Hospital Advisory Committee

Board Room, Level 2, Main Block,
Wakari Hospital Campus, Dunedin and by zoom link

06/09/2021 09:00 AM - 11:30 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, 6 September 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 two months:

- Lyndell Kelly – Trustee, NZ Brain Tumour Trust added.
- Moana Theodore – Royal Society Te Apārangi Council removed.
- Ben Pearson – added.
- Roger Jarrold – Advisor to Health Transition Unit on Finance/Procurement added.
- Pete Hodgson and Chris Fleming – New Dunedin Hospital entries updated.

Background

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

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

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 (updated 26.08.2021)	Ex-officio Member, Executive 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		
	25.06.2021	Director and Shareholder, Kiwood Limited	Nil (farm forestry plot).	
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.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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	
	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		
	25.06.2021	Trustee, New Zealand Brain Tumour Trust		
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 Otākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil, does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.123.2019	*Shareholder in Te Kaika		
	24.06.2021	Te Rau Ora Directorship		
	24.06.2021	Needle Exchange Services Trust (NEST) member		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings Ltd	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~~	Removed 01.07.2021	
	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	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		
	18.06.2021	Treasury: Health Reform Challenge Panel		
	26.08.2021	Advisor to Health Transition Unit on Finance/Procurement		
Benjamin Pearson (Crown Monitor)	21.07.2021	Consultant Paediatrician, South Canterbury DHB		

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
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
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~~	Removed 28.06.2021.
	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.
	28.06.2021	Director, Te Kura Taka Pini Limited	100% owned by Te Rūnanga o Ngai Tahu.
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	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	18.12.2017 (updated 26.08.2021)	Ex-officio Member, Executive Steering Group, New Dunedin Hospital	
	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
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	

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
	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
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 5 July 2021, commencing at 9.00am in the Board Room, Level 2, Main Block, Wakari Hospital Campus, Dunedin

Present:	Mrs Jean O'Callaghan	Chair
	Dr Justine Camp	Committee Member *(by zoom)*
	Dr John Chambers	Committee Member
	Hon Pete Hodgson	Board Chair and Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member
	Dr Moana Theodore	Committee Member
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Simon Donlevy	General Manager, Medicine Women's & Children *(by zoom)*
	Ms Jenny Hanson	Acting Chief Nursing & Midwifery Officer
	Dr Hywel Lloyd	Acting Executive Director Quality and Clinical Governance Solutions
	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
	Mr Rory Dowding	Interim Executive Director Strategy, Primary and Community
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting. A special welcome was extended to Dr Hywel Lloyd, Acting Executive Director Quality and Clinical Governance Solutions, Ms Jenny Hanson, Acting Chief Nursing and Midwifery Officer and Mr Simon Donlevy, General Manager, Medicine Women's and Children. An opening karakia was provided by Mr Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer/Interim Executive Director Mental Health.

2.0 APOLOGIES

Apologies were received from Board Advisor, Mr Andrew Connolly and Mrs Jane Wilson, Chief Nursing and Midwifery Officer.

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. Dr Lyndell Kelly requested that her interest as a member of the NZ Brain Tumour Trust be added to the register.

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 3 May 2021 be approved and adopted as a true and correct record of the meeting."

5.0 MATTERS ARISING

There were no matters arising that were not already included in the agenda.

6.0 REVIEW OF ACTION SHEET – INFORMATION PAPERS

The Committee considered the information papers attached to the Action Sheet and the verbal update from the Executive Director, Specialist Services (EDSS), Mr Patrick Ng. An update was provided on the provision and challenges with Positron Emission Tomography-Computed Tomography (PET-CT) and it was noted that there are no known publicly provided PET-CT facilities in New Zealand.

Resourced and Physical Bed Numbers – Dunedin Hospital (tab 5.1)

The Committee considered the report and the verbal update provided by the EDSS.

A summary of the next actions was provided:

- There is to be a focus on the day of surgery admittance versus day surgery at Dunedin Hospital. There may be an opportunity to provide more day surgery in Dunedin Hospital.
- HAC is to be provided with the number of resourced and physical bed numbers for Southland Hospital. The report for HAC is to include the figures for Dunedin and Southland Hospitals and include Mental Health beds.
- An update is to be provided on the current state of Aged Residential Care by the Interim Executive Director of Strategy Primary and Community (EDSPC).

The Quality and Improvement Manager, Mr Patrick O'Connor, joined the meeting at 9.37am.

Letters Process (tab 5.2)

The Committee considered the report and the verbal update from the Acting Executive Director Quality and Clinical Governance Solutions (EDQCGS), Dr Hywel Lloyd and the Quality and improvement Manager, Mr Patrick O'Connor. The challenges with rationalisation of the template letters due to compatibility issues with IPM were outlined and the advice from the Information Technology (IT) team is that the work be undertaken as part of the Patient Information Care System (PICS) project in late 2021/early 2022. The Committee expressed concern at a further hold-up with the process around letters with on-going concerns from

patients around content and timeliness and requested that the matter be progressed prior to the next meeting.

A summary of the next actions was provided:

- Rationalisation of the template letters is to commence immediately.
- Equity is to be a consideration as a recognised part of the process.
- HAC is to be provided with an update on a proposed service by service approach and what can be achieved ahead of the commencement of the PICS project.
- The report to the September 2021 HAC meeting is to include the actions taken to date in relation to progress with the letter improvement process.

The Quality and Improvement Manager left the meeting at 9.53am.

Recruitment Update (tab 5.3)

The Committee considered the update on recruitment to long-term vacancies and the verbal update by the EDSS. In discussion the following was highlighted.

- The challenge with recruitment to nursing vacancies across the district.
- The Acting Chief Nursing and Midwifery Officer, Ms Jenny Hanson, advised that Southern DHB is working closely with the Southern Institute of Technology and the Otago Polytechnic on "Return to Nursing Programmes".
- In relation to Physiotherapy vacancies, the Chief Allied Health Scientific and Technical Officer, Ms Kaye Cheetham, provided an update on the challenges, with a large differential between salaries in private and public. An update was provided on recruitment successes to some of the 8.5 FTE vacancies for Physiotherapists at Southland Hospital. Other steps taken to mitigate the staff shortage included outsourcing and providing assistance from Dunedin staff.
- The need for HR to keep a focus on vacancies and be proactive and aware of upcoming retirements and resignations and undertake advance planning for recruitment.
- The CEO advised on the nationwide shortage of nurses in aged residential care facilities – believed to be 750 FTE at the current time. He also advised his concern with surgical beds closed in Dunedin currently with staff shortages and the impact of the closing of the border due to COVID-19, which has impacted recruitment.
- The pay parity issues for nursing between Australia and New Zealand and also between the public health system in NZ and Aged Residential Care facilities in NZ.
- Recruitment strategy, mitigation and proactive approaches and processes and the need to commence discussions with staff in key roles who are close to retirement age. Utilise a "grow your own" approach.
- The need to be more innovative with models of care, using health care assistants and a team based model, particularly in a ward environment.
- Suggestion that SMO appointments could be made prior to them finishing their training and be dependent on them meeting certain criteria.
- An update was provided on the work progressing with Kia Ora Hauora in terms of growing the Māori Health workforce and the training incubator programme.

The Board Chair advised the need for flexibility with recruitment and to look at what can be done locally to grow the workforce. The Otago Polytechnic has increased their nursing student intake from 110 to 135 and the Southern Institute of Technology has increased their nursing student intake from 90 to 150 this year.

The Polytech has undertaken to increase student numbers further if instructed to by the Ministry of Health (MoH). Both institutes advise the need for good quality clinical placements during training and Southern DHB needs to be part of that solution.

The EDSS responded to concerns raised around the outsourcing of recruitment.

The importance of Human Resource (HR) staff ensuring correct process for Visa requirements for overseas applicants was highlighted.

A summary of the next actions was provided:

- Hamish Brown, Project Director Dunedin Hospital Development and Transition Support and the Dunedin Hospital New Build team to present to HAC on the work they have done around workforce modelling for the future.
- The EDSS is to work with Tanya Basel, Executive Director People and Capability, to present to the HAC on a regular basis on the wider recruitment processes, including equity requirements being met.
- The Clinical Chiefs are to advise on how flexible Southern DHB is being in terms of providing good clinical placement opportunities.

It was resolved:

"That the Hospital Advisory Committee recommends that the Board have a focus on the recruitment processes and look at the wider issues such as growing the workforce, having good clinical placements and encouraging clinical services to have a five year workplan that includes workforce."

Enhanced Generalism/Medical Assessment Unit (MAU) (tab 5.4)

The Committee considered the report on enhanced generalism and the Medical Assessment Unit and noted the verbal update by the EDSS advising that it was anticipated that the decant would be completed and the build commenced in approximately two months. An update was provided on the challenges with the decant process, reflected in the risk register attached to the report. The Board Chair requested clarification in order for the Board to be in a position to approve expenditure related to the MAU and a discussion is to take place at the Board excluded session of the meeting on 6 July 2021.

7.0 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 equity working group and the workplan included in the report. The EDSS requested members' feedback on the presentation "Equity in Outpatients", put together by the working group and included in the report. The presentation is to be presented to all clerical teams running outpatient services and is intended to raise awareness of equity issues. Work is being done to "normalise" equity reporting across all services and this will be reflected in the HAC report. Committee member, Dr Moana Theodore, is to forward documentation to the EDSS relating to Māori experiences with the health system and barriers to service and

unable to attends (UTA). Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer (CMHSIO), acknowledged the work done by equity champion, Janine Cochrane, General Manager, Surgical Services and Radiology and advised on the reduction in Southland UTAs through the employment of a 0.5 kaiawhina, focussing on that area. The Board Chair acknowledged the work being done and the importance of the equity work being rolled out through mainstream services. In response to Committee member, Dr Justine Camp, the CMHSIO advised the need to look at the provision of Pacific services in Dunedin and confirmed that a recruitment process is underway for kaiawhina services in Dunedin, taking the learnings from the progress made in Southland. Discussion was held on the success of the Cancer Co-ordinator/Navigator roles, with very few UTAs in the Oncology area. The CMHSIO advised that it is hoped that the triage tool used for cancer services can be adopted for use in other areas. A request was made for the Iwi Governance Committee (IGC) to receive a copy of the equity information and presentation.

Surgical Performance - Case Weight Discharges (CWD)

The EDSS provided a verbal update on CWD performance against plan and responded to members' queries. He advised on the high cost impact when elective activity is postponed at peak times due to acute demand.

Outpatient Performance ESPI 2

The EDSS provided a verbal update on ESPI 2 Outpatient Performance and work being done with the relevant specialties to address breaches.

Inpatient Performance ESPI 5

The EDSS responded to a query around Theatre capacity at Dunedin Hospital noting the expansion of capacity at Mercy Hospital and outsourcing to Timaru Hospital. Some low acuity capacity will also be sourced through Queenstown commencing in December 2021. It is expected that the timing for the additional Theatre in Southland will be known in two months' time. The EDSS advised that intervention rates data indicate there is some fine tuning that could be done and this will be investigated and reported back to the HAC. The Interim Executive Director Strategy, Primary and Community (EDSPC), Mr Rory Dowding, advised that discussions are being held with Specialist Services in terms of requirements for next year, taking patient need into account. There is a risk of losing Theatre Nurses to private providers.

Emergency Department (ED)

The EDSS provided a verbal update, noting that his report should be updated to include the word "Daily" on the right hand column of the tables on page 13 (Average Daily Presentations). An update was provided on the benchmarking work completed by Ernst Young at Southland Hospital. Their report is currently being drawn up and it is believed that it is likely to indicate the requirement for an increase in treatment spaces from 21 to 26. Any suggested changes will improve flow and have a positive impact on the 95% target. Clarification was provided on the reference to Ambulatory Sensitive Hospitalisations (ASH) in the first paragraph on page 14 of the EDSS report.

Radiology

The EDSS provided a verbal update.

Oncology

The EDSS provided a verbal update on the key areas being worked on within the Oncology services and responded to queries. He highlighted the importance of recruitment, the benchmarking work underway and processes for outsourcing. Discussion was held on the merits and challenges for patients and their whānau with outsourcing to Christchurch. The EDSS advised that travel is funded for a support person to accompany the patient and work is being done with the Community Health Council to ensure the best support possible is being provided for the patient and their whānau in line with the agreed approach. A survey will be undertaken to assess the outsource experience for patients and their whānau and where improvements can be made.

Colonoscopy

The EDSS provided a verbal update, with a particular focus on the new section included in the report related to 'colonoscopy decline rates', and responded to members' queries. Wait times are not currently included in the report. A brief discussion was held on staffing and recruitment within the service.

Financial Performance Summary

The EDSS presented the Specialist Services financial results (tab 6.2) for the month of May 2021, outlined the contributing factors to the adverse $1.9M variance for the month and responded to members' queries.

An update was provided on the potential recruitment of a Neurosurgeon with an offer made. The challenges with recruitment in this area were outlined and it was noted that the position is a joint role with both Southern DHB and the University of Otago (UoO).

***It was resolved**:*

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

CONFIDENTIAL SESSION

At 11.30am the CMHSIO provided a closing karakia and 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:*
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.*

Confirmed as a true and correct record:

Chair: _____ Date: _____

HOSPITAL ADVISORY COMMITTEE

ACTION SHEET

As at 27 August 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
July 2021	**Review of Action Sheet – bed numbers** (Minutes Item 6.0)	HAC to be provided with the number of resourced and physical bed numbers for Southland Hospital. The report is to include the figures for Dunedin Hospital and the Mental Health beds.	EDSS	Refer to item 5.1	6 September 2021
July 2021	**Review of Action Sheet – bed numbers** (Minutes Item 6.0)	An update is to be provided on the current state of Aged Residential Care.	EDSPC	Refer to item 5.2	6 September 2021
July 2021	**Review of Action Sheet – letters process** (Minutes item 6.0)	A report is to be provided to HAC outlining the actions taken to date in relation to progress with the letter improvement process. As part of the process: • Rationalisation of the template letters is to commence immediately. • Equity is to be a consideration as a	EDQCGS	Refer to item 5.3	6 September 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		recognised part of the process. • Update on a service by service approach and what can be achieved ahead of the commencement of the PICS project.			
July 2021	**Review of Action Sheet – Recruitment** (Minutes item 6.0)	Hamish Brown, Project Director Dunedin Hospital Development and Transition Support and the Dunedin Hospital New Build team are to present to HAC on the work they have done on workforce modelling for the future.	PDDHD&TS	An update will be provided at the meeting.	6 September 2021
July 2021	**Review of Action Sheet – Recruitment** (Minutes item 6.0)	The EDSS is to work with Tanya Basel, Executive Director, People and Capability (EDPC) to provide a regular update to HAC on the wider recruitment processes ensuring that equity requirements are met.	EDPC/EDSS	Refer to item 5.4	6 September 2021
July 2021	**Review of Action Sheet – Recruitment** (Minutes item 6.0)	The Clinical Chiefs are to update HAC on how flexible Southern DHB is being in terms of providing good clinical placement opportunities.	CNMO/CMO/ CAHSTO	AHS&T offer student placements, internships or work based training for all allied health scientific and technical professions. All trainees are well supervised and provided with relevant learning opportunities according to their level of experience. Calendars are set with student offers yearly. Education providers regularly	6 September 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				revisit student numbers throughout the year with staff taking additional students as able. Some supervision is provided solely by our staff while for other professions provide a clinical tutor from the university who connects with students throughout the placement. Supervisors receive training from the schools on level of supervision required for the level of the student. We have a strong relationship with all education providers through a contracting model. A further verbal update will be provided at the meeting.	
July 2021	**EDSS Report – Equity** (Minutes item 7.0)	The IGC is to receive a copy of the equity information and presentation.	PA		**Complete**
August 2021	**Southland Dental Unit's General Anaesthetic Waiting List** (CPHAC minute 10.0)	Further advice, including possible solutions, to be submitted to the September HAC meeting.	EDSP&C/ EDSS	Refer to item 5.5	

HAC Action

HAC to be provided with the number of resourced and physical bed numbers for Southland Hospital. The report is to include the figures for Dunedin Hospital and the Mental Health beds.

Below is the data as of the 11th August 2021. This indicates both the resourced and physical beds within Mental Health Southland and Dunedin hospitals.

Mental Health

MHAID Wards	Speciality	Physical Beds	Resourced Beds	Resourced %
Ward 9A	Medium Secure	15	13	86%
Ward 9B	Intensive Care	15	15	100%
Ward 9C	Acute Short Stay	16	16	100%
Ward 10A	Medium Secure	12	12	100%
Ward 11	Inpatient Sub Acute Rehab	16	16	100%
Helensburgh Cottage	Medium Secure	4	4	100%
Ward 6C	MH Older Persons	12	12	100%
Southland	IPMHU	16	16	100%
Total		**106**	**104**	**98%**

Southland Hospital

Department	Specialty	Physical Beds	Resourced Beds	Resourced %
Assessment, Treatment & Rehabilitation (ATR)	Older persons Health	30	18	60% **
CCU	Critical Care	6	6	100%
Maternity	Maternity	18	18	100%
Medical Ward	General Medicine	38	38	100%
Neonatal	Neonatal Intensive Care	6	6	100%
Surgical Ward	General Surgery, Orthopaedics, Women's Health, Urology, ENT, Ophthalmology	42	42	100%
Children's Ward	Paediatrics	13	13	100%
Total		**153**	**141**	**92%**

**60% (noting some beds spaces have been converted to offices spaces for community teams. A plan is being developed to increase resourced beds, initially by 8.

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	20	83%
Surgical (4HDU)	Surgical High Dependency Unit (HDU	6	4	67%
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	16	44%
Older Persons Assessment Liasion (OPAL)	Older Persons Health	8	4	50%
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**	**272**	**82%**

HAC Action

Provided by Rory Dowding, Acting Executive Director, Strategy Primary and Community

HAC to be provided with an update on the current state of Aged Residential Care bed numbers.

The Aged Residential care sector is currently under sustained pressure, with particular pressures in nursing workforce. In July, three facilities reported risk under the Section 31 notifications, with 9 shifts in hospital level facilities without an RN on site this month. In all cases, mitigations were put in place.

A survey to facilities, which about half responded to, shows that:

- Facilities have concerns around the number of RNs (Registered Nurses) to safely staff their facility
- RNs are regularly working more than 40 hours per week
- Clinical Managers are working more than one shift per week on the floor
- Facilities have denied admission to potential residents due to staffing levels

Leaders in the sector are struggling to maintain their leadership responsibilities under the current level of stress.

An indication of these challenges is the number of patients who are in a sub-optimal setting on any given day. For Monday, August the 23rd, the following patients are receiving care in a sub-optimal location.

	In Hospital	At Wrong Level in Aged Residential Care	At Home in Community/ Hospice	Total
Psychogeriatric Care (D6) District	0	5	1	6
Hospital Level Care (Dunedin)	2	1	2	5
Hospital Level Care (Southland)	0	1	0	1
Secure Dementia Care (Dunedin)	4	1	2	7
Secure Dementia Care (Southland)	0	0	3	3
Rest Home Care (Dunedin)	2		6	8
Total	8	8	14	30

HAC Action

Update provided by:

Hywel Lloyd, Executive Director Clinical Governance and Quality (Acting)
Patrick O'Connor, Quality and Performance Improvement Manager

---

A report is to be provided to HAC outlining the actions taken to date in relation to progress with the letter improvement process. As part of the process:

- Rationalisation of the template letters is to commence immediately.
- Equity is to be a consideration as a recognised part of the process.
- Update on a service by service approach and what can be achieved ahead of the commencement of the PICS project.

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 ultimately will 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 and asked us to investigate whether we could put the Canterbury templates into our current IPM systems. Unfortunately, due to the age and functionality of our systems this will involve considerable cost and effort.

Working with the Consumer Experience Manager we are now approaching this on a service by service basis. We have made changes to some of the Oncology letters and will move onto Ophthalmology next. The order in which we will assess Services' letters will be based on the volume of letters and the potential sensitivity of letters to patients as well as looking at complaints about letters. We plan to align letters to the Canterbury letter templates where possible.

In anticipation of running into the same problems as the Canterbury DHB, where consulting with each Service about the changes to the letters added considerable time and effort to the change, we ask that the Board consider mandating changes to the letters. This is ultimately what the Canterbury DHB had to do after many months of effort in consulting each Service.

July 2021: Recruitment Summary – Prepared by Jayne Jepson, Recruitment Manager

Acronym

FTE	Full time equivalent		AHS&T	Allied Health Scientific and Technical		NETP	Nursing Entry To Practice
Admin	Administration		SMO	Senior Medical Officer		O&G	Obstetrics and Gynaecology
RN	Registered Nurse		RMO	Resident Medical Officer		ED	Emergency Department
RM	Registered Midwife		MIQ	Managed Isolation and Quarantine		ENT	Ear Nose Throat
Mgmt	Management		CCDM	Care Capacity Demand Management		Neuro	Neurosurgery

RECRUITMENT

The tables below illustrate vacancy headcount numbers, FTE and type of contract across the SDHB in total and as per Directorate as of 31 July 2021. The previous month is included for comparison.

This data and report simply records recruiting activity in SuccessFactors, not the RFR system.

Note that the number of FTE is the true representation of open vacancies, because the number of vacancies is made up of "bits" of FTE as in the table of total vacancies below.

PART ONE: SOUTHERN DHB TOTAL VACANCIES

SOUTHERN DHB TOTAL VACANCIES									
		Admin	RN / RM	AHS&T	SMO	RMO **	Mgmt	Support	July TOTAL
Budgeted FTE		609.18	1,871.04	774.17	326.74	334.59	137.30	102.60	4,155.62
FTE vacant		28	113.65	76.775	27.6	43.6	30.8	8.5	331.08
% of workforce vacant		4.60%	6.07%	9.92%	8.45%	13.03%	22.43%	8.28%	7.89%
Number of vacancies		41	166	95	33	44	35	18	433
Type of Contract	*Permanent*	33	130	79	32	43	29	10	356
	Fixed Term	3	15	11	1	1	5	0	36
	Casual	5	21	5	0	0	1	8	41

** Note that the RMO vacancies recorded here include those being recruited for in the current annual RMO recruitment round which skews the percentage of vacancies.

PART TWO: SOUTHERN DHB TOTAL VACANCIES BY DIRECTORATE

** Vacancies classified as Corporate are all other areas of the DHB not included in the other directorates as specified above.*

PART THREE: SIGNIFICANT VACANCY/RECRUITMENT UPDATES

Position	Status Update
Tier 2	
Executive Director – Strategy, Primary & Community	Acting, pending resignation
Executive Director – Quality & Clinical Governance Solutions	Acting, under review
Programme Director Digital Transformation	Interviewing
Chief Medical Officer	Advertising
Tier 3	
Director of Midwifery	Interviewing
Service Improvement Manager	Interviewing
General Manager Building and Property Services	Advertising
Tier 4	
Service Manager – Emergency & Medicine (Southland)	Acting resigned, under review
Chief Medical Physicist (fixed term)	Advertising
Primary Care Manager	Offer
Emergency Management Manager	Advertising
Tier 5 and below	
Charge Midwife Manager – Southland	Interviewing
Charge Nurse Manager – Surgical Southland	Interviewing
Charge Anaesthetic Technician – Southland (long term vacancy)	Under review
Project Manager – Telehealth	Offer extended
Project Manager – Building & Property Services	Advertising
Lead Business Analyst – Digital team	Offer declined – Rebrief
Unit Manager – Ophthalmology & ENT (Dunedin)	Offer accepted, starting August
Senior Medical Physicist (parental leave cover)	Advertising
Chief Medical Physicist (parental leave cover)	Advertising
Team Leader – Vision Hearing / New Born Hearing screening	On Hold
Associate Charge Nurse Manager – Community Services	Advertising
3 x Physiotherapist – Southland Hospital	Offers accepted
Registered Midwives: 2 Dunedin, 9 Southland	Advertising
Pou Whakatere	Offer
Assistant Financial Accountant	Offer
SMO – Dunedin: Neurology Senior Registrar (Lakes), Renal Consultant Clinical SME – Digital, Joint Clinical Orthopaedics, Medical Oncology, Haematology, Public Health	 Started Advertising Offer
SMO – Southland: O&G, Emergency, Radiology, Orthopaedics	Re-advertising

Position	Status Update
RMO – Southland (significant core vacancies): General Surgery Registrar x 1, House Officer x 2, O&G Registrar, ED Registrar	Advertising
RMO – Dunedin (significant core vacancies): General Medicine Registrar x 2, ED Registrar General Surgical (Neuro) Registrar Orthopaedics Registrar	 Offered Advertising Offered

RMO Recruitment Round	Status
PGY2+, House Officers, Registrars Annual recruitment round: • 24 teams with multiple RMO vacancies in each • 519 Applications • 1557 Reference checks requested and received ACE (PGY1) Recruitment • Shortlisting of x50 applicants for both Dunedin and Southland (from approx. 200 for each hospital). Applications printed off to take to selection meeting in August	• Majority of services have shortlisted applications, still waiting on others. • Working through offer approvals via SuccessFactors and drafting letters of offers. 75 to be offered so far. • House Officers are still being reviewed.

Oncology Campaign
Oncology recruitment and attraction campaign underway targeting candidates for the roles below. Media is inclusive of passive and reactive options across domestic and international markets. A landing page has been developed: www.sdhboncology.co.nz where advertising / media will forward candidates for further information and is a way to track success of the campaign. A video has been filmed with key personnel within the Southern Blood and Cancer services and is currently being edited to be included in the campaign. We have also engaged our advertising agency to undertake active search activity on the SMO and Physicist roles.
SMO: • 2 x Radiation Oncologists • 2 x Medical Oncologists • 1 x Haematologist
RMO: • 2 x Radiation Oncology • 1 x Medical Oncology • 1 x Haematology
Medical Physicists: • 3 x Medical Physicists
1 x Radiation Therapist
2 x Registered Nurses

Other campaigns
We have various advertising 'mini' campaigns running domestically and internationally to attract talent through to our vacant positions. The following are active currently: • Generic Nursing – including focuses on mental health, Southland • Anaesthetic technicians • Medical Imaging Technologists • Midwifery • SMO – Radiology (Intervention), Rheumatology

Current Challenges

- Immigration: Restrictions on Immigration / Border closure challenges include: Immigrants needing to come to NZ on a visitor visa, in the hope it can become a work visa on arrival; MIQ spots are few and far between; paperwork required to support immigration is becoming a significant job with emergency requests and time sensitive allocations adding to paperwork already required; the number of current employees that will require Immigration support with their visa renewals and impending Immigration changes will require resource. The pathway to residency will cease to exist in the near future which will present challenges for attraction of key talent into our long term vacancies.
    - Letter and response that has been sent to MBIE on behalf of the 20DHBs to highlight the current challenges and implications on our workforce refer to (appendix a).

- Corporate vacancies are especially being impacted by the government pay freeze and the impending Health NZ changes – we are seeing candidates pull out, being offered higher salaries elsewhere, and significant decreases in candidate applications.
- Nursing / Healthcare assistant recruitment: We are seeing a decline in numbers of applications across all vacancies and reduced quality of talent. Vacancies are rising, in particular with CCDM resource. There is a plan to attract a Healthcare assistant cohort. All New Graduate nurses on the NETP programme are employed on a fixed term contract, these nurses are to be offered permanent contracts for retention purposes.
- Ideas to try and attract further talent to Southern DHB:
    - Develop and implement employee referral programme
    - Review relocation policy to include all disciplines (not just SMO and Executive)
    - Develop Employer Brand across Southern DHB to sell 'our story' in the market

Equity

- We are currently working with Allied Health and Maōri Health Directorate to implement a Maōri Health Strategy for Allied Health Recruitment, led by Kaye Cheetham and Gilbert Taurua. This is at draft proposal stage. The plan is to initially launch this within Allied Health before rolling out across the remainder of the DHB workforces.
- Actions are underway from the Disability Community Working Group regarding the recruitment process and accessibility feedback received.
- A workforce survey is ready for distribution to ascertain ethnicity of our existing staff which will support future focus areas in recruitment.

MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HĪKINA WHAKATUTUKI

16 August 2021

Keriana Brooking
Chief Executive
Hawkes Bay DHB
On behalf of 20 DHB Workforce Management Group

Via e-mail: Allison.plumridge@tas.health.nz

Kia ora Keriana

Thank you for your letter of 28 July regarding workforce pressures facing the health sector. Thank you also for the information on work to reduce reliance on foreign workers that is currently underway within District Health Boards.

Expressions of interest and residence applications under the Skilled Migrant Category

You are correct that there are currently no selections being made from the pool of expressions of interest. As a consequence of the COVID pandemic, the Government suspended selections in April 2020. We are aware of the frustration and uncertainty experienced by applicants and their employers as a result of this decision and we are actively working with Ministers on resuming selections.

While selections are suspended, skilled professionals can stay in New Zealand while employed on a temporary work visa, although we appreciate this is not the same as having the certainty that comes with residence and does not address concerns about being able to purchase property.

Processing of residence applications

Demand for residence under the Skilled Migrant Category and Residence from Work categories has risen significantly over the last few years. This has resulted in longer decision times and we acknowledge the impact this has on applicants. We continue to look at ways of streamlining the processing of applications to ensure applications can be processed as quickly as possible.

Applications that meet the criteria to be prioritised (if they earn twice the median wage or hold occupational registration as required by immigration instructions) are allocated to an immigration officer within two weeks and generally decided within four months. Many applicants working in the health sector roles are benefitting from this prioritisation.

Applications in the non-priority queue are allocated in date order and we are currently allocating applications from November 2019. Immigration New Zealand reaches out to applicants approximately two months before their application is allocated to an immigration officer to request updated information to ensure that once allocated, the application can be decided promptly where all requirements are met.

Applications in the non-priority queue cover a range of sectors. We acknowledge the impact this queue is having on the healthcare sector, in particular for aged care workers.

Ministry of Business, Innovation and Employment

15 Stout Street, Wellington 6011
PO Box 1473, Wellington 6140

Temporary entry options

As you mention, Work to Residence applications can continue to be made. The majority of applications for medical professionals under this category have been allocated for assessment and if the application meets requirements, it will be decided promptly. Immigration New Zealand has received high volumes of work visas in recent months and this has extended processing times. We are working to decide work visa applications as quickly as possible.

Immigration New Zealand is also working towards the introduction of the new Accredited Employer Work visa in mid-2022.

The Government has recognised the importance of health workers from the beginning of the border exceptions programme initiated after the closure of New Zealand's border. Since 31 March 2020, over 7,500 critical health workers and their dependents have been approved a border exception enabling them to apply for a visa and travel to New Zealand. Border exception requests and subsequent visa applications receive priority processing. The critical health worker border exception is the key mechanism for facilitating the entry of health workers from offshore whilst border restrictions are in place. This work will continue to be a high priority.

The border exceptions system remains dynamic, and sits alongside quarantine-free travel arrangements, reflecting the Government's focus on reconnecting New Zealand with the world in a phased approach, to keep communities safe and our economy operating. We are aware of the impact on offshore workers, including those from very high-risk countries such as India, as well as New Zealand citizens and permanent residents and their families. However, this is part of the Government's overall strategy for managing COVID risk and Immigration New Zealand has no ability to grant exceptions to these restrictions.

COVID-19 and the subsequent border closure highlighted how reliant some sectors are on foreign workers. It is good to see your commitment to reducing this reliance and I would encourage the District Health Boards to continue this work.

I realise this response cannot fully alleviate your concerns given the current uncertainty, but I hope the information provided helps to assure you that immigration settings recognise the importance of the health workforce and that prioritised pathways are in place to ensure critical health workers who are offshore are able to come to New Zealand.

Nāku noa, nā

Carolyn Tremain
Te Tumu Whakarae mō Hikina Whakatutuki
Secretary for Business, Innovation & Employment and Chief Executive

cc Ashley Bloomfield, Chief Executive, Ministry of Health

All District Health Boards

28 July 2021

Carolyn Tremain
Chief Executive
Ministry of Business Innovation and Employment

Tēnā koe Carolyn

Urgent Immigration Issues and the Pressures on the Workforce in Health

The health sector in Aotearoa New Zealand is facing considerable pressures. Key to ensuring continuity of patient care during this time is ensuring a strong workforce supply. I am writing to you on behalf of the 20 DHBs to outline the critical workforce issues that DHBs are experiencing which are being greatly exacerbated by the immigration challenges our current and future employees are facing.

Current Situation

As you will be aware, the health sector is currently reliant on employing overseas trained health professionals to meet the health service needs of New Zealanders. DHBs understand that this level of reliance is not desirable and have initiatives underway to reduce this over time (outlined below).

We understand and support the Government's focus on 'growing our own' and undertaking a system-wide review of the immigration policy settings to ensure they align to goals for the economy and the wellbeing of New Zealanders. However, many of the actions to train, attract and retain more New Zealand health professionals have long term benefit realisation and therefore the dependence on overseas trained professionals will continue for at least the medium term. Currently DHBs are experiencing immigration issues with their existing workforce and for those we are trying to employ from overseas.

System Under Pressure

You will be aware that our hospitals are also experiencing very high levels of occupancy at present and some sites are even in "code red" where they are deemed to be at extreme levels. This is obviously an unsustainable situation and places even more pressure on our existing workforce. We are very concerned about this situation and for the potential for further deterioration if there are no changes to assist with at least securing the existing workforce.

Challenges for the Existing Overseas Trained DHB Workforce

Skilled migrant category visas

For the existing workforce, we have large numbers of employees who have entered the country on skilled migrant category visas and have lodged Expressions of Interest (EoI) for residency but these

applications are not currently being processed by Immigration New Zealand (INZ). We are unable currently to determine exactly how many of our staff are in this category however we have many examples, and figures in the media from INZ quote 901 registered nurses and 235 doctors. People enter the country as skilled migrants and have the expectation they will have a relatively direct path to residency. Under this scheme they can immediately submit an EOI for residency and then wait for an invitation to submit an application for residency. i.e. a two- stage process. Currently, people are submitting EOIs but there are no invitations to submit applications for residency. As a result, our staff are in limbo not knowing if or when they will obtain residency. The result is that they are unable to settle in New Zealand, secure mortgages and buy houses, educate their children as residents etc. For the individuals this is distressing and for the health sector it poses considerable risk as these people possess valuable and hard to source skills and many are considering leaving the country if their situation cannot be resolved promptly.

Work to residence visas

We also have employees who are on a work to residence visa as a pathway to residency after two years minimum in the country. We understand people can apply for a resident visa after working for two years on a work visa as long as they continue to meet the visa conditions (which specify the employer and the role). INZ advises resident visa applications from doctors are allocated to a case officer within a few weeks however people who are not prioritised wait for about 20 months. Priority is given to occupations on the Long-Term Skills Shortage List (LTSSL). Not all our current hard-to-fill roles are currently on the LTSSL. For example, nurses who work in Aged Residential Care are on the LTSSL but not those working in hospital settings.

There is also a talent category for those occupations on salaries above $79,560 requiring accreditation. We are unable to specify how many of our staff are waiting to be assigned a case officer under this visa category but we understand that this visa pathway is due to close on 31 October 2021.

To put this into context, DHBs had almost 3,400 vacancies as at 31 March and a third of these were nursing i.e. 1,200. This was prior to going into winter, before DHBs were impacted by RSV and flu, the COVID-19 vaccination response and increased sick leave of staff.

We are currently collating our June quarter workforce data but it is expected that vacancies will have increased. These vacancies are putting DHBs under considerable pressure to maintain service delivery and are placing the existing workforce under strain which is leading to retention issues. It also impacts the ability to attract people into health professions.

Many of the vacancies also require experienced staff i.e. given the acuity of the patients we require nurses with five years plus experience and some roles are not suitable for new graduates.

Challenges for the Health Workers Seeking Employment in NZ

DHBs also report challenges with expediting the entry of skilled workers into the country. New Zealand has relied on nurses from the Philippines, India and the United Kingdom to supplement the locally trained workforce. While nurses are deemed a critical workforce and have priority for entry into the

country (as do other critical health and disability workers) numbers are considerably reduced from pre-COVID levels. Nurses from India need to be particularly motivated to immigrate to NZ as they need to spend 14 days in a third country on exiting India prior to coming to NZ and undertaking the NZ MIQ 14 days quarantine. The Philippines has also closed its borders to health workers leaving that country. With the overseas pipelines constrained it becomes even more important that we can retain our existing workforce.

Critical Occupancy Levels in New Zealand Hospitals

DHBs are currently experiencing increased admissions to hospitals with a flow-on impact to ICU. We are also experiencing increased presentations in emergency departments – ref Appendix 1 percentage of time over 90% Occupancy. The health system is under pressure with increasing acute demand currently exacerbated by RSV and other winter illnesses.

The workforce challenges in the primary sector and the increased acuity of patients are also leading to flow on effects to hospitals including increased presentations to ED and admissions.

We are also experiencing high levels of staff sickness which is having an impact on our ability to undertake planned care while we are concurrently providing a pandemic response.

We are concerned about the system's ability to be ready for a 'surge response'. The opening of borders is also likely to see an increase in communicable diseases (such as RSV and measles) that require immediate response. In order to respond to 'surge' the system will have to redirect workforce from areas like planned care. This will have long term impacts on the health and wellbeing of New Zealanders.

The Wider Employment Situation

Traditionally, there has been a flow of nursing staff and health care assistants (HCAs) from ARC and community providers to DHBs. Overseas trained nurses often work in ARC as HCAs while they obtain registration then move to DHBs on registered nursing positions. ARC providers have sourced a high percentage of their workforce from overseas. This is particularly so in larger centres.

With impending settlements in DHB nursing employment agreements and Pay Equity, nursing and HCAs positions in DHBs will attract applicants from other employers such as ARC and primary and community providers.

DHBs do not want to adversely impact the service delivery of other providers. If DHBs can reduce their vacancies through securing existing staff and having ready access to required overseas talent the likelihood of this occurring will reduce.

Work Currently Underway by DHBs to Reduce Reliance on Overseas Trained Workforce

DHBs are committed to reducing the health sector's reliance on overseas trained professionals over the longer term. This is aligned with the Governments focus. Appendix 2 outlines current initiatives

which will give a sense of the DHBs focus on developing an Aotearoa New Zealand trained health workforce. However, this does not address our current immediate workforce pressures.

Summary

DHBs are experiencing significant challenges to maintain safe levels of services that are being exacerbated by workforce supply challenges. Most importantly this includes the risk that existing overseas trained employees will leave due to an inability to secure their futures as residents of New Zealand.

DHBs are working to reduce their reliance on overseas trained health professionals but will continue to require a significant proportion of the workforce to come from overseas for the foreseeable future.

The health system also needs to be resourced for responsiveness and currently it is stretched to do so with workforce a high concern.

Therefore, DHBs seek your immediate attention to:

1. ensure our current overseas trained staff can have a direct and prompt path to residency; and
2. that overseas health professionals are facilitated to enter NZ as required to avert a crisis in the health sector.

I would be happy to discuss this matter with you directly. If you or your department would like any further information on the current DHB immigration issues then please contact Allison Plumridge, Director Workforce at TAS – Allison.plumridge@tas.health.nz

Ngā mihi

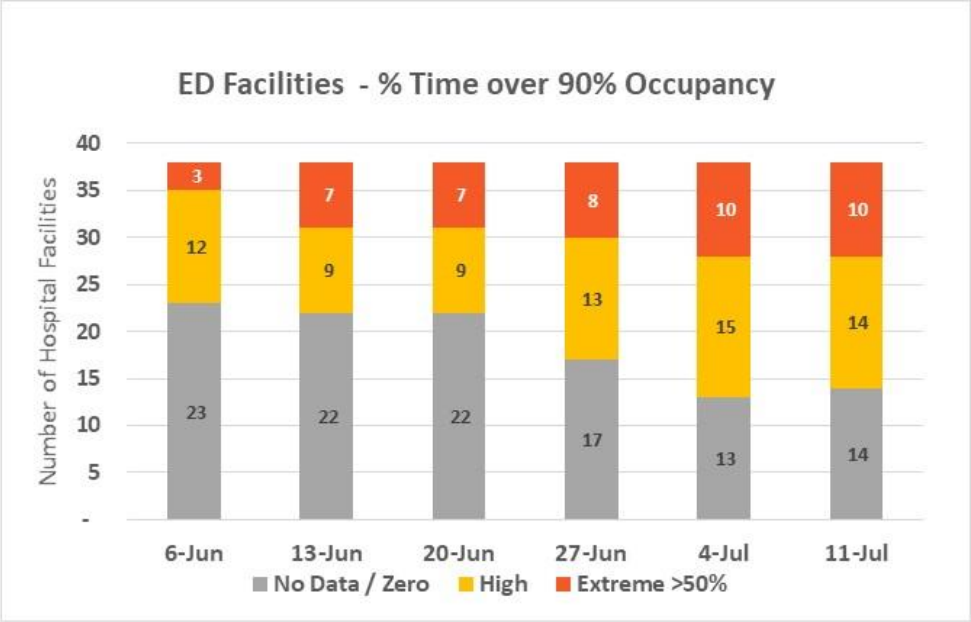
Keriana Brooking

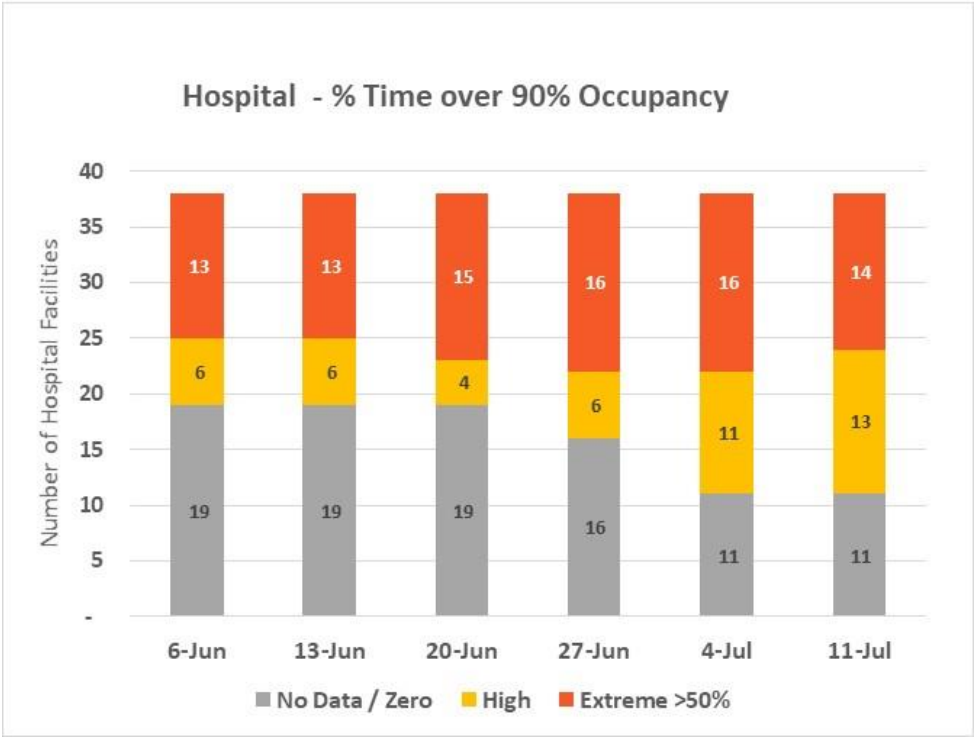
CE Hawkes Bay DHB

20 DHB Workforce Management Group Lead CE for Immigration

CC
20 DHB Chairs and Chief Executives
Amy Wilson, Acting DDG Health Workforce, Ministry of Health

Appendix 1 – Percentage Time over 90% Occupancy Over the Last Six Months





Appendix 2 – Work Currently Underway by DHBs to Reduce Reliance on Overseas Trained Workforce

Supply initiatives

DHBs are committed to reducing the health sector's reliance on overseas trained professionals over the longer term. Work is underway on a DHB led Nursing Pipeline Project to achieve a shared understanding of the pre-registration pipeline, working with the Tertiary Education Commission (TEC) and training providers. The Ministry of Health, New Zealand Nurses Organisation (NZNO), the New Zealand Nursing Council (NZNC), Aged Re Care (ARC) providers, and nursing leaders from across the sector are involved. This is about ensuring the supply and demographics of nurses better match demand, and meet population needs.

DHBs have also been increasing the supply of medical professionals. For example, DHBs provided 381 first year training placements in 2013 and this has increased to 552 for 2022. DHBs are also working with the tertiary sector and the regulatory authorities to streamline qualification pathways for Allied Health professions to assist with the supply and deployment of a range of professions.

Retention

DHBs are committed to fully implementing the Care Capacity Demand Management System (CCDM) which matches nursing resourcing in hospitals to patient acuity. This requires DHBs to provide additional FTEs to ensure patient and staff safety. An additional 340 nursing FTES are required to meet CCDM commitments.

Work is also progressing on health and safety and wellbeing initiatives to raise standards across the sector and ensure that people are safe and well while at work.

DHBs are also progressing Pay Equity processes for a range of female dominated professions such as nurses and midwives. The outcome of these settlements should be positive on recruitment and retention.

Recruitment

Kiwi Health Jobs is a DHB owned job portal to assist in streamlined recruitment both on and offshore. DHBs are currently upgrading the platform to provide a better experience for candidates and functions such as talent pooling which should facilitate more efficient matching of candidates to roles.

FOR INFORMATION

HAC Action Item: 5.6 Southland Dental Unit's General Anaesthetic Waiting List (Minute 10.0)

Action: Further advice, including possible solutions, to be submitted to the September HAC meeting.

Date: 6 September 2021

Submitted By: District Oral Health Service Manager

Presented by: Executive Director Strategy Primary and Community

---

Update

Clinical Lead Oral Health - Dr Tim Mackay and the Oral Health team have developed a plan for the recovery of the Southland General Anaesthetic (GA) list for the next six months, bearing in mind the current impact of New Zealand's second Covid-19 lockdown is not fully understood at the time of writing but will increase waiting list numbers again due to cancellation of GAs over the period of lockdown.

BACKGROUND

Prior to Covid-19, the Oral Health service has traditionally sat with approximately 120 patients on the list. The Southland service generally has two half day lists per week with 4-5 cases depending on case-mix, this has meant the waitlist historically sat in the 3-4 month range.

Since Covid, the Oral Health Service (like all services) at Southland Hospital has at times had to drop lists when short of Anaesthetic Technicians and Nursing staff. In addition to this, the Oral Health Service are also picking up some work from Otago catchments that are usually completed by the School of Dentistry. The Oral Health service are jointly completing a report on the School of Dentistry for the next CPHAC committee.

Further to the above, the Mobile Surgical Services (MSS) has helped provide service closer to home in Queenstown, Dunstan, Oamaru, Gore and Balclutha. There have been significantly less MSS sessions available for the first half of 2021 as the MSS was prioritised for other work

The main inflow of work for the Southland GA list comes from the Community Oral Health service (COHS), which has been working hard to catch up on arrears and currently has a level of staff vacancy that puts some pressure on ability to deliver preventive services.

MITIGATION:

1. The service picks up any list that is offered – whether at Southland Hospital or Southern Cross. The Oral Health service is at an advantage where it can rapidly source patients at short notice for surgery.

2. MSS has another 9 full days of operating before Christmas - this will be approximately another 80-90 cases.

3. Dr Mackay has secured Mobile Surgical for a week at Southland Hospital – this will treat another 40-45 cases.

4. Dr Mackay has been doing community based assessments (Queenstown and Invercargill) since September 2020 – has seen 320 kids for assessment – this has stopped them coming to hospital for an assessment.

    1. Approximately one third go onto GA – so controlling inflow as best as possible

2. Approximately one third are sedated and managed in the community then discharged back to COHS

3. Approximately one third advice/reassurance and discharge back to COHS.

OUTCOME

Based on reducing the list down to usual levels within the next 6 months i.e., by 1 February 2022:

- We have 21 weeks left this year – less 3 for Christmas/New Year = 18 + 3 in January = 21 weeks
- Southland Hospital = 21 x 8 cases = 168
- Mobile Surgical = 9 days x 8 cases = 72
- Mobile Surgical = 5 days in January = 5 x 8 = 40

Plan to treat 280 cases – all things being equal.

The Dental Service is unable to re-commence dentistry until the region is in Alert Level 2, therefore the potential impact to both the General Aesthetic list and arrears list potentially could be significant depending on the length of time we remain in Alert Levels 3-4. This plan will need re-scoped when the impact of the Alert Level lockdown is known.

FOR INFORMATION

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

Proposed by: Patrick Ng, EDSS

Meeting of: Hospital Advisory Committee, 06 September 2021

Recommendation

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

Purpose

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

1. Equity

Timeframe	Action	Update 4 August 2021
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).	Meeting regularly See dashboardbelow 2x workshops held (Dunedin), Invercargill booked for 25 August 2021. Further workshops planned in Radiology, ENT, Eyes. Themed and prioritising workshop planned early September 2021 to co-construct the equity plan recommendations
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.	

Our equity programme continues to work to the above plan and kicked off with 2 workshops with Dunedin outpatient teams. The workshops were used both to disseminate key information, why equity considerations are important and how inequity in healthcare can come about and to collect information from participants about how equity can be improved at SDHB. The next workshops are planned for the last week of August (Southland Outpatient Services), but we will reassess these as we would like to gain maximum participation and the COVID lockdown may not be conducive to this.

Workshops will then be run with other key services who provide their own outpatient services, the ear, nose and throat service (ENT), ophthalmology service and the radiology service. There has also been interest from the women and children's service and a workshop will be booked for this service, too. As our initial focus is on the cardiology and respiratory services, we are also looking at booking a workshop for the cardiology testing service in the coming weeks.

Specifically, these sessions have the following aims:

- To learn about some elements of equity at SDHB.
- To discuss processes in Outpatients and Radiology and how they may help and hinder equity outcomes.
- To develop some key discussion points for what might change and enable this to be taken back to the teams.
- To co-construct specific strategies to improve equity outcomes.
- To identify how the Equity in Outpatients and Radiology group can help the outpatient teams improve their approach to equity in how they work.

The content of these workshops covers:

- Education slides showing local data.
- Question slides, allowing information to be captured on the following themes.
    - What causes DNAs (unable to attend situations)?
    - Why does it matter?
    - What could we do to prevent DNA, unable to attend situations?
    - What can we do differently?

The key themes derived from these workshops will be pulled into the overarching strategy. We are conscious that whilst internal information and a localised approach are of great importance, we also need to be cognizant of good practice (and even best practice) which is occurring elsewhere. We are thankful for the information supplied by one of our Board members and this has been printed and combined as a binder of materials. We are now allocating sections of the binder out between the EDSS, GM Surgery and Radiology and others and will organise a mini-workshop for this group so that key themes and opportunities from these publications can be shared and incorporate into the overall strategy and approach.

The EDSS has also made contact with the equivalent Chief Operating Officer role at Auckland DHB, and when the visit that was originally planned for reviewing Care Capacity Demand Management and the planning tools is reinstituted (after lockdown) a meeting with relevant individuals in the equity and reporting team will also be facilitated as part of that visit so that the tools, approach and data capture used by Auckland can be reviewed with the intention of learning what could be adopted at SDHB.

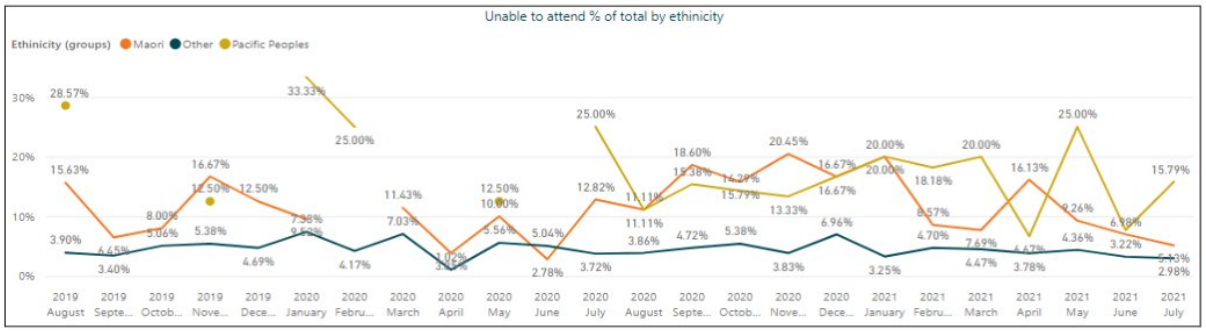
At this stage in our journey, we have identified the following (loose set of themes) from the outpatient workshops, which, if developed into a change program could make a meaningful difference.

- There are opportunities to improve our processes for sending invitations to attend appointments.
- There are opportunities to improve the content of the letters that we generate.
- Provision of access to cultural support in our outpatient environment could also make a meaningful difference.

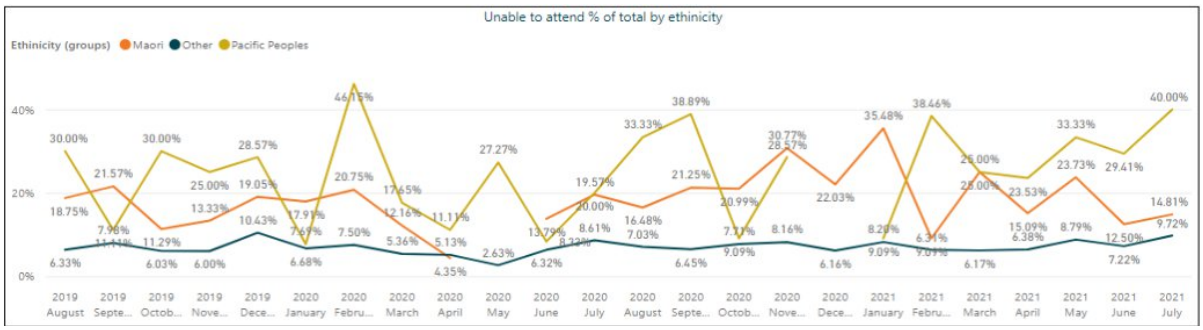
A study has also been completed recently on 20 Māori patients with lung cancer. This is being presented to the clinical council and the study will also be made available to the Board. The study should provide useful learning and insight into how early cancer was detected, the journey once cancer was detected and what can be done to improve the journey. The insights, once available will assist both our equity improvement work and also our cancer care improvement work.

Equity Dashboard for '*equity in outpatients and radiology group'*

Cardiology – Unable to attend % (New and Followup appointments)

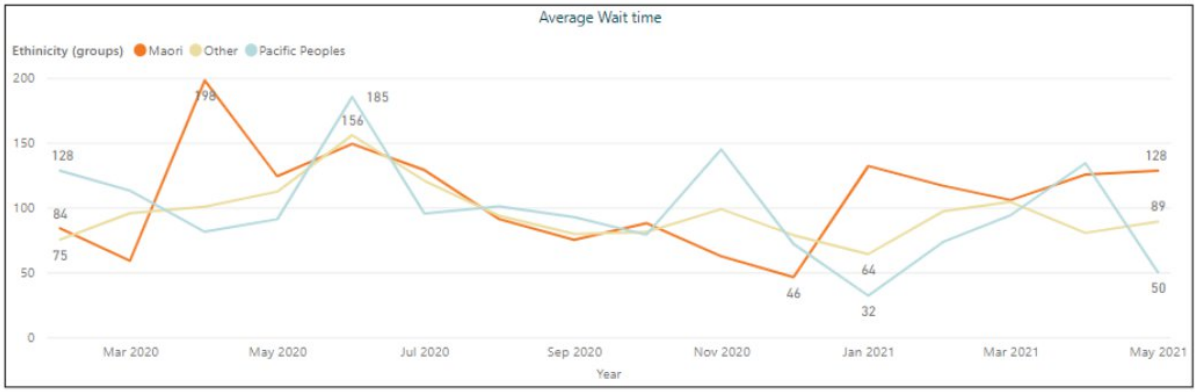


Respiratory – Unable to attend % (New and Followup appointments)



Cardiology – Average waiting time (New apointments)

Respiratory – Average waiting time (New apointments)

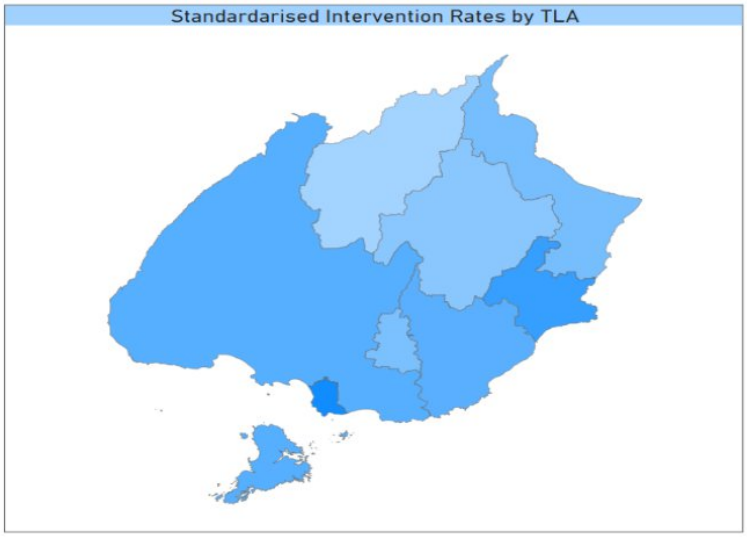


These charts appear to show an improvement in unable to attend rates for Maōri in the last 6 months when compared to the 'other' population which includes European. However, this is not as a consequence of specific actions that we are aware of (we have heard that there has been an increased focus on tele-health, but this is yet to be quantified). The dashboard provides us with a useful time series so that we can track how Māori and Pasifika compare to the Other category over time and so that we can track the success of the interventions we pilot, once these have been formulated. The charts do identify that Paskifka patients have high rates of unable to attend rates for both cardiology and respiratory compared to both the other groups. Whilst they are a small population compared to the other two populations we do need to investigate and understand what is causing this variation for this group of our population. A topic for a University student could be to investigate the available data and determine why Māori unable to attend rates have improved in the last 6 months (and whether this trend is likely to continue), and why Pasifika rates remain high (whether because of data aberration or because of relevant factors within that population). We will make contact with our University colleagues to see whether we could partner with an interested University student, provide the data and benefit from the conclusions of a study. This approach is similar to a study that is already underway on diabetes.

As well as equity between ethnicities, it is important that we give consideration to equity between our rural and urban populations and it will also be important to cross reference these two equity issues in the future to understand, for example, what factors drive the highest levels of inequity overall. For example, if our highest levels of inequity are found in Māori and Paskifka who live rurally and have high deprevation, as a cohort this category may represent our highest priority for addressing equity issues. If this is the case what are our highest priorities and which areas will produce the greatest improvements?

With the help of our Planning and Funding colleagues we have managed to break down our cardiology and respiratory intervention rate data by locality within our district, per the following charts.

Cardiology Standard Invervention Rates by Locality



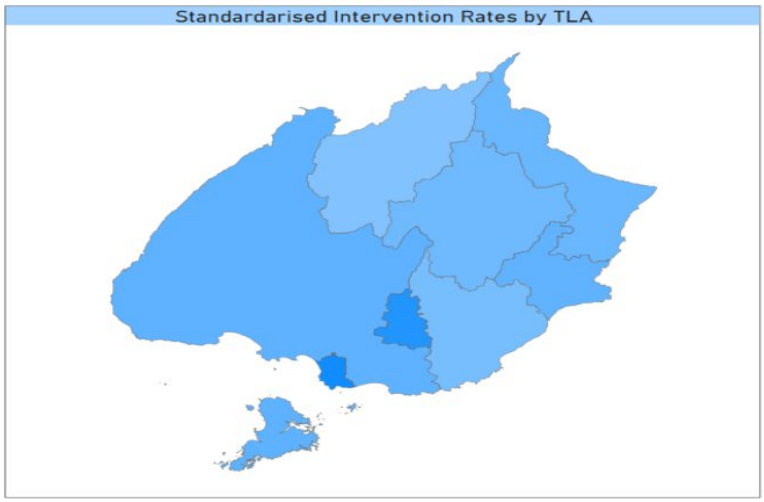
TLA	SIR
Central Otago district	75.55
Clutha district	119.24
Dunedin city	151.95
Gore district	89.76
Invercargill city	185.44
Queenstown-Lakes district	53.12
Southern DHB	129.39
Southland district	121.74
Waitaki district	93.43
Total	**113.29**

Standardised intervention rates (SIRs) take into account the demographic make up of each district (including age, ethnicity and sex), and seek to provide an adjusted intervention rate that is comparable to other populations. Please note that the standardised intervention rates provided by the Ministry are only at SDHB level and that our planning and funding team have been unable to standardise for deprevation. As a consequence the SIRs noted above do not reconcile to the overall SDHB SIR rate. The rate is per 10,000 people in the population. Generally our intervention rates for Cardiology at DHB level compare well nationally, but we need to refine this analysis further to understand how our interevention rates at Territorial Local Authority (TLA) level compare nationally. We will continue to enhance this analysis and will provide an assessment of how each of our TLA's compares to national intervention rates once this becomes clearer.

Tentatively, the cardiology standardised intervention rates above suggest that those living in the districts which have base hospitals (Dunedin City and Invercargill City) have the highest intervention rates whilst more rural locations such as Gore have lower intervention rates. Of note is that some of the lower deprivation districts (e.g. Queenstown Lakes) have lower intervention rates too. The fact that deprivation is not accounted for yet is likely to be a factor further investigation is required to robustely understand these rates.

Overall, at this stage, the rates are suggesting to us that those districts less proximate to the base hospitals (Southland Hospital and Dunedin Hospital) have lower intevention rates which supports the observation that has been made in the past – that rurality is also a barrier to access and this needs to be better understood. Tentative conclusions suggest that we appear to be over intervening in the districts immediately proximiate to the hospitals and under invervening in more remote districts. We will investigate this further and action may be required to be deliberate about intervening more for our rural TLA's and to achieve this by reducing the rate of intervention in our non-rural TLA's.

Respiratory Standard Intervention Rates by Locality



TLA	SIR
Central Otago district	21.32
Clutha district	19.86
Dunedin city	24.10
Gore district	36.18
Invercargill city	39.44
Queenstown-Lakes district	17.66
Southern DHB	26.54
Southland district	24.40
Waitaki district	22.60
Total	**25.79**

Interestingly, SIRs show a tighter banding for respiratory across all locations and are at similar levels for, e.g. Gore and Invercargill but with lower rates at Queenstown / Central Otago and Gore.

Tentative Conclusions

Whilst the data needs further review our initial observations are that:

- Cardiology appointment attendence rates appear to be improving for Māori (further work will be undertaken to understand why and whether this will become a sutainable pattern). They remain a problem for Paskifika people.
- Rurality appear to be a determinant in terms of access to cardiology services and rural equity issues need further analysis, understanding and then action.
- Respiratory appointment unable to attend rates remain high for Māori and are higher again for Paskifika people. More work is required to bring these rates down.
- Rurality appears to be less of a determinanent in terms of access to respiratory services but districts like Queenstown appear to be underserviced.

2. Surgical Performance – Case Weight and Discharges

The following tables outline our case weight discharge (CWD) and discharge performance for July of the 2021/22 financial year and compares this to the elective plan (our target).

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 for the July 2021/22 financial year we are -64 CWD behind plan as per the first circle in the first table. The second table shows the 2021/22 discharges against plan, for the service provider view we are 107 discharges behind plan.

The 'population' view in the case weight discharge (CWD) table is an overall target which includes both the hospital delivered CWD and the net CWD delivered by other DHBs for our population (the difference between what we delivered for other DHBs and what other DHBs delivered for us). It is the service provider target minus inter district inflows plus intra district outflows. The second circle shows that for July we are 46.4 CWD behind this target as per the second circle in the first table.

The second table shows the 2021/22 discharges against plan, for the population view we are 104 discharges behind plan.

As our hospital delivered services cannot influence the population target, they are focused on achieving the 'service provider' hospital target.

Date 01/07/2021 31/07/2021

As at: 6/08/2021

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	117.6	105.3	12.4		2.5	-2.5	51.1	51.1	0.0	168.8	153.9	14.8	149.7	-32.1	174.6	-5.9
PUC Total	**117.6**	**105.3**	**12.4**		**2.5**	**-2.5**	**51.1**	**51.1**	**0.0**	**168.8**	**153.9**	**14.8**	**149.7**	**-32.1**	**174.6**	**-5.9**
Surgical PUC																
S00.01 General Surgery	271.3	266.3	5.1		0.2	-0.2	20.2	20.2	0.0	291.6	286.3	5.3	299.1	-27.8	310.9	-19.3
S05.01 Anaesthesia Services	0.4	0.0	0.4		0.0	0.0	0.0	0.0	0.0	0.4	0.0	0.4	0.9	-0.5	0.9	-0.5
S15.01 Cardiothoracic	153.7	125.8	27.9		1.7	-1.7	1.9	1.9	0.0	155.6	125.9	29.7	199.3	-45.6	200.2	-44.6
S25.01 Ear Nose and Throat	119.0	120.9	-1.9		0.1	-0.1	1.7	1.7	0.0	120.7	122.5	-1.8	117.8	1.2	118.0	2.7
S30.01 Gynaecology	93.4	100.2	-6.7		0.1	-0.1	7.9	7.9	0.0	101.3	107.9	-6.6	106.2	-12.8	116.8	-15.5
S35.01 Neurosurgery	46.7	33.1	13.6		3.7	-3.7	14.7	14.7	0.0	61.4	44.0	17.3	53.7	-7.0	56.9	4.4
S40.01 Ophthalmology	65.5	108.4	-42.9	0.5	0.6	-0.1	0.6	0.6	0.0	65.6	108.4	-42.8	110.7	-45.2	110.2	-44.6
S45.01 Orthopaedics	354.4	418.1	-63.7	16.3	26.1	-9.8	9.8	9.8	0.0	347.9	401.8	-53.9	537.7	-183.3	527.3	-179.4
S55.01 Paediatric Surgical Services	7.6	15.4	-7.8		0.0	0.0	6.9	6.9	0.0	14.5	22.3	-7.8	14.1	-6.5	29.1	-14.6
S60.01 Plastic & Burns	53.3	59.2	-5.9	2.1	0.2	1.9	16.1	16.1	0.0	67.3	75.1	-7.8	60.7	-7.3	62.4	4.9
S70.01 Urology	91.8	97.4	-5.6		0.2	-0.2	3.1	3.1	0.0	94.9	100.2	-5.3	100.4	-8.6	103.4	-8.5
S75.01 Vascular Surgery	88.6	77.4	11.2		1.0	-1.0	2.5	2.5	0.0	91.1	78.9	12.2	54.0	34.6	58.2	32.9
PUC Total	**1,345.8**	**1,422.2**	**-76.4**	**19.0**	**34.2**	**-15.2**	**85.4**	**85.4**	**0.0**	**1,412.3**	**1,473.4**	**-61.2**	**1,654.6**	**-308.8**	**1,694.4**	**-282.1**
PUC Total	**1,463.4**	**1,527.4**	**-64.0**	**19.0**	**36.6**	**-17.6**	**136.6**	**136.6**	**0.0**	**1,581.0**	**1,627.4**	**-46.4**	**1,804.3**	**-340.9**	**1,869.0**	**-288.0**

Financial Period 1 1

Financial Year 2022

As at: 6/08/2021

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	45	48	-3		1	-1	12	12	0	57	60	-3
PUC Total	**45**	**48**	**-3**		**1**	**-1**	**12**	**12**	**0**	**57**	**60**	**-3**
Surgical PUC												
S00.01 General Surgery	177	153	24		1	-1	7	7	0	184	160	24
S05.01 Anaesthesia Services	2	0	2		0	0	0	0	0	2	0	2
S15.01 Cardiothoracic	24	20	4		0	0	0	0	0	24	20	4
S25.01 Ear Nose and Throat	112	144	-32		0	0	3	3	0	115	146	-31
S30.01 Gynaecology	106	96	10		0	0	4	4	0	110	100	10
S35.01 Neurosurgery	12	10	2		1	-1	5	5	0	17	14	3
S40.01 Ophthalmology	119	200	-81	1	1	0	1	1	0	119	200	-81
S45.01 Orthopaedics	158	179	-21	3	4	-1	8	8	0	163	183	-20
S55.01 Paediatric Surgical Services	10	18	-8		0	0	7	7	0	17	24	-7
S60.01 Plastic & Burns	60	58	2	2	0	2	7	7	0	65	64	1
S70.01 Urology	91	90	1		0	0	2	2	0	93	92	1
S75.01 Vascular Surgery	23	31	-8		1	-1	0	0	0	23	31	-8
PUC Total	**894**	**998**	**-104**	**6**	**8**	**-2**	**44**	**44**	**0**	**932**	**1,033**	**-101**
PUC Total	**939**	**1,046**	**-107**	**6**	**9**	**-3**	**56**	**56**	**0**	**989**	**1,093**	**-104**

The hospital 'provider' view was behind target by 64 CWD. As noted in previous reports, we have been faced with roster gaps on the inpatient wards due to nurse vacancies and illness and key perioperative staffing gaps in Southland.

When we compared Dunedin's CWD delivery to July of last year, once we had 'normalised' the results to make them comparable (removed weekend lists and additional outsourcing completed in July of last year, adjusted for an additional working day this year and adjusted for an unanticipated delay in the refurbishment of one of our theatres), we found that the underlying elective delivery in July of this year was comparable to July of last year in Dunedin. Dunedin has had very similar levels of acute activity (whether measured in discharges, CWD or acute operating hours) to last year.

Southland's elective CWD was considerably more compromised. After normalising July last year and July this year and comparing them, Southland completed 92 less CWD this year than last year, representing a 24% drop in elective delivery year on year. Whilst Southland completed similar levels of acute discharges this year compared to last year, acute hours used within scheduled hours (which are between 8am and 10pm) increased by 22%, suggesting that a key part of the issue for Southland has been the complexity of the acute cases undertaken. Whilst managed carefully and kept to a minimum, Southland also dropped 6 operating lists either because of perioperative staffing gaps, or because of having to stand down teams who had worked exceedingly long hours in acute theatre prior to their scheduled elective theatre lists. The Southland team have worked hard to recruit more perioperative staff and have confirmed a number of appointments. The majority of perioperative vacancies will be filled between now and the end of this year, provided that we don't face higher than normal resignations / staff turnover.

In addition to these challenges, we had to wind down elective surgery in the latter part of August to empty the hospital for the planned nurses strike and this has now been supplanted by lockdown. As with all other DHBs our immediate response to the lockdown has been to cancel all non-urgent planned care work. However, we have sought and received guidance from the Ministry that we can undertake more planned care work where this can be safely achieved, and we are working on a plan which will see more routine work completed in the coming weeks.

The impact of lockdown and the nursing strikes (if they resume in the future) now means that it is inevitable that more outsourcing will be required in order to meet the elective target we have agreed with the Ministry (and therefore earn all available revenue and maximise the amount of surgery completed). Once we come out of lockdown, we will therefore gear up to complete higher levels of outsourcing than previously planned for. Our demand for outsourcing is likely to be higher than the capacity available in the district and we will review options for outsourcing out of the district, noting that other DHBs are likely to be in a similar situation and placing higher than usual demands on the outsource providers across the country.

In prior years our elective plan (now called the plan care plan) which is agreed to with the Ministry has been the 'production plan' that has been worked to. This plan identifies the case weights and discharges that we are aiming to achieve by specialty and the difference between what can be achieved internally and what must be outsourced to achieve the overall case weight discharge target (and therefore earn 100% of the available revenue target) is completed using outplacement and outsourcing which we have a budget for.

For this year, as well as completing the elective plan, phasing it and loading it as the target we are working to each month, we have also completed a rudimentary 'production plan' which compares the elective plan to what we believe we will deliver based on our most recent performance (the last financial year). This reconciliation suggests that without mitigations to further improve our elective performance we would need to outsource up to 1,200 additional case weights of surgery against a production plan of circa 17,500 case weights. We are planning several initiatives to improve internal productivity and therefore reduce the dependency on outsourcing to achieve our elective plan.

These initiatives include the following:

- Implementation of additional inpatient beds in Southland. Additional beds have been identified in the Assessment, Treatment and Rehabilitation (AT&R) in Southland hospital. A model is being developed (led by the acting General Manager in Southland) to convert 8 of these bed spaces into outlier medical beds. This will then allow outlier medical patients that are going into the surgical wards to reduce, which will correspond with more elective surgery being able to be completed.

- Development of a 5th theatre in Southland. We have focused our efforts on the business case for 'fit for purpose' Emergency Department capacity, but this case will now be with the Board for the Board meeting in September. We can now turn our attention to progressing the 5th theatre Southland business case in the next couple of months. Our work to date suggests that whilst we successfully got funding from the Ministry, we are likely to need additional funding to develop a fit for purpose 5th theatre, and we will engage with the Ministry on the possibility of additional funding as we work up this business case.

- Implementation of acute surgical capacity. Modelling has shown that we have between 25-28 hours too little acute capacity in Dunedin. This in turn translates into elective cases being cancelled for priority acute cases. An additional 8 hours of acute list time is being planned for Saturdays initially, and we will progressively recruit to cover this, plus add 4 hours to the end of a regular acute list each working day. The key to ensuring that these are used productively is to maintain theatre utilisation at circa 85% for this additional list time, in line with our normal elective list utilisation. Provided that this is maintained, because it is circa 3 X more expensive to complete surgery in an outsourced setting, there will be a robust payback for investing in the additional acute time, as the counterfactual would be elective activity lost to acute work would have to be outsourced and maintaining this level of utilisation either means that less outsourced elective work needs to occur than is currently budgeted for, or, acute volumes have grown and we have an obligation to complete these anyway. The GM Surgery and Radiology is taking the lead on this and we are aiming to have sufficient resources recruited (or alternative arrangements made) to be able to run the Saturday lists permanently by the end of the calendar year and sufficient perioperative staff employed to be able to supply the Monday to Friday additional acute hours by early in the next calendar year. We also need a short notice elective process to be completed and finalised in parallel so that we can be confident that this additional resourced time will always be utilised.

- Whilst CCDM will primarily enable us to safely staff the beds we do have, rather than opening additional beds, being able to safely staff our wards will improve our chances of being able to continue with surgery during peak loads on the hospital. The ramp up of CCDM will be dependent on the success of recruitment but on the assumption that we recruit successfully we should see this translate into better elective delivery and we will incorporate this into future production plan modelling.

Ideally production planning should be a bottom up construction of our elective activity for the year based on the theatre lists that are currently allocated to the specialities and the average case mix which the specialities put through the theatre lists. This then needs an overlay to account for acute demand through the hospital and the impact that this has on planned elective lists. The plan then needs to take into account the length of stay of the case mix and reconcile this with the available inpatient beds on the surgical wards and also reconcile this to the competing demand of acute surgery and medical outliers onto the surgical ward during peak

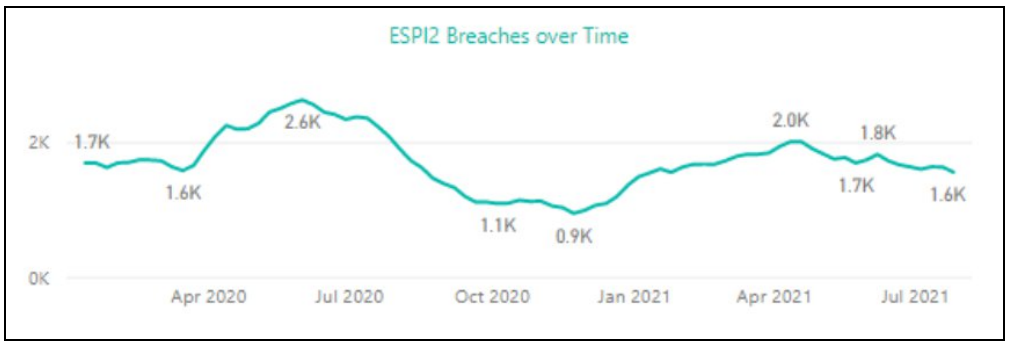
medical demand. Once this is constructed as a baseline of what is likely to be delivered, discussions can occur to tweak the allocation of lists to specialities based on the need to intervene more or less in a particular speciality. Once these changes are added in a final plan can be worked to.

This is a relatively specialised and complex planning process. The Ministry of Health have offered to provide expert advise on how to construct a production plan and on we will seek advise from them and from visiting Auckland (whom we believe have a mature production planning process) to guide us in how to construct a full production plan.

3. Outpatient Performance Elective Service Patient Flow Indicator (ESPI) 2

The following chart shows the total number of 'ESPI' outpatient appointments on our waiting list over time. It shows growing wait lists coming out of the COVID lockdown from last year. The peak in demand previously reported on in the early part of the calendar year is noted in the trend and the overall wait lists have since stabilised.

And the following chart shows that the ESPI 2 'breaches' (defined as those patients who had to wait longer than the Ministry target of 120 days) has started to drop, following a peak during this calendar year in April. The number of ESPI 2 breaches was 1,815 in the first week of June and this had decreased by 240 to 1,575 by the end of July. Whilst we have made good progress in some services, we are facing risks in other services which will be explained further into the report.



ESPI 2 Breaches by Speciality and Directorate

The following table breaks our breaches down by speciality to highlight the key areas of ESPI non-compliance. It also splits the breaches by directorate and demonstrates that specialties with the largest number of breaches are primarily in the surgical and radiology directorate.

Our ESPI 2 performance is improving in the key specialties of orthopaedics, general surgery, ENT and obstetrics and gynaecology in Dunedin. However, these specialities in Southland account for a relatively large proportion of our overall breaches (e.g., circa 230 for orthopaedics Southland, circa 100 for general surgery in Southland, circa 350 for ENT in Southland and circa 120 for obstetrics and gynaecology in Southland). I.e., circa 50% of our overall breaches are in these Southland services.

ESPI 2 performance is increasingly becoming disproportionately a Southland issue due to various issues primarily related to staffing gaps. This will be covered in more detail further in the report.

For the next HAC report we have asked for this report to be split out to show the Dunedin share compared to the Southland share of the total breaches to further highlight this issue.

All specialities

Neurosurgery	83	5%
Orthopaedics	368	23%
Haematology	14	1%
Gynaecology	159	10%
Vascular	60	4%
Cardiology	55	3%
Urology	4	0%
ENT	382	24%
Plastics	50	3%
Respiratory	14	1%
General Surgery	169	11%
Dermatology	24	2%
Renal Medicine	2	0%
Neurology	34	2%
Ophthalmology	55	3%
General Medicine	5	0%
Rheumatology	61	4%
Diabetes	4	0%
Endocrinology	25	2%
Gastroenterology	10	1%
Oncology	0	0%
Paed Medicine	1	0%
Paed Surgery	0	0%
Radiation Oncology	0	0%
Anaesthesia	0	0%
Total	**1579**	

Surgery

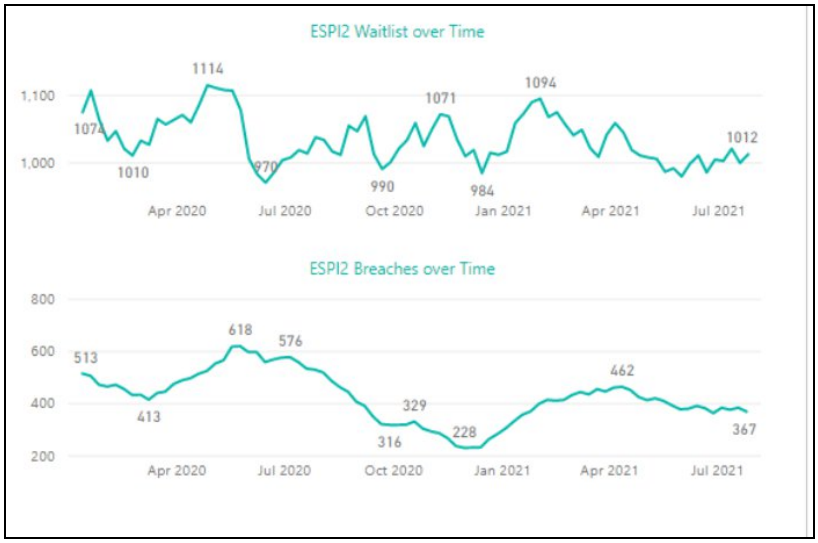
Neurosurgery	83
Orthopaedics	368
Vascular	60
ENT	382
Plastics	50
General Surgery	169
Urology	4
Ophthalmology	55
Paed Surgery	0
Anaesthesia	0
Breach share	**74%**

Medicine

Haematology	14
Gynaecology	159
Cardiology	55
Respiratory	14
Dermatology	24
Renal Medicine	2
Neurology	34
Diabetes	4
Rheumatology	61
General Medicine	5
Endocrinology	25
Gastroenterology	10
Oncology	0
Paed Medicine	1
Radiation Oncolog	0
Breach share	**26%**

Orthopaedic Outpatient Waitlist and ESPI 2 Breaches

The following chart shows how the orthopaedic wait list and ESPI 2 breaches have tracked over time. Good progress has been made with overall breach numbers since coming out of lock down last year and since volumes spiked earlier in this calendar year. The approximate split between Dunedin and Southland is 138 in Dunedin and 230 in Southland. The prioritisation tool is well established in Dunedin and has been a key tool that has enabled us to bring the number of breaches down in this service over time. We are continuing to use this tool to help manage the demands on the service. We do not use this tool in Southland. Due to long-term capacity challenges in the service (including long term vacancies in key orthopaedic surgery roles), the service has applied tight acceptance criteria for some time.



Gynaecology Outpatient Waitlist and ESPI 2 Breaches

Recently, the service has run weekend clinics and this has helped to improve ESPI 2 performance for July as indicated on the following charts.

As noted earlier, the main challenges that we have are in the Southland service. The Southland service has regular Senior Medical Officer staffing (SMO) of 5.8 FTE. However, we have had regular gaps in this service for some time (maternity leave and vacancies). The service has used locums whenever it has been able to find them but this has been insufficient to consistently provide the capacity required. We also provided an additional locum to the service as part of recovery after the last COVID lockdown but as this hasn't been sufficient to consistently lift us above establishment capacity, we have still had an underlying capacity issue that we haven't been able to fully address.

Our challenges are now amplified as one of our SMO must return overseas for a period of time and combined with our other vacancies we will be down to as little as 1.8 FTE in a team that has an establishment FTE of 5.2. A number of vacancies have now been recruited into but these new recruits won't start until later this calendar year / early in the New Year.

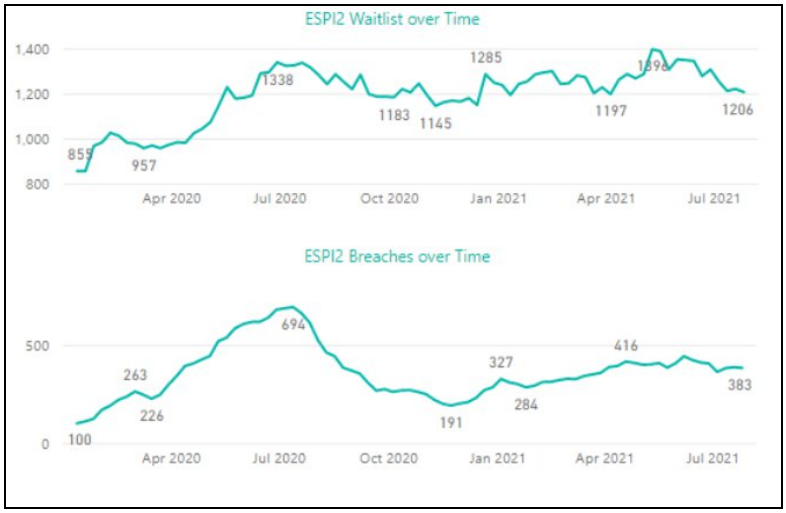
The General Manager for Medicine, Women and Children is working on a plan to minimise the risks for the Southland service in the coming months. The plan involves utilising all available locum

capacity we can find, working with the Dunedin service to determine whether there are opportunities to move the boundaries / provide care for patients in Dunedin who would normally receive care at Southland hospital and reviewing the data collected during the trial of the prioritisation tool with the clinicians in the service to determine if the rate at which referrals are accepted can be safely reduced during the next 4 months whilst we are dealing with the capacity risks noted above.

Based on recent successful recruitment the capacity in the service will improve from early next year and we will also review the underlying demands on the service using the data collected from using the prioritisation tool to determine if further SMO (and associated roles) are required to match the demands place on this service but the next 4-6 months will be very challenging and the GM will be managing the situation carefully.

ENT Outpatient Waitlist and ESPI 2 Breaches

ENT remains a challenge with only a small decrease in the waitlist and number of breaches. As noted previously the key challenge is in Southland, as Dunedin is within 20 first specialist assessment (FSA) of achieving compliance whilst Southland has between 350 and 363 ESPI 2 breaches. As noted previously the Southland service has carried vacancies for some time, but the first of 2 new SMO have now started in Southland under the supervision (as required by the Medical Council) of our Dunedin SMO. The two service managers are working together to determine how best to utilise Dunedin capacity to support Southland. The EDSS has asked the GM Surgery and Radiology to organise a further meeting with the SMO who triage referrals for the district to discuss implementation of the prioritisation tool for Southland referrals to safely reduce the number of routine referrals received until the existing backlog has been systematically caught up.



Inpatient Performance ESPI 5

The inpatient wait list has grown since the start of the calendar year, partly due to high volumes experienced at the start of the calendar year but also due to the challenges we had gaining access to inpatient beds earlier this year, particularly for orthopaedic surgery. The total wait list now appears to be stabilising. ESPI 5 breaches (where patients had to wait longer than 120 days for their inpatient surgery once they were confirmed for surgery) reduced slightly from June to July which was pleasing.

However, we do have ongoing access issues to theatre for elective surgery, particularly in Southland. We are managing this as carefully as possible but are unable to provide the same rate of elective surgery there has historically been able to for the reasons noted earlier. This, combined with anticipated productivity losses from the COVID lockdown and possible nursing strikes in the future, does mean that we now need to turn our attention to completing higher volumes of outsourcing alongside our internal delivery but this is also limited, as outsource providers don't usually accept the more complex surgeries and we have pulled high number of our less complex surgeries from our wait lists in the last few months as many of these can be done as day cases which has meant we could keep our theatres operating when we would otherwise be constrained due to the ability to staff our inpatient beds.

ESPI 5 breaches by speciality

Seventy-three percent of our breaches are in three specialties highlighted in red, below.

Surgery		
Neurosurgery	21	1%
Orthopaedics	754	43%
Vascular	59	3%
ENT	365	21%
Plastics	72	4%
General Surgery	166	9%
Gynaecology	33	2%
Urology	49	3%
Paediatric Surgery	24	1%
Dental Surgery	49	3%
Ophthalmology	172	10%
Cardiothoracic	4	0%
Max Fax	2	0%
Total	**1770**	

Orthopaedic ESPI 5 Breaches

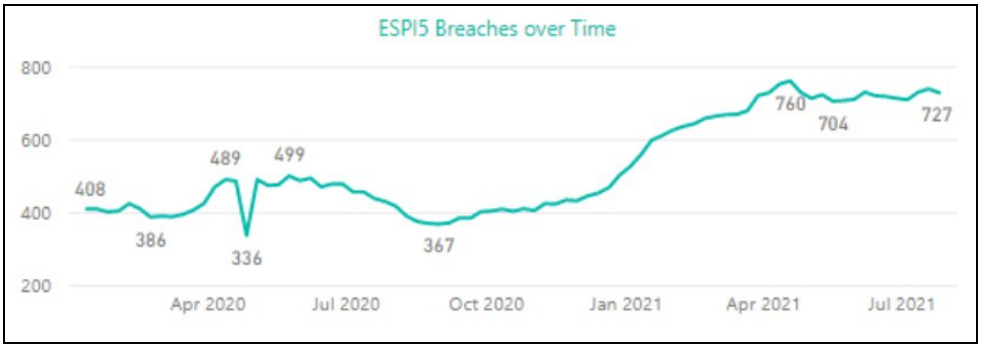
The large number of breaches in the orthopaedics service reflects the impact of high demand, the nursing crisis which led to bed closures earlier in the calendar year and the impact of high acute demand (also earlier in the calendar year). The Timaru hospital initiative has led to 3 orthopaedic

patients per week receiving their operation at Timaru hospital and we are looking to continue that initiative throughout 2021/22.

On the 10th of August an Orthopaedic recovery planning workshop was led by the General Manager of Surgery Radiology and include surgeons, manager, nursing and allied health staff. Although the opportunity to complete more internal orthopaedic surgery was discussed in detail, the limitations in our current environment mean that there appear to be few 'quick wins' internally that will lead to more elective orthopaedic surgery.

We will progress the ideas that came out of the workshop but the workshop has highlighted to us the importance of outsourced surgery in order to meaningfully reduce the long waits on our orthopaedic wait lists. As noted earlier, surgeons are often uncomfortable agreeing to do more complex cases as outsourced cases (known as 'ASA 3' and 'ASA 4' cases). However, we do need to get more of the complex surgery done in order to reduce the long waits on our wait list. We will re-engage with Southern Cross on the possibility of completing more of this complex surgery both in Christchurch (if we are successful in re-engaging and gaining agreement to get some of our outsourced work completed there), and at Queenstown when they open their new private hospital there later this year / early next year. We will also review how our patients are currently classified, as there may be a number of patients who are on the boundary of 'ASA 2' and 'ASA 3' who, with agreement could be completed as 'ASA 2' cases in private.

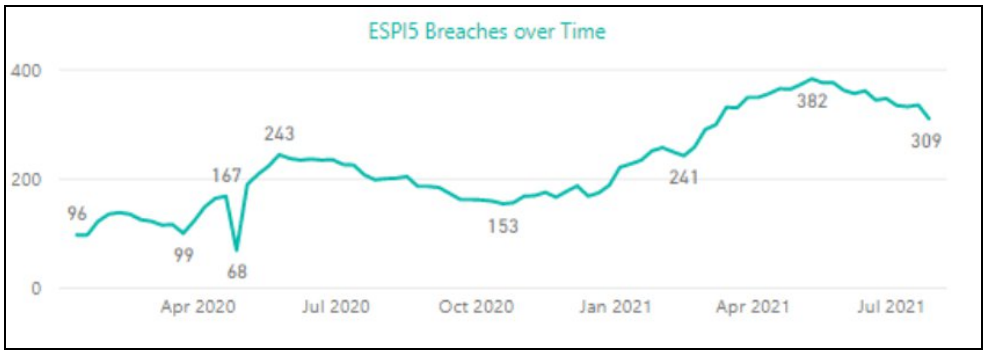
We will also continue to look for opportunities to complete more elective orthopaedic surgery as outplaced activity (outplaced activity involves paying the private hospital for the theatre and the inpatient recovery and implant costs, but providing our own surgeon, anaesthesia and perioperative staff). Completing more under this arrangement would come at a lower cost than outsourced surgery and would provide more certainty that we can complete our theatre lists without cancellations due to the inability to supply inpatient beds in turn due to staffing gaps or acute pressures.



ENT ESPI 5 Breaches

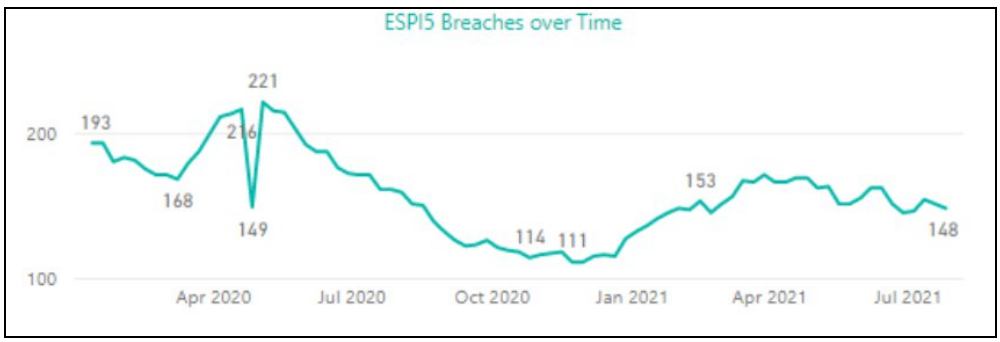
Although there has been a slight decrease in July the ENT breaches are now higher than they have been historically. An initiative which will reduce the number of breaches is the completion of procedures that can be undertaken by a GP with a special interest (GPSI) in a GP setting. In partnership with our Planning and 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 continuing to review the waiting list to see what can be re-directed to primary care.

The overall waiting list for ENT surgery has been steadily increasing since August 2020. The service has been carrying vacancies in Southland and staff from Dunedin are making regular trips to conduct surgery and clinics. The addition of a new surgeon in Southland has helped the service but they require supervision until passing the medical council requirements to operate independently. Another surgeon will arrive over the next couple of months but will face the same restrictions on their practice. For the next six months, until the service is fully staffed on both sites, the service is working through raising the entry score for surgery. The effects of raising the score, and to what level, are currently being discussed with the clinical leaders and the Ministry of Health (MOH). However, this should result in a noticeable decrease in patients being added to the list and along with other initiatives should put the service in a much better position going into 2022.



General Surgery ESPI 5 Breaches

As noted in our previous report we now believe we are on top of our more urgent cases (high volumes of urgent cancer cases were received by the service late last calendar year / early in the current calendar year and were subsequently prioritised and completed). 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. This may be disrupted by our latest COVID lockdown although we are continuing to operate on urgent cases during the lockdown, if cases aren't being diagnosed at the same rate as they usually would be during lock-down we are likely to have another wave of priority cancer cases to deal with once lockdown ends.



4. Emergency Departments

Per the following table, demand on our emergency departments increased in July compared to the calendar year to date, consistent with us moving into winter. The average daily presentations were up more markedly in Dunedin (132 compared to a year to date average of 126) than in Southland (110 compared to a year to date average of 108).

July 2021	Admitted	Non Admit	Admit %	Presentations	Avg Daily
Southland	747	2,669	21.9%	3,416	110
Dunedin	1,167	2,939	28.4%	4,106	132
Calender YTD July 2021	**Admitted**	**Non Admit**	**Admit %**	**Presentations**	**Avg Daily**
Southland	4,746	18,245	20.6%	22,991	108
Dunedin	7,404	13,768	27.1%	27,320	126

A number of days of extreme pressure have been reported and we have seen these translate into access pressure for inpatient beds, and the hospitals changing status from green to yellow to orange (with a couple of brief periods of red). The resulting pressure has been particularly felt by the Operations team who have then instituted actions to increase discharging and enable the flow into inpatient beds to resume.

Per the following table, both the total presentations and the volumes in the highest triage categories (1 and 2) have increased markedly at Dunedin hospital, though this is not the case for Southland hospital where total volumes have marginally increased whilst the triage 1 and 2 categories have decreased slightly.

In Dunedin, as well as the high volumes we have also had reports of roster gaps which have been unable to be filled either due to increased rates of illness or vacancies. This has contributed to the

Dunedin Emergency Department receiving a 'performance improvement notice' (PIN notice). We understand this to be a challenge nationally, with 12 notices issued to ED departments across the country. We have met with the Dunedin health and safety representatives and have agreed on some immediate actions. A key action is to undertake a benchmarking exercise of both our Emergency Departments so that we can get a true sense of whether there are obvious resourcing issues (excluding the vacancies which we are working hard to fill) when compared to other hospitals.

In Southland, winter pressures have been further exacerbated by the need to review and treat 2 COVID positive patients from the Mattina which was docked in Bluff in July. Ultimately, these patients were reviewed outside of the Emergency Department and then subsequently admitted directly into the inpatient medical ward. The need to admit these patients has highlighted that significant investment is required to ensure we have suitable negative pressure rooms with functional anti-chambers in Southland hospital.

Performance against the 95% target for July averaged circa 71% in Dunedin and circa 82% in Southland. We understand performance to be in the region of 82% on average nationally.

As noted previously, the key initiative that will improve flow in Dunedin and de-congest the Emergency Department is the implementation of generalism combined with the opening of the medical assessment unit build proximate to the Emergency Department. Agreement has been reached with respiratory, rheumatology, neurology, gastroenterology and cardiology about which patients will be admitted under the Generalist team. Two of the three Generalist roles being recruited to are still expected to arrive in August. Once these roles are in place, we will commence regular reporting on the impact these roles are having on the management of internal medicine admissions. Progress has been made recently with the decanting of the Fraser Building which will be required for the services and the physiotherapy gym to move so that demolition of the future medical assessment space can commence, prior to construction. A lease has been signed so that the mental health services currently occupying some of this space can move, and a location at Wakari has been confirmed for another of the services occupying the current space. The majority of movements scheduled for late September are currently on track. We have also had to notify two current users of the Fraser Building gymnasiums that the space will be unavailable during the demolition and building work. These are the Phoenix Club and the Asthma Society. We have met with the Phoenix Club and we believe that we have found a solution for them which involves access to the existing staff gym and the existing physiotherapy gym (prior to its demolition) as a back-up. We have also asked to meet with the Asthma Society to discuss options for them as well, but this has been held up by the COVID lockdown. We will aim to meet with them as soon as possible.

We have completed a full draft of the business case to expand the Southland Emergency Department (providing fit for purpose spaces and a small number of additional Emergency Department beds). This was presented to the ELT with the outcome being that the second option (the preferred option) was requested to be re-worked to reduce the capital cost. We have established capital parameters to work to and have been back to our Emergency Department clinical colleagues to identify a new preferred option, using these constraints. This has been worked on by the clinical team and the building and property team over the last two weeks. We anticipate landing on a re-worked preferred option in the coming days and we will then finalise the business case and put it into the Board papers. The preferred option involves expanding the emergency department outside of the existing hospital footprint. A key advantage of this option is that it is not dependent on decanting and rebuilding existing services and it will thus be able to be constructed more quickly than the other option in the case.

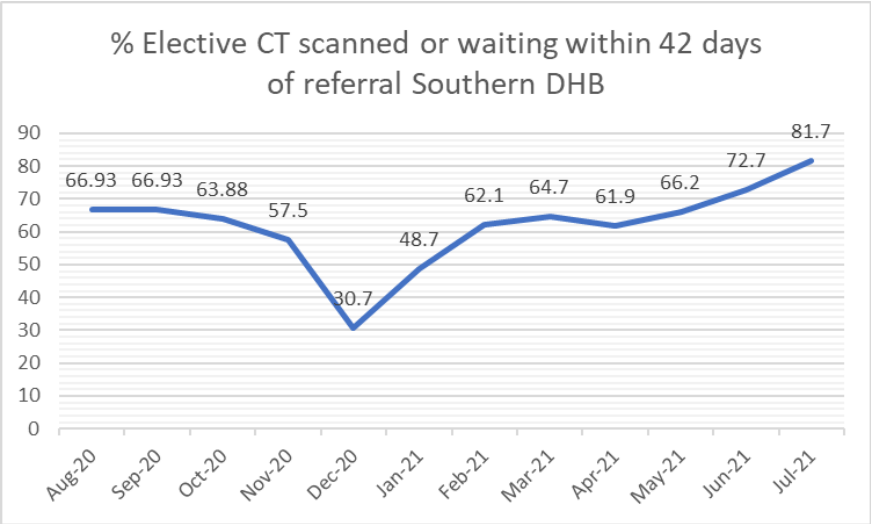
5. Radiology

The service continues to work with their information technology colleagues to get regular reports into production. In the meantime, the service manager has manually compiled the results and then performed the necessary calculations to determine the performance of each modality.

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

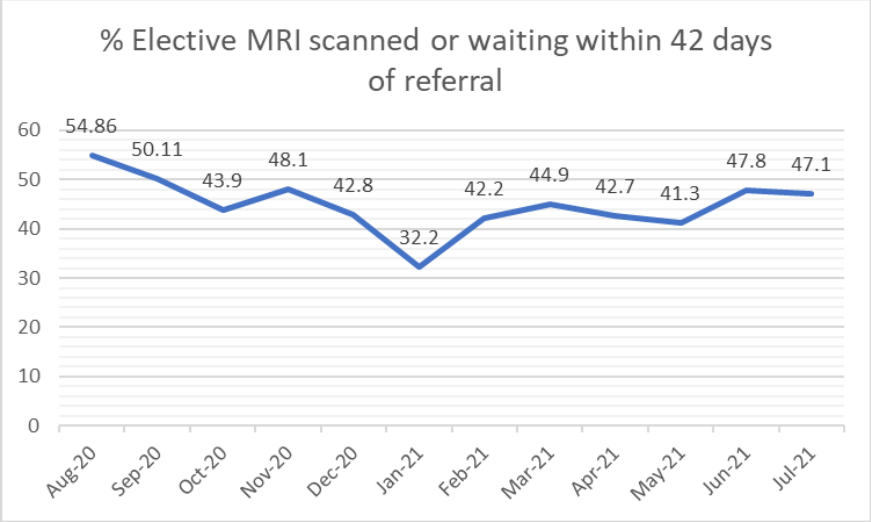
CT performance was up on both sites (Southland, 97.3%, Dunedin 69%). This appears to be both a consequence of reduced demand combined with good use of internal capacity, which has been well staffed. The overall result of 81.7% is the highest result achieve for some time on this modality.

The most recent update on the arrival of the second CT is that it has arrived in the country and we are now expecting to have the machine installed and commissioned in late September (noting that there are risks to this timeline associated with the COVID lockdown). The additional capacity provided by the second CT in Dunedin should set us up well for progressively working towards achieving the Ministry target in the coming months.



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

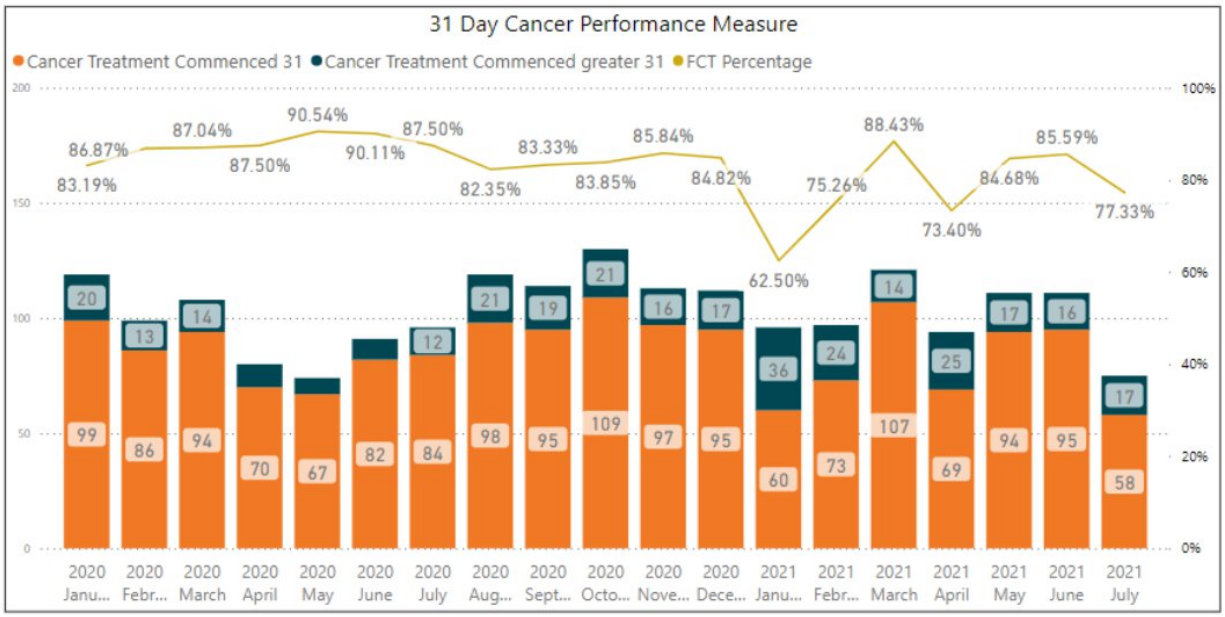
July MRI performance was 70.8% in Southland and 39% in Dunedin for an overall result of 47.1%. This again highlights that SDHB will benefit from the implementation of the second MRI in Dunedin and the capital request will be raised for the second machine as soon as the procurement process has been concluded. Discussions have been initiated with our Building and Property colleagues to get the building works underway as soon as possible, so that, in a similar manner to the CT machine the works are completed in parallel with the relatively long lead in time to get the machine into the country so that, where possible, the critical path is the lead in time for the machine to arrive, rather than the building work.



6. Oncology

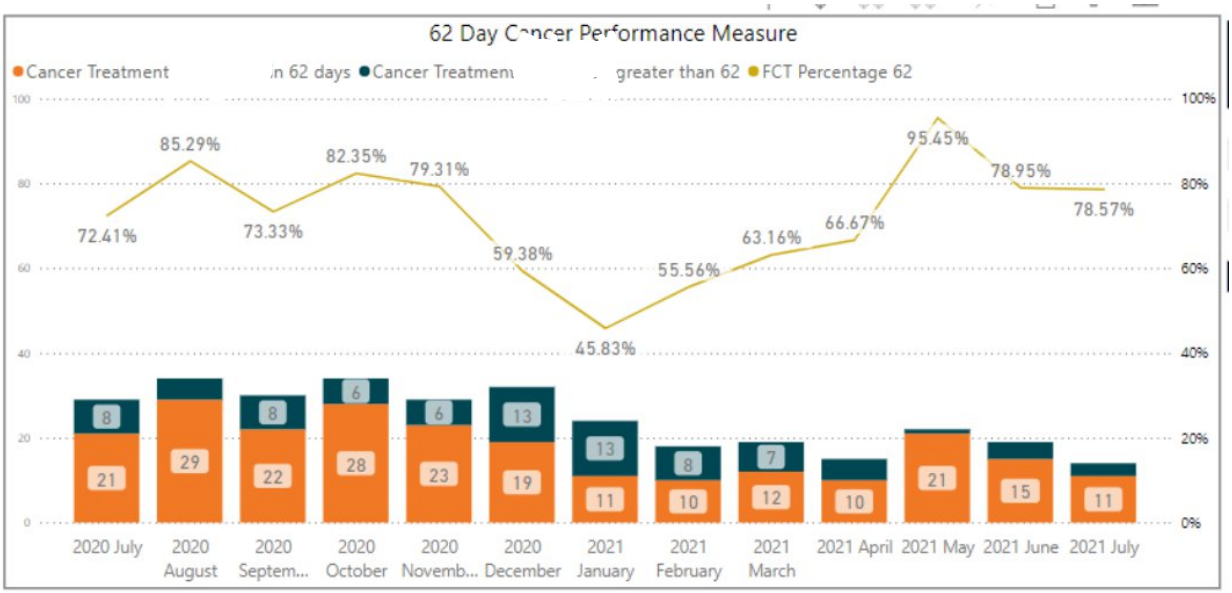
31 day performance

31 day performance measures the time from the decision to treat until the first treatment has been completed. For the last quarter of the last financial year, performance averaged 82.53%, which is close to the target of 85%. The month by month performance is shown in the following chart.



62 day performance

62 day performance reflects the time taken between receipt of the referral and first treatment. As previously noted, our reported performance against this measure has been low relative to the other DHBs. However, we have now added an additional resource into the reporting team and we have instituted two monthly meetings. In the first of the monthly meetings we are identifying the patients who are likely to go over 62 days by the 20th of the month (when the cases get reported as 'breached'), and we are asking for explanations. This is allowing us to identify patients who have chosen to delay or who have an unusual or complex treatment path. In both cases we can code these as non-breaches. We are also looking at those patients who are at risk of genuinely breaching to determine what actions can be taken to prevent a breach. And where a breach is inevitable, we are maintaining a log of the breach reasons which will enable us to consider process improvements which will improve our services in the longer term. Although we were only recently started these improvements, our reporting for the overall quarter has lifted. Our March year to date result was 71%, but our quarter ended June 30th averaged at 80.4%. We will continue to apply this rigor going forward and we anticipate further improvement in these results.



We are continuing to work on the three oncology services. As we provide a weekly update to the Board, we will provide a key summary of progress in this (HAC) report rather than detailing all of the work that is occurring, as follows:

- The radiation oncology wait list is now down to 108, compared to 160 several months ago. The movement has been achieved by being able to consistently lift the rate of outsourcing to St Georges in Christchurch, using Ikon in Wellington as an additional provider more recently, and through two of our own Radiation Oncology completing extra paid clinics for us in weekends. Our ability to continue to make progress may be challenged during the COVID lockdown as we will lack the ability to send new patients to the outsource providers. However, we are managing performance carefully on a weekly basis.

- The medical oncology wait list has remained static at circa 60 – 70. Although this wait list hasn't seen the increases, we saw in radiation oncology (prior to the successful establishment

of regular outsourcing) we are concerned about the impending departure of a locum medical oncologist. We have put a call out to our colleague DHBs asking whether they may have medical oncologists looking for locum work and we have asked our recruitment partners, HainesAttract to prioritise these roles (both locum and permanent) in our recruitment campaign. We have recently put a job offer out for a permanent Senior Medical Officer (SMO) and we have another SMO who is looking like we will be able to put an offer out to them, as well (found via the HainesAttract campaign). If successful with both, we will have a good level of capacity in the service from early next year, but we do need to land on a solution to put additional temporary capacity in over the coming months.

- The haematology wait list has also remained static at circa 60 – 70 with most of the waits in the low risk / low acuity category. We believe we have found a solution that will increase this services' capacity for new appointments by up to 30% per week. The solution involves using clinical nurse specialists to see other types of outpatient appointments and providing capacity for the SMOs to see more 'new' patients. We are now in the process of implementing this solution.

In addition to the above, we have gone 'live' with the HainesAttract recruitment campaign and will monitor it on a monthly basis. And we have verbally committed to the benchmarking exercise which Ernst & Young will complete for us. This will identify what our staffing levels are in all three of our oncology services and how these compare to the other cancer centres. This will enable us to propose additional investment to close any obvious gaps with the intention of ensuring that our first step in addressing resourcing challenges in the services is to ensure that we have comparable staffing levels to our peers.

7. Endoscopy

The 'real-time' wait list and the 'maximum wait time' reports below were run on the 4th of August and reflect performance as at that date. The other reports reflect performance at the end of July.

Overall, the real time wait list reflects that, on average, symptomatic urgent and non-urgent patients are being seen well within target / clinically indicated timeframes (14 and 42 days), but that the average wait for surveillance patients is still relatively high, reflecting our ongoing efforts to catch up on the non-symptomatic (surveillance) backlog in Southland.

Real time waitlist - combined

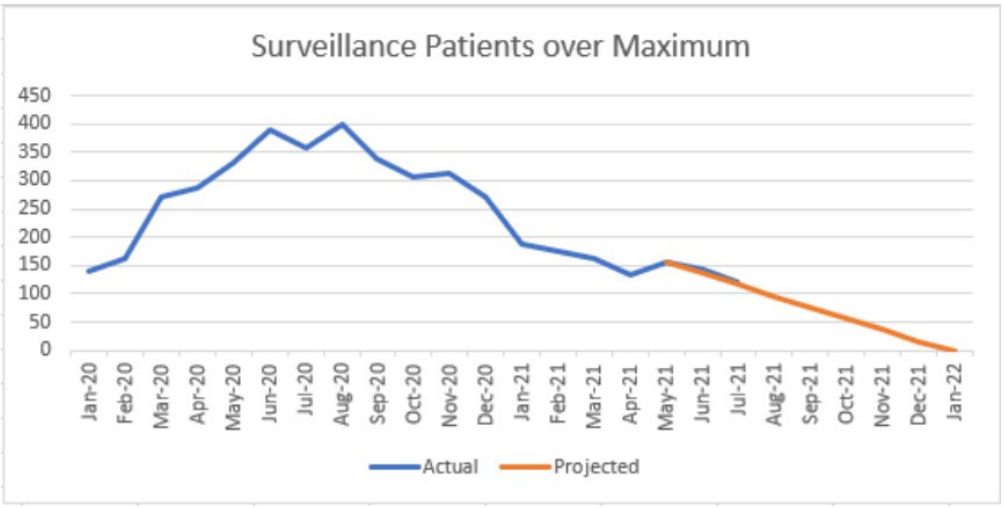
Priority new	No of Waiting Patients	Average waiting time	Median Wait time	Longest Wait
Diag Urgent	9	6.67	6.00	12
Diag Non-Urgent	149	29.80	24.00	137
Diag Planned and Staged	11	72.09	48.00	139
NBSP	41	12.41	11.00	34
SURV	418	73.67	58.00	300

Per the following table, the number of surveillance patients waiting over the maximum timeframe (120 days past due date) is declining and the service advises that they continue to be on target to reduce this to zero by January 2022. However, this plan may end up having to extend as a consequence of the latest L4 lockdown.

Maximum Wait time Breach

Hospital	Urg >30	Non urg >90	SURV >120	NBSP > 45
Dunedin		3	7	
Southland		1	93	
Total		**4**	**100**	

This problem is almost exclusively in Southland and surveliance colonoscopies are being prioritised over other endoscopic interventions, all lists are being filled where possible, patients are being sent to Dunedin where appropriate and weekend lists are also being undertaken. Per the following chart there has been good progress on reducing the backlog.



Per the following table the urgent 14 day target was missed in July with a result of 87% against a target of 90% and 67% against a target of 70% respectively. The urgent category involved a very small number of patients and patient factors (rather than flow) was the key reason for delay. The non-urgent category was slightly impacted by the prioritisation of long waiting surveillance scopes for 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
31 December 2020	92.86%	2.86%	91.34%	21.34%	98.68%	3.68%
31 March 2021	94.23%	4.23%	89.58%	19.58%	97.96%	2.96%
30 June 2021	84.00%	-6.00%	85.96%	15.96%	98.82%	3.82%
28 February 2021	88.89%	-1.11%	85.06%	15.06%	100.00%	5.00%
31 October 2020	92.59%	2.59%	84.87%	14.87%	96.63%	1.63%
30 September 2020	89.80%	-0.20%	82.79%	12.79%	97.25%	2.25%
31 May 2021	90.20%	0.20%	82.37%	12.37%	98.98%	3.98%
30 April 2021	92.68%	2.68%	80.68%	10.68%	96.91%	1.91%
30 November 2020	100.00%	10.00%	79.93%	9.93%	100.00%	5.00%
31 January 2021	79.49%	-10.51%	75.38%	5.38%	98.46%	3.46%
31 August 2020	85.71%	-4.29%	74.52%	4.52%	97.25%	2.25%
31 July 2020	91.23%	1.23%	68.95%	-1.05%	97.78%	2.78%
31 July 2021	86.67%	-3.33%	67.42%	-2.58%	100.00%	5.00%

Per the following chart, the non-urgent category deteriorated most in Southland, as a consequence of responding to a Ministry of Health request to prioritise surveillance patients waiting over their maximum waiting time within available capacity. The re-classification of 'planned and staged' onto the non-urgent wait list (as this category is being phased out and is now down to 4 patients) is also likely to have contributed to the performance change in the non-urgent category.

Region	Dunedin						Southland					
End of Month	Diag Urgent 14 days (90%)	Var Urgent	Non Urgent 42 days (70%)	Var Non Urgent	NBSP 45 Days (95%)	NBSP Var	Diag Urgent 14 days (90%)	Var Urgent	Non Urgent 42 days (70%)	Var Non Urgent	NBSP 45 Days (95%)	NBSP Var
31 July 2020	97.22%	7.22%	80.84%	10.84%	100.00%	5.00%	80.95%	-9.05%	54.68%	-15.32%	93.10%	-1.90%
31 August 2020	85.71%	-4.29%	75.78%	5.78%	97.22%	2.22%	85.71%	-4.29%	72.55%	2.55%	97.30%	2.30%
30 September 2020	87.10%	-2.90%	83.42%	13.42%	98.63%	3.63%	94.44%	4.44%	81.82%	11.82%	94.44%	-0.56%
31 October 2020	94.59%	4.59%	83.33%	13.33%	96.49%	1.49%	88.24%	-1.76%	88.12%	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%	90.34%	20.34%	98.11%	3.11%	83.33%	-6.67%	93.59%	23.59%	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%	77.22%	7.22%	100.00%	5.00%
31 March 2021	93.33%	3.33%	93.79%	23.79%	98.55%	3.55%	95.45%	5.45%	82.65%	12.65%	96.55%	1.55%
30 April 2021	88.89%	-1.11%	83.01%	13.01%	96.77%	1.77%	100.00%	10.00%	77.68%	7.68%	97.14%	2.14%
31 May 2021	87.80%	-2.20%	80.85%	10.85%	98.39%	3.39%	100.00%	10.00%	84.40%	14.40%	100.00%	5.00%
30 June 2021	81.58%	-8.42%	87.41%	17.41%	100.00%	5.00%	91.67%	1.67%	83.70%	13.70%	96.88%	1.88%
31 July 2021	77.14%	-12.86%	78.70%	8.70%	100.00%	5.00%	100.00%	10.00%	50.00%	-20.00%	100.00%	5.00%

Per the following chart session utilisation is good in Dunedin, and there is additional room capacity available but this is not currently resourced. Recruiting additional nurses within the 2021/22 budget will lead to increased room utilisation.

There is additional room capacity in Southland but more resource would be required to utilise it.

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%	78.98%	77	2751	52.10%	63.68%	24.92%	171	7221	71.64%	103.75%	65.41%
November	191	7737	70.08%	76.76%	80.59%	160	5747	70.43%	72.56%	59.86%	194	7454	67.52%	100.19%	77.65%
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	**1383**	**54160**	**73.27%**	**116.32%**	**73.75%**	**784**	**28675**	**64.93%**	**96.35%**	**39.05%**	**1308**	**49776**	**66.47%**	**142.05%**	**67.78%**
January	173	6814	70.98%	78.87%	64.53%	137	4825	71.80%	77.32%	45.69%	158	5835	63.98%	90.05%	55.26%
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%	79.12%	112	4110	61.16%	63.43%	38.92%	203	7830	67.97%	98.86%	74.15%
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%
June	196	7584	75.24%	0.00%	71.82%	96	3501	66.31%	0.00%	33.15%	198	7551	62.93%	0.00%	71.51%
July	206	7802	70.67%	0.00%	70.67%	118	4192	58.22%	0.00%	37.97%	218	8179	68.16%	0.00%	74.09%
August	5	235	48.96%	0.00%	48.96%	7	265	55.21%	0.00%	55.21%	6	205	42.71%	0.00%	42.71%
Total	**2630**	**103211**	**75.18%**	**97.74%**	**75.45%**	**1460**	**52943**	**65.27%**	**83.56%**	**38.70%**	**2397**	**92347**	**66.57%**	**118.03%**	**67.51%**

Notes

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

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

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

8. Caseweight, Discharges and Volumes

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,518	**989 Actual YTD vs 1,093 Plan YTD, as at July 2021**

Note the above discharges exclude improvement action plan volumes.

FOR INFORMATION

Item: Financial Report for the period ended 31 July 2021

Proposed by: Grant Paris, Management Accountant

Presented by: Patrick Ng, Executive Director of Specialist Services

Meeting of: 06 September 2021

Recommendation

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

Purpose

1. To provide the Hospital Advisory Committee with the financial performance for the month and year to date ended 31 July 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: **July 2021**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **23 August 2021**

Overview

Results Summary for Specialist Services

1. July 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
46,843	47,369	(526)	Revenue	46,843	47,369	(526)	568,129
24,667	24,991	324	Less Workforce Costs	24,667	24,991	324	313,696
12,791	13,199	408	Less Other Costs	12,791	13,199	408	153,118
9,385	**9,179**	**206**	**Net Surplus / (Deficit)**	**9,385**	**9,179**	**206**	**101,315**

For July 2021, Specialist Service had a contribution to non-clinical and overhead costs of $9.4m, which is $0.2m favourable to budget.

2. Surgical Performance – Case Weights and Discharges

Provider Activity View

Planned Care refers to the Government funding for specific purchase units to deliver healthcare services to our population. This view represents the specific purchase units against which the Planned Care is measured. The Ministry of Health determines planned Care targets annually.

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 inter district flow (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.

This total elective caseweights delivered in this report can be reconciled to the service provider case weight report in the HAC Publilc report as follows:

Elective case weights excluding maternity actuals for July:	1,745
Minus: elective medical case weights actuals for July:	-399
Add: medical case weights which count for elective plan (from HAC report) for July:	+117
Equals: total elective case weight actuals delivered against plan for July	1,464
Elective case weights excluding maternity plan for July:	1,723

Appendix 1: Financial Report for the Hospital Advisory Committee

Minus: elective medical case weights plan for July	-301
Add: medical case weights which count for elective plan (from HAC report) for July	+105
Equals: total elective case weight plan for July:	1,527

On this basis we delivered 64 case weights (CWD) less than the elective plan for the month of July.

Jul-21				Jul-20	YEAR ON YEAR		YTD 2021/22				YTD Jul-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,599	1,503	96	6%	1,579	20	Acute	1,599	1,503	96	6%	1,579	20
1,026	*990*	*36*	*4%*	1,051	(25)	Otago	*1,026*	990	36	4%	1,051	(25)
573	*513*	*60*	*12%*	528	45	Southland	*573*	513	60	12%	528	45
399	301	98	33%	372	27	Elective	399	301	98	33%	372	27
355	264	91	34%	332	23	Otago	*355*	264	91	34%	332	23
44	37	7	19%	40	4	Southland	*44*	37	7	19%	40	4
1,998	1,804	194	11%	1,951	47	Total Medical Caseweights	1,998	1,804	194	11%	1,951	47
						Surgical Caseweights						
1,188	1,196	(8)	-1%	1,142	46	Acute	1,188	1,196	(8)	-1%	1,142	46
802	827	(25)	-3%	829	(27)	Otago	*802*	827	(25)	-3%	829	(27)
386	369	17	5%	313	73	Southland	*386*	369	17	5%	313	73
1,346	1,422	(76)	-5%	1,655	(310)	Elective	1,346	1,422	(76)	-5%	1,655	(309)
1,015	1,032	(17)	-2%	1,217	(202)	Otago	*1,015*	1,032	(17)	-2%	1,217	(202)
331	390	(59)	-15%	438	(107)	Southland	*331*	390	(59)	-15%	438	(107)
2,534	2,618	(84)	-3%	2,797	(264)	Total Surgical Caseweights	2,535	2,618	(84)	-3%	2,797	(263)
						Maternity Caseweights						
129	93	36	39%	105	24	Acute	129	93	36	39%	105	24
102	68	34	50%	67	35	Otago	*102*	68	34	50%	67	35
27	25	2	8%	38	(11)	Southland	*27*	25	2	8%	38	(11)
349	371	(22)	-6%	409	(60)	Elective	349	371	(22)	-6%	409	(60)
223	222	1	0%	280	(57)	Otago	*223*	222	1	0%	280	(57)
126	149	(23)	-15%	129	(3)	Southland	*126*	149	(23)	-15%	129	(3)
478	464	14	3%	514	(36)	Total Maternity Caseweights	478	464	14	3%	514	(36)
						TOTALS						
2,916	2,792	124	4%	2,826	90	Acute	2,916	2,792	124	4%	2,826	88
1,930	1,885	45	2%	1,947	(17)	Otago	1,930	1,885	45	2%	1,947	(17)
986	907	79	9%	879	107	Southland	986	907	79	9%	879	107
2,094	2,094	0	0%	2,436	(343)	Elective	2,094	2,094	0	0%	2,436	(342)
1,593	1,518	75	5%	1,829	(236)	Otago	1,593	1,518	75	5%	1,829	(236)
501	576	(75)	-13%	607	(106)	Southland	501	576	(75)	-13%	607	(106)
5,010	4,886	124	3%	5,262	(253)	Total Caseweights	5,010	4,886	124	3%	5,262	(252)
						TOTALS excl. Maternity						
2,787	2,699	88	3%	2,721	66	Acute	2,787	2,699	88	3%	2,721	66
1,828	1,817	11	1%	1,880	(52)	Otago	1,828	1,817	11	1%	1,880	(52)
959	882	77	9%	841	118	Southland	959	882	77	9%	841	118
1,745	1,723	22	1%	2,027	(283)	Elective	1,745	1,723	22	1%	2,027	(282)
1,370	1,296	74	6%	1,549	(179)	Otago	1,370	1,296	74	6%	1,549	(179)
375	427	(52)	-12%	478	(103)	Southland	375	427	(52)	-12%	478	(103)
4,532	4,422	110	2%	4,748	(217)	Total Caseweights excl. Maternity	4,532	4,422	110	2%	4,748	(216)

Appendix 1: Financial Report for the Hospital Advisory Committee

SDHB Monthly HAC Statement of Financial Performance -July 2021

Monthly Actuals $000s	Monthly Budget $000s	Monthly Variance $000s	Monthly Variance FTE		Year to date Actuals $000s	Year to date Budget $000s	Year to date Variance $000s	Year to date Variance FTE	Annual Budget $000s
				REVENUE					
				Government & Crown Agency Sourced					
826	802	24		MoH Revenue	826	802	24		9,628
0	0	0		IDF Revenue	0	0	0		0
894	991	(97)		Other Government	894	991	(97)		11,590
1,720	**1,793**	**(73)**		**Total Government & Crown**	**1,720**	**1,793**	**(73)**		**21,218**
				Non Government & Crown Agency Revenue					
19.17649	165.586	(146)		Patient related	19	166	(146)		1,987
153.9849	177.856	(24)		Other Income	154	178	(24)		2,134
173	**343**	**(170)**		**Total Non Government**	**173**	**343**	**(170)**		**4,121**
44,950	45,232	(283)		Internal Revenue	44,950	45,232	(283)		542,790
46,843	**47,369**	**(526)**		**TOTAL REVENUE**	**46,843**	**47,369**	**(526)**		**568,129**
				EXPENSES					
				Workforce					
				Senior Medical Officers (SMO's)					
6,297	6,490	193	20	Direct	6,297	6,490	193	20	80,024
369	351	(18)		Indirect	369	351	(18)		4,207
239	156	(83)		Outsourced	239	156	(83)		1,696
6,905	**6,997**	**92**	**20**	**Total SMO's**	**6,905**	**6,997**	**92**	**20**	**85,927**
				Registrars / House Officers (RMOs)					
4,046	3,886	(161)	(7)	Direct	4,046	3,886	(161)	(7)	49,650
63	233	170		Indirect	63	233	170		2,796
0	30	30		Outsourced	0	30	30		331
4,109	**4,149**	**40**	**(7)**	**Total RMOs**	**4,109**	**4,149**	**40**	**(7)**	**52,777**
11,014	**11,146**	**132**	**13**	**Total Medical costs (incl outsourcing)**	**11,014**	**11,146**	**132**	**13**	**138,704**
				Nursing					
9,332	9,562	231	(7)	Direct	9,332	9,562	231	(7)	123,916
30	1	(29)		Indirect	30	1	(29)		12
(1)	3	4		Outsourced	(1)	3	4		37
9,360	**9,566**	**206**	**(7)**	**Total Nursing**	**9,360**	**9,566**	**206**	**(7)**	**123,965**
				Allied Health					
2,314	2,356	41	16	Direct	2,314	2,356	41	16	29,150
47	25	(21)		Indirect	47	25	(21)		472
135	46	(89)		Outsourced	135	46	(89)		544
2,496	**2,427**	**(69)**	**16**	**Total Allied Health**	**2,496**	**2,427**	**(69)**	**16**	**30,165**
				Support					
165	200	36	3	Direct	165	200	36	3	2,294
(6)	1	7		Indirect	(6)	1	7		11
0	0	0		Outsourced	0	0	0		(0)
159	**201**	**42**	**3**	**Total Support**	**159**	**201**	**42**	**3**	**2,306**
				Management / Admin					
1,633	1,636	3	(8)	Direct	1,633	1,636	3	(8)	18,386
1	9	8		Indirect	1	9	8		104
4	6	2		Outsourced	4	6	2		66
1,638	**1,650**	**12**	**(8)**	**Total Management / Admin**	**1,638**	**1,650**	**12**	**(8)**	**18,556**
24,667	**24,991**	**324**	**16**	**Total Workforce Expenses**	**24,667**	**24,991**	**324**	**16**	**313,696**
3,444	3,326	(118)		**Outsourced Clinical Services**	3,444	3,326	(118)		38,612
0	0	0		**Outsourced Corporate / Governance Services**	0	0	0		0
0	0	0		**Outsourced Funder Services**	0	0	0		0
7,658	8,082	424		**Clinical Supplies**	7,658	8,082	424		92,441
756	885	129		**Infrastructure & Non-Clinical Supplies**	756	885	129		10,314
				Non Operating Expenses					
932	906	(26)		Depreciation	932	906	(26)		11,750
0	0	0		Capital charge	0	0	0		0
0	0	0		Interest	0	0	0		0
12,791	**13,199**	**408**		**Total Non Personnel Expenses**	**12,791**	**13,199**	**408**		**153,118**
37,458	**38,190**	**732**		**TOTAL EXPENSES**	**37,458**	**38,190**	**732**		**466,814**
9,385	**9,179**	**206**		**Net Surplus / (Deficit)**	**9,385**	**9,179**	**206**		**101,315**

Appendix 1: Financial Report for the Hospital Advisory Committee

3. *Revenue*

Revenue was $0.53m unfavourable to budget in July due to;

1. Internal Revenue was $0.28m less than budget due to the under-delivery of Planned Care procedures.

2. Patient Related Revenue was $0.15m under budget due to virtually no revenue from ineligible patients being booked.

3. ACC revenue was lower than budget in High Tech Imaging and ACC elective surgery. The majority of this was due to revenue accrued for in June that has not eventuated.

4. *Workforce Costs*

Monthly result
Workforce costs (personnel plus outsourcing) were $0.32m favourable to budget in July 2021 with full time equivalent (FTE) 16 favourable to budget.

FTE
FTE is 16 under budget in July summarised in the following table. All staff types have either favourable variances (offset by increased outsourced personnel) or are close to budget.

Budgeted FTE increases to 2,557FTE by June 2022 an increase of 167FTE.

Staff Type	Actual FTE Jul21	Budget FTE Jul21	Monthly Variance	%	YE Budget FTE	
SMO	238	258	20	8%	264	
RMO	323	316	(7)	(2%)	336	
Nursing	1,212	1,205	(7)	(1%)	1,317	CCDM progressive increase
Allied	290	306	16	5%	325	
Support	35	38	3	8%	38	
Mgmt / Admin	277	268	(9)	(3%)	277	
	2,375	**2,390**	**16**	**1%**	**2,557**	

Senior Medical Officer (SMOs)

SMOs were $0.1m favourable and 20 FTE favourable for the month.

Direct payroll costs are $0.19m favourable in July reflecting the level of vacancies. This is partially offset by outsourced costs which are $0.1m unfavourable, due to outsourced vacancy cover in;

- Paediatrics
- Obstetrics and Gynaecology and
- Ear Nose and Throat

RMOs

RMOs were $0.04m favourable and 7 FTE unfavourable for the month.

Direct costs were $0.16m unfavourable in July, the largest single driver of this being overtime which was $0.1m over budget. The areas where this was of significance were;

- Dunedin RMO unit, General Surgery and Orthopaedics
- Southland Obstetrics and Gynaecology

Appendix 1: Financial Report for the Hospital Advisory Committee

Nursing

Nursing was $0.20m favourable and 7 FTE unfavourable in July

Nursing FTE

As expected, the gap between budgeted and actual FTE has become a lot closer in July with additional Nursing FTE being budgeted in the 21/22 financial year (Nursing 79FTE over budget last month). During the year as vacancies are filled, the trend is for negative variances to increase, however in 21/22 we have phased the additional CCDM resource into the budget over the 12 months. In July, an additional 14.7FTE were added to the budget for Care Capacity Demand Management (CCDM) increasing progressively to 95.7FTE by June 2022.

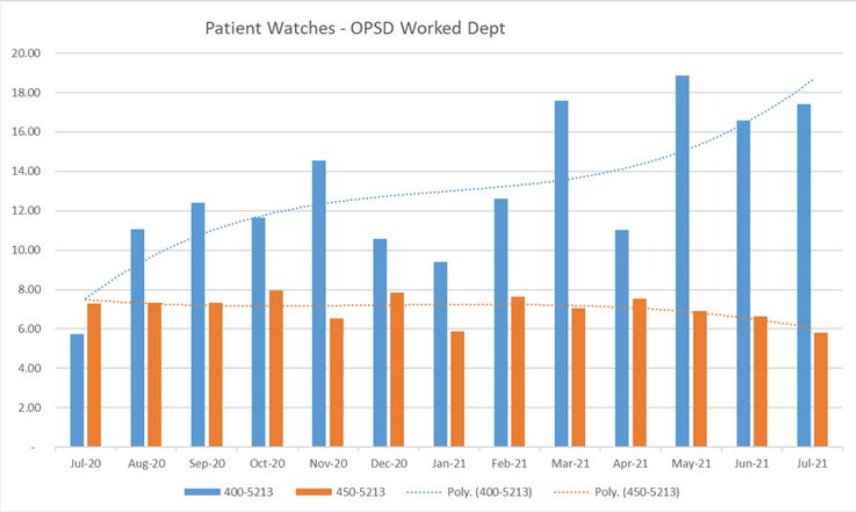
CCDM Allocation to cost centres

GL Code		GL Code Name	Sub	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
2210	Otago	Registered Nurses	40	3.80	16.10	28.29	32.29	41.99	45.19	46.19	54.39	55.79	57.59	59.29	59.29
2235	Otago	HCA	40	3.60	7.60	8.60	8.60	8.60	8.60	8.60	8.60	8.60	8.60	8.60	8.60
2210	Southland	Registered Nurses	40	7.34	7.34	11.84	14.74	16.32	17.32	17.32	21.22	21.22	21.22	21.22	21.22
2235	Southland	HCA	40	-	1.50	3.10	6.60	6.62	6.62	6.62	6.62	6.62	6.62	6.62	6.62
				14.74	**32.54**	**51.83**	**62.23**	**73.53**	**77.73**	**78.73**	**90.83**	**92.23**	**94.03**	**95.73**	**95.73**

As noted above however FTE is still over budget driven by;

- Unrealised savings for Valuing Patient Time (-22 FTE), Positive shifts (-10 FTE) offset partially by
- Ordinary time is 18FTE favourable to budget reflecting vacancies in areas such as the Critical Care Unit which continues to recruit to full staffing levels.
- Overtime continues over budget (14FTE as staff cover for vacant shifts).
- Sick leave also remains over budget by 11FTE in line with prior year trends.

Patient watches remain an area of focus with watch hours in Dunedin remaining high as per the graph below. The need for a patient watch is reviewed at each shift handover with an online log of all patient watches maintained that allows monitoring by managers. This includes the length of time the watch has been in place and the reason for the watch. To reduce cost where possible, patients are combined into rooms to allow one watch to be in place and family are asked if they can watch. (Note - a 100-day patient has been recently discharged who had a 16hr patient watch in place.)



Appendix 1: Financial Report for the Hospital Advisory Committee

Allied Health

Allied Health costs were $0.07m unfavourable and 16FTE favourable to budget in July.

The unfavourable dollar variance was driven by outsourcing required in the Dunedin Anaesthesia Service and Southland Perioperative to cover vacant roles.

The material FTE variances are shown below.

		Sum of Actual FTE	Sum of Budget FTE	Sum of Variance FTE	
Total Allied workforce EDSS		290.02	305.6	15.58	
Allied Health by service, variance <> 2 FTE					
SSRD	Radiology Service	89.40	103.61	14.21	Impact of MRT vacancies plus budget includes additional staff for second CT.
SSRD	Perioperative and ICU Dunedin Service	35.05	40.52	5.47	Vacancies - covered by outsourced
MWCD	Southern Blood and Cancer Service	43.07	46.97	3.90	
SSRD	Specialist Surgical Services Dunedin Service	10.82	13.82	3.00	Offset with Technicians (part of Model of care changes from 2019/20 yet to be implemented)
MWCD	Medical, Womens and Childrens Service	0.30	(5.05)	(5.35)	vacancy factor
SSRD	General Manager Surgical Services & Radiology Service	0.40	(8.91)	(9.31)	vacancy factor

Support

Support staff were $0.04m favourable and 3FTE favourable in July due to vacancies in sterile services at both sites.

Management and Administration

Management/Admin dollars were $0.01m favourable and 8FTE over budget in July.

The majority of the unfavourable FTE is driven by annual leave not taken and IMEDX savings yet to be realised.

- Leave - The majority of this staff type (with the exception of clinical related positions such as ward receptionists) are not budgeted to be covered when on annual leave. If annual leave taken is less than budgeted, this will result in higher costs and FTE recorded in the month, as the staff budgeted to be on annual leave will be working. Leave taken is 5FTE under budget in July resulting in increased Ordinary FTE compared to budget.

- IMEDX savings were budgeted as per the business case (approx. 3FTE). To date, these have not been realised.

Appendix 1: Financial Report for the Hospital Advisory Committee

5. *Outsourced Clinical Services Costs*

Outsourced services were $0.12m unfavourable in July driven by Outsourced Clinical Services as shown below.

Account	Actual $000's MTD	Budget $000's MTD	Variance $000's MTD
3615 - Outsourced Laboratory Service	1,492	1,492	(0)
3620 - Outsourced Laboratory Send away Tests	0	0	0
3630 - Outsourced Breast screening	99	116	17
3640 - Outsourced Radiology Service	152	167	14
3642 - Outsourced CT Scans	35	60	25
3646 - Outsourced Lithotripsy		6	6
3647 - Outsourced MRI Scans	27	34	7
3650 - Outsourced Other Radiology Procedures	33	36	3
3651 - Outsourced Audiology	26	2	(24)
3653 - Outsourced Ophthalmology	1	44	43
3665 - Outsourced Clinical Services - Surgical	788	758	(30)
3675 - Outsourced Vascular Assessments	104	77	(27)
3690 - Outsourced Clinical Services - Other	688	534	(154)
	3,444	**3,326**	**(118)**

The $0.15m variance in Outsourced Clinical Services is due to

1) Saving of $0.1m loaded as part of the budget saving initiative (full year impact $1m).

2) Outsourced charges in Southland relating to;

- Orthopaedics
- ENT and
- Ophthalmology

Appendix 1: Financial Report for the Hospital Advisory Committee

6. *Clinical Supplies (excluding depreciation)*

Clinical supplies were favourable to budget by $0.42m in July 2021, variances over $10k shown below:

Account Code	Actual $000's MTD	$000's MTD	Variance $000's MTD	Budget $ Annual Budget
4320 - Endoscopic Instruments	161	42	(118)	491
4955 - Air Ambulance	507	420	(87)	5,035
4290 - Diagnostic Supplies	136	76	(61)	906
4510 - Cardiac Implants	340	295	(45)	3,538
4050 - Bandages and Dressings	157	130	(27)	1,557
4515 - Cement and Glue	72	47	(25)	560
4536 - Other Joint Prostheses	23		(23)	
4035 - Continence and Hygiene	69	46	(23)	548
4140 - Procedure Packs	151	129	(22)	1,545
4010 - Blood and Tissue Supplies	964	945	(19)	10,270
4555 - Orthopaedic Implants	238	221	(17)	2,651
4960 - Patient Transport and Accommodation	27	12	(15)	143
4435 - Other Patient Appliances	7	19	12	227
4905 - Health Promotion and Education	(0)	13	13	156
4070 - Blades and Knives	19	35	16	420
4330 - Monitoring Equipment	14	31	17	365
4100 - Radioactive Supplies	11	29	18	348
4080 - Infusion Injection Supplies	240	263	23	3,158
4370 - Clinical Equipment - Service Contracts	314	338	24	4,057
4565 - Spinal Implants	62	87	25	1,039
4535 - Knee Joint Prostheses	100	127	26	1,516
4190 - Patient Consumables	324	352	28	4,225
4325 - Respiratory Equipment	40	73	33	850
4130 - Tubes Drains Suction	54	94	40	1,123
4115 - Closure Supplies	135	177	41	2,118
4560 - Shunts and Stents	130	176	46	2,107
4025 - Catheters and Introducers	143	191	48	2,293
4604 - Pharmaceuticals	2,158	2,221	63	23,476
4235 - Sterilising Consumables	61	132	72	1,586
4590 - Implants and Prostheses - Other	(23)	87	110	1,045
4530 - Hip Joint Prostheses	126	248	122	2,968
4315 - Instruments - Minor Purchases	133	266	132	3,089
Grand Total	7,658	8,082	424	92,441

1) The move to FPIM Oracle in July has meant that many items in clinical supplies are coded to different codes than previous as the national catalogue / coding is adopted. An example of this is Endoscopic equipment which is $0.12m over budget reflecting the correct coding of laparoscopic equipment previously coded to minor equipment. There is a net variance of $14k between these 2 accounts.

2) Air ambulance was $0.09m over budget for the month, due to;

- $0.07m of additional costs incurred with increased Neurosurgery flights to Christchurch due to reduced Neurosurgery service in Dunedin a result of the SMO being on leave.
- Helicopter charges incurred a 10% price increase, which has impacted the month unfavourably by $0.03m.

Appendix 1: Financial Report for the Hospital Advisory Committee

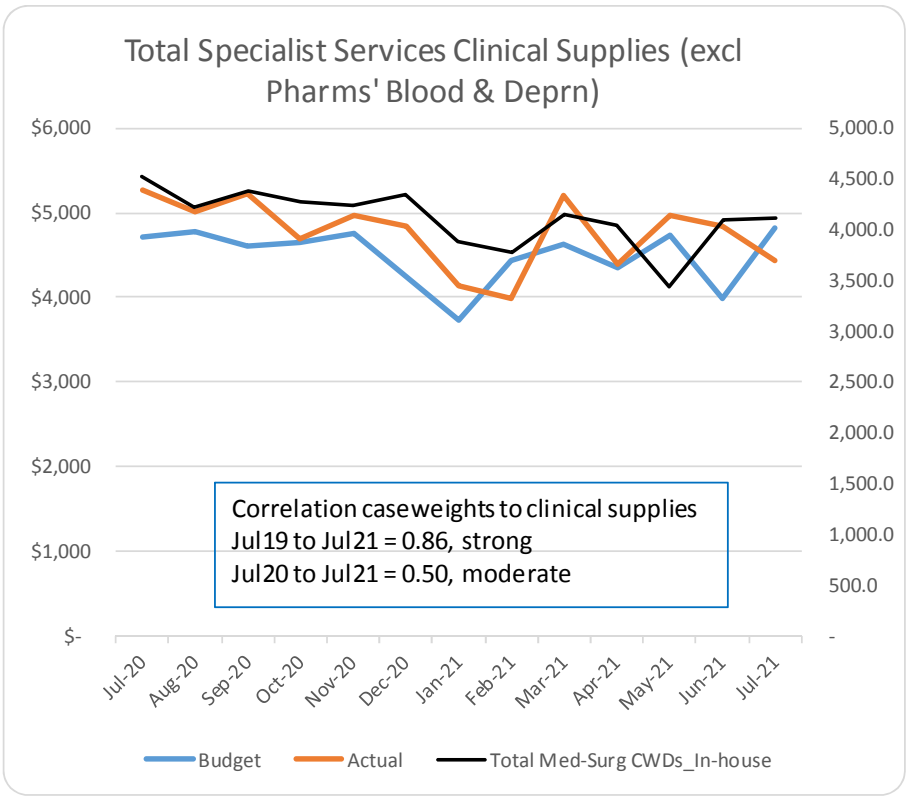
3) Cardiac Implants were $0.04m over budget in the month reflecting additional TAVI's implanted compared to budget. Given the overrun last year, the budget was increased to approx. 4 TAVI's a month, however this was exceeded in July.

4) Implants as a whole were favourable by $0.2m due mainly to Hips and Other Implants. This variance didn't appear to reflect activity, so it was considered prudent to accrue additional expenditure into Implants and Treatment costs, due to the risk of unrecognised expenditure created with the implementation of FPIM.

   These adjustments were recognised in a different portfolio as a holding accrual and will be transferred into Specialist Services if the August results shows July charges to be understated.

We have graphed clinical supplies (excluding depreciation, blood and pharmaceuticals) against Medical / Surgical and Maternity caseweights as below and calculated the correlation, which excludes the additional expenditure that has been accrued mentioned above.

The case weight delivery in July is tracking higher than previously compared to actual costs suggesting that costs may be missing and the decision to accrue additional costs into July makes sense.



Appendix 1: Financial Report for the Hospital Advisory Committee

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

Infrastructure and Non Clinical supplies were $0.13m favourable in July as tabled below.

The two material favourable variances in Telecommunications and Other Operating Expenses appear to be due to allocation errors. We therefore expect additional costs to be booked next month in Specialist Services as costs are correctly allocated from other areas of the DHB.

This favourable variance should therefore be viewed as a timing difference within Specialist Services.

Group 1 Name	Actual $000s	Budget $000s	Variance $000
Hotel Services, Laundry & Cleaning	455	450	(5)
Facilities	11	27	16
Transport	99	96	(2)
IT Systems & Telecommunications	67	118	51
Professional Fees and Expenses	15	25	10
Other Operating Expenses	110	169	60
	756	**885**	**129**

8. *Non-operating Expenses*

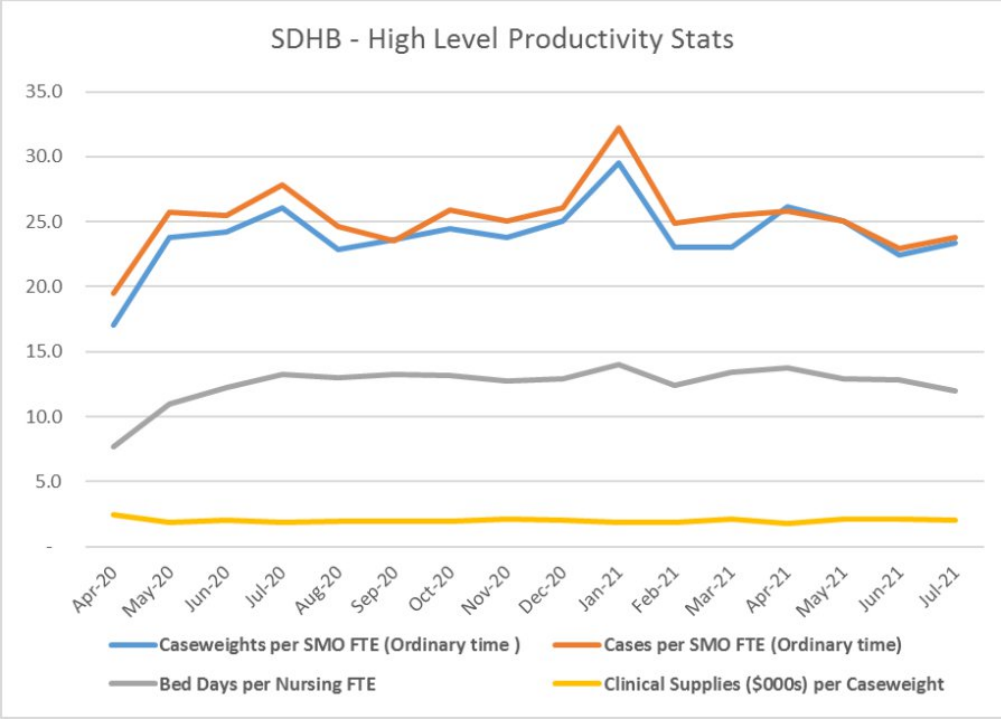
These costs relate to depreciation charges for clinical equipment and are close to the monthly budget.

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

The graph shows a fairly 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 the utilisation of staff on hand during this period was higher while maintaining delivery.

The current month shows a slight increase in productivity represented by the upward 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	Jun-21	Jul-21	Av over 13 months
Caseweights	2,607	4,034	4,438	5,040	4,678	4,843	4,752	4,632	4,844	4,333	4,267	4,684	4,713	4,705	4,568	4,608	4,667
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	4,676	4,690	4,880
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**	**0.91**	**1.01**	**1.00**	**0.98**	**0.98**	**0.96**
Bed Days	6,330	9,099	10,785	11,565	11,389	11,438	11,271	11,015	11,442	10,733	10,520	11,246	11,569	11,299	11,287	10,676	11,188
Cases (excl Day case)	1,775	2,588	2,774	3,104	2,981	2,892	2,979	2,884	2,942	2,742	2,698	3,039	2,720	2,533	2,673	2,888	2,852
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**	**4.3**	**4.5**	**4.2**	**3.7**	**3.9**
SMO FTE (Ordinary Time)	153	169	183	193	205	205	194	195	194	147	185	203	180	187	204	197	191
Nursing FTE (Ordinary time)	824	831	879	870	878	866	858	866	888	766	846	840	842	874	878	890	859
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	10,389	10,421	10,194
Depreciation Clinical Supplies	853	835	850	846	851	815	894	913	932	934	938	944	938	944	898	889	903
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	9,491	9,532	9,291
	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**	**Jun-21**	**Jul-21**	
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	23.0	26.1	25.1	22.4	23.4	24
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	23.0	23.8	26
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	13.4	13.7	12.9	12.9	12.0	13
Clinical Supplies ($000s) 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	1.8	2.1	2.1	2.1	2

SDHB - Budget 2021/22

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	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	56,654
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)	202	198	205	195	196	204	153	197	212	175	193	200	194
Nursing FTE (Ordinary time)	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	10,517
Clinical Supplies less Depreciation	8,587	8,658	8,329	8,386	8,526	7,998	7,229	7,781	8,352	7,826	8,547	8,111	98,330
Caseweights per SMO FTE (Ordinary time)	24.2	26.4	24.0	24.6	24.2	21.0	27.1	22.2	24.1	24.8	26.4	23.7	292
Cases per SMO FTE (Ordinary time)	25.3	27.4	24.9	25.7	24.7	21.8	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	11.9	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.