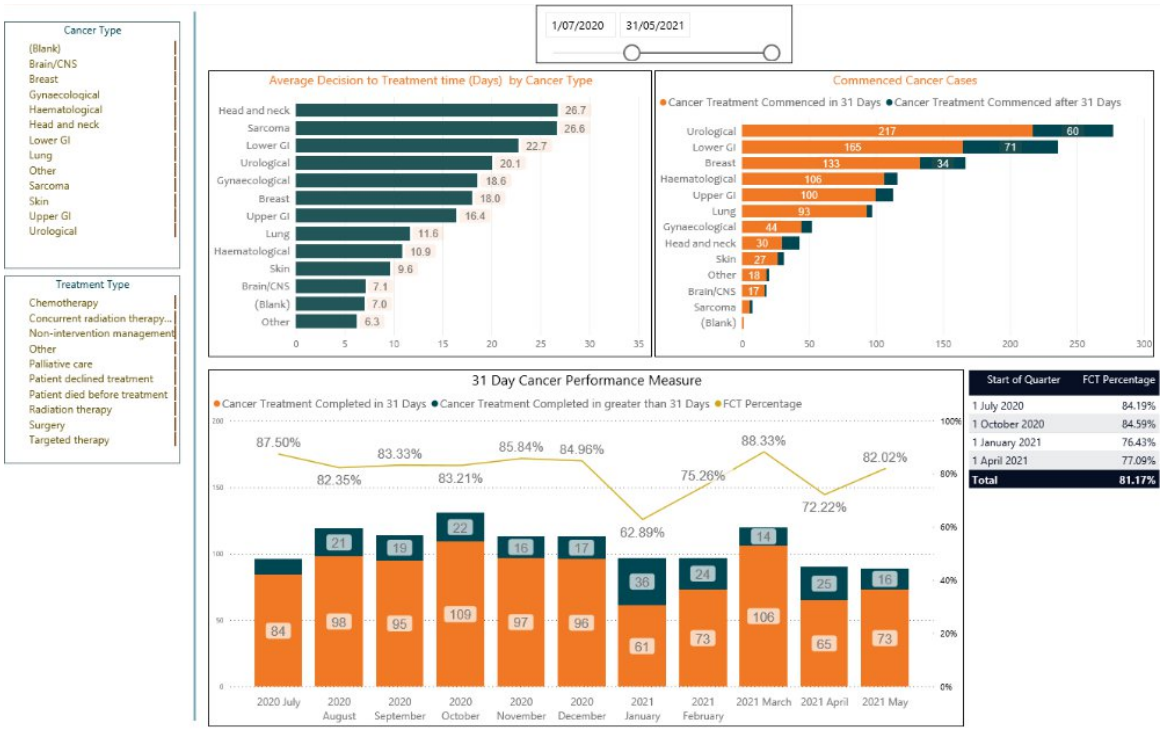
Within constraints the Radiology service is continuing to outsource long wait patients to Pacific Radiology, particularly in Dunedin. And South Otago patients are now being directed to Southland for their MRI examination rather than Dunedin.

Similar to the CT modality, more MRI capacity is required in Dunedin. With operating costs now confirmed in the 2021/22 budget to run more capacity on a second machine later in the year and with a second MRI machine for Dunedin expected to be approved when the capital for 2021/22 is prioritised, Radiology has started the tender process for the purchase of an additional MRI at Dunedin, with equipment selection expected to be completed in July 2021. As part of the selection process potential vendors have been asked to review the current Radiology location to confirm that a second machine can be installed there. We remain hopeful that there is space to accommodate a second MRI machine and respondents have been specifically asked to provide their fit out specifications and to review the space that has been identified in the radiology service for the second machine.

7. Oncology

31 day performance reflects the elapsed time from decision to treat until first treatment occurs.

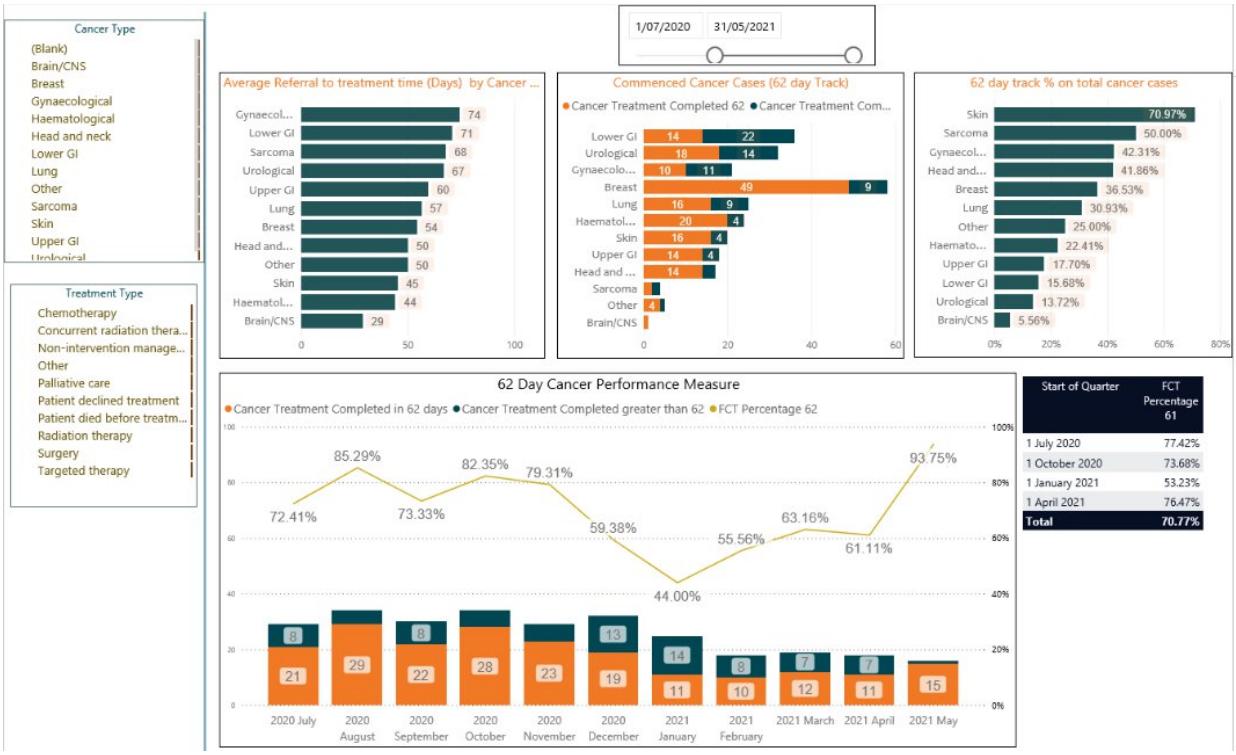
31 day faster cancer treatment performance



Performance was close to the 85% target for the first 2 quarters, but then deteriorated in the first quarter of the calendar year (to 76.43%). A quick review suggests that the previous year did not see this trend so it does not appear to be driven by seasonality. We did encounter high surgical cancer volumes in the early part of this calendar year which we believe is associated with the lag of pent up demand during COVID working its way through. Interestingly, the volume of FCT identified cancers did not grow significantly during this period, but cancers identified as FCT only account for between 15% and 25% of all cancers.

We have focused our initial efforts on analysing the 62 day performance but we will also analyse 31 day performance for future reporting. This will include a review of the uses of the reason codes and whether there were specific delays leading to first treatment (e.g., diagnostics). May performance may be indicating a return to normal (with the April deterioration possibly driven by less available working days due to statutory holidays), but as noted above, good analysis is required to reach firm conclusions about what has driven recent performance.

62 day faster cancer treatment performance



As noted in other reporting, 62 day FCT performance is a function of the use of the delay codes (which is dependent on investigation capacity to improve reporting) and is also a function of the number of patients that go over 62 days before the reason codes are applied.

The use of reason codes varies across DHBs, so a better comparable measure may be the absolute number of patients going over 62 days before the reason codes are applied. We have a higher number of patients going over 62 days before reason codes are applied than the average (validating our need to invest in staffing and other opportunities to improve flow and timeliness), but, according to our analysis, six other DHBs had a similar percentage who went over before reason codes were applied. However, they then applied the non-breaching reason codes at a higher rate and their final result was commensurately higher.

On the basis that investigation and the application of appropriate reason codes where applicable is important in terms of overall reporting we have approved an additional FTE to assist the Cancer Coordinator role in these investigations (the current FTE is 0.5). Once recruited, we will establish protocols for investigating all cases on the Faster Cancer Treatment data base to determine their status and apply the corresponding reason code. The available delay codes are 'patient reason' (chosen to delay), 'clinical consideration' (co-morbidities) and capacity constraint (resulting from lack of resources (theatre, equipment, facilities or workforce) or process constraint including administrative errors). The first two reason codes do not count as a delay for the purposes of FCT reporting whereas the last category does count as a delay.

Oncology Wait Lists

A snapshot of the current wait lists for the three services is as follows.

Combined Monthly View

	Specality desc	Haematology				Oncology				Radiation Oncology			
Year	Month	FSA Authorised (Demand)	FSA SEEN	other exits	Waitlist	FSA Authorised (Demand)	FSA SEEN	other exits	Waitlist	FSA Authorised (Demand)	FSA SEEN	other exits	Waitlist
⊟ 2020	July	39	27	4	56	72	48	19	57	93	65	10	90
	August	37	34	8	57	59	64	9	62	113	94	16	117
	September	40	27	2	80	76	63	9	52	133	113	12	92
	October	31	34	2	68	60	39	11	76	93	90	6	116
	November	30	33	1	61	83	61	9	80	126	103	14	129
	December	28	17	3	80	67	52	13	96	117	101	17	147
⊟ 2021	January	21	29	2	77	38	36	15	77	81	69	17	118
	February	41	17	4	96	50	43	10	43	95	80	15	122
	March	30	27	2	108	55	53	10	29	118	99	12	127
	April	29	18	7	102	60	35	6	65	79	66	10	155
	May	21	46	7	72	59	61	6	52	85	100	30	108

Capacity Average/ Month

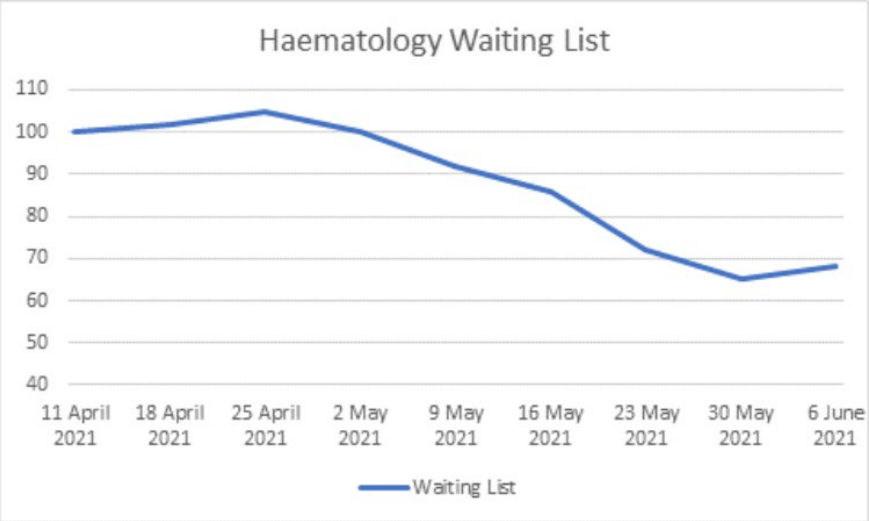
Haematology	Oncology	Radiation Oncology
31.91	61.09	103.55

Of most significance is the radiation oncology wait list, which grew to 155 per month before coming back to 108 (it is currently circa 120) with outsourcing being used to reduce the wait list. Weekly reporting to the CEO, Cancer Control Agency and the Board is now in place to explain the progress on a range of initiatives which are underway to improve the wait list and associated waiting times.

Haematology

There has been a positive reduction of the waiting list during the month of May, as demonstrated by the following chart. The majority of the haematology waiting list is not acute cancers and patients are predominately being attended to in an appropriate timeframe.

Haematology Waiting List



Additional clinics have been run in this service to reduce the waiting list and recruitment is underway in the haematology nursing team. The service is looking to into the possibility of relocating their venesection clinic in house which would allow an increased number of patients to be seen. Recruitment into their Senior Medical Officer (SMO) role has proven difficult, and the service is considering employing a Resident Medical Officer (RMO), i.e., a more junior doctor who can still see patients in clinic as a short term measure.

Medical Oncology

Key to this service is the recruitment of additional SMO and nursing, so that there is sufficient capacity within the SMO team to enable the existing SMO to take leave and undertake more non-clinical work. The service has also signalled the immediate need for more nursing to enable chemotherapy to be delivered more quickly (reducing the delay before this service is provided), and for additional typing capacity to be provided so that the typing does not get into backlog.

In response to these immediate needs, an additional SMO has been signed off ahead of next years' budget so that recruitment can begin immediately, fixed term additional nursing has been signed off and the roles are being recruited into and outsourced typing has commenced, and the backlog has now been removed. Longer term staffing is needed in this (as well as the other services) and the priorities for next year are indicated later in this report.

Radiation Oncology

A key focus is the wait list for radiation oncology. We ideally want the wait list to be between 50-70 patients, as this is a key indicator that we can see all patients within clinically indicted wait times. However, in previous months the wait list has been as high as 155.

A brief modelling exercise we completed a couple of months ago shows that the long-term average for first specialist appointments being approved by the service each week is 21. We have 4.8 full time SMO who are available for 42 weeks out of 52 weeks per annum. On the working assumption of 5 FSA per SMO per week we are a little short on capacity to see the anticipated annual volumes.

However, higher rates of sickness, the 'Mondayisation' of public holidays and the impact of this on clinics and so on exacerbate our capacity shortfall.

Although we are hiring for additional SMO, they have proven difficult to attract, either as locum or permanently, so we have implemented an outsourcing approach, where low complexity patients are outsourced to St Georges in Christchurch.

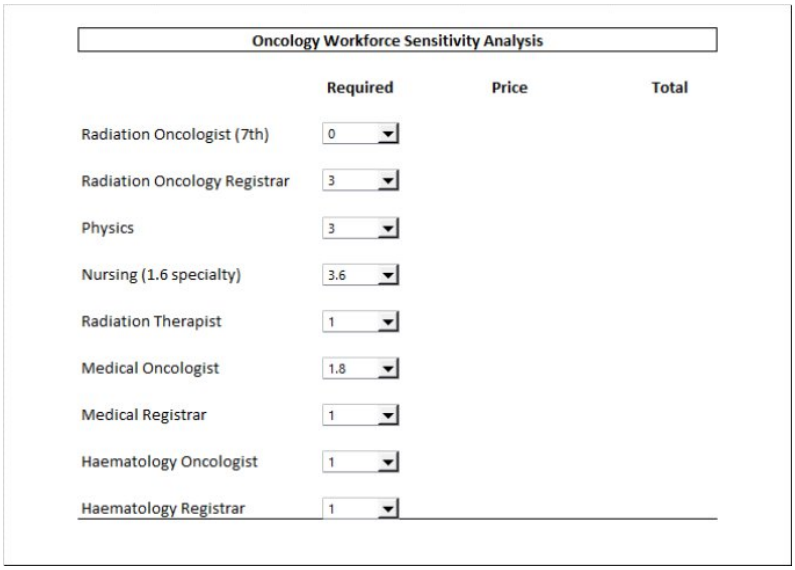
As outsourcing has now been offered to all long waiting patients, we will move to outsourcing being determined at the time of the referral in the coming weeks for particular groups of patients who are suitable for outsourcing. This will enable us to scale outsourcing up or down depending on the doctor capacity we currently have available within the service.

Work across the 3 Oncology Services

A number of initiatives are being worked on across all 3 services in partnership with our colleagues at the Cancer Control Agency (CCA). A brief summary of these initiatives is as follows:

- Following a visit from the Chief Executive of the Cancer Control Agency, the CCA has recommended that we find a suitable partner to launch an extensive marketing and attraction campaign to enable us to recruit additional staff into a number of the oncology workforces. We have confirmed a partner and will commence this work in the coming weeks.
- The CCA is assisting us to benchmark our current level of staffing across all workforces against other centres. We have supplied our staffing numbers and will receive feedback on how our staffing compares and what we need to prioritise.
- We have approached a consultancy service to assist us in developing a 10 year strategic plan for all 3 services. The strategy would address future growth in demand for the services, staffing gaps (connected to the benchmarking exercise), model of care changes where appropriate, future capital investment and would also look at processes, systems and connection to other services (such as surgery). We are expecting a proposal for review next week.
- We are looking at immediate software improvements that would enable us to see patients on an electronic whiteboard and to track them better with electronic workflow. A specification will be developed in the coming weeks and we will then put the specification out to market and select a developer to build it. It will be a low-cost solution which will be consistent with the future information technology roadmap (as there is key input from the SDHB Lead Solutions Architect). The intention is to build something quickly, get value from it and then allow it to be replaced at some point in the future.
- We have tendered the outsourcing work for radiation oncology treatment and have confirmed a provider for this service.

We have worked with the Clinical Leaders and the services to identify our immediate priorities for additional staffing in the 2021/22 financial year and have identified the following list of initial priorities.



Oncology Workforce Sensitivity Analysis			
	Required	Price	Total
Radiation Oncologist (7th)	0		
Radiation Oncology Registrar	3		
Physics	3		
Nursing (1.6 specialty)	3.6		
Radiation Therapist	1		
Medical Oncologist	1.8		
Medical Registrar	1		
Haematology Oncologist	1		
Haematology Registrar	1		

The intention is that these roles will be included in the 2021/22 budget which will enable important initial progress to be made whilst we refine the total staffing requirements for the coming years from the benchmarking and strategy work. In discussing the priorities with the clinical leaders, a key theme was offering placements to RMO's so that junior doctors could be trained to become the future senior doctor workforce, which would reduce the risks we currently face when trying to recruit senior doctors into our organisation (there is a good chance of retaining trainees one they have completed their training). This was a common theme across all 3 services.

8. Colonoscopy

Colonoscopy reporting continues to be developed and refined with the inclusion of declines for colonoscopy and the reason for the decline now able to be reported.

The real time wait list (which was run on 14 June 2021) continues to show good performance, with the average and median wait times for patients diagnosed as urgent or semi-urgent sitting inside the 14 and 42 day targets in both the Dunedin and Invercargill hospital locations. The Ministry of Health Colonoscopy Waiting Time Indicator is also being met for urgent and non-urgent symptomatic colonoscopies as well as for the National Bowel Screening Programme.

Average wait times for surveillance scoping remain outside the 84 day target but are within target for Dunedin and are the subject of a recovery plan for Southland. The Ministry of Health Colonoscopy Waiting Time Indicator is not being met (not shown in the tables). This sits at 57% (the target is 70%) which is a significant improvement from the January result, which was 36%.

The recovery for Southland Surveillance has been slowed due to nursing vacancies in Dunedin that have eroded the capacity across the District and therefore Southland patients have been unable to be offered appointments in Dunedin to the extent that had been planned. Weekend lists, the review of the patients against the new guidelines and trying to ensure all available capacity is used remain the strategies for recovery and once the nursing vacancies in Dunedin are resolved patients from Southland will again be offered appointments in Dunedin.

Colonoscopy Combined Wait List

Real time waitlist - combined

Priority new	No of Waiting Patients	Average waiting time	Median Wait time	Longest Wait
Diag Urgent	11	10.18	11.00	21
Diag Non-Urgent	176	30.48	24.50	88
Diag Planned and Staged	58	41.22	37.50	105
NBSP	35	16.66	14.00	58
SURV	488	98.63	84.00	305

Colonoscopy Maximum Wait Times

Maximum Wait time Breach

Hospital	Urg >30	Non urg >90	SURV >120	NBSP > 45
Dunedin			14	
Southland			147	1
Total			**161**	**1**

The maximum waiting time 'breach' numbers are higher than previously reported. As noted in previous reporting, there were previously challenges with reporting this accurately as 'booked' events overwrote the date for the previously unscheduled event. This issue has now been addressed in our systems and reporting extracts and the change in the method of deriving the data has driven the slight increase in the numbers. This can now be reported consistently and accurately. Further enhancements are being worked on for surveillance wait list waiting times and once this final set of enhancements is made, we will have made our reporting as accurate as we believe to be possible within the limitations of our current systems.

Colonoscopy Performance Against Ministry Target (Combined)

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%	68.73%	-1.27%	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%	84.87%	14.87%	96.63%	1.63%
30 November 2020	100.00%	10.00%	79.93%	9.93%	100.00%	5.00%
31 December 2020	92.86%	2.86%	91.34%	21.34%	98.68%	3.68%
31 January 2021	79.49%	-10.51%	75.38%	5.38%	98.46%	3.46%
28 February 2021	88.89%	-1.11%	85.00%	15.00%	100.00%	5.00%
31 March 2021	94.23%	4.23%	89.49%	19.49%	97.96%	2.96%
30 April 2021	92.68%	2.68%	78.07%	8.07%	96.91%	1.91%
31 May 2021	90.20%	0.20%	67.78%	-2.22%	98.94%	3.94%

The waiting time indicators for the district were met for all symptomatic patients in April. In May the waiting time indicator was met for urgent symptomatic patients but the non-urgent category was slightly below target (achieved 68% against a target of 70%).

The waiting time indicators split by region are noted in the table below.

Colonoscopy Performance Against Ministry Target (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%	54.29%	-15.71%	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%	88.12%	18.12%	96.88%	1.88%
30 November 2020	100.00%	10.00%	85.05%	15.05%	100.00%	5.00%	100.00%	10.00%	70.48%	0.48%	100.00%	5.00%
31 December 2020	100.00%	10.00%	90.40%	20.40%	98.11%	3.11%	83.33%	-6.67%	93.51%	23.51%	100.00%	5.00%
31 January 2021	80.00%	-10.00%	78.91%	8.91%	100.00%	5.00%	78.95%	-11.05%	69.01%	-0.99%	94.44%	-0.56%
28 February 2021	90.00%	0.00%	88.96%	18.96%	100.00%	5.00%	87.50%	-2.50%	76.92%	6.92%	100.00%	5.00%
31 March 2021	93.33%	3.33%	93.71%	23.71%	98.55%	3.55%	95.45%	5.45%	82.65%	12.65%	96.55%	1.55%
30 April 2021	88.89%	-1.11%	82.01%	12.01%	96.77%	1.77%	100.00%	10.00%	72.22%	2.22%	97.14%	2.14%
31 May 2021	87.80%	-2.20%	68.70%	-1.30%	98.31%	3.31%	100.00%	10.00%	66.15%	-3.85%	100.00%	5.00%

Finally, our session utilisation (based on Provation data) was as follows.

Dunedin Provation Session Utilisation

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

Location	Dunedin										southland Endoscopy				
Room	Blue Room					Green Room									
Year	No of Procedures	Total Time	Utilization	Utilization by 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	**1247**	**49051**	**77.42%**	**83.08%**	**77.42%**	**676**	**24268**	**65.66%**	**72.23%**	**38.30%**	**1089**	**42571**	**66.68%**	**98.54%**	**67.19%**
July	256	9583	79.86%	86.80%	86.80%	106	3516	56.35%	61.04%	31.85%	170	6573	62.24%	88.35%	59.54%
August	231	8831	83.63%	87.61%	87.61%	101	3683	69.75%	76.73%	36.54%	200	7590	65.89%	98.83%	75.30%
September	194	7649	75.88%	79.68%	72.43%	107	3954	68.65%	82.38%	37.44%	206	8061	69.97%	101.78%	76.34%
October	226	8719	82.57%	90.82%	82.57%	77	2751	52.10%	63.68%	26.05%	171	7221	71.64%	103.75%	68.38%
November	191	7737	70.08%	76.76%	76.76%	160	5747	70.43%	72.56%	57.01%	194	7454	67.52%	100.19%	73.95%
December	149	6532	71.62%	75.60%	59.17%	125	4617	73.99%	76.95%	41.82%	148	5672	62.19%	98.47%	51.38%
2021	**976**	**38539**	**73.66%**	**82.77%**	**68.04%**	**563**	**20717**	**66.40%**	**69.61%**	**36.58%**	**886**	**33841**	**67.14%**	**96.58%**	**59.75%**
January	173	6814	70.98%	78.87%	67.60%	137	4825	71.80%	77.32%	47.87%	158	5835	63.98%	90.05%	57.89%
February	194	7814	74.00%	90.44%	81.40%	118	4371	65.04%	65.04%	45.53%	171	6440	70.61%	99.38%	67.08%
March	208	8355	75.68%	79.12%	75.68%	112	4110	61.16%	63.43%	37.23%	203	7830	67.97%	98.86%	70.92%
April	197	7753	70.23%	80.76%	73.42%	78	2829	58.94%	62.04%	26.79%	149	5545	60.80%	85.57%	52.51%
May	204	7803	77.41%	85.56%	77.41%	118	4582	73.43%	79.55%	45.46%	205	8191	71.10%	106.65%	81.26%
Total	**2223**	**87590**	**75.72%**	**82.95%**	**72.99%**	**1239**	**44985**	**66.00%**	**71.00%**	**37.49%**	**1975**	**76412**	**66.89%**	**97.66%**	**63.68%**

This report indicates that the 'blue' room in Dunedin was reasonably well utilised both in terms of the room's utilisation and the schedules that were completed in that room. However, the 'green' room whilst reasonably well utilised in terms of session utilisation was underutilised in room utilisation. There is also a third room in Dunedin that is currently only used for bronchoscopy twice each week and is not shown in the table above. There is plenty of additional capacity available to schedule more sessions into the 'Green' room and also the unutilised room. The resourcing of this additional capacity would not only provide the appropriate capacity for undertaking colonoscopies (and other endoscopic procedures) but also provide sufficient capacity to undertake the necessary training for gastroenterology, general surgical and nurse endoscopist trainees. Additional nursing capacity has been included in the budget priorities for 2021/22.

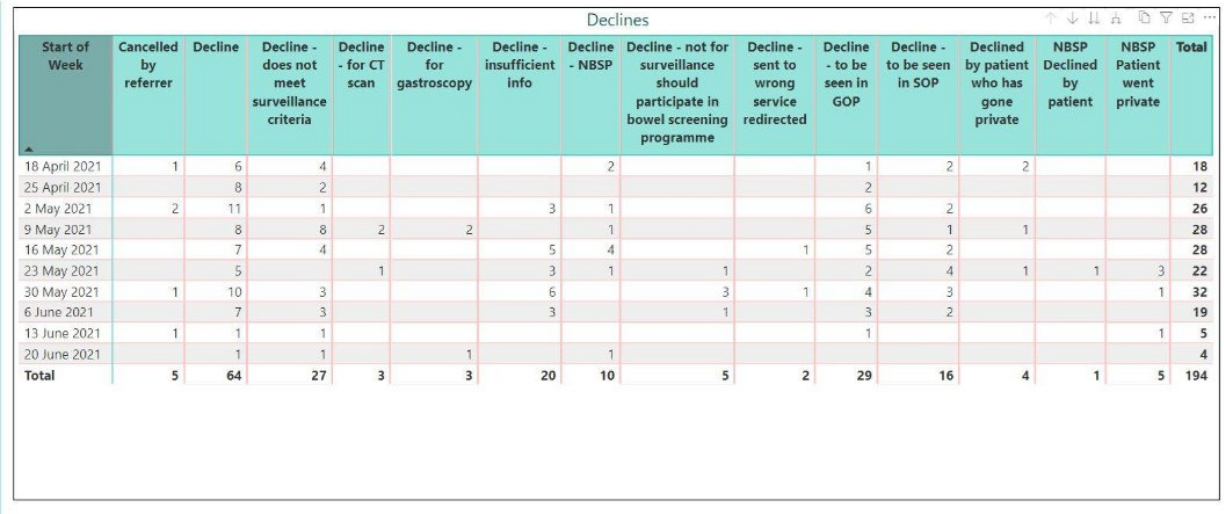
With more nurse resourcing it would be possible to schedule more sessions.

Session utilisation for the Southland Endoscopy suite remains at 98% but the room utilisation is at 67%. Although on face value this suggests that more staffing would allow for greater capacity to be utilised this is unlikely as the utilisation reflects the necessity of scheduling to fit in with other non-endoscopy commitments (3 sessions per week) as opposed to unused space.

Overall, we have sufficient physical capacity to complete more endoscopy in Dunedin but we are currently constrained by our staffing levels.

Colonoscopy Decline Rates

We have developed a new report which enables us to see the reasons for colonoscopy declines. This enables us compare outright declines with declines for reasons such as choosing another diagnostic pathway.



Declines

Start of Week	Cancelled by referrer	Decline	Decline - does not meet surveillance criteria	Decline - for CT scan	Decline - for gastroscopy	Decline - insufficient info	Decline - NBSP	Decline - not for surveillance should participate in bowel screening programme	Decline - sent to wrong service redirected	Decline - to be seen in GOP	Decline - to be seen in SOP	Declined by patient who has gone private	NBSP Declined by patient	NBSP Patient went private	Total
18 April 2021	1	6	4				2			1	2	2			18
25 April 2021		8	2							2					12
2 May 2021	2	11	1			3	1			6	2				26
9 May 2021		8	8	2	2		1			5	1	1			28
16 May 2021		7	4			5	4		1	5	2				28
23 May 2021		5		1		3	1	1		2	4	1	1	3	22
30 May 2021	1	10	3			6		3	1	4	3			1	32
6 June 2021		7	3			3		1		3	2				19
13 June 2021	1	1	1							1				1	5
20 June 2021		1	1		1		1								4
Total	**5**	**64**	**27**	**3**	**3**	**20**	**10**	**5**	**2**	**29**	**16**	**4**	**1**	**5**	**194**

For patients declined from the week commencing the 25th of April 2021 to the 6th of June 2021 a total of 162 referrals were not accepted for colonoscopy out of a total of 848 that were received giving a raw decline rate of 19%. However as per the table below the actual number of patients that were not redirected to another service or were cancelled was 58, giving an absolute decline rate of 6.8%.

Sum of Referrals Declined	Grand Total
Cancelled by referrer	3
Colonoscopy - Declined	2
Decline	56
Decline - does not meet surveillance criteria	21
Decline - for CT scan	3
Decline - for gastroscopy	2
Decline - insufficient info	20
Decline - NBSP	7
Decline - to be seen in GOP	27
Decline - to be seen in SOP	14
Declined by patient who has gone private	2
NBSP Declined by patient	1
NBSP Patient went private	4
Grand Total	**162**

Key

SOP – Surgical outpatients
GOP – Gastroenterology outpatients
NBSP – National Bowel Screening Programme

9. Caseweight, Discharges and Volumes

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,518	**10,858** Actual YTD vs 11,407 Plan YTD, as of May 2021.

Note the above discharges exclude improvement action plan volumes.

Equity in outpatients

What is our role in creating equity in Outpatients and Radiology?

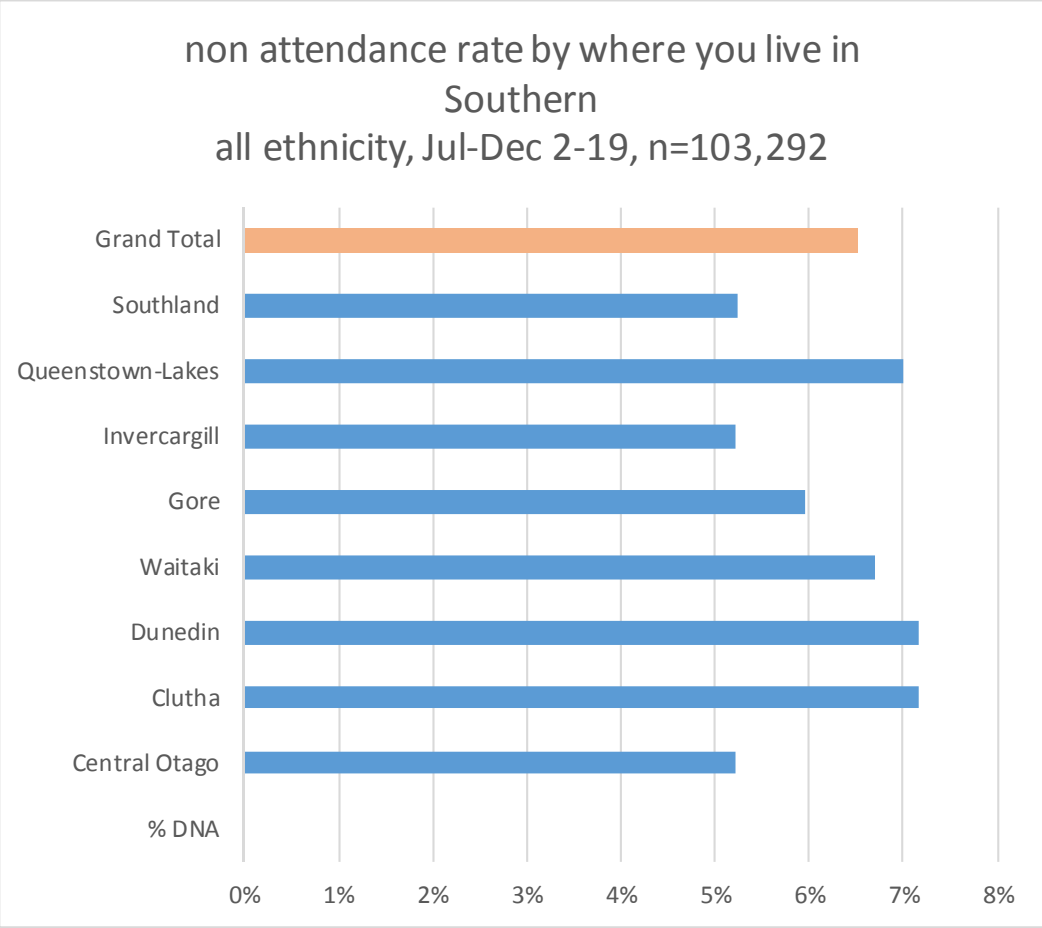
The aim of this session:

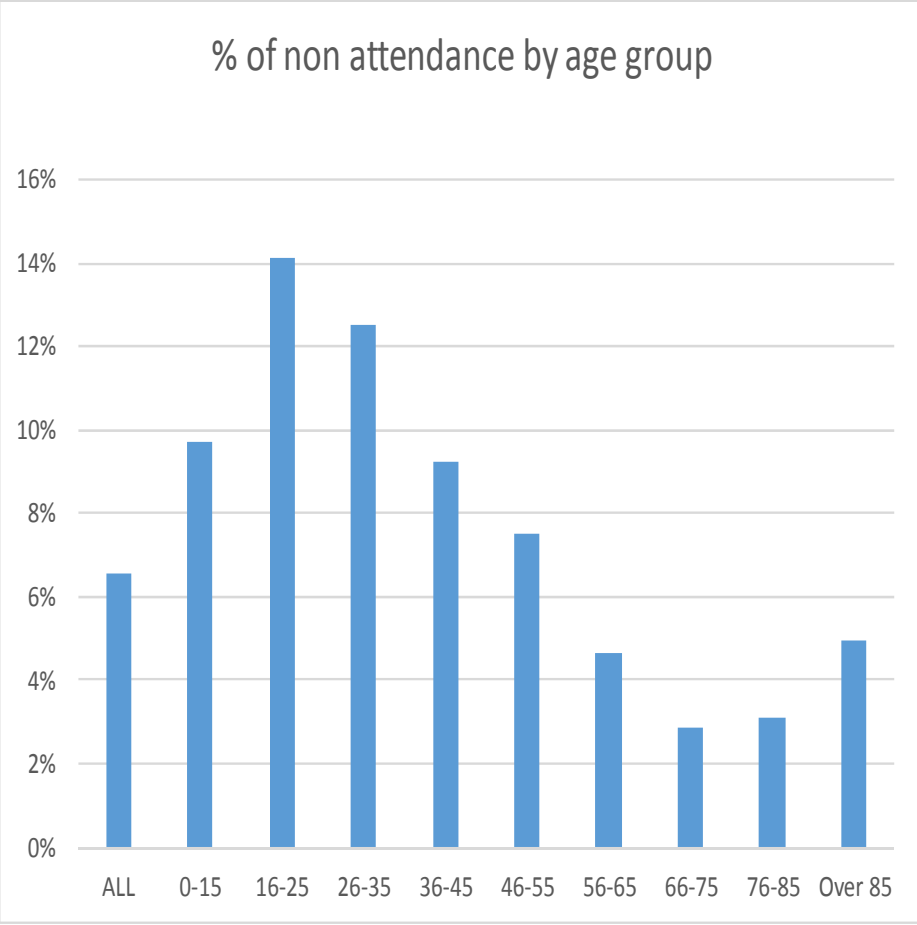
1. Learn about some elements of equity at Southern
2. Discuss processes in Outpatients and Radiology and how they may help and hinder equity outcomes
3. Develop some key discussion points for what might change - to take back to the teams.
4. Identify how we can help

Elements of equity at Southern

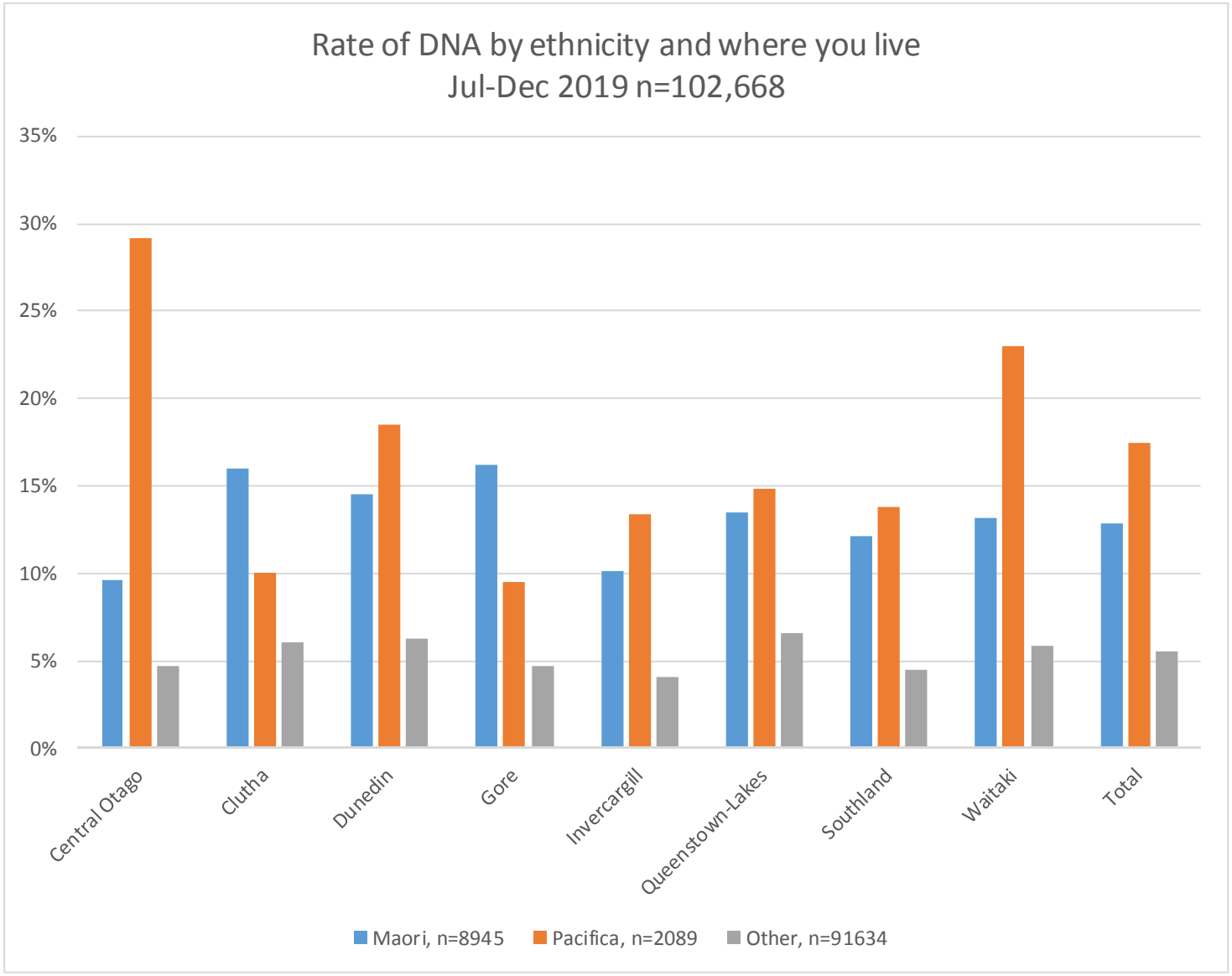
- Unable to attend rates
- Complex pathways
- Cancer outcomes

A walk through the outpatient Unable to Attend data Jul-Dec 2019





Non attendance by where you live and ethnicity

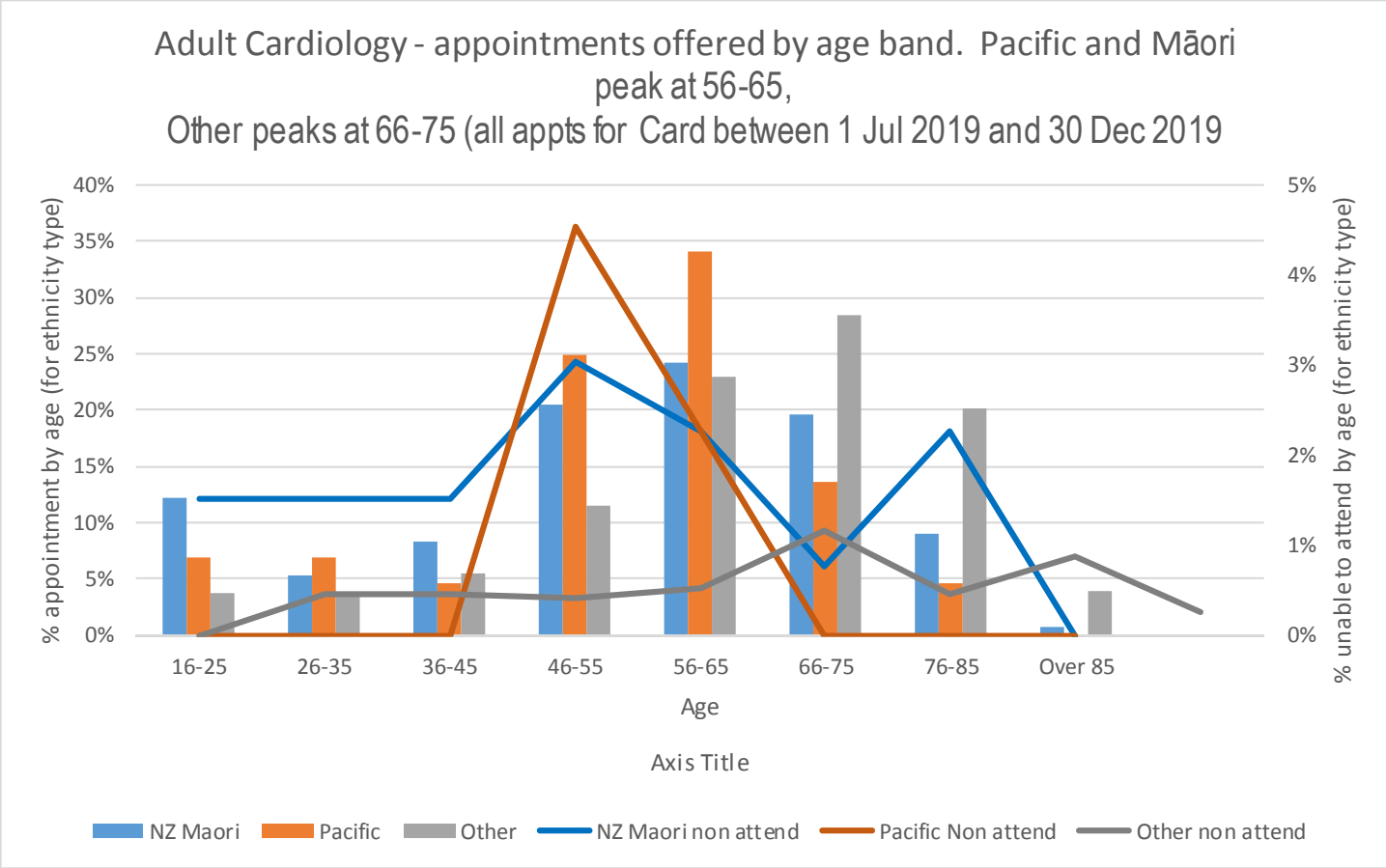


Dunedin – types of clinics – high overall Cannot Attend rates 1 July to 31 December 2019

% Cannot Attend	Māori	Other	Pacific Island	Grand Total
Community referred tests - respiratory	24%	9%	27%	11%
Respiratory - 1st attendance	25%	8%	60%	10%
Respiratory - Subsequent attendance	22%	7%	27%	8%
Sleep Apnoea Assessment	24%	8%	24%	10%
Sleep breathing disorder long term supply and support	17%	9%	33%	11%

Respiratory rates August 2020 to February 2021	Māori	Other	Pacific	Total
Attended	302	3613	84	3999
Unable to Attend	95	292	24	411
Total	397	3905	108	4410
Unable to attend rate	24%	7%	22%	9%

Profile of Adult Cardiology appointment volumes and Cannot Attend Rates



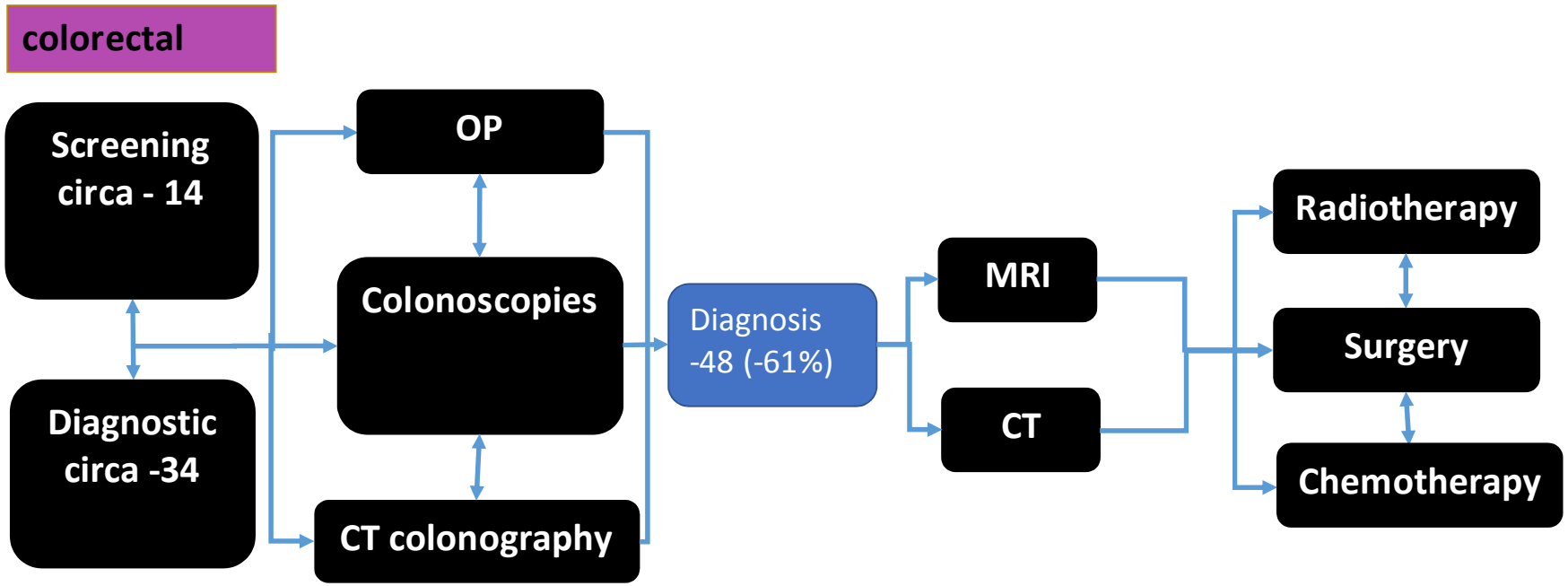
What causes DNAs?

- brainstorm

Why does it matter?

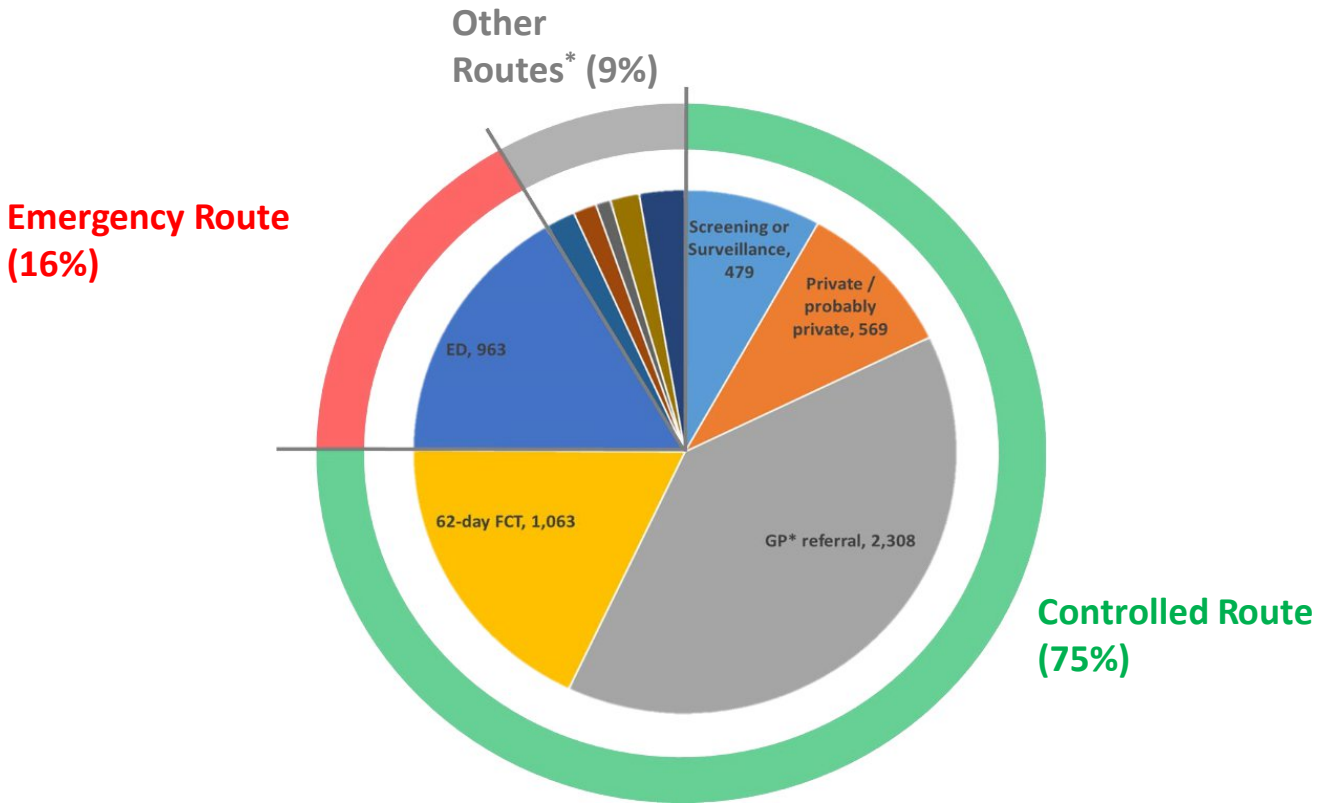
- brainstorm

There are a lot of appointments to get a diagnosis of and treatment of cancer (example colorectal pathway)



*Faster Cancer Treatment database

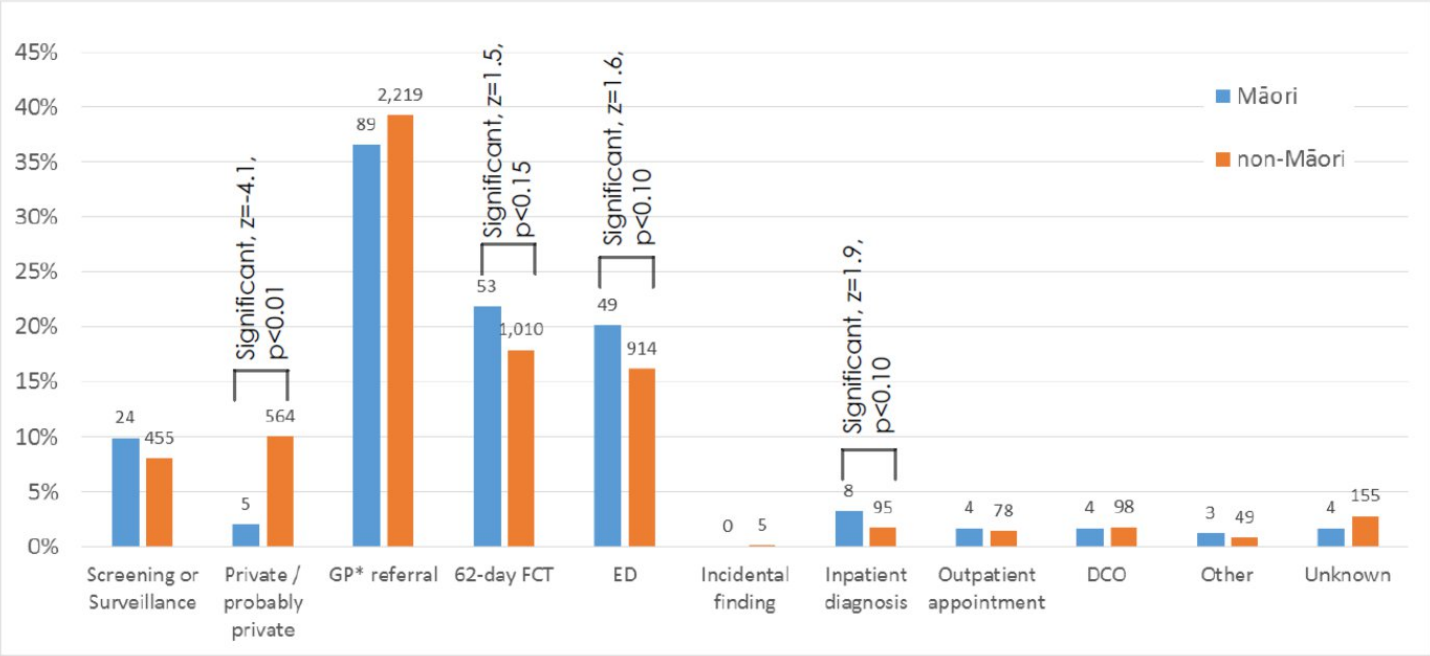
Part B - Route to Diagnosis (RTD)



*Other includes: outpatient appointment, inpatient diagnosis, death certificate only, incidental finding, other and unknown

Ethnicity and RTD

Māori cancer patients were more likely than non- Māori to first access cancer services via ED presentation, 62-day FCT and Inpatient diagnosis routes. They were also less likely to first access cancer services via a private route.



ED presentation, 62-day FCT and Inpatient diagnosis were the routes to diagnosis with the worst one year survival.

Example of what one group did to promote equity

- Cancer Nurse Coordinator who provide navigation support were concerned that they would miss seeing patients who really needed help if they relied on a ‘referral’ system
- They set up a system which identifies the highest risk groups of patients to work with without relying on a referrer to remember to refer or a patient identifying that they need help.

The "Rules"

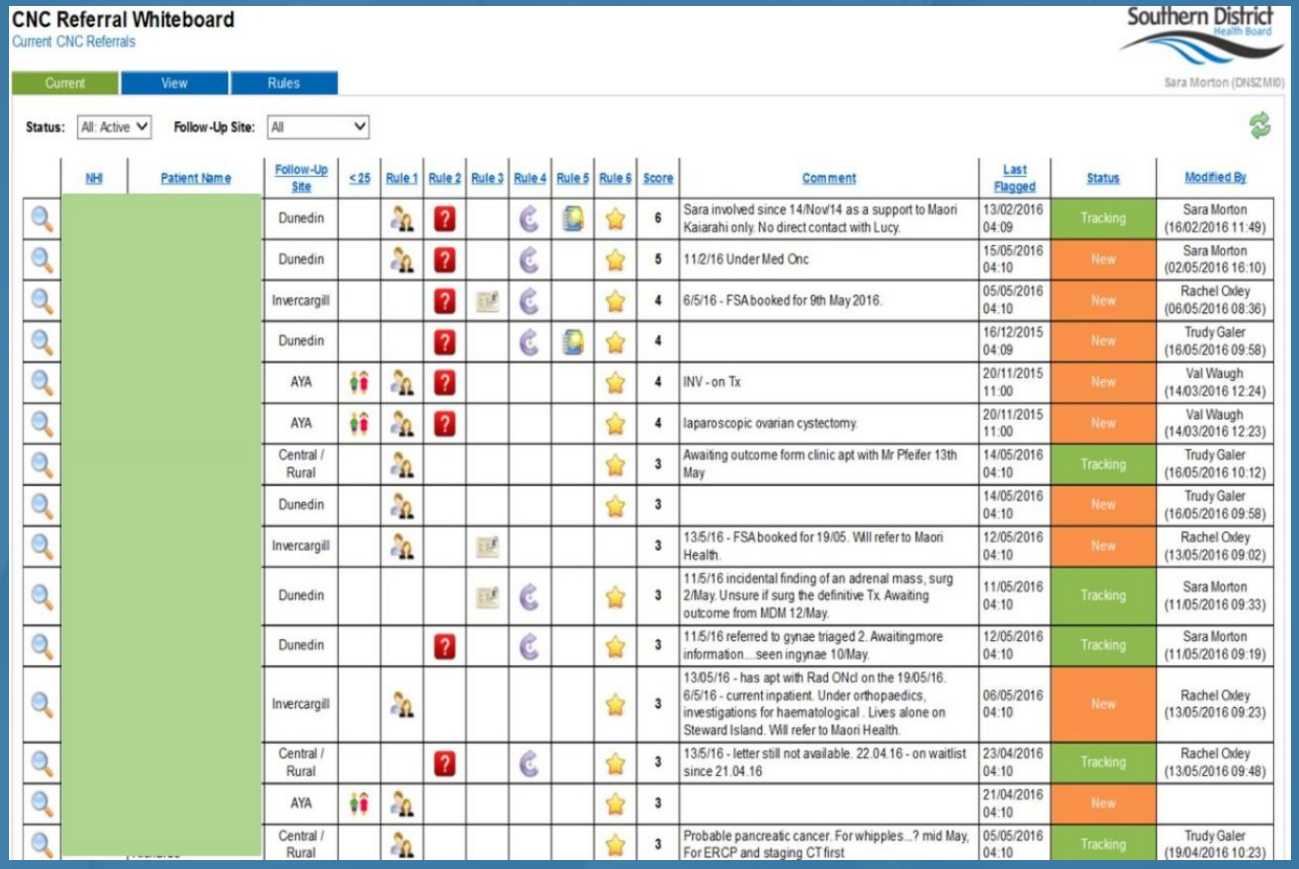
CNC Referral Whiteboard

Rules Definition

Current | View | Rules

	Rules	Score Weight
	Maori or Pacific Islander	2
	> 2 DNAs in the last 12 months	1
	All Mental Health Speciality (including CADS and DASS)	1
	Inpatient Presentations in the last 12 months	1
	Deprivation via Address	1
	>= 2 Non Cancer Speciality	1

The Whiteboard



CNC Referral Whiteboard

Current CNC Referrals

Southern District Health Board

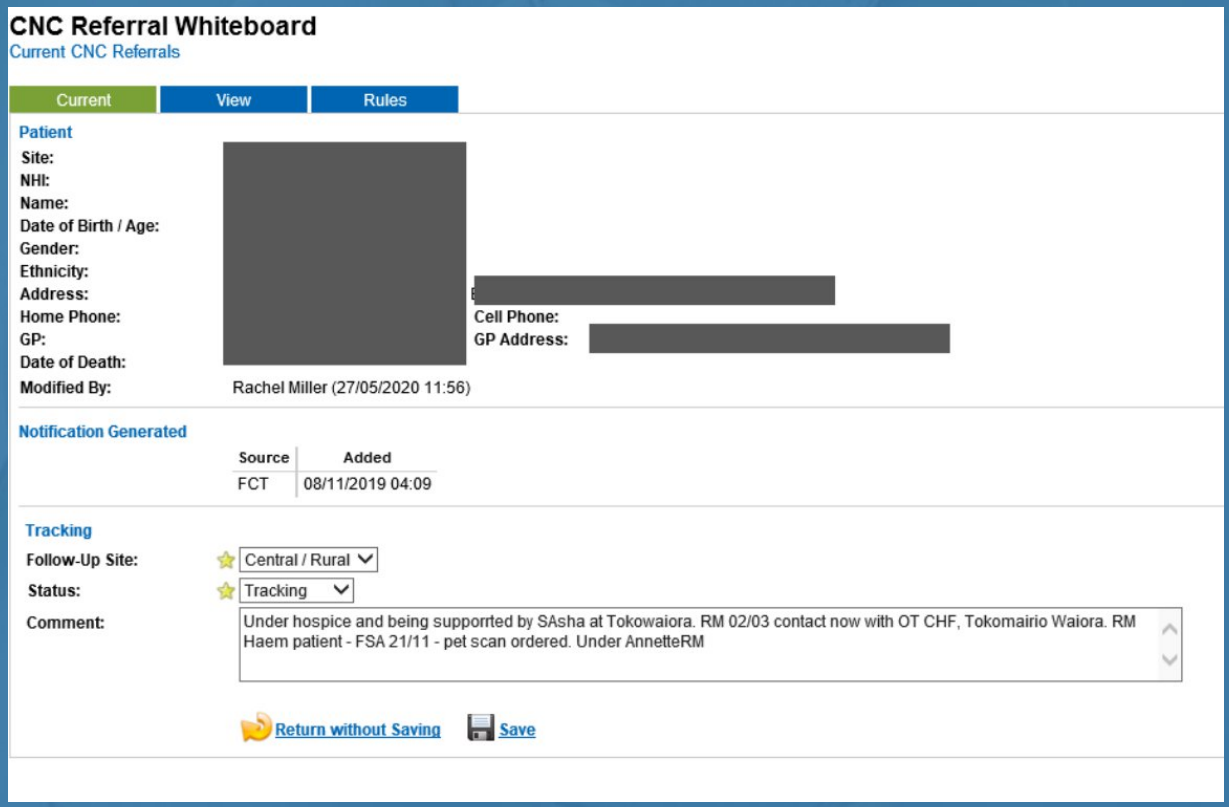
Sara Morton (DNSZM10)

Current | View | Rules

Status: All: Active | Follow-Up Site: All

NHI	Patient Name	Follow-Up Site	<25	Rule 1	Rule 2	Rule 3	Rule 4	Rule 5	Rule 6	Score	Comment	Last Flagged	Status	Modified By
		Dunedin								6	Sara involved since 14/Nov/14 as a support to Maori Kaiarahi only. No direct contact with Lucy.	13/02/2016 04:09	Tracking	Sara Morton (16/02/2016 11:49)
		Dunedin								5	11/2/16 Under Med Onc	15/05/2016 04:10	New	Sara Morton (02/05/2016 16:10)
		Invercargill								4	6/5/16 - FSA booked for 9th May 2016.	05/05/2016 04:10	New	Rachel Oxley (06/05/2016 08:36)
		Dunedin								4		16/12/2015 04:09	New	Trudy Galer (16/05/2016 09:58)
		AYA								4	INV - on Tx	20/11/2015 11:00	New	Val Waugh (14/03/2016 12:24)
		AYA								4	laparoscopic ovarian cystectomy.	20/11/2015 11:00	New	Val Waugh (14/03/2016 12:23)
		Central / Rural								3	Awaiting outcome form clinic apt with Mr Pfeifer 13th May	14/05/2016 04:10	Tracking	Trudy Galer (16/05/2016 10:12)
		Dunedin								3		14/05/2016 04:10	New	Trudy Galer (16/05/2016 09:58)
		Invercargill								3	13/5/16 - FSA booked for 19/05. Will refer to Maori Health.	12/05/2016 04:10	New	Rachel Oxley (13/05/2016 09:02)
		Dunedin								3	11/5/16 incidental finding of an adrenal mass, surg 2/May. Unsure if surg the definitive Tx. Awaiting outcome from MDM 12/May.	11/05/2016 04:10	Tracking	Sara Morton (11/05/2016 09:33)
		Dunedin								3	11/5/16 referred to gynae triaged 2. Awaitingmore information....seen ingynae 10/May.	12/05/2016 04:10	Tracking	Sara Morton (11/05/2016 09:19)
		Invercargill								3	13/05/16 - has apt with Rad ONcl on the 19/05/16. 6/5/16 - current inpatient. Under orthopaedics, investigations for haematological . Lives alone on Steward Island. Will refer to Maori Health.	06/05/2016 04:10	New	Rachel Oxley (13/05/2016 09:23)
		Central / Rural								3	13/5/16 - letter still not available. 22.04.16 - on waitlist since 21.04.16	23/04/2016 04:10	Tracking	Rachel Oxley (13/05/2016 09:48)
		AYA								3		21/04/2016 04:10	New	
		Central / Rural								3	Probable pancreatic cancer. For whipples...? mid May, For ERCP and staging CT first	05/05/2016 04:10	Tracking	Trudy Galer (19/04/2016 10:23)

The Detail (when patient clicked on)



CNC Referral Whiteboard

Current CNC Referrals

Current | View | Rules

Patient

Site:
NHI:
Name:
Date of Birth / Age:
Gender:
Ethnicity:
Address:
Home Phone:
GP:
Date of Death:
Modified By: Rachel Miller (27/05/2020 11:56)

Cell Phone:
GP Address:

Notification Generated

Source	Added
FCT	08/11/2019 04:09

Tracking

Follow-Up Site: Central / Rural
Status: Tracking
Comment: Under hospice and being supporrted by SAsha at Tokowaiora. RM 02/03 contact now with OT CHF, Tokomairio Waiora. RM Haem patient - FSA 21/11 - pet scan ordered. Under AnnetteRM

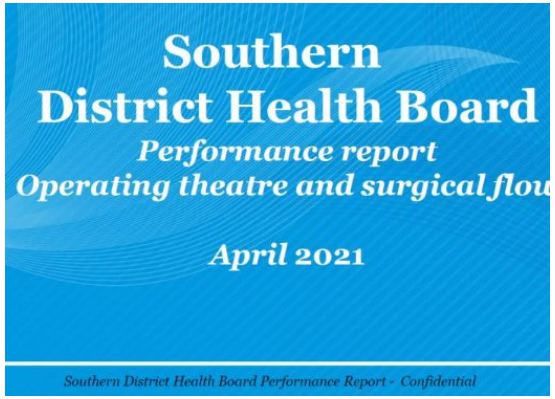
Return without Saving | Save

What could we do to reduce DNAs?

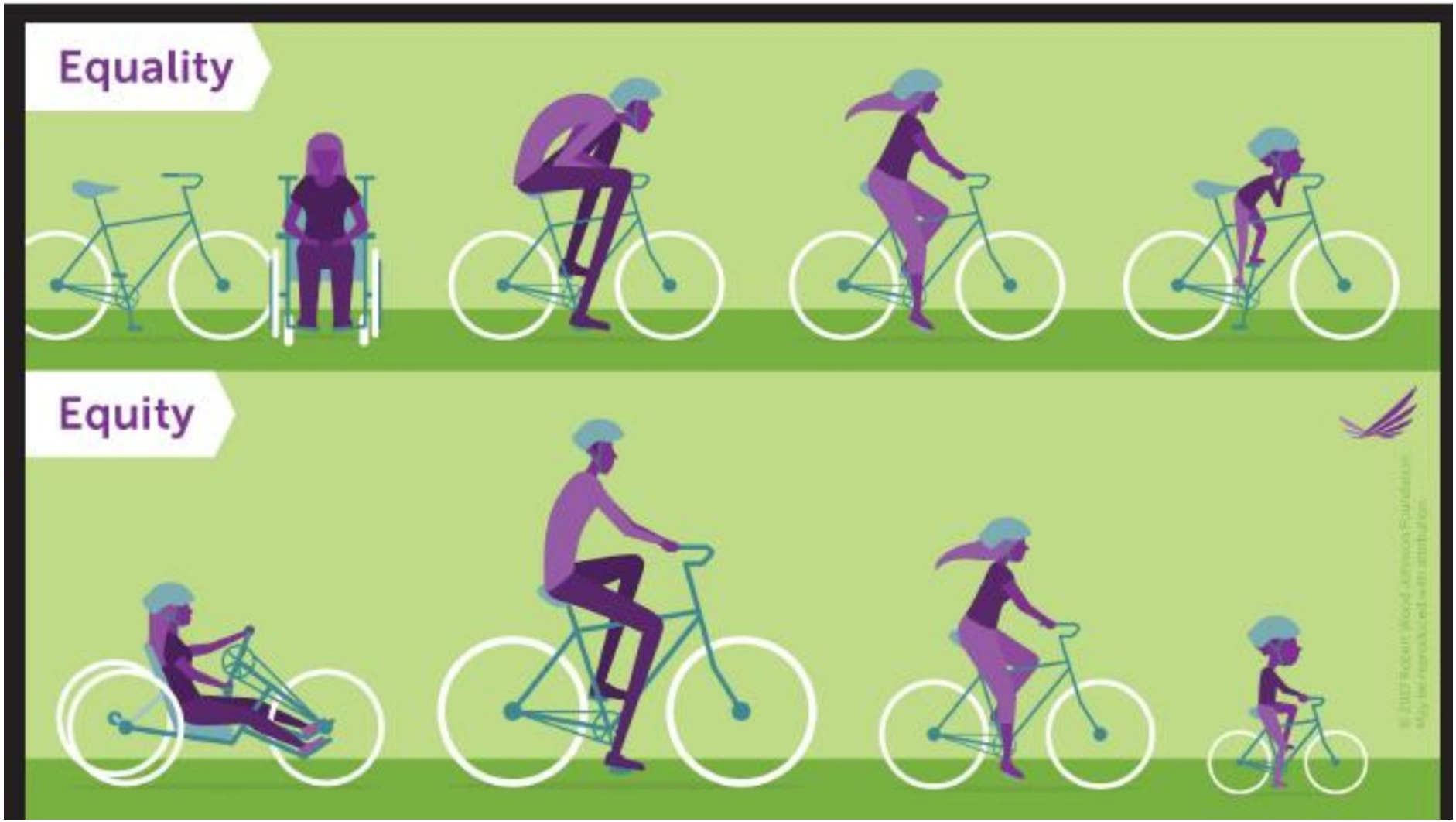
- brainstorm

Waiting for Surgery

- Patients treated at Southern DHB wait longer to receive care than at peer DHBs. Māori patients wait about the same time as peers in other DHBs, and a shorter time than non-Māori in Southern DHB.
- Compared to peers, Southern DHB has on average a greater percentage of patients on the waitlist deferred or rebooked, particularly Māori.

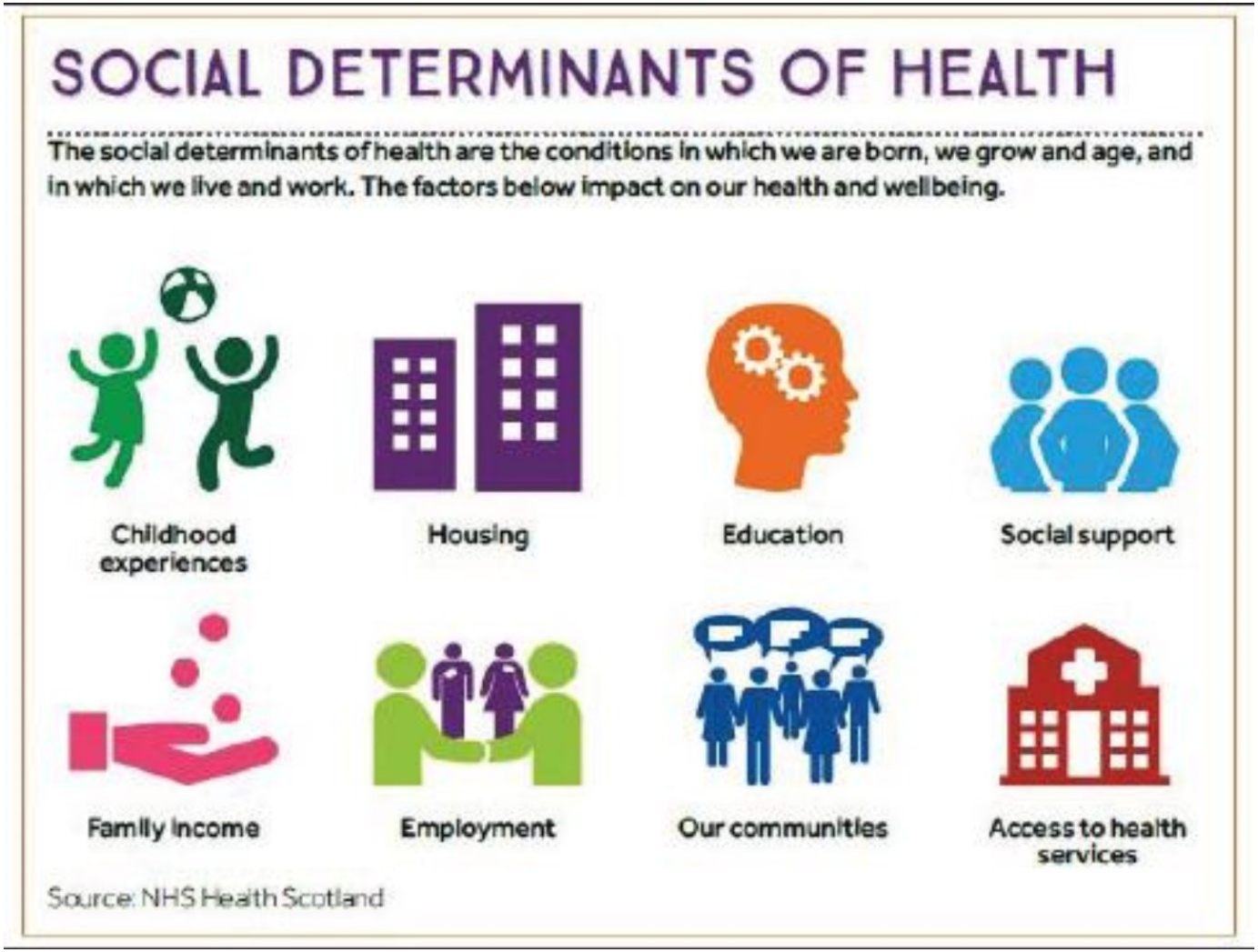


The difference between equity and equality

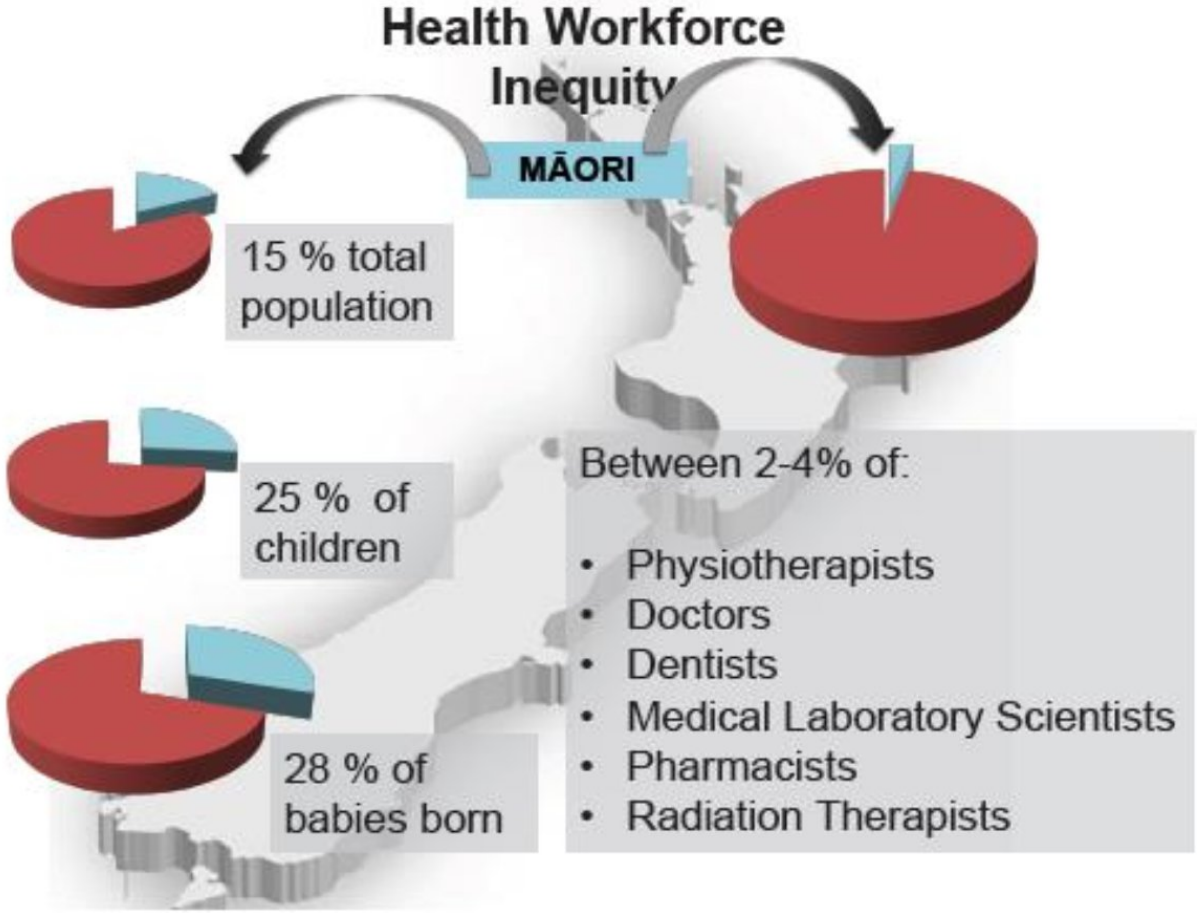

Equality
Equity

Regardless of your culture, ethnicity, beliefs…

the social determinants of health are seen as the *same* the world over



So in New Zealand – these are the stats



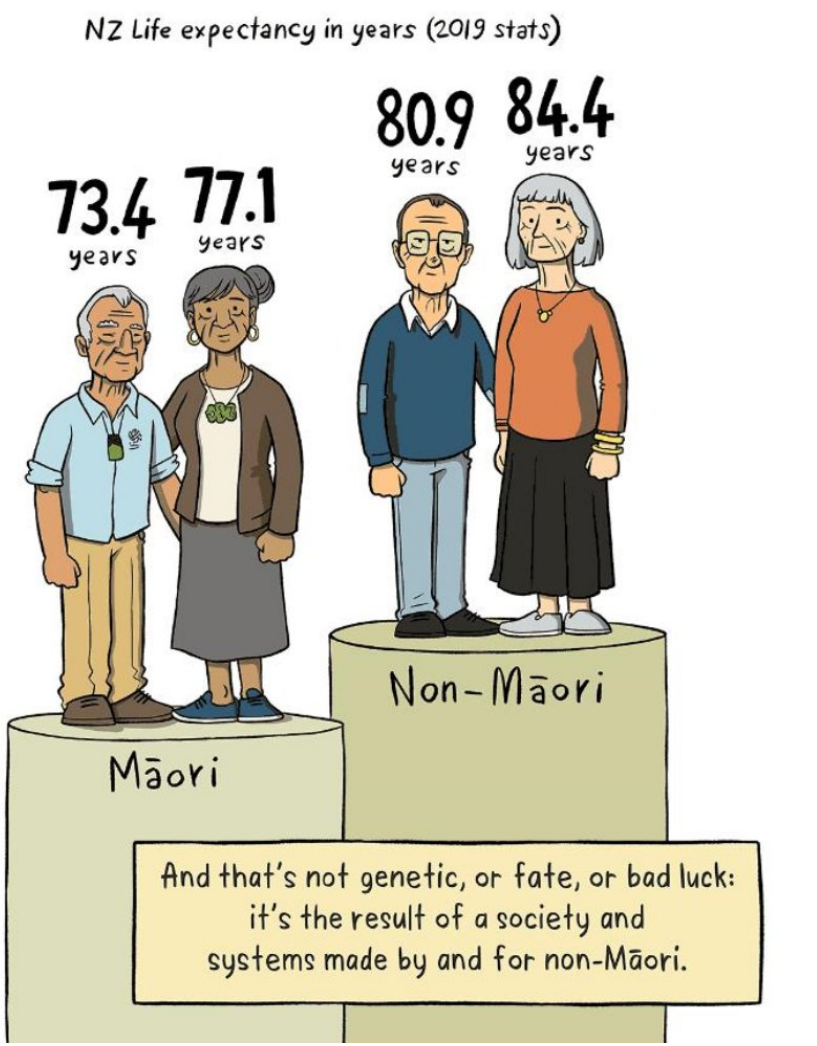
The University of Otago is trying to combat this problem by having a pro-equity entry criteria into Health Sciences.

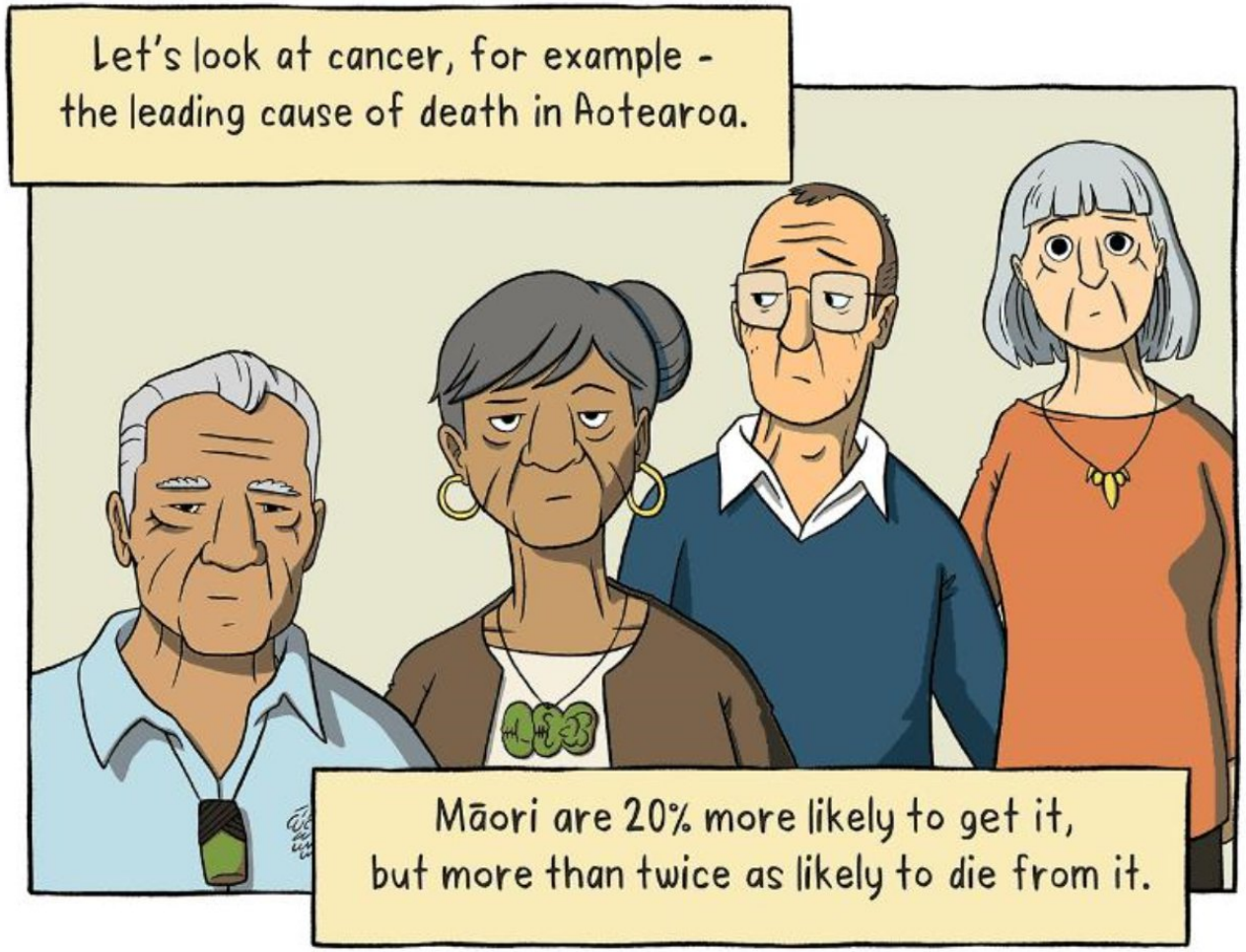
6.1

How is our work in outpatients and diagnosti important?

Produced with permission from the spin-off, May 2021

https://thespinoff.co.nz/society/the-side-eye/19-05-2021/the-side-eyes-two-new-zealands-the-2700-day-gap/?fbclid=IwAR0p6W29xPamt3_dXe1EWKp7PcyWfS8vOi2d_p3xSFMd-0BYayUlSYTSBug#.YKRY0N1d8eM.facebook

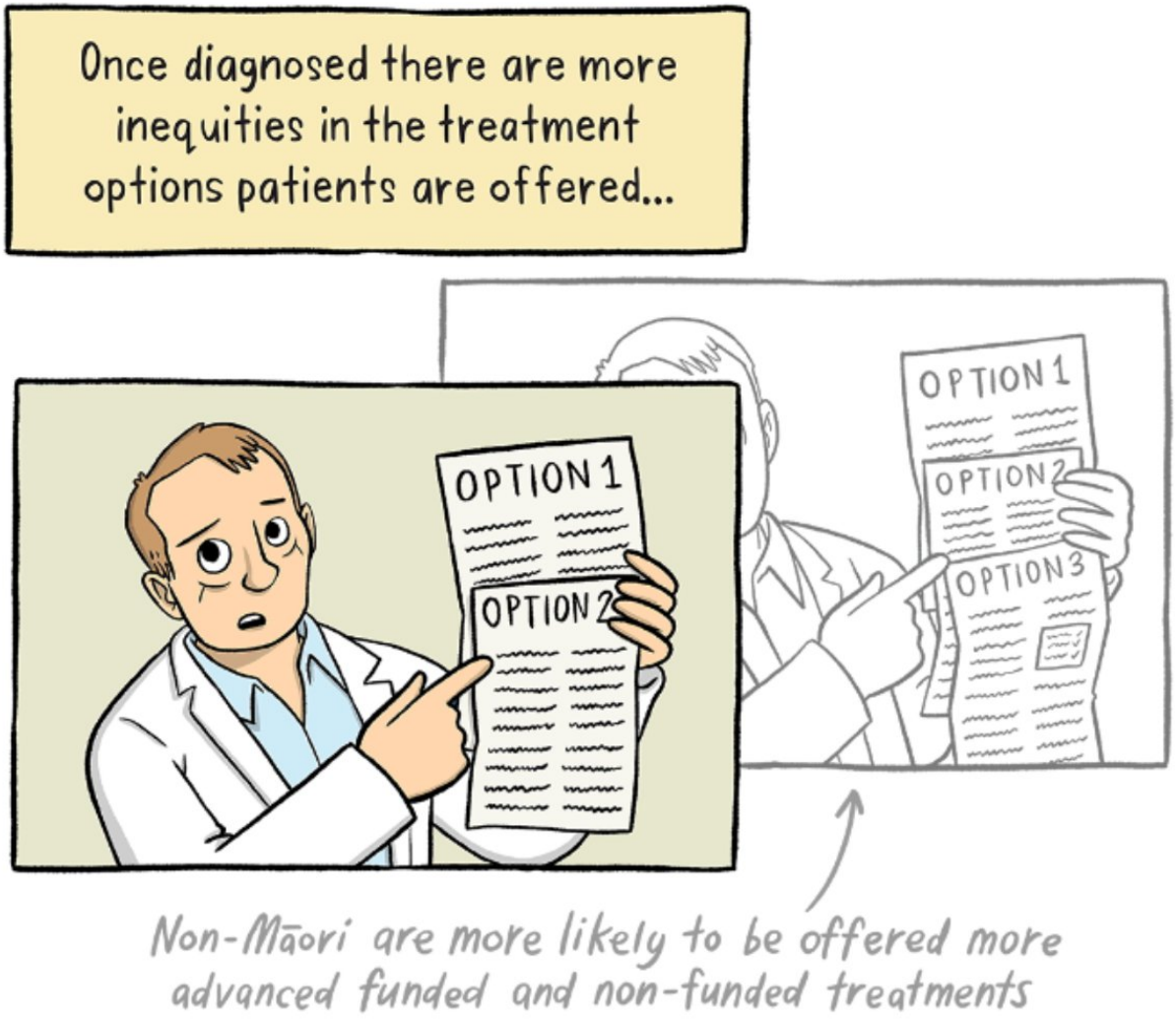


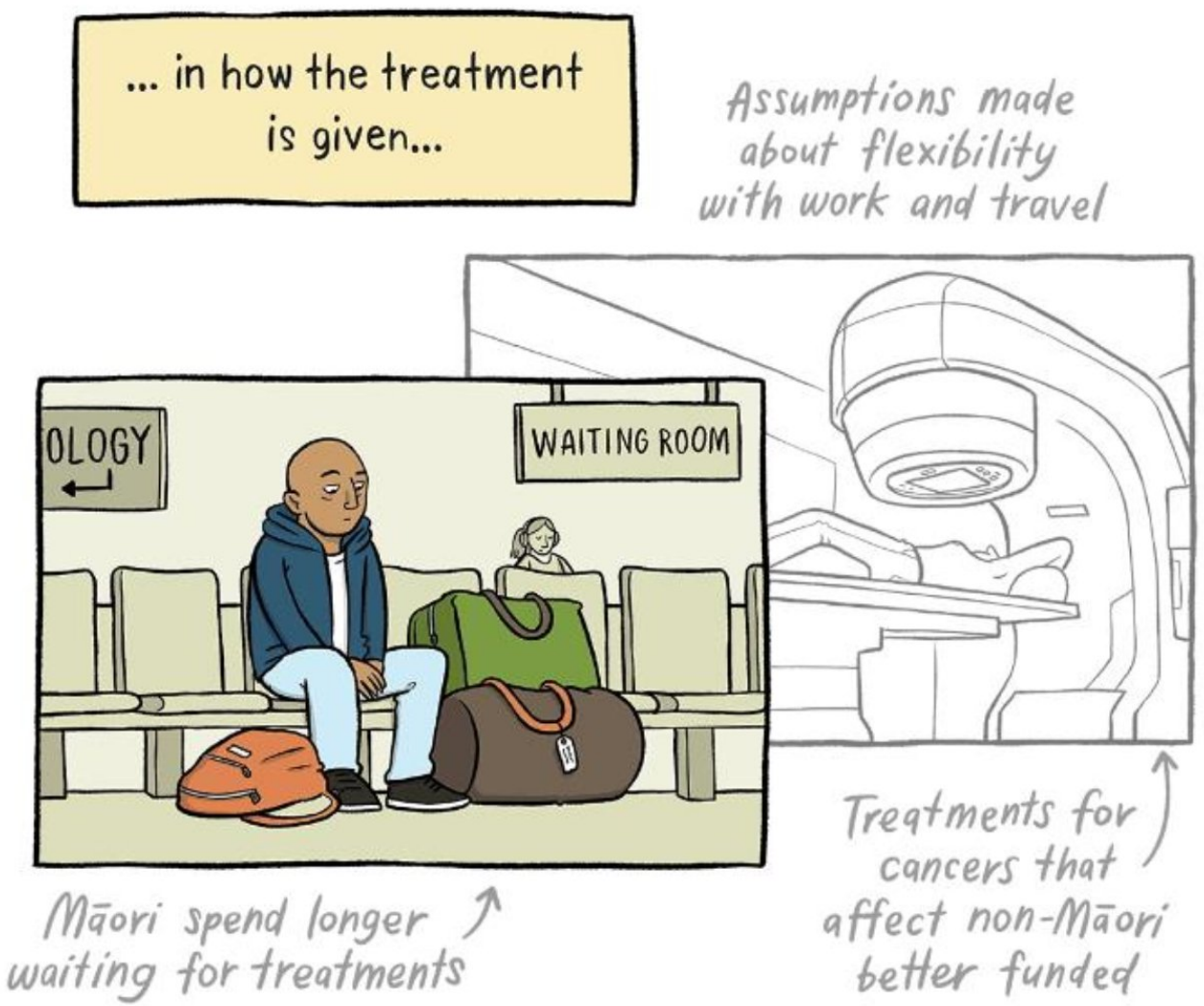

Let's look at cancer, for example -
the leading cause of death in Aotearoa.
Māori are 20% more likely to get it,
but more than twice as likely to die from it.


From going to the doctor about it in the first place...
GP clinics not set up to be welcoming spaces for Māori
Lack of access
Distrust from previous racist experiences

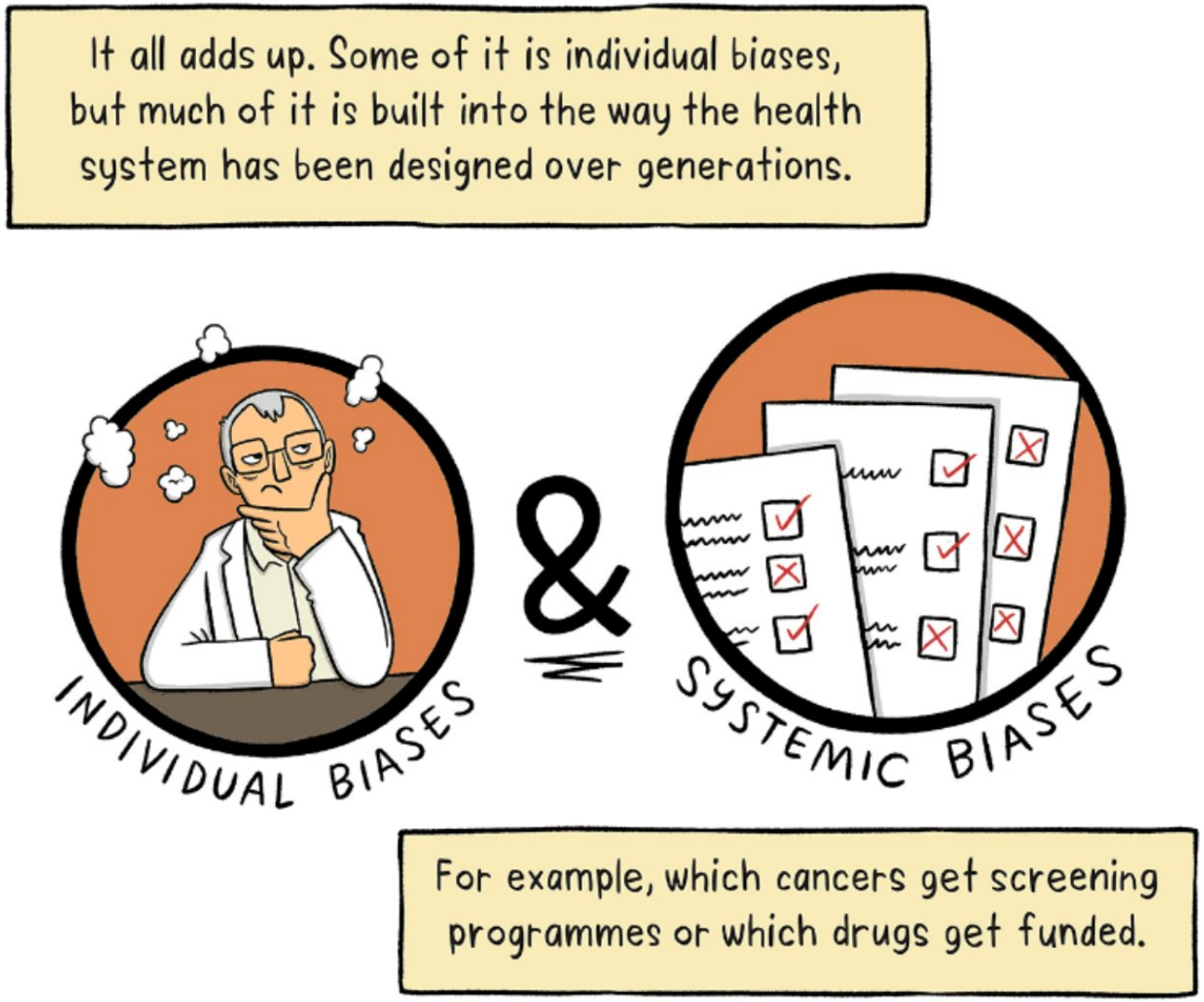

... through to getting a timely diagnosis...
Māori have longer wait times
Some doctors less likely to believe and take seriously until condition is severe

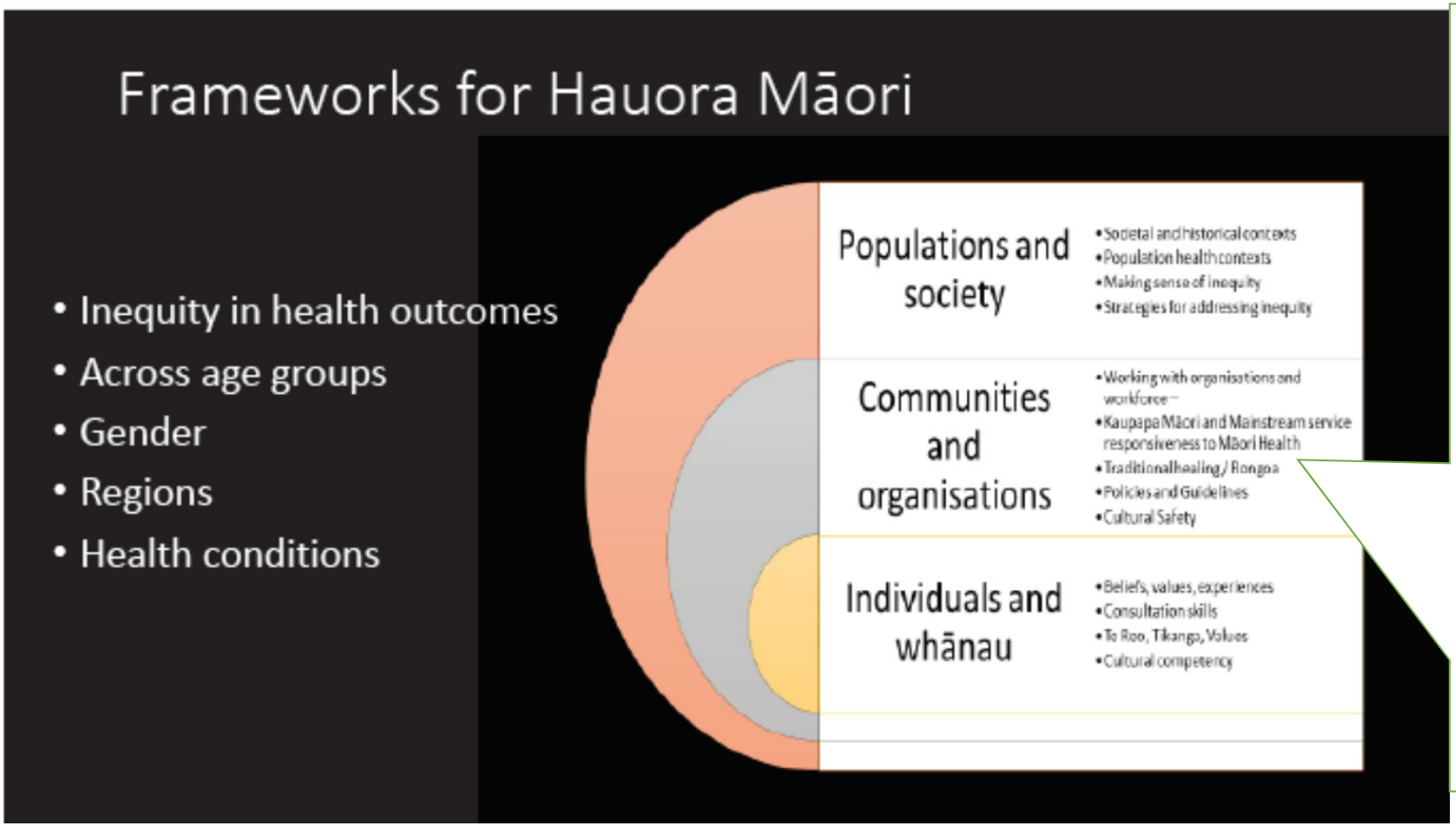

...and how the diagnosis is explained and understood.
Doctors don't always tailor explanations to the audience
I UNDERSTAND.
WHAT ABOUT MY WHĀNAU?
AM I GOING TO DIE?
Focus on individual, not whānau


Once diagnosed there are more inequities in the treatment options patients are offered...
OPTION 1
OPTION 2
OPTION 1
OPTION 2
OPTION 3
Non-Māori are more likely to be offered more advanced funded and non-funded treatments


... in how the treatment is given...
Assumptions made about flexibility with work and travel
OLOGY
WAITING ROOM
Māori spend longer waiting for treatments
Treatments for cancers that affect non-Māori better funded


... all the way through to inequities in end of life care and bereavement support.
Tailored to non-Māori customs around death


It all adds up. Some of it is individual biases, but much of it is built into the way the health system has been designed over generations.
INDIVIDUAL BIASES
&
SYSTEMIC BIASES
For example, which cancers get screening programmes or which drugs get funded.



What can we change to:

1) Our processes?
2) Our environment?
3) Our communication?
4) Our priorities?

Source: lecture notes, Esther Willing, Køhatu – Centre for Hauora Maori, Division of Health Sciences, Otago University

What could we change to ensure that our Outpatients promotes equity?

Taha tinana (physical health)

The capacity for physical growth and development.

Good physical health is required for optimal development.

Our physical 'being' supports our essence and shelters us from the external environment. For Māori the physical dimension is just one aspect of health and well-being and cannot be separated from the aspect of mind, spirit and family.

https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

discussion

Taha wairua (spiritual health)

The capacity for faith and wider communication.

Health is related to unseen and unspoken energies.

The spiritual essence of a person is their life force. This determines us as individuals and as a collective, who and what we are, where we have come from and where we are going.

A traditional Māori analysis of physical manifestations of illness will focus on the wairua or spirit, to determine whether damage here could be a contributing factor.

discussion

Taha whānau (family health)

The capacity to belong, to care and to share where individuals are part of wider social systems.

Whānau provides us with the strength to be who we are. This is the link to our ancestors, our ties with the past, the present and the future.

Understanding the importance of whānau and how whānau (family) can contribute to illness and assist in curing illness is fundamental to understanding Māori health issues.

discussion

Taha hinengaro (mental health)

The capacity to communicate, to think and to feel mind and body are inseparable.

Thoughts, feelings and emotions are integral components of the body and soul.

This is about how we see ourselves in this universe, our interaction with that which is uniquely Māori and the perception that others have of us.

What can we do differently?

Brainstorm and discussion

FOR INFORMATION

Item: Financial Report for the period ended 31 May 2021

Proposed by: Grant Paris, Management Accountant

Presented by: Patrick Ng, Executive Director of Specialist Services

Meeting of: 05 July 2021

Recommendation

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

Purpose

1. To provide the Hospital Advisory Committee with the financial performance for the month and year to date ended 31 May 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: **May 2021**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **14 June 2021**

Overview

Results Summary for Specialist Services

1. May 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 $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000	Budget $000
45,478	45,160	318	Revenue	497,058	496,751	307	541,965
24,517	23,822	(695)	Less Workforce Costs	273,522	266,829	(6,693)	292,043
13,450	11,917	(1,533)	Less Other Costs	139,954	127,775	(12,179)	138,761
7,512	**9,422**	**(1,910)**	**Net Surplus / (Deficit)**	**83,583**	**102,147**	**(18,564)**	**111,161**

For May 2021, Specialist Service had a contribution to non-clinical and overhead costs of $7.5m, which is $1.9m unfavourable to budget.

2. Surgical Performance – Case Weights and Discharges

Provider Activity View

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

Medical services case weight delivery (CWD) was higher than the planned volumes for 2020 (planned volumes did not take into account COVID), however May 2021 acute medical delivery was below planned volume, which can be seen as positive. This is a change from the year to date (YTD) delivery that is slightly over target by 3% (491) CWD.

Surgical acute delivery for the year is on the planned volume, however May 2021 has seen a reduction of surgical acute CWD against the plan by 17% (231 CWD). Electives were 2% (36 CWD) under delivered against plan for the month so did not offset the lower than acute volumes.

From now through to the end of the financial year, comparisons to the 2020 actual volumes include COVID-19 preparation for the impact and the lock down period under Alert Level 4 which reduced levels of healthcare delivery.

Appendix 1: Financial Report for the Hospital Advisory Committee

May-21				May-20	YEAR ON YEAR		YTD 2020/21				YTD May-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,412	**1,507**	**(95)**	**-6%**	**1,254**	**158**	**Acute**	**16,217**	**15,726**	**491**	**3%**	**15,558**	**659**
905	*996*	*(91)*	*-9%*	850	55	Otago	10,842	10,388	454	4%	10,245	597
507	*511*	*(4)*	*-1%*	404	103	Southland	5,375	5,338	37	1%	5,313	62
366	**312**	**54**	**17%**	**281**	**85**	**Elective**	**3,782**	**3,161**	**621**	**20%**	**3,367**	**415**
315	275	40	15%	254	61	Otago	3,294	2,779	515	19%	2,900	394
51	37	14	38%	28	23	Southland	488	382	106	28%	467	21
1,778	**1,819**	**(41)**	**-2%**	**1,535**	**243**	**Total Medical Caseweights**	**19,999**	**18,887**	**1,112**	**6%**	**18,925**	**1,074**
						Surgical Caseweights						
1,074	**1,287**	**(213)**	**-17%**	**887**	**187**	**Acute**	**13,388**	**13,392**	**(4)**	**0%**	**12,360**	**1,028**
701	900	(199)	-22%	558	143	Otago	9,263	9,358	(95)	-1%	8,661	602
373	387	(14)	-4%	329	44	Southland	4,125	4,034	91	2%	3,698	427
1,499	**1,535**	**(36)**	**-2%**	**1,316**	**182**	**Elective**	**14,334**	**14,797**	**(463)**	**-3%**	**13,532**	**802**
1,192	1,116	76	7%	990	202	Otago	10,765	10,753	12	0%	10,038	727
307	419	(112)	-27%	326	(19)	Southland	3,569	4,044	(475)	-12%	3,493	76
2,573	**2,822**	**(249)**	**-9%**	**2,203**	**369**	**Total Surgical Caseweights**	**27,723**	**28,189**	**(467)**	**-2%**	**25,892**	**1,830**
						Maternity Caseweights						
136	**93**	**43**	**46%**	**152**	**(16)**	**Acute**	**1,152**	**977**	**175**	**18%**	**1,145**	**7**
89	68	21	31%	106	(17)	Otago	832	712	120	17%	815	17
47	25	22	88%	46	1	Southland	320	265	55	21%	330	(10)
365	**370**	**(5)**	**-1%**	**353**	**12**	**Elective**	**4,168**	**3,858**	**310**	**8%**	**3,697**	**471**
207	222	(15)	-7%	208	(1)	Otago	2,530	2,312	218	9%	2,202	328
158	148	10	7%	145	13	Southland	1,638	1,546	92	6%	1,495	143
501	**463**	**38**	**8%**	**505**	**(4)**	**Total Maternity Caseweights**	**5,320**	**4,835**	**485**	**10%**	**4,842**	**478**
						TOTALS						
2,622	**2,887**	**(265)**	**-9%**	**2,294**	**328**	**Acute**	**30,757**	**30,095**	**662**	**2%**	**29,063**	**1,692**
1,695	1,964	(269)	-14%	1,514	**181**	Otago	20,937	20,458	479	2%	19,721	**1,216**
927	923	4	0%	780	**147**	Southland	9,820	9,637	183	2%	9,341	**479**
2,230	**2,217**	**13**	**1%**	**1,951**	**278**	**Elective**	**22,284**	**21,816**	**468**	**2%**	**20,596**	**1,688**
1,714	1,613	101	6%	1,451	**263**	Otago	16,589	15,844	745	5%	15,140	**1,449**
516	604	(88)	-15%	499	**17**	Southland	5,695	5,972	(277)	-5%	5,455	**240**
4,852	**5,104**	**(252)**	**-5%**	**4,244**	**607**	**Total Caseweights**	**53,041**	**51,911**	**1,130**	**2%**	**49,659**	**3,382**
						TOTALS excl. Maternity						
2,486	**2,794**	**(308)**	**-11%**	**2,141**	**345**	**Acute**	**29,605**	**29,118**	**487**	**2%**	**27,918**	**1,687**
1,606	1,896	(290)	-15%	1,408	**198**	Otago	20,105	19,746	359	2%	18,906	**1,199**
880	898	(18)	-2%	733	**147**	Southland	9,500	9,372	128	1%	9,011	**489**
1,865	**1,847**	**18**	**1%**	**1,597**	**267**	**Elective**	**18,116**	**17,958**	**158**	**1%**	**16,899**	**1,217**
1,507	1,391	116	8%	1,243	**264**	Otago	14,059	13,532	527	4%	12,938	**1,121**
358	456	(98)	-21%	354	**4**	Southland	4,057	4,426	(369)	-8%	3,960	**97**
4,351	**4,641**	**(290)**	**-6%**	**3,739**	**611**	**Total Caseweights excl. Maternity**	**47,721**	**47,076**	**645**	**1%**	**44,817**	**2,904**

Planned Care and Improvement Action Plan

In addition to the required FY21 Planned Care, further inpatient targets and funding have been approved per the Improvement Action Plan (IAP). The MoH require that budgeted production must be achieved before we can access the IAP funding on the targeted services.

As at 31 May 2021, the Planned Care is 506.1 Case Weight Delivery (CWD) under the original target. The limitations on the resourced bed capacity impacted significantly on the achievement of the Planned Care targets. As a result, revenue has been adjusted down by $2,652k, after allowing for an estimated $154k of Canterbury DHB late coding of CWD activity.

A plan to recover elective surgical delivery as much as possible by the end of the financial year has a core outsourcing focus and as such the outsourced surgery in the June month will be higher than planned.

Appendix 1: Financial Report for the Hospital Advisory Committee

SDHB Monthly HAC Statement of Financial Performance -May 2021

Monthly					Year to date				Annual
Actuals $000s	Budget $000s	Variance $000s	Variance FTE		Actuals $000s	Budget $000s	Variance $000s	Variance FTE	Budget $000s
				REVENUE					
				Government & Crown Agency Sourced					
782	814	(32)		MoH Revenue	8,835	8,949	(114)		9,762
0	0	0		IDF Revenue	0	0	0		0
955	714	241		Other Government	10,659	7,835	2,824		8,603
1,737	**1,527**	**210**		**Total Government & Crown**	**19,494**	**16,784**	**2,710**		**18,365**
				Non Government & Crown Agency Revenue					
574	184	390		Patient related	1,588	2,029	(441)		2,214
160	183	(23)		Other Income	1,823	2,014	(191)		2,197
734	**368**	**366**		**Total Non Government**	**3,411**	**4,043**	**(632)**		**4,411**
43,008	43,266	(258)		Internal Revenue	474,153	475,923	(1,770)		519,189
45,478	**45,160**	**318**		**TOTAL REVENUE**	**497,058**	**496,751**	**307**		**541,965**
				EXPENSES					
				Workforce					
				Senior Medical Officers (SMO's)					
5,811	6,267	456	13	Direct	68,983	69,962	979	8	76,626
309	355	46		Indirect	3,962	3,907	(55)		4,262
215	149	(66)		Outsourced	3,612	1,627	(1,985)		1,777
6,334	**6,772**	**438**	**13**	**Total SMO's**	**76,558**	**75,496**	**(1,062)**	**8**	**82,665**
				Registrars / House Officers (RMOs)					
4,296	3,968	(328)	(22)	Direct	44,546	44,035	(511)	(6)	48,299
233	230	(3)		Indirect	2,382	2,525	143		2,755
25	28	3		Outsourced	414	302	(112)		329
4,554	**4,225**	**(329)**	**(22)**	**Total RMOs**	**47,342**	**46,862**	**(480)**	**(6)**	**51,383**
10,888	**10,997**	**109**	**(9)**	**Total Medical costs (incl outsourcing)**	**123,900**	**122,358**	**(1,542)**	**1**	**134,048**
				Nursing					
9,427	8,950	(477)	(83)	Direct	103,925	101,343	(2,582)	(50)	110,709
4	1	(3)		Indirect	169	11	(158)		12
20	3	(17)		Outsourced	64	34	(30)		37
9,450	**8,954**	**(496)**	**(83)**	**Total Nursing**	**104,158**	**101,388**	**(2,770)**	**(50)**	**110,758**
				Allied Health					
2,320	2,118	(202)	(11)	Direct	24,671	23,531	(1,140)	(11)	25,827
(29)	25	54		Indirect	450	431	(19)		456
132	43	(89)		Outsourced	1,391	462	(929)		504
2,424	**2,186**	**(238)**	**(11)**	**Total Allied Health**	**26,512**	**24,424**	**(2,088)**	**(11)**	**26,787**
				Support					
162	178	16	3	Direct	1,898	2,005	107	3	2,216
(1)	1	2		Indirect	5	10	5		11
0	0	0		Outsourced	0	0	0		0
161	**179**	**18**	**3**	**Total Support**	**1,904**	**2,015**	**111**	**3**	**2,227**
				Management / Admin					
1,570	1,491	(79)	(2)	Direct	16,894	16,489	(405)	(5)	18,055
9	9	0		Indirect	90	94	4		102
15	6	(9)		Outsourced	65	61	(4)		66
1,593	**1,505**	**(88)**	**(2)**	**Total Management / Admin**	**17,048**	**16,643**	**(405)**	**(5)**	**18,223**
24,517	**23,822**	**(695)**	**(103)**	**Total Workforce Expenses**	**273,522**	**266,829**	**(6,693)**	**(62)**	**292,043**
3,659	3,209	(450)		**Outsourced Clinical Services**	36,682	33,790	(2,892)		36,350
0	0	0		**Outsourced Corporate / Governance Servic**	0	0	0		0
0	0	0		**Outsourced Funder Services**	0	0	0		0
7,928	7,002	(926)		**Clinical Supplies**	83,410	75,536	(7,874)		82,237
875	764	(111)		**Infrastructure & Non-Clinical Supplies**	9,474	8,328	(1,146)		9,075
				Non Operating Expenses					
987	942	(45)		Depreciation	10,388	10,122	(266)		11,099
0	0	0		Capital charge	0	0	0		0
0	0	0		Interest	0	0	0		0
13,450	**11,917**	**(1,533)**		**Total Non Personnel Expenses**	**139,954**	**127,775**	**(12,179)**		**138,761**
37,967	**35,739**	**(2,228)**		**TOTAL EXPENSES**	**413,476**	**394,604**	**(18,872)**		**430,804**
7,512	**9,422**	**(1,910)**		**Net Surplus / (Deficit)**	**83,583**	**102,147**	**(18,564)**		**111,161**

3. *Revenue*

Ministry of Health (MoH) Revenue

MoH revenue was $0.03m unfavourable to budget for the month and $0.11m unfavourable year to date. The main contributors are detailed below:

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Personal Health-side contracts	(19)	(96)	The monthly variance continues to be 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. YTD these unfavourable variances are partially offset by favourable Radiology revenue received.
Public Health-side contracts	6	197	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)	(214)	Contracts have been reconciled to match eligible personnel to the delivery.
Other	1	(1)	
Total	**(32)**	**(114)**	

Other Government Revenue

Other Government revenue was $0.24m favourable in May and $2.82m favourable year to date. The major drivers for this are shown below.

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Haemophiliac rebate	168	1,663	Rebate reflecting increased cost and volume year to date.
ACC	102	1,002	Additional Orthopaedics ACC revenue claimed in May.
Other	(29)	159	
Total	**241**	**2,824**	

Patient related revenue

Patient related revenue was $0.39m favourable to budget in May due to the invoicing of two patients that had been treated for 4 months. YTD patient related revenue is still $0.44m less than budget.

Other Income

Other income is $0.02m under budget in May and $0.19m unfavourable 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. (Offset by lower salaries paid).

Appendix 1: Financial Report for the Hospital Advisory Committee

Internal Revenue

Internal revenue is $0.25m under budget for the month and $1.77m unfavourable year to date. The monthly variance includes a $0.6m reduction related to under-delivery of Planned Care volumes.

4. *Workforce Costs*

Monthly result
Workforce costs (personnel plus outsourcing) were $0.69m unfavourable to budget in May 2021 driven by RMO, Nursing and Allied Health costs which all had significant unfavourable FTE variances. Operationally full time equivalent (FTE) were 103 unfavourable to budget.

FTE
FTE is 103 over budget in May summarised in the following table. Nursing continues to be the main driver of the unfavourable monthly and year to date variance, however along with Nursing, RMOs are also 7% above budgeted levels in May.

Staff Type	Actual FTE May21	Budget FTE May21	Monthly Variance	%	Actual FTE YTD May21	Budget FTE YTD May21	YTD Variance
SMO	238	251	13	5%	240	247	8
RMO	344	322	(22)	(7%)	324	318	(6)
Nursing	1,252	1,169	(83)	(7%)	1,206	1,156	(50)
Allied	298	287	(11)	(4%)	293	282	(11)
Support	36	39	3	8%	36	38	3
Mgmt / Admin	280	278	(2)	(1%)	279	273	(5)
	2,449	**2,346**	**(103)**	**(4%)**	**2,377**	**2,316**	**(62)**

Senior Medical Officer (SMOs)

SMOs were $0.44m favourable and 12.8 FTE favourable for the month. Year to date SMOs are $1.06m unfavourable, 7.8 FTE favourable.

Expected favourable direct SMO costs as a result of favourable 13FTE are driven by;

- Training continuing to be less than budget 9FTE for month and 6FTE YTD
- Annual leave taken higher than budgeted 2FTE
- Continuing vacancies

These have been offset by higher overtime payments ($0.11m driven by extra hour's payments, additional radiologist reads and SMOs covering RMO roster gaps).

Outsourced costs are $0.07m unfavourable in a number of areas;

	Monthly Variance $000s	YTD Variance $000s
3019 General Surgery	(4)	(419)
3012 Paediatric Department Medical Staff	(70)	(381)
3036 Obstetrics and Gynae Medical Staff	(46)	(377)
3026 Ear Nose and Throat Medical Staff	(9)	(310)
8000 Executive Director Specialist Services	(22)	(240)
3000 General Medicine Medical Staff	22	(134)
	(129)	(1,861)

As can be seen in the table opposite, most of the areas driving the monthly unfavourable variance are also unfavourable year to date. Areas such as Paediatrics and Obs & Gynae are driven by vacancies. The ENT vacancy has been filled in Southland so while over ytd, there is no longer a need for locum cover.

RMOs

RMOs were $0.33m unfavourable and 22 FTE unfavourable for the month. Year to date RMOs are $0.48m unfavourable and 6 FTE unfavourable to budget.

1. Invercargill RMOs were 14 FTE over budget in May, all of this in ordinary time suggesting rosters worked higher than budgeted. This was due to;
    - RMO unit – 8.1FTE over budget – under budgeted 2 FTE (fixed in 21/22 budget), annual leave taken 2FTE less than budget
    - RMO Medical – 1.8FTE over budget – currently over recruited.
    - RMO Orthopaedics – 3.5FTE over budget due to paired roles which have been occurring due to the inexperience of the current registrars.

2. Dunedin RMOs are 8FTE unfavourable to budget, once again 7.4FTE of this in ordinary time.
    - RMO Unit – 3.4FTE over budget – Generalism business case approved 2FTE (budget held at CEO level) and annual leave taken 3.7FTE less than budgeted.
    - Anaesthesia – 1.9FTE over budget – annual leave taken 1FTE less than budgeted.
    - Gen Surgery – 1.5FTE over budget – annual leave 0.6FTE less than budgeted.
    - Paediatrics – 1.2FTE over budget – over recruited in Dunedin for 2-3 months with someone leaving.
    - Radiation Oncology – 1 FTE over budget covering long term SMO vacancy.

Nursing

Nursing was $0.50m unfavourable and 83 FTE unfavourable for the month. Year to date Nursing was $2.77m and 49.6 FTE unfavourable.

Nursing FTE

1. Health Care Assistants were 23FTE over budget, the main driver being patient watches not fully budgeted for. This was a lot higher than the ytd average of 13FTE driven by the Dunedin and Invercargill Medical wards.

2. Registered Nurses were 98FTE over budget partially offset by 17FTE Midwife vacancies and 15FTE Enrolled Nurse vacancies. This is around 20FTE higher than the year-to-date variance and is driven by;
    3. FTE savings in Nursing budgeted for Valuing Patient Time (-22 FTE), Positive shifts (-10 FTE) which have not been met.
    4. Statutory FTE (including day in lieu) 15FTE over budget. This budget shortfall has been relatively consistent all year reflecting more staff are entitled to the day in lieu than calculated by the budget.
    5. Sick leave was 15FTE higher than budget (12FTE ytd) reflecting staff's greater awareness to stay home if ill. The budget was set on pre COVID levels.
    6. Other leave also reported a less favourable variance than usual as special leave was granted to staff who felt unwell after receiving their COVID vaccinations.
    7. Annual leave taken was only 74% of budgeted (18FTE less than budget). There will be a number of these staff who work. This increases ordinary time FTE.

Nursing Rates

In general, rates paid to Nursing staff were less than budgeted due to;

1. The higher % of lower paid Health Care Assistants.

2. The Registered Nurse budget did not correctly reflect the lower overall profile of staff once the new grads joined the ward rosters. This is because the budget takes the staff profile at a particular point in time (usually November) and steps staff up grades automatically.

3. Offsetting these favourable rate variances, unpaid days were $0.26m unfavourable in May and $0.07m unfavourable ytd. We had expected this to balance out across the year, however with significantly more staff now than budgeted, this is unlikely.

4. Annual leave accrued also has an unfavourable rate variance which leads to this being up to $0.15m unfavourable monthly (previously reported on and corrected in 2021/22 budget)

Allied Health

Allied Health costs were $0.24m and 11 FTE unfavourable to budget in May. Year to date Allied Health costs were $2.09m unfavourable and 10.5 FTE unfavourable.

MRTs and Sonographers are 6.5FTE over budget largely because of recruiting above budget in expectation of natural attrition that did not occur. The cycle of attrition changed however due to COVID resulting in a higher level of staff being in place all throughout this year (YTD 8FTE over budget).

Subsequent to month end, there have been 4 resignations in Invercargill, so we expect this favourable FTE variance to reduce.

The 20/21 budget includes a vacancy factor of 17FTE in Allied Health staff as below.

Account	Account Description	VF 20/21
2438	Cultural Workers	2.90
2473	Pharmacists	2.00
2477	Pharmacist Technicians & Assistants	1.40
2484	MRTs & Sonographers	2.00
2508	Technicians	6.58
2520	Other Allied Health Staff	2.00
Grand Total		**16.88**

Technicians included back pay adjustment of $0.08m this month for historical claim, which offset the favourable 2FTE variance.

Outsourced Technicians are $0.1m unfavourable ($0.92m year to date) mainly across Anaesthesia Service (Dunedin), Ophthalmology and Audiology continuing to cover vacant roles.

Support

Support was close to budget for the month and 3 FTE favourable. Year to date support is $0.10m favourable and 2.5 FTE favourable.

Management and Administration

Management/Admin dollars were $0.9m and 2FTE over budget in May. Year to date they were $0.4m favourable and 5FTE unfavourable.

Excluding clinical related positions such as Ward receptionists, the majority of this staff group are not budgeted with cover. If annual leave taken is less than budgeted, this will therefore result in higher costs and FTE recorded in the month. Although annual leave taken was 91% of budget in May, this still effectively resulted in an additional 2FTE to budget.

Ordinary time was 5.5FTE over budget explained by the annual leave variance and sick and training leave that were 4.38FTE under budget.

Apart from the impact of annual leave, the largest driver of the monthly variance is overtime which is 1.7FTE over budget. This due mainly to Radiology where staff are required to do scheduling out of hours to keep up with the workload.

5. *Outsourced Clinical Services Costs*

Outsourced services were $0.45m unfavourable in May and $2.89m 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 Clinical Services - Other	723	398	(325)	5,067	4,169	(898)	4,550
Outsourced Surgical Services	935	767	(168)	9,197	7,638	(1,559)	7,813
MRI Scans	76	37	(39)	943	370	(573)	404
Radiology Service	189	173	(16)	2,155	1,752	(403)	1,912
Audiology	5	2	(3)	48	22	(26)	24
Laboratory Sendaway Tests	1		(1)	19	5	(14)	5
Laboratory Service	1,477	1,477	0	16,250	16,251	1	17,728
Other Radiology Procedures	42	43	1	443	435	(8)	475
Breast Screening	104	108	4	1,221	1,095	(126)	1,196
Lithotripsy		7	7	30	70	40	77
CT Scans	54	65	11	509	656	147	716
Ophthalmology	16	49	33	74	490	416	535
Vascular Assessments	36	83	47	726	836	110	913
	3,658	**3,209**	**(449)**	**36,682**	**33,789**	**(2,893)**	**36,348**

1) Other Outsourced clinical services are unfavourable in May primarily to Radiation Oncology activity at St George's Cancer Centre to assist with wait times, making up $0.22m of the $0.33m variance.

2) Outsourced Surgical Services are $0.17m unfavourable for the month and $1.16m unfavourable YTD. Orthopaedics, Ear Nose & Throat and Urology are the largest drivers of the ytd variance along with $0.7m expended on the Improvement Action Plan activity in prior months.

Appendix 1: Financial Report for the Hospital Advisory Committee

6. *Clinical Supplies (excluding depreciation)*

Clinical supplies were unfavourable to budget by $0.93m in May 2021, the material year to date variances > $0.15m summarised below:

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Blood and Tissue Supplies	993	629	(364)	9,663	6,861	(2,802)	7,490
Pharmaceuticals	1,864	1,555	(309)	20,092	18,224	(1,868)	19,725
Patient Consumables	319	120	(199)	3,308	2,108	(1,200)	2,207
Cardiac Implants	186	114	(72)	2,082	1,324	(758)	1,420
Disposable Instruments	228	202	(26)	2,834	2,295	(539)	2,507
Air Ambulance	708	451	(257)	4,957	4,553	(404)	4,971
Pacemakers	81	108	27	1,492	1,113	(379)	1,213
Dressings	126	115	(11)	1,442	1,171	(271)	1,278
Clinical Equipment - Gain/Loss on Disposal				237		(237)	
Clinical Equipment - Operating Leases	25	18	(7)	341	109	(232)	127
Renal Fluids & Supplies	112	98	(14)	1,176	995	(181)	1,085
Spinal plates and screws	57	75	18	926	759	(167)	829
Clinical Equipment - Service Contracts	313	327	14	3,760	3,602	(158)	3,929
Others (ytd variances < $0.15m)	2,189	2,256	67	23,718	23,354	(364)	25,487
Screws, nails and plates	216	253	37	2,320	2,513	193	2,747
Shunts and Stents	206	196	(10)	1,731	1,980	249	2,162
Hip Prostheses	189	290	101	2,275	2,759	484	3,053
Knee Prostheses	113	191	78	1,052	1,813	761	2,006
	7,925	**6,998**	**(927)**	**83,406**	**75,533**	**(7,873)**	**82,236**

1) Pharmaceutical costs were $0.3 over budget for the month and $1.9m unfavourable year to date.

   This has been consistently over budget throughout the year. Budgets were based on the Pharmac Forecast on hand at the time however actual activity has varied from that forecast.

   Expected savings budgeted mainly for high cost Mabs (e.g., Rituximab etc) that were phased into the latter half of the year have not flowed through to the Provider as expected.

2) Blood and Tissue Supplies are over budget $0.36m in May and $2.8m ytd. The majority of this variance is due to a $0.17m 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 $0.19m over budget due to price being higher than budgeted and acuity and patient requirements.

3) Patient consumables over budget driven by unmet clinical theatre supplies savings loaded from October onwards ($0.06m per month increasing to $0.11m from January and $0.18m from March 2021).

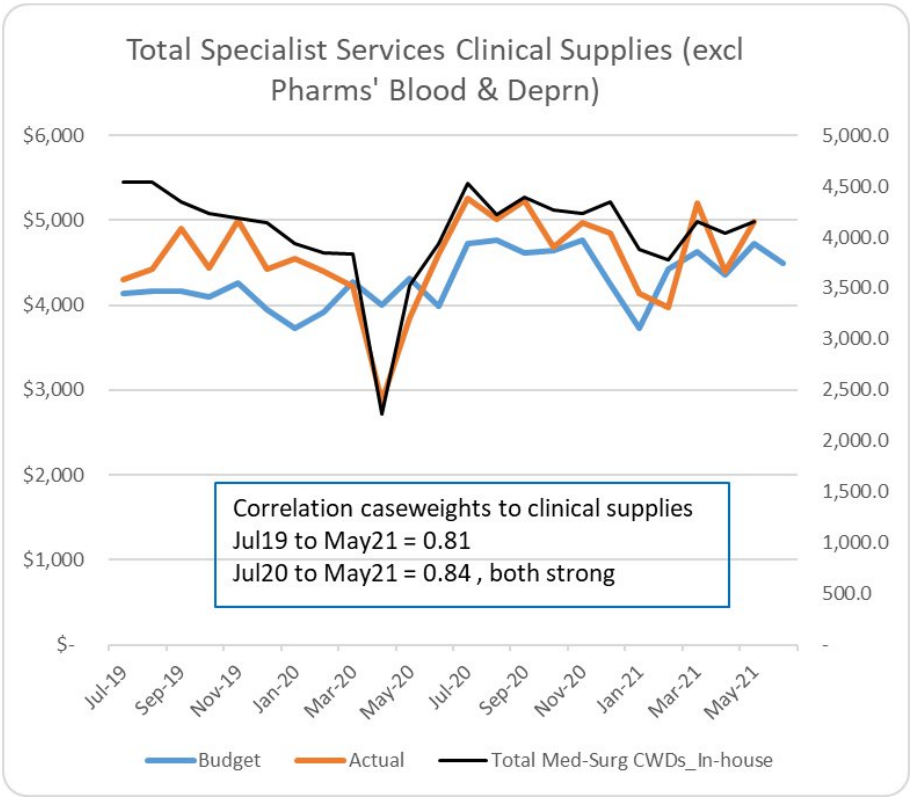
4) Cardiac Implants are $0.07m over budget in the month and $0.76m ytd reflecting additional TAVI's implanted compared to budget.

5) Air ambulance was $0.26m over budget for the month and $0.40m unfavourable ytd. In May there were 50 flights at average $12k per flight. This was a higher volume than usual due to there being 8 neurosurgery flights, a result of the SMO being on leave. Only 2 of these 8 Neurosurgery flights were lower cost fixed wing flights. There was also 1 PICU flights for $50k.

6) Clinical equipment – Gain/loss on disposal is $0.2m over budget ytd due to write off of assets as the asset ledger is tidied as part of the FPIM implementation.

Appendix 1: Financial Report for the Hospital Advisory Committee

We have graphed clinical supplies (excl depreciation, blood and pharmaceuticals) against Medical / Surgical and Maternity caseweights as below and calculated the correlation.



This shows a strong correlation between activity and cost but does demonstrate that the budget has been insufficient to cover the cost of delivery.

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

These costs were $0.11m favourable to budget in May and $1.15m 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	455	429	(26)	4,884	4,642	(242)	5,057
Facilities	19	21	2	261	229	(32)	250
Transport	111	90	(21)	1,008	950	(58)	1,038
IT Systems & Telecommunications	89	87	(2)	1,209	947	(262)	1,034
Professional Fees and Expenses	40	24	(16)	300	267	(33)	292
Other Operating Expenses	161	113	(48)	1,811	1,292	(519)	1,405
	875	764	(111)	9,473	8,327	(1,146)	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 $
Cost of Goods Sold	8		(8)	186		(186)	
Bureau and Outsourcing Fees	9		(9)	175		(175)	
Stock Adjustments	12		(12)	129		(129)	
Cleaning Supplies	41	27	(14)	426	298	(128)	324
Printing & Forms	31	9	(22)	214	122	(92)	131
Other Equipment - Minor purchases	17	16	(1)	261	174	(87)	190
Stationery & Supplies	36	32	(4)	450	368	(82)	400
Postage, Courier & Freight	48	40	(8)	508	431	(77)	471
Others (Year to dat variances < $0.07m)	673	626	(47)	7,123	6,784	(339)	7,396
Corporate Training		14	14		149	149	163
	875	**764**	**(111)**	**9,472**	**8,326**	**(1,146)**	**9,075**

1) Cost of Goods sold / Stock Adjustment 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.

2) Bureau fees are driven by unbudgeted costs relating to the new IMedX transcription service that has been implemented in Southland. This has offset savings in staffing / postage however the savings will depend on if IMedX is rolled out further across SDHB.

3) Cleaning supplies are over budget both monthly and ytd, driven mainly by additional cleaning costs in theatres.

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, hence the year to date combined overspend of $0.33m. Going forward into 2021/22 there has been an attempt to right-size the budget to current forecast where the spend is expected to continue.

8. *Non-operating Expenses*

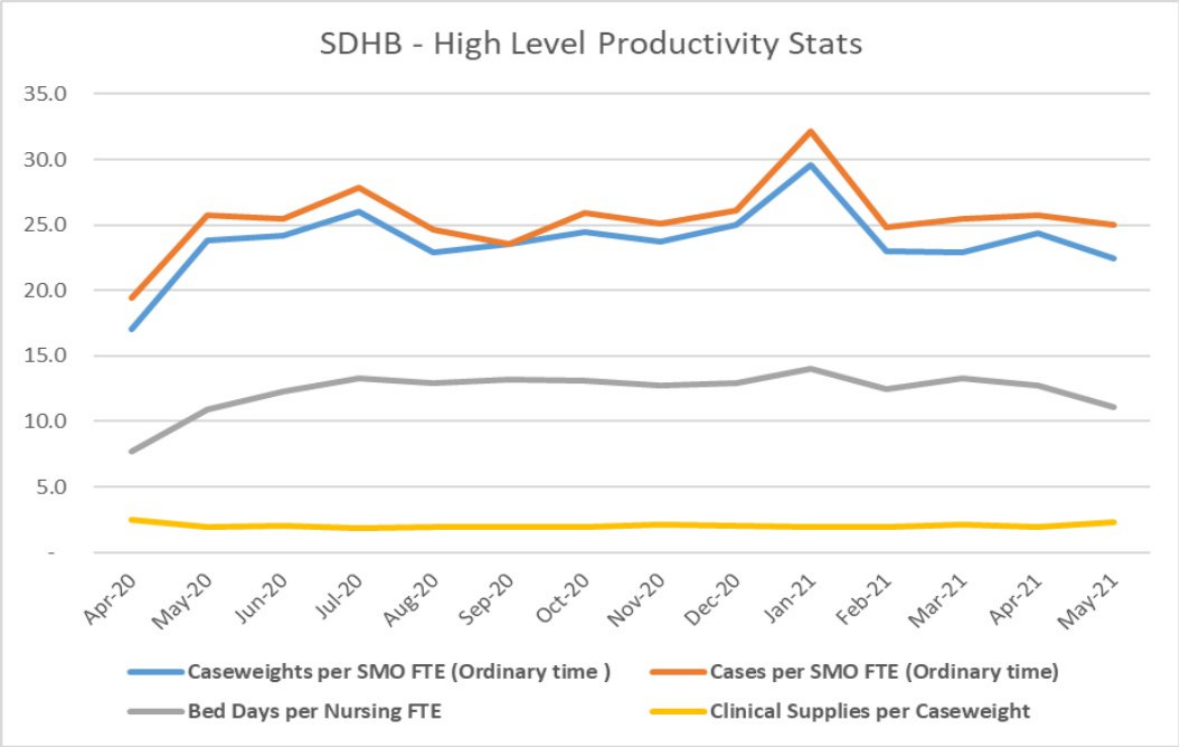
These costs relate to depreciation charges for clinical equipment and were over budget this month due to the unbudgeted depreciation incurred on the $1.8m of Respiratory equipment donated by the MoH for COVID resurgence.

Productivity Statistics
The graph below shows some high level productivity statistics using certain FTE types and caseweights as the base. The details behind this are shown on the table on the following page.

The graph shows a consistent picture over the 14 months with the exception of:

- April 20 where delivery was impacted by COVID, and
- January 21, where although activity decreased, FTE decreased by a bigger % due to Christmas leave. This suggests that either the utilisation of staff on hand during this period was higher or we utilised more outsourcing to maintain delivery (or a mixture of both)

The current month shows a slight decrease in productivity represented by the downward trend in the graphs



Appendix 1: Financial Report for the Hospital Advisory Committee

SDHB Med / Surg / Maternity

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Av over 13 months	Current 11 months annualised
Caseweights	2,607	4,034	4,438	5,041	4,677	4,833	4,751	4,630	4,843	4,332	4,267	4,664	4,403	4,203	4,547	55,249
Cases	2,974	4,364	4,676	5,383	5,039	4,826	5,038	4,889	5,050	4,720	4,609	5,176	4,650	4,696	4,855	58,992
Caseweights per Case	**0.88**	**0.92**	**0.95**	**0.94**	**0.93**	**1.00**	**0.94**	**0.95**	**0.96**	**0.92**	**0.93**	**0.90**	**0.95**	**0.90**	**0.94**	**0.94**
Bed Days	6,330	9,099	10,785	11,565	11,383	11,425	11,268	11,008	11,437	10,729	10,520	11,198	10,741	9,732	10,838	132,007
Cases (excl Day case)	1,775	2,588	2,774	3,103	2,982	2,892	2,980	2,884	2,944	2,742	2,699	3,044	2,786	2,712	2,856	34,656
ALOS	**3.6**	**3.5**	**3.9**	**3.7**	**3.8**	**4.0**	**3.8**	**3.8**	**3.9**	**3.9**	**3.9**	**3.7**	**3.9**	**3.6**	**3.8**	**3.8**
SMO FTE (Ordinary Time)	153	169	183	193	205	205	194	195	194	147	185	203	180	187	188	190
Nursing FTE (Ordinary time)	824	831	879	870	878	866	858	866	888	766	846	840	842	874	854	854
Clinical Supplies	7,358	8,440	9,721	10,333	10,067	10,320	10,179	10,615	10,818	9,185	8,982	10,958	9,514	10,737	9,990	121,864
Depreciation Clinical Supplies	853	835	850	846	851	815	894	913	932	934	938	944	938	944	895	10,855
Clinical Supplies less Depreciation	6,505	7,605	8,871	9,487	9,215	9,505	9,285	9,702	9,886	8,251	8,044	10,014	8,576	9,793	9,095	111,009
Caseweights per SMO FTE (Ordinary time)	17.1	23.8	24.2	26.1	22.9	23.6	24.5	23.8	25.0	29.6	23.0	22.9	24.4	22.4	24.3	292.5
Cases per SMO FTE (Ordinary time)	19.5	25.8	25.5	27.8	24.6	23.6	25.9	25.1	26.1	32.2	24.9	25.4	25.8	25.1	26.0	312.5
Bed Days per Nursing FTE	7.7	10.9	12.3	13.3	13.0	13.2	13.1	12.7	12.9	14.0	12.4	13.3	12.8	11.1	12.7	154.7
Clinical Supplies per Caseweight	2.5	1.9	2.0	1.9	2.0	2.0	2.0	2.1	2.0	1.9	1.9	2.1	1.9	2.3	2.0	2.0

SDHB 21/22 Budget

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Total
Caseweights	4,887	5,224	4,924	4,789	4,739	4,280	4,139	4,375	5,103	4,348	5,103	4,743	56,653
Cases	5,112	5,428	5,107	5,010	4,838	4,453	4,404	4,525	5,245	4,507	5,251	4,897	58,777
Caseweights per Case	**0.96**	**0.96**	**0.96**	**0.96**	**0.98**	**0.96**	**0.94**	**0.97**	**0.97**	**0.96**	**0.97**	**0.97**	**0.96**
Bed Days	11,647	12,449	11,735	11,414	11,294	10,200	9,863	10,427	12,161	10,362	12,163	11,303	135,018
Cases (excl Day case)	3,008	3,193	3,004	2,947	2,846	2,619	2,591	2,662	3,086	2,652	3,089	2,881	34,578
ALOS	**3.9**	**3.9**	**3.9**	**3.9**	**4.0**	**3.9**	**3.8**	**3.9**	**3.9**	**3.9**	**3.9**	**3.9**	**3.9**
SMO FTE (Ordinary Time) - Provider	202	198	205	195	196	204	153	197	212	175	193	200	194
Nursing FTE (Ordinary Time) - Provider excl Outpatients	895	910	925	929	925	940	892	937	946	925	948	946	927
Clinical Supplies	9,424	9,504	9,189	9,249	9,394	8,904	8,141	8,655	9,229	8,705	9,427	9,026	108,847
Depreciation Clinical Supplies	837	846	860	863	868	906	912	874	877	879	880	915	10,518
Clinical Supplies less Depreciation	8,588	8,657	8,329	8,386	8,526	7,998	7,229	7,781	8,352	7,826	8,546	8,111	98,329
Caseweights per SMO FTE (Ordinary time)	24.3	26.3	24.0	24.6	24.2	21.0	27.1	22.2	24.0	24.8	26.5	23.8	292
Cases per SMO FTE (Ordinary time)	25.4	27.4	24.9	25.7	24.7	21.9	28.8	23.0	24.7	25.8	27.2	24.5	303
Bed Days per Nursing FTE	13.0	13.7	12.7	12.3	12.2	10.9	11.1	11.1	12.9	11.2	12.8	12.0	146
Clinical Supplies per Caseweight	1.8	1.7	1.7	1.8	1.8	1.9	1.7	1.8	1.6	1.8	1.7	1.7	2

In Confidence Session:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
Executive Director of Specialist Services Report 1. Faster Cancer Treatment	Feedback is provided in confidence.	Section 9(2)(ba) protect information which is subject to an obligation of confidence and making available of the information would be likely to prejudice the supply of similar information.