Hospital Advisory Committee

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

01/11/2021 09:00 AM - 11:30 AM

APOLOGIES

An apology has been received from Dr Ben Pearson, Crown Monitor.

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Hospital Advisory Committee, 1 November 2021

Recommendation

That the Hospital Advisory Committee (HAC) receive and note the Interests Registers.

Purpose

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

Changes to Interests Registers over the last month: Nil

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 their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	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.	
	26.08.2021	Idea Services Board of IHC	Possible conflict with contracts and service delivery models.	
Tuari Potiki	09.12.2019	Employee, University of Otago		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil, does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.123.2019	*Shareholder in Te Kaika		
	24.06.2021	Te Rau Ora Directorship		
	24.06.2021	Needle Exchange Services Trust (NEST) member		
	28.08.2021	Chair, NZ Drug Foundation (3 month appointment)		
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	Advisor to Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020 (Updated 28.01.2021)	Chair, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		
	18.06.2021	Treasury: Health Reform Challenge Panel		
	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
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

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017 (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	Inde is part of WSP's Digital Health Collective, the consultancy service supporting the NDH Digital Infrastructure and Digital Facility Services
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
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		
	02.08.2021	Heart Core, Leadership Team		
	02.08.2021	Murihiku Project - part of role with University of Otago		

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 6 September 2021, commencing at 9.00am via zoom

Present:	Mrs Jean O'Callaghan	Chair
	Dr John Chambers	Committee Member
	Hon Pete Hodgson	Board Chair and Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mr Ben Pearson	Crown Monitor
	Mr Peter Crampton	Board Member
	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Chris Fleming	Chief Executive 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
	Ms Tanya Basel	Executive Director People and Capability
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting. Mr Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer/Interim Executive Director Mental Health acknowledged the recent passing of Moana Theodore's father-in-law, Richard Skipper and provided an opening karakia.

2.0 APOLOGIES

Apologies were received from Committee members Dr Justine Camp and Dr Moana Theodore. Apologies for lateness were received from Crown Monitors, Mr Roger Jarrold and Mr Ben Pearson and Committee member, Dr John Chambers and Miss Lesley Soper for early departure at 11.00am.

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. The Chair asked that the Interests Register be updated to show her appointment as a member of the Idea Service

Board for the IHC group, noting that it was for the Service Delivery arm, looking after people in the community.

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 5 July 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

The Committee considered the action sheet and attached information papers and the verbal update from the Executive Director, Specialist Services (EDSS), Mr Patrick Ng. The presentation on workforce modelling for the future for the new Dunedin Hospital has been held over till the next meeting, with the need for further work to be done to reflect more accurate assumptions from inception. Significant workforce challenges are being signalled.

The Committee considered the reports attached to the action sheet and the verbal updates. The following highlights were noted:

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

- The EDSS confirmed that the rural hospitals appear to have adequate capacity in terms of beds.
- The shortage of inpatient beds in Southland is a challenge and more beds are to be opened on the Southland Hospital site. This has been budgeted for in the current financial year.
- It was agreed that future reports are to include staffed beds, in addition to physical and resourced beds. The EDSS advised he would update future reports to include a column showing the average bed closures for the month.

Crown Monitor, Roger Jarrold joined the meeting.

- Members are to be updated on what the risk to patient care and delivery is as a result of staffing shortages.
- The Day of Surgery Admittance beds are showing as '0' resourced as there are no overnight stays.

Aged Residential Care bed numbers (tab 5.2)

- The issue of workforce shortages is on-going.
- Whilst the report shows the total number of patients receiving care in a sub-optimal location as 30 at 23 August 2021, this needs to be balanced against the fact that on average there are over 100 people plus per month going into residential care.
- People have a choice of what residential care they wish to go into and may choose to wait in the community for longer to get their preferred choice.

Letters Review (tab 5.3)

- Members noted their concern over the lack of progress with the rationalisation of the template letters.
- An update was provided on the misunderstanding around the Oncology letters.
- A request was made that the letters currently going out be looked at and changed. This should be done quickly and sensitively.
- The Acting Executive Director Quality and Clinical Governance Solutions provided an assurance that action would be progressed prior to the next HAC meeting, ensuring that the most sensitive letters are addressed first.

Crown Monitor, Ben Pearson and Committee member, Dr John Chambers, joined the meeting.

- The Board Chair suggested that the process be project managed.
- It was agreed that the Service Managers need to implement the agreed changes as part of the process.
- The Ministry of Health needs to agree to any changes to the standard letters.
- It was agreed that a project plan is to be provided for the next meeting and that the EDSS liaise with Service Managers to confirm their responsibilities as part of the process.

Recruitment Update (tab 5.4)

An update was provided by Ms Tanya Basel, Executive Director People and Capability, with the following key issues highlighted:

- The challenge with recruitment and the impact on immigration and residency with the closed borders due to COVID.
- The recruitment campaigns currently underway.
- A request was made for future reporting to include the length of time that a vacancy exists and potential risks and problems as a result of delays in recruitment.
- Future reporting is to include vacancy forecasting.
- The Executive Director People and Capability agreed the need to provide detailed service planning.
- The importance of workforce planning and the need to keep a focus on vacancies and be proactive and aware of upcoming retirements and resignations and undertake advance planning for recruitment.
- A request was made for staff turnover rates to be included in future reporting. For the past financial year the staff turnover rate was 9.4% against a national average of 12.1% across the 20 DHBs.
- A request for a more accurate means of capturing the SMO vacancies, e.g. by service.
- Opportunity for Medical and Radiation Oncology trainees to take up positions within Southern DHB and recruitment requiring Registrars to work across the district. The CMO advised that one RMO contract has a limit on distance so RMOs cannot rotate more than 60km. There are a number of specialties that allow rotation across the district and the South Island.
- The HAC Chair advised that further discussion will be held on workforce at the Board meeting on 7 September 2021 and noted the importance of recruitment and retention of health professionals within Southern DHB.
- The Chief Nursing and Midwifery Officer, Mrs Jane Wilson, provided an update on the shortage of Midwives across Southern DHB and the need to ensure that quarterly reporting for Southern DHB is being presented in the same way as other DHBs. Further work is being done in this area.

Southland Dental Unit's General Anaesthetic Waiting List (tab 5.5)

- The Interim Executive Director Strategy, Primary and Community (EDSPC) apologised that the report was out of date with the ability of dental to operate under Level 3 and 4 with the current COVID outbreak and advised that the mitigation strategies within the report need refreshed.
- A further report will be provided once the impact of the current COVID lockdown on services is known.
- The Board Chair acknowledged the report and noted his concern at the waiting list, which needs to be much lower than 120, noting the impact on children in pain waiting on their dental treatment.
- The CEO confirmed that the issue is Theatre availability and not a staffing resource issue.
- The benefit of having the Surgical Bus was noted.
- A request was made for the opportunity to be taken to investigate the role and effect of fluoridation within Southern DHB, acknowledging that low numbers in some areas may impact the results.
- Discussion was held on the possibility of the Dental School providing dental chairs further south and the EDSPC advised that this would be included in a report on the Dental School being provided for the next Community and Public Health Advisory Committee (CPHAC) meeting.

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, with emphasis on:

- Southern DHB's equity programme and workshops planned.
- The impact of COVID on progress with the plan.
- Proposed visit to Auckland DHB to review Care Capacity Demand Management (CCDM) and meet with relevant individuals in the equity and reporting team so that the tools, approach and data capture used can be reviewed with the intention of informing what could be adopted at Southern DHB.
- Understanding why cardiology appointment attendance rates appear to be improving for Māori, but remain a problem for Pasifika people.
- Further analysis of rurality on equity needs to be explored.
- The report on a study of Māori Lung Cancer patients is pending and the findings from this will inform the work being done.
- The EDSS and General Manager, Surgical and Radiology Services are to meet with Board member, Peter Crampton, to discuss the intersection of rurality, ethnicity and socio-economic deprivation.
- The reference in the report to "opportunities to improve the content of the letters that we generate" was noted and this will form part of the overall project to improve letters.
- A suggestion was made that the Hospital foyers be modified to include a more cultural appearance and incorporate Te Reo Māori and the CEO and Chief Māori Health Strategy & Improvement Officer will explore this further. Whilst there is cultural input into the new Dunedin Hospital, work should be done looking at Southland Hospital and the current Dunedin Hospital.

Surgical Performance - Case Weight Discharges (CWD)

An update was provided, with the following highlighted and the EDSS responded to queries.

- Implementation of acute surgical capacity and the need to increase the hours for acute surgery in Dunedin. An increase of 28 hours per week will be achieved through staffing for a regular eight hour Saturday acute list and staffing to add four hours to one regular acute list every day Monday through to Friday. Francis Health identified the 28 hours when they assisted Southern DHB with its elective work. The additional acute hours will result in more elective surgery as it is anticipated that there will be less cancellations.
- The EDSS provided a verbal update on CWD performance against plan and advised on the challenges with Southland Hospital. To improve the situation in Southland the following is planned:
    - Funding is available in the current year to open 12 additional in-patient beds in Southland.
    - Planning is underway for the fifth Theatre.
    - Additional staffing is required, particularly in the Perioperative teams.
- An update was provided on the Production Plan, which is being looked at alongside the Elective Services Plan.
- A shortfall has been identified and initiatives have been put in place to address this, including putting acute capacity into Dunedin.
- Changes to the production plan model will be undertaken, based on improvements achieved from implementing the initiatives outlined.
- The extent to which the successful implementation of CCDM will result in more consistent patterns in keeping inpatient beds open.
- Concerns were raised around the ability to staff a fifth Theatre in Southland and whether there is capacity to provide additional weekend work. An update was provided by the EDSS, noting that regular elective work does not generally happen in either Dunedin or Southland Hospital at the weekend. There is a regular planned acute list undertaken on a Sunday in Dunedin.
- The EDSS responded to concerns raised relating to the comparison between outputs in July 2020 and July 2021. Further discussion is to be held at the Finance Audit and Risk Committee meeting.
- An update was provided on the relationship between acute and elective surgery. It is critical to identify how many patients are getting their acute surgery within a clinically appropriate time to avoid harm.
- Coming out of COVID, higher volumes of outsourcing will be required to recover the elective plan. The numbers required will be higher than what can be provided through local providers and capacity outside the district will need to be explored.
- The EDSS responded to concerns raised around the use of the prioritisation tool across the district and apparent inequity in access to services between Dunedin and Southland and noted that a district approach is being used. He advised the need to further investigate to see if there is more that can be done to ensure the resources are being shared across the district. The CEO advised the need to apply the prioritisation tool in a different way to achieve a more equitable outcome across the district.
- Clarification was provided on progress with the purchase of the MRI machine and the savings gained by including the purchase in a package of three with two CT scanners. Board approval will be sought at the Board meeting on 7 September 2021.

- Further discussion was held on:
  - The standard intervention rates in Southland.
  - Emergency Department (ED) presentations in Southland and the need for on-going support from WellSouth PHN.
  - The high intervention rates for Cardiac Surgery, noting that Cardiac is an "entitlement based service".
  - ESPI 2 breaches, access to Orthopaedic Surgery and recruitment to Orthopaedic Surgeon position in Southland.
  - The EDSS is to report back on the status of recruitment into the Orthopaedic specialist positions in Southland and a comparison against the recruitment process in Dunedin. The report is to include feedback on how much the caseload is being distributed across Southern DHB and whether there is capacity to do more of that for Orthopaedics.
  - The importance of having a uniform prioritisation tool across the district so any gaps can be readily identified.
  - Recruitment to specialist positions in Southland needs to be a major focus for HR.
  - Acknowledgement of the national shortage of Orthopaedic Surgeons and exploring ways of reducing the lists utilising resources we do have, e.g. Physiotherapists and upskilling General Practitioners to do simple procedures.
  - Utilisation of the MRI facility which is being run into the evening and at weekends.
  - A triaging service is now in place for ENT minor lesion procedures to be done in the community by General Practitioners with a special interest (GPSI). There is potential for more work to be done in this area.
  - There is funding available to expand the role of Physiotherapists. However, there is a significant shortage of Physios in Southland.
  - There is a shortage of six Dentists in Southland resulting in young people not being able to get oral health check-ups.
  - Whether there is a planning process looking at the configuration of GPSIs throughout the district and the load they may take off the surgical waiting lists. The EDSS is to arrange for the information, in a review undertaken by the General Manager Surgical and Radiology, looking at the ability of GPSIs to do minor skin lesions in the community to be included in the next HAC agenda. A request was made for reporting on the actual and potential capacity for GPSIs to take load away from in-patient hospital care. The EDSPC advised that the use of GPSIs in Southland as outlined was a planned investment to address a gap in service in the Southland community in a planned and co-ordinated way by the provider arm, primary care and the funder arm of Southern DHB.
  - The pressures on the Emergency Department (ED) in July 2021, particularly in Dunedin, and the response to the Nurses issuing a Performance Improvement Notice (PIN). The EDSS provided an update on the actions taken as a result of the PIN. A report will be provided for a future meeting outlining the actions taken as a result of the PIN and any recommendations.

Financial Performance Summary

Crown Monitor, Mr Roger Jarrold, queried the low bed days for July 2021 (compared to March, April May and June 2021) as outlined in appendix one of the Finance Report. The EDSS is to investigate and report back on the low bed days.

The EDSS presented the Specialist Services financial results (tab 6.2) for the month of July 2021, outlined the contributing factors to the positive variance of $200K for

the month and noted the key drivers for the results. He responded to members' queries.

An update was provided on the challenges with the implementation of the Finance, Procurement and Information Management (FPIM) system reporting for the month and it is anticipated that the actual figures for the month will change. Taking the expected adjustments into account, it is anticipated that the $200K favourable result is likely to be a circa $200K unfavourable result.

***It was resolved**:*

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

8.0 GENERAL

Production Plan

The HAC Chair advised the need for HAC and Finance Audit and Risk Committee (FARC) members to see the Production Plan with the outsourcing. Further work is required to ensure everything is included when refining and developing the Production Plan further and the EDSS advised that the team are keen to see how Auckland does it, to help inform the local process. The Crown Monitor, Mr Roger Jarrold, noted that the average length of stay increased markedly in July 2021 and he noted the importance of CCDM and rostering aligning with the production planning.

The CEO advised on the areas of Production Planning and Production Engineering and noted that money is available for Production Engineering, which will look at the flow right across the system. It is proposed to look at how Auckland DHB does their Production Planning and then Southern DHB will recruit to supplement skills in this area.

RMO Rostering

The EDSS advised on progress with centralisation of RMO rostering. An update will be provided for the next meeting.

9.0 CONFIDENTIAL SESSION

At 11.17am the CMHSIO provided a closing karakia and it was resolved that the Hospital Advisory Committee move into committee to consider the previous public excluded meeting minutes.

***It was resolved**:*

"That the minutes of the public excluded session of the Hospital Advisory Committee meeting held on 5 July 2021 be approved and adopted as a true and correct record."

A patient complaint related to transfer of a patient between hospitals within Southern DHB was noted. An official letter was not received by Southern DHB and the issue raised the need for better systems and processes to be put in place. As the matter had not been publicly notified, further discussion is required outside the meeting.

The meeting closed at 11.54am.

Confirmed as a true and correct record:

Chair: _____ Date: _____

HOSPITAL ADVISORY COMMITTEE

ACTION SHEET

As at 18 October 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2021	**Review of Action Sheet – bed numbers** (Minutes Item 6.0)	Future reports to HAC are to include the number of staffed beds, in addition to the resourced and physical bed numbers for Southland Hospital, Dunedin Hospital and the Mental Health beds.	EDSS	Refer to item 5.1.	**Complete**
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 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.	EDQCGS	Refer to item 5.2.	**Complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		• The MoH needs to agree to any changes to the standard letters. • A project plan is to be provided for the November meeting. • The EDSS is to liaise with the Service Managers to confirm their responsibilities as part of the process.			
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	A workforce presentation has been scheduled for an upcoming Board meeting.	**Complete**
July and Sept 2021	**Review of Action Sheet – Recruitment** (Minutes item 6.0)	The regular update to HAC from Tanya Basel, Executive Director, People and Capability (EDPC) is to include: • Vacancy forecasting. • The length of time that a vacancy exists and potential risks and problems as a result of delays in recruitment. • Staff turnover rates against the national average of DHBs.	EDPC	A report is being provided for the upcoming Board meeting.	**Complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	EDSS Report (Minutes Item 7.0)	• A more accurate means of capturing the SMO vacancies, e.g., by service. • Recruitment to Specialist positions in Southland is to be a major focus for HR.			
Sept 2021	**Recruitment Update** (Minutes Item 6.0)	Ensure that the quarterly reporting on the shortage of Midwives across Southern DHB is presented in the same way as other DHBs.	CNMO	CNMO to follow up with TAS re data extract for core midwives working across SDHB and primary units.	**Complete**
Sept 2021	**Review of action sheet – Southland Dental Unit's General Anaesthetic Waiting List** (Minutes Item 6.0)	A further report is to be provided for HAC once the impact of the current COVID lockdown on services is known.	EDSPC	Oral Health is being reported to CPHAC.	**Complete**
Sept 2021	**EDSS Report - Equity** (Minutes Item 7.0)	A report on a study of Māori Lung Cancer patients is pending and the findings are to be reported back to HAC.	EDSPC/EDSS	The lung cancer study has been completed and a brief paper from the GM S&R is attached. Refer to 5.3. The EDSS has also summarised key findings in the HAC report.	**Complete**
Sept 2021	**EDSS Report - Equity** (Minutes Item 7.0)	The EDSS and GM Surgical and Radiology Services are to meet with Peter Crampton to discuss the intersection of	EDSS	Meeting held on 23 September. The EDSS and GM S&R sent 5 proposed research topics	**Complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		rurality, ethnicity and socio-economic deprivation.		which, if picked up would further investigate the intersection between ethnicity, rurality and social depravation.	
Sept 2021	**EDSS Report – Surgical Performance CWD** (Minutes Item 7.0)	Investigate whether more can be done to ensure equity in access to orthopaedic and other services between Dunedin and Southland. The prioritisation tool may need to be applied in a different way to achieve more equitable outcomes across the district.	EDSS	Although access to publicly funded surgery is scored consistently at both hospitals using the same score across the district, it should be noted that 'overrides', where the surgeon overrides the score and approves for surgery are circa 9% in Southland and circa 15% in Dunedin. Whilst access for surgery is consistent (not withstanding overrides), access for an outpatient appointment varies, with tighter access (due to management of capacity constraints) in Southland, and better access in Dunedin. Further work is required to understand the underlying rate at which an outpatient appointment is accepted in	**Complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				each hospital, because different approaches are taken to ordering diagnostics (e.g., before / after accepting an FSA and the manner in which the fracture clinic is used at both sites also varies. We have requested the incoming improvement manager to undertake a study and we propose holding this action open until we have those conclusions, which will then clarify whether actions can be taken to improve equity between hospitals for FSA appointments.	
Sept 2021	**EDSS Report** (Minutes Item 7.0)	The EDSS is to report back on the status of recruitment into the Orthopaedic specialist positions in Southland.	EDSS	The Southland Orthopaedic service has 4.87 budgeted FTE. They currently have a 0.81 FTE vacancy which they are actively recruiting for. The SMO's do a 1-4 on-call, so are currently dependent on locum support for call pending successful recruitment into the vacancy.	**Complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2021	**EDSS Report** (Minutes Item 7.0)	Provide an update from GM Surgery & Radiology on the completion of minor skin lesions in the community by GPSIs (GP's with a special interest).	EDSS	A new contract has been signed between the P&F team and the PHO which increases the number of skin lesions funded to be completed by GPSIs from 1,200 to 2,000. The PHO is also being funded to triage these skin lesions. The project is working towards commencing with the additional GPSI work by the end of the calendar year and once underway will reduce ENT referrals by circa 15 per week, which is the equivalent of several operating lists every week.	**Complete**
Sept 2021	**EDSS Report** (Minutes Item 7.0)	A report is to be provided outlining the actions taken and recommendations as a result of the Nurses in ED in Dunedin issuing a Performance Improvement Notice (PIN).	EDSS	A benchmarking study has been undertaken in Auckland which included 18 participating hospitals. We are meeting with the author of the study to determine whether the results will be applicable for our benchmarking work as this would avoid the need for ourselves, Waikato and the Hawkes Bay to duplicate this work. Once we understand the validity of the work, we can then collect our own data and	**Complete**

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				compare against this, formulate our working group and work towards our conclusions.	
Sept 2021	**Financial Performance Summary** (Minutes Item 7.0)	Investigate and report back to HAC on the low bed days for July 2021, compared to March, April, May and June 2021.	EDSS	Upon further investigation it was found that the finance report was incorrect. The July bed days are very comparable to the prior months. A full report comparing July volumes and bed days to July in the prior year has been completed and will be submitted to FARC (this was submitted in Board papers in October).	**Complete**
Sept 2021	**RMO Rostering** (Minutes Item 8.0)	An update on centralisation of RMO rostering is to be provided for the next meeting.	EDSS	This is on hold pending the finalisation of the proposal for change.	**On hold**

Bed Numbers

Physical beds compared to resourced beds compared to actual staffed beds (September month)

Per the Board action, a report has been developed that enables us to map the actual staffing of September beds to the budgeted / resourced beds. The result for **Dunedin** is per the following table.

Dunedin Hospital Adult Inpatient Beds - Physical, Resourced and Actual Staffing (September)

Adult Inpatient Wards	Speciality	Physical Beds	Resourced Beds	Resourced %	Sept Beds	Sept % of Resourced
Surgical (3Surg)	orthopaedic	54	54	100%	51	94%
Surgical (4a)	General surgery	24	20	83%	20	100%
Surgical (4HDU)	Surgical High Dependency Unit (HDU	6	4	67%	4	100%
Surgical (4c)	Gen surgery/ vascular / urology	30	25	83%	26	104%
Intensive Care Unit (ICU)	ICU / Neurosurgery HDU	12	10	83%	10	100%
Assessment, Treatment, Rehabilitation (6 ATR)	Older Persons Health	44	24	55%	21	88%
Cardiac & Respiratory (7a)	Cardiac / Respiratory	24	24	100%	20	83%
Critical Care Unit (7b)	Critical Care Unit (CCU)	10	8	80%	8	100%
Cardiology & Renal (7c)	Cardiology / Renal	16	16	100%	16	100%
Medical Assessment Unit (IMAU)	MAU (internal medicine)	8	8	100%	8	100%
Inernal Medicine (8 Med)	Internal Medicine / Gastro	40	40	100%	39	98%
Stroke unit	Stroke	8	6	75%	7	117%
Oncology (8c)	Oncology/Haematology	16	14	88%	14	100%
Total for Adult Inpatient Wards		**292**	**253**	**87%**	**244**	**96%**

Notes:

- To produce this report, we had to make some modifications to what we had previously reported, wards that do not provide overnight stay have been removed and some wards have been consolidated to make them consistent with our Power BI reports.

- Some wards were overstaffed, e.g., where demand was higher than planned and the flexible resources per our planned / budgeted flexi-staffing were deployed to these wards to help manage demand.
- Overall, 87% of our physical beds were resourced budgeted and 96% of our budgeted beds were actually staffed for the month of September.

The **Southland** numbers are as follows:

Southland Speciality	Physical Beds	Resourced Beds	Resourced %	September Beds	September % of resourced
Critical Care	6	6	100%	6	100%
Medical Ward	38	38	100%	38	100%
Rehabilitation Services	26	18	69%	19	105%
Surgical Ward	42	42	100%	42	100%

All resourced beds in Southland remained open during the month of September, with the rehabilitation ward opening slightly more than their resourced beds to cope with demand.

The **Mental Health** bed numbers are as follows:

Mental Health Wards	Physical Beds	Resourced Beds	Resourced %	September Beds	September % of resourced
Ward 9A	15	13	86%	13	100%
Ward 9B	15	15	100%	15	100%
Ward 9C	16	16	100%	16	100%
Ward 10A	12	12	100%	12	100%
Ward 11	16	16	100%	16	100%
Helensburgh Cottage	4	4	100%	4	100%
Ward 6C	12	12	100%	12	100%
Southland MHU	16	16	100%	16	100%

In discussion with Mental Health, for the month of September, all beds were opened and available staffing was applied to keep the beds open.

3 beds have, however, been closed due to staffing levels in the month of October.

5.2

FOR INFORMATION

Item: SDHB Letters Process Update

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

Patrick O'Connor, Quality and Performance Improvement Manager

Meeting of: 1 November 2021

Recommendation

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

Purpose

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

Specific Implications For Consideration

2. Quality and Patient Safety

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

3. Equity

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

Background

The background to this initiative can be referred to in previous papers to the Committee.

Update & Discussion

4. The Patient Letters Plan (Appendix A) was endorsed on 6 October by:

    a. The Executive Director for Specialty Services
    b. General Manager of Operations and Southland
    c. General Manager Surgical Services & Radiology
    d. General Manager Medicine Woman's & Children

5. In this period, we have taken the following actions:

    a. Worked with the PICS team to get an update on project progress and template functionality

b. Identify high volume letters and letters likely to cause psychological. IT have supplied additional data on templates
c. Investigated the complaints from consumers related to letters
d. Worked with Services and updated letter templates and ensure they are closely aligned with CDHB PICs templates

6. PICs is a standardised system across the South Island, and we will be implementing the Canterbury templates in the southern region which means that patients across the South Island will receive standardised letters wherever they are.

7. PICs will provide us with the functionality we need to be more culturally appropriate with our voice in letters for Māori and other ethnicities. IPM provides limited functionality to customise letters from data held within the system. PICs is ultimately the answer to some of the major issues with letters. PICS is scheduled to be implemented in 18 months.

8. Addressing equity will require an overarching strategy with multiple channels of communication. Equity is not restricted to ethnicity but also issues such as disability and locality. Greater insight into our requirements is emerging from the Disability Working Group creating our Disability Action Plan This will require a co-design approach and is potentially a large piece of work. We expect this will accelerate with PICs and further direction from HealthNZ.

9. We have agreed, as directed by the ED of Specialty Services, an embargo on new templates being placed into IPM.

10. IT have assisted us with identifying templates and reported usage over the last year. Across our two IPM systems we have 1,572 (at the last count). Roughly two thirds of these reside in our Dunedin IPM system and the remaining in the Southland system.

11. The volume of templates is driven by the limited functionality of IPM. Only a few data items can be pulled into the letter template. Information specific to Services and additional information must be hard coded into the template.

12. Additional variation is driven by individual services and clinician requirements. These templates fall into 23 categories. As we work with individual services their templates will be rationalised.

The Top Categories and Number of Templates

Template type	No of templates
Outpatient appointment notification	599
Change of outpatient appointment	187
Placed on waiting list	157
Failed to attend outpatient appointment - to patient	121
Contact Document	102

13. The information above is helping us target letters that need changing. We reviewed the letter templates to understand the scope of the problem and the impact on patients. We found that most templates are fit for purpose and generally provide the right information to patients. Most letters are very functional in nature and informative we feel this is a positive finding.

14. Templates requiring improvement relate to communication on wait listing. We believe these letters are more likely to cause psychological distress to patients.

15. We also reviewed our complaints data for the last year to seek more insights into why consumers have problems with letters. Unfortunately, it appears that consumers complain about letters informally as only one out of our 927 complaints related to a letter they received.

16. Our approach is focused on changing high volume templates and letters that are more likely to cause psychological harm. Our four-step process to change these letters is to for:

    a. The Service and IT team to provide the identified templates to us for review.
    b. The Customer Experience Manager reviews the letter templates and makes changes,
    c. The Service Manager endorses the changes and
    d. IT put the new templates into production.

17. In addition to the waitlisting letters, we will also focus on letters relating to admissions and referrals as these have also been identified as a cause psychological distress.

18. The high letter volume Services we have targeted are Ophthalmology, Oncology, Orthopaedics and ENT. These Services make up 40% of all our wait list letters. Progress to date is as follows:

Service	Template rationalisation before/after	Customer Experience Review	Service Manager endorses	IT implemented
Ophthalmology	Reviewed and rationalised from 13 to 5 letters for Outpatients	Completed	Completed	Underway
Oncology	Reviewed 6 templates relating to telephone appt; follow up appts; wait list	Complete No changes required to telephone or follow up appts; changes	Completed	Completed

		required to wait list letter		
Orthopaedics	Awaiting templates from new Service Manager	Awaiting templates	Not started	Not started
ENT	Awaiting templates from Service Manager	Awaiting templates	Not started	Not started

19. Through our review none of the changes we have made or propose require MOH approval.

Next Steps & Actions

With what we have learned over the last two months we will concentrate on wait list letters. Our plan to tackle wait list letters is as follows:

Action	Who	Date Due
Review Orthopaedics wait list templates and update templates (if required)	Customer Experience Manager	20 October 2021
Review and endorse changes	Service Manager - Orthopaedics	22 October 2021
Put templates into production	IT	25 October (Week of)
Review ENT wait list templates and update templates (if required)	Customer Experience Manager	20 October 2021
Review and endorse ENT changes	Service Manager - ENT	22 October 2021
Put ENT templates into production	IT	25 October (Week of)
Select further Services to review	Customer Exp Manager/Quality and Performance Improvement Manager	25 October (Week of)
Agree with PICS Project Manager on next steps and timeline for letters rationalisation with PICS resource	Customer Exp Manager/Quality and Performance Improvement Manager/PICS PM	1 November 2021

Appendices

Appendix A **Patient Letters Plan – Sep 21 – updated**

Patient Letter Plan – September 21 – updated

Background

A project is underway to replace our current Hospital Patient Administration System (PAS). Our current patient administration system is called iPM. This product was originally supported by iSOFT and latterly CSC. We have two different versions of iPM in Southern one in Southland the other in Otago. The two versions are difficult to integrate and there is poor interoperability. The South Island has a strategy to move all DHB patient administration systems to the Orion product called PICs. PICs will replace the two versions of IPM in Southern. PICs has been implemented in two of the South Island DHBs, and implementation in the remaining DHBs is underway. Its functionality allows for the implementation of a standard suite of letter templates across Services. There is a dedicated PICs project to move iPM to PICs. Part of the work to be undertaken is to implement the Canterbury letter templates into the Southern PICs system. This will lead to the standardisation of patient letters across the South Island.

One of the key issues with patient letters is a lack of standardisation. Most of these letters utilise data that comes out of our iPM systems. Each Service has a series of templates that are unique to their perceived needs. With 23 Services this means we have hundreds of templates that are used. These templates can vary in tone and wording and have led to several complaints. Work has been done in the past but due to the fragmented nature of our Services and the dated functionality of our iPM systems it is difficult to implement a comprehensive solution.

A further complication is that the DHB services also utilise several other systems including: iMEDX, Cardiobase, eScription,Gynae+,Soprano, nscribe, EasyRIS, InQuiry, MedDocs and Titanium.

The Hospital Advisory Committee (HAC), a subcommittee of the Board asked if we could implement the Canterbury letter templates into our existing iPM systems. IT informed us that to implement the Canterbury templates from PICS you either had to upgrade and customise IPM or change all the hard coded templates. Given the cost associated with an upgrade, and that iPM is a sunset system, and the resource required to change all the templates in a short period of time neither of these options is viable.

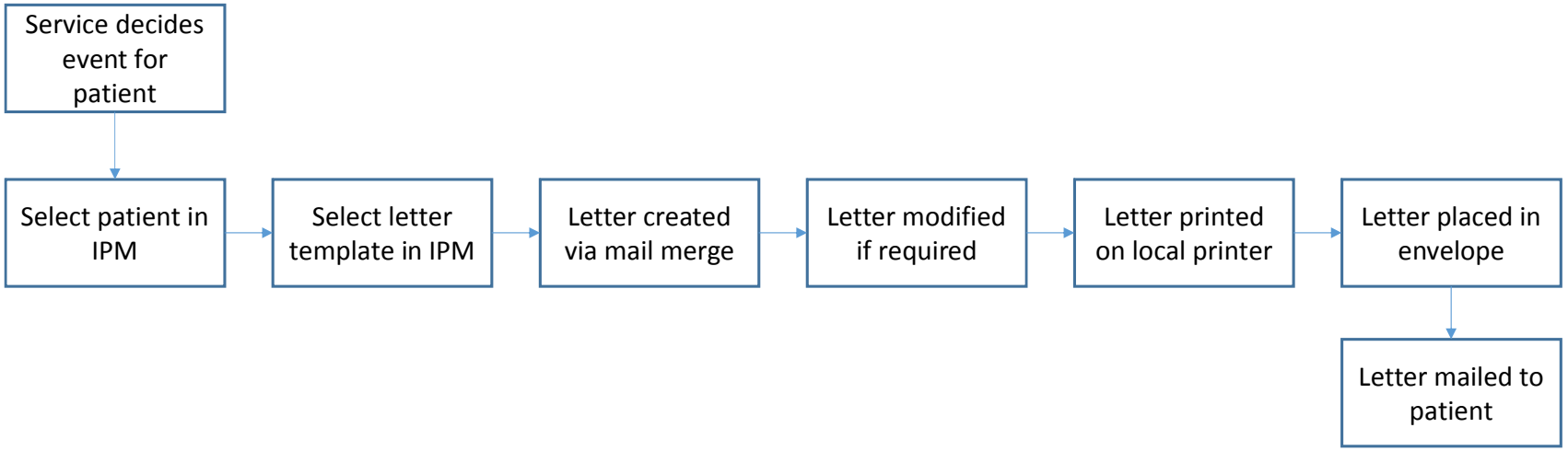
Given the desire to standardise letters we have adopted an approach based on prioritisation. Letter templates that may cause psychological harm and templates used in a high volume of letters will be reviewed and amended first. See the plan section below for more details.

The challenge to standardise all letters based on templates is complicated by the current letters process within iPM. All letters generated can be changed by the administration staff as they are created at the service level prior to printing again on individual printers within services. There is no centralised letter generation and sending mechanism.

Current Letter Process

Each of the letters sent in the last six months follows this process. Each letter is created individually and is manually printed, folded and placed in an envelope

Figure 1 Current Letter Process



Current Situation

The Southern DHB sent more than 350,000 items of mail in the last year. That equates to roughly 1,800 items sent each working day. The great majority of these are letters to patients.

There are roughly 1,500 templates sitting in our IPM systems

Letter templates fall into the following categories:

- Outpatient appointment notification
- Placed on waiting list
- Change of outpatient appointment
- Multiple outpatient appointment notification
- Admission offer
- Contact Document
- Rejection of referral
- Referral acknowledgement - to patient
- Failed to attend outpatient appointment - to patient
- Cancelled Outpatient Appointment Letter - Patient
- Cancelled Outpatient Appointment Letter - GP
- Referral acknowledgement - to GP
- Failed to attend outpatient appointment - to referring doctor
- Removal from waiting list
- Referral Summary
- Waiting list removal letter - to GP
- Change of multiple outpatient appointments
- Reassessment to Patient

Plan and Progress

Prioritisation

Our approach has been to prioritise based on the possibility of psychological harm and volume of letter by Service.

The two letters with the greatest possibility of psychological harm are rejection of referral and placed on wait list. The top 5 Services by volume are:

Table 1 Letter volumes by service

Service	% Of letter volume
Ophthalmology	18
Orthopaedics	10
ENT	7
Allied Health	6
Oncology	5
General Surgery	4

Principles To Update the Letters

The letter process is just a small aspect of a whole consumer communication strategy and plan. The sending of a letter is just a single option of a broader communication channel. Letters as a mechanism of communication are seen as 'the old way'.

A learning from the Canterbury DHB experience of implementing new templates is that considerable time can be spend engaging and debating the wording of letter templates. We understand that CDHB had a full time FTE working on this for nearly a year. We hope to shortcut this process by only asking the Service to tolerate the changes rather than actively engage and debate the changes.

The message from HAC was to 'Just get on with it'. There are two diametrically opposite approaches to the re-wording of letters. Dictate to services that this is the letter you will use versus setting up of multiple committees and reference groups to progress the letter rewrite by being totally inclusive and collaborative.

The approach we plan to undertake is an agile and pragmatic process to reword the letters. For the Consumer liaison team to reword the letter templates send the updates to the services and ask them if they believe the wording change is an improvement and "Can this be lived with'. It does not need to be perfect just more empathic, considered and consumer connected. This is to avoid a repetitive time consuming, resource hungry, loop to perfection.

The principles the Consumer liaison team will follow will be

1. To ensure the templates follow the Ministry of Health guideline for consumer letters.
2. To ensure the templates are similar to the Canterbury PICs template format as much as possible
3. Improve the 'voice' of the letter to be more empathic and considered and consumer connected.

The process we will follow:

Process	Owner	Action
Step 1	Q&CGS – Consumer Experience Manager	Reviews letter template and amends based on principles
Step 2	The Service	Service Manager confirms the service can 'live with' amended template.
Step 3	IT	Implement template by updating iPM
Step 4	Next Template	

Organisational sign Off process

To ensure we can undertake the revision of the templates in a fast agile pragmatic process. We will require the Executive Director of Specialty Series to endorse the plan. The plan is to be presented to the General Managers for consideration and dissemination to the Service mangers. When the management group are in agreement then the letter template process can proceed.

Reporting on Progress

To report on progress with the Letter update we will follow RAG status reporting.

Sign Off of the Plan

The agreement to proceed has been confirmed by HAC and HAC require the agreement of this plan by the Executive Director of Specialty Services.

Update

The Executive Director Specialty Services and the General Managers for Surgical Services and Radiology and the General Manager for Medicine Woman's and Children have also agreed with the approach taken.

5.3

Review of 20 Māori patients diagnosed with lung cancer – what can we learn?

Project team:

Debbie Skinner, Rachel Miller, Blair McLaren, Hywel Lloyd, Ben Brockway, Janine Cochrane, Gilbert Tauroa.

Background:

In February 2020 key leaders in the provision of cancer services at Southern DHB met to discuss equity issues. We determined that to review 20 consecutive Māori patients diagnosed with lung cancer would provide insight into equity issues at Southern.

We know that throughout New Zealand, patients with lung cancer generally have a late diagnosis of cancer that is often not curable. We also know that early diagnosis of lung cancer is curable. We know from a previous project at Southern [1] that Māori cancer patients are more likely than non-Māori, to first access cancer services via the more urgent routes of the Emergency Department, the Faster Cancer Treatment 62-day urgent pathway and inpatient admission. This was shown to be statistically significant as can be seen below in figure 1.

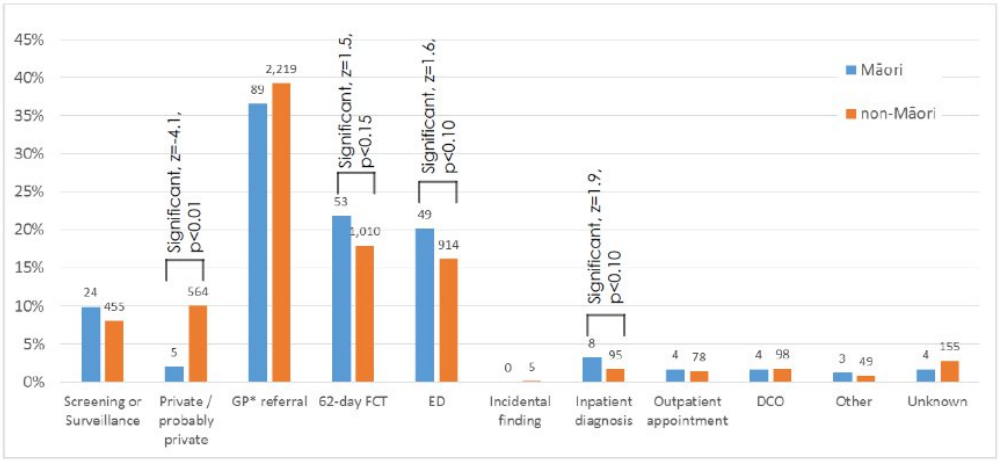


Figure 1: Ethnicity and Routes to Diagnosis (2018)

Aim:

This project has three aims.

- Document key diagnostic and treatment dates for 20 consecutive Māori patients undergoing lung cancer support at Southern DHB.
- Compare findings to what others have found.
- Identify recommendations that would improve outcomes and experiences of patients and shine a light on equity issues at Southern DHB.

Method:

20 consecutive Māori patients with lung cancer were identified via the SDHB Faster Cancer Treatment data base that collects information regarding referral, diagnosis and treatment dates. Patients were treated between February 2018 and February 2020. The project Lead for

[1] Faster Cancer Treatment Routes to Diagnosis Part A and B Presentation to Faster Cancer Steering Group 2018: Cochrane, Pointer, Duncan, Galer, Meldrum, Miller, Norton, Oxley, Potter, Proctor, Riley, Tapp, Jewell and the FCT and Cancer Nurse Coordinator teams across the South Island

Faster Cancer Treatment reviewed all patients, collecting data onto a spreadsheet. Further data was sought from the Primary Health Organisation to identify GP attendance in the 3 years prior to the diagnosis date. Analysis was shared with the project team and other colleagues to validate findings and guide further the analysis.

Findings:

Of the 20 patients, 14 lived in the Southland area (6 Otago), 12 were female and 8 were male. 12 received their lung cancer diagnosis via the Emergency Department, 4 via referral from GP and 4 via an incidental finding. 11 had a cancer staging with the most advanced disease (stage four), 6 patients were stage three, 1 stage two, 2 stage one. The age of patients was as follows: between 45 and 55years, 1; 55-64 years,9; 65-74 years,7; 75years+,3. Figure 2 shows the types of first treatment provided.

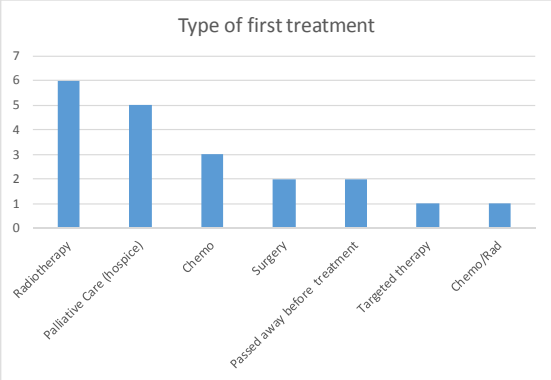


Figure 2: Types of first treatment received by 20 Māori lung cancer patients.

Although not part of this study, a quick comparison showed no discernable difference in waiting times between Māori and non-Māori once a referral to secondary care.

Data showed that all patients had contact with their GP in the previous 3 years. Patients with more advanced disease had variable attendance at the GP prior to diagnosis (see table 1).

Range of appointments with GP in preceding 3 years before diagnosis of lung cancer.		Frequency of attendance at GP with more advanced disease (stage 4)
Range	Patient	
1 to 10 visits	8	3
11 to 20 visits	3	3
21 to 30 visits	4	2
31 to 40 visits	4	2
41 to 50 visits	1	1

Table 1: Number of appointments to GP in the preceding 3 years before lung cancer diagnosis

50% of patients were not referred into secondary care in the two years preceding diagnosis - 10 patients had no referrals into secondary care, 8 patients were referred to other services (i.e., not respiratory) and 2 were referred into Respiratory.

19/20 patients were flagged for input from the Cancer Nurse Coordinators (CNC). 14 had active contact with the Cancer Nurse Coordinator Service. 5/20 were not actively managed by

the Cancer Nurse Coordinators either because they declined or there were other appropriate support services in place. One patient did not have CNC input.

Priority patients for Cancer Nurse Coordinator input (in which Māori and Pasifika are prioritized) is determine by a Southern DHB electronic Equity Tool which highlights the patients that are most likely to benefit from assistance with navigation. The tool identifies patients through an application that uses an algorithm over iPM patient data[2]. This means that as soon as there is a cancer flag applied (or other identification across systems), the patient is assigned an equity score. The higher the score, the further up the Cancer Nurse Coordination list a patient will appear. The Cancer Nurse Coordinators (who are based in secondary care and not specifically Māori) make contact with and support patients as soon as they appear on the list. In other words, they do not have to wait for referrals or notification via clinics or GPS.

Discussion:

Aotearoa is about to undertake its first trial into a lung cancer screening programme. It will focus on screening processes that will reduce lung cancer inequities for Māori compared to non-Māori. A National programme is at least 5 years away, however, should an opportunity arise to undertake early implementation (or an extension of a trial), we know that this would bring great benefit to Southern given our data is very similar to the larger North Island populations.

Whilst support from Cancer Nurse Coordinators appears comprehensive for this group of patients, it would be more appropriate for there to be a Māori Cancer Nurse Coordinator to provide broader cultural support at this critical time incorporating taha tinana (physical health), taha wairua (spiritual health), taha whanau (family health) and taha hinengaro (mental health).

Implementation of the Southern Equity Tool has been a game changer in terms of the speed with which support can be provided to patients who otherwise may find navigation of a complex cancer system difficult. It is easy to see how the tool may assist in routine hospital processes to support pro-equity strategies from a) which patients to phone and which to receive a letter, b) which patients to up-prioritise and see sooner, c) which patients to seek support for social needs.

Recommendation:

1. Feedback to GPs on the outcomes of the project
2. Recruit a Māori Cancer Nurse Coordinator to support Māori with cancer diagnoses
3. Modify and roll-out the Equity Tool to more general use in outpatients to improve equity of access and outcome.

Prepared by: Dr Janine Cochrane, General Manager Surgery and Radiology, October 2021

[2] The Equity Tool currently applies the following scores to each patient flagged: Māori or Pacific Islander – 2, >2 DNAs in the last 12 months – 1, All mental health specialty – 1, inpatient presentation in the last 12 months – 1, deprivation via address – 1, >=2 non cancer specialties – 1. The total is out of 7 points.

Presentation - Generalism

- Simon Donlevy – General Manager, Medicine, Women's and Children's
- Kathy Orr, Project Manager
- Sarah Kalmakoff, Service Manager, Medicine, Women's and Children's
- Dion Astwood, Consultant

FOR INFORMATION

Item: Chief Operating Officer (COO) – September 2021 report

Proposed by: Patrick Ng, COO

Meeting of: Hospital Advisory Committee, 01 November 2021

Recommendation

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

Purpose

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

1. Equity

A working group which included the GM, Surgery and Radiology, the Chief Māori Health Strategy and Improvement Officer, Primary and Community Medical Director, Clinical Leader for Medical Oncology, the Clinical Leader for Respiratory and a number of others recently completed a project on Màori Lung Cancer patients.

For simplicity they selected 20 Māori Lung Cancer tumour stream patients and undertook a study to better understand how these patients accessed secondary care and the stage their cancer was at when they did gain access. We have included a brief report on their study in HAC papers.

The stage of the patients' cancer at the time of presentation is important, as those with an early diagnosis will have a better rate of survival than those with a more advanced disease.

The project was consistent with an earlier study, which identified that Màori were more likely than non-Màori to access secondary care services via an urgent pathway such as Emergency Department presentation, Faster Cancer Treatment 62 day urgent pathway and inpatient admission rather than a non urgent referral pathway from a GP.

Their survey took 20 consecutive patients and traced their journey into secondary care services. It is important to temper the findings of the study with the approach that was taken (i.e. the study did not seek to draw a statistically validated sample).

Nothwithstanding this the study found that:

a. There was disproportionate cancers identified in Southland compared to Dunedin (14 compared to 6).

b. More women were diagnosed than men (12 compared to 8).

c. Of the 20, the majority (12) were diagnosed through an emergency department presentation (of the remainder, 4 were via GP referall and 4 were an incidental finding).

d. The majority had advanced disease with 17 diagnosed at either stage 3 or stage 4.

e. Nearly half (9 of the 20) were in the age cohort of 55-64 years.

The study also concluded that once the patient presented to secondary care there was no discernable difference between Māori and Non- Māori waiting times.

Although all patients had made several visits to their GP prior to their diagnosis, only 2 out of the 20 patients studied had been referred into respiratory services (8 patients had been referred to other services and 10 patients had not been referred to secondary care prior to diagnosis).

The study did not make a direct comparison to a non- Māori cohort (i.e. as a control group for comparative analysis) and this could be an enhancement for a future study which would allow us to better understand disparities.

Neverthless, the very low rate of referral from primary care into respiratory services (i.e. 10%), and the very high rate of diagnosis via an Emergency Department presentation (50%) is concerning and points to the problems with detecting this condition without a national screening programme as well as possible barriers to referral from primary care to secondary care. We need to look into the barriers to referrals in more depth if we are going to collectively identify actions that will improve equity and access in the future and we will pick this up with our Primary Care colleagues for further discussion and investigation.

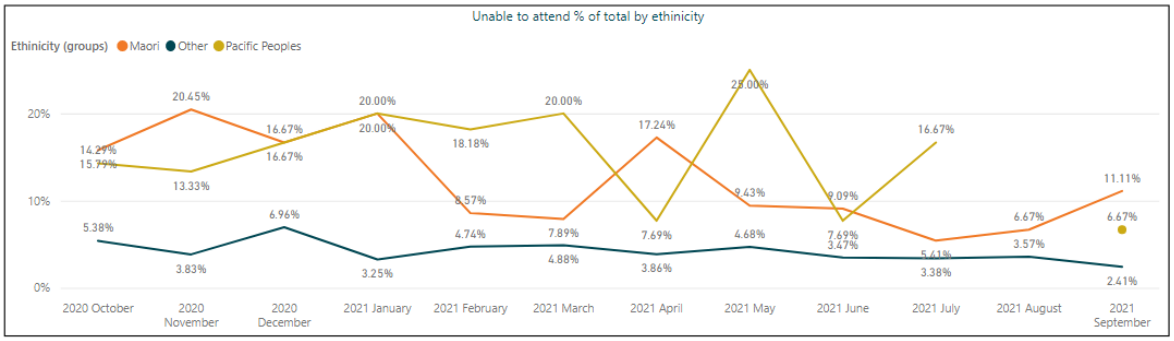
An initiative that has been in place for a number of years at Southern District Health Board is the equity tool. The cancer services use the equity tool to identify patients based on a scoring system which weights ethnicity (Màori and Pasifika), depravation and frequency of presentation (amongst other criteria) to determine which patients are raised as priority patients for navigation support via the Cancer Nurse Coordinators. By assigning those patients who score at the appropriate threshold to a Cancer Nurse Coordinator we can be confident that those who need coordination and additional support are getting additional assistance. There would be further value in undertaking a brief study on how well this has worked over the last few years and what difference it has made for those who have been identified and guided through the secondary care services they need. We have noted this as a good topic for a future study.

Equity workshops were carried out in Dunedin Outpatients (covering Cardiology/Respiratory and other medicine and surgical specialties) in June/July 2021. The workshops in Southland have been postponed twice due to COVID. They have since been re-scheduled for mid October. It is reassuring that a recent project at the Westcoast DHB demonstrated that with education/awareness being raised with administration teams alone, that DHB was able to significantly reduce their unable to attend rates. Our objectives are to provide awareness, and to improve how we book Màori and Pasifika patients. Our aim through the awareness workshops is to agree the changes that need to happen and understand the operational requirements. We will then develop incremental improvements, implement and test these and add to them as our understanding continues to improve. We expect to start trialing change to our scheduling from November 2021 onwards.

Cardiology First Specialist Assessment and Follow Up Unable to Attend Rates

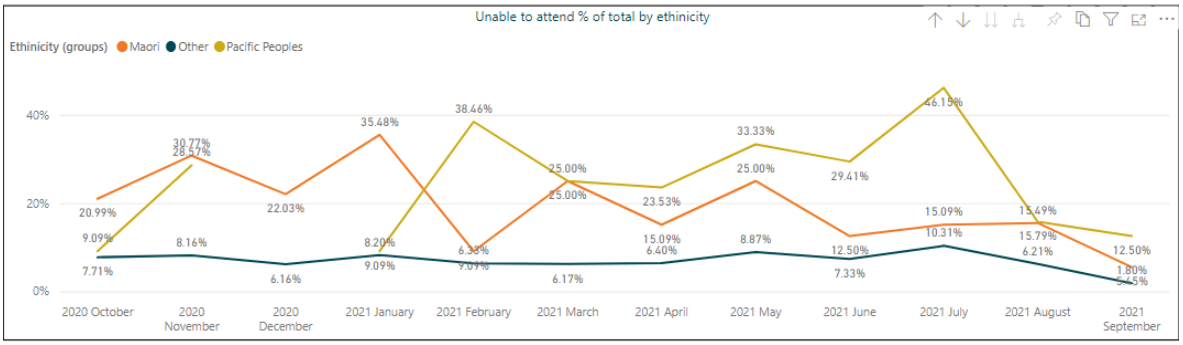
For the month of September the unable to attend (UAA) rates for Pasifika were 7% (noting very low numbers) and the rate for Màori was 11%. The rate for 'Other' was 2%. The September month was impacted by the COVID lockdown. Whilst the Pasifika rate may be a statistical anomoloy based on the low number of patients the uptick for Màori against an improvement for non-Màori may signal access challenges during COVID that were not present for non-Màori and it would be good to understand this better. To this end we have contacted Peter with several research proposals which, if picked up by interested University

students would give us better insights into the combined ethnicity and rurality challenges to access that are faced in our district.



Respiratory First Specialist Assessment and Follow Up Unable to Attend Rates

The unable to attend rate for Pasifika was 13% in September. Màori was 2% in September and 'Other' was 6%. Whilst the low Màori UUA rates are very encouraging we do not have good 'cause and effect' information to support this. We will monitor the modifications to the booking process from November to establish cause and effect with the intention of improving the UAA rates on an ongoing basis. This will be important in order for us to better understand what actions are / can be taken that are / will lead to better UAA rates for both our Paskifika and Màori patients.



2. Surgical Performance – Case Weight Discharges

The following tables outline our case weight discharge (CWD) and discharge performance for the September 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 September 2021/22 financial year to date we are -647.8 CWD behind plan, per the first circle in the first table. Case weight discharges measure the effort and complexity associated with surgery. For example, a cardiothoracic case is typically in the region of 6.8 CWD and a single case will consume a half day list, whereas a cataract case is typically in the region of 0.3 to 0.5 of a case weight and as 3 or 4 cases will be done on a half day list. The second table shows the 2021/22 discharges against plan, for the service provider view we are -683 discharges behind plan. The discharges record the actual number of patients who received surgery and then got discharged, irrespective of complexity.

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 September year to date we are -652.4 CWD behind this target and -681 discharges behind target.

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

Date 01/07/2021 30/09/2021 As at: 7/10/2021

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	336.8	324.9	11.9		8.2	-8.2	116.6	153.3	-36.6	453.4	470.6	-17.2	384.3	-47.5	496.0	-42.6
PUC Total	**336.8**	**324.9**	**11.9**		**8.2**	**-8.2**	**116.6**	**153.3**	**-36.6**	**453.4**	**470.6**	**-17.2**	**384.3**	**-47.5**	**496.0**	**-42.6**
Surgical PUC																
S00.01 General Surgery	757.1	821.0	-63.9	0.6	0.0	0.6	40.7	60.7	-20.0	797.2	881.0	-83.8	859.0	-101.9	885.9	-88.6
S05.01 Anaesthesia Services	1.2	0.0	1.2		0.0	0.0	0.0	0.0	0.0	1.2	0.0	1.2	1.6	-0.5	1.6	-0.5
S15.01 Cardiothoracic	381.5	387.9	-6.3		5.2	-5.2	3.7	5.7	-1.9	385.2	388.4	-3.2	461.7	-80.2	474.5	-89.3
S25.01 Ear Nose and Throat	300.4	373.3	-72.9	1.6	0.4	1.2	3.7	5.2	-1.4	302.5	378.0	-75.6	365.8	-65.5	371.8	-69.4
S30.01 Gynaecology	245.4	309.1	-63.7		0.4	-0.4	40.9	23.6	17.3	286.4	332.3	-45.9	288.9	-43.5	339.1	-52.7
S35.01 Neurosurgery	102.0	101.7	0.3		11.2	-11.2	37.6	44.0	-6.4	139.6	134.6	5.0	112.5	-10.5	140.6	-1.0
S40.01 Ophthalmology	178.7	321.3	-142.6		0.6	-0.6	3.9	1.7	2.2	182.6	322.5	-139.8	274.3	-95.6	277.6	-94.9
S45.01 Orthopaedics	1,026.9	1,310.0	-283.1	67.7	76.7	-8.9	66.1	29.5	36.6	1,025.3	1,262.8	-237.6	1,344.2	-317.3	1,278.0	-252.8
S55.01 Paediatric Surgical Services	24.7	51.4	-26.7		0.0	0.0	24.4	20.8	3.6	49.1	72.2	-23.0	35.2	-10.5	85.7	-36.6
S60.01 Plastic & Burns	114.7	182.8	-68.1	2.1	0.7	1.4	22.3	48.3	-26.0	134.9	230.4	-95.5	164.2	-49.4	181.0	-46.1
S70.01 Urology	314.7	300.5	14.2		0.7	-0.7	7.4	9.4	-1.9	322.2	309.1	13.0	325.6	-10.9	336.4	-14.2
S75.01 Vascular Surgery	290.8	238.9	51.9		3.0	-3.0	2.5	7.4	-4.9	293.3	243.3	50.0	209.2	81.6	213.2	80.1
PUC Total	**3,738.2**	**4,397.9**	**-659.7**	**72.0**	**98.8**	**-26.8**	**253.2**	**256.3**	**-3.0**	**3,919.4**	**4,554.7**	**-635.3**	**4,442.4**	**-704.2**	**4,585.3**	**-665.8**
PUC Total	**4,075.0**	**4,722.8**	**-647.8**	**72.0**	**107.0**	**-35.0**	**369.9**	**409.5**	**-39.6**	**4,372.8**	**5,025.3**	**-652.4**	**4,826.7**	**-751.7**	**5,081.3**	**-708.4**

Financial Period 1 3 Financial Year 2022 As at: 7/10/2021

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	136	150	-14		4	-4	26	36	-10	162	184	-22
PUC Total	**136**	**150**	**-14**		**4**	**-4**	**26**	**36**	**-10**	**162**	**184**	**-22**
Surgical PUC												
S00.01 General Surgery	421	471	-50	1	0	1	12	22	-10	432	491	-59
S05.01 Anaesthesia Services	6	0	6		0	0	0	0	0	6	0	6
S15.01 Cardiothoracic	61	63	-2		1	-1	3	1	2	64	63	1
S25.01 Ear Nose and Throat	303	444	-141	2	1	1	6	8	-2	307	451	-144
S30.01 Gynaecology	280	296	-16		1	-1	18	12	6	298	307	-9
S35.01 Neurosurgery	27	31	-4		3	-3	12	15	-3	39	43	-4
S40.01 Ophthalmology	305	593	-288		1	-1	5	2	3	310	593	-283
S45.01 Orthopaedics	432	560	-128	5	11	-6	35	23	12	462	572	-110
S55.01 Paediatric Surgical Services	34	54	-20		0	0	23	20	3	57	74	-17
S60.01 Plastic & Burns	130	178	-48	2	1	1	11	21	-10	139	198	-59
S70.01 Urology	290	278	12		1	-1	4	6	-2	294	283	11
S75.01 Vascular Surgery	103	96	7		2	-2	0	1	-1	103	95	8
PUC Total	**2,392**	**3,062**	**-670**	**10**	**20**	**-10**	**129**	**131**	**-2**	**2,511**	**3,170**	**-659**
PUC Total	**2,528**	**3,211**	**-683**	**10**	**25**	**-15**	**155**	**167**	**-12**	**2,673**	**3,354**	**-681**

The large variance to target reflects the impact that the COVID lockdown had on surgical delivery. Surgical delivery was ramped up as quickly as possible for the month of September as lockdown restrictions were lifted and this is reflected in closer performance to the target for the month of September than what was achieved in August per the following tables.

Period: 3 | Financial Year: 2022 | As at: 7/10/2021

MTD CASEWEIGHTS

	MTD Service Provider View			- MTD IFL			+ MTD OFL			MTD Population View		
PUC	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance
Non Surgical PUC												
Non Surgical PUC with Surgical DRG	103.6	108.0	-4.4		2.7	-2.7	51.1	51.1	0.0	154.7	156.6	-1.9
PUC Total	**103.6**	**108.0**	**-4.4**		**2.7**	**-2.7**	**51.1**	**51.1**	**0.0**	**154.7**	**156.6**	**-1.9**
Surgical PUC												
S00.01 General Surgery	264.4	274.6	-10.2		0.0	0.0	20.2	20.2	0.0	284.7	294.6	-9.9
S05.01 Anaesthesia Services	0.6	0.0	0.6		0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.6
S15.01 Cardiothoracic	142.0	128.8	13.2		1.7	-1.7	1.9	1.9	0.0	143.8	129.0	14.8
S25.01 Ear Nose and Throat	109.3	124.1	-14.8	0.7	0.1	0.5	1.7	1.7	0.0	110.4	125.7	-15.3
S30.01 Gynaecology	91.2	102.8	-11.6		0.1	-0.1	7.9	7.9	0.0	99.1	110.5	-11.4
S35.01 Neurosurgery	34.6	33.8	0.9		3.7	-3.7	14.7	14.7	0.0	49.3	44.8	4.5
S40.01 Ophthalmology	63.3	116.6	-53.3		0.0	0.0	0.6	0.6	0.0	63.9	117.2	-53.3
S45.01 Orthopaedics	357.1	434.6	-77.5	16.5	25.2	-8.6	9.8	9.8	0.0	350.4	419.2	-68.9
S55.01 Paediatric Surgical Services	9.2	17.1	-7.9		0.0	0.0	6.9	6.9	0.0	16.1	24.0	-7.9
S60.01 Plastic & Burns	44.2	60.7	-16.5		0.2	-0.2	16.1	16.1	0.0	60.3	76.6	-16.3
S70.01 Urology	121.4	99.9	21.5		0.2	-0.2	3.1	3.1	0.0	124.5	102.8	21.7
S75.01 Vascular Surgery	122.8	79.4	43.4		1.0	-1.0	2.5	2.5	0.0	125.3	80.9	44.4
PUC Total	**1,360.1**	**1,472.4**	**-112.3**	**17.2**	**32.3**	**-15.0**	**85.4**	**85.4**	**0.0**	**1,428.3**	**1,525.3**	**-97.1**
PUC Total	**1,463.7**	**1,580.4**	**-116.7**	**17.2**	**35.0**	**-17.7**	**136.5**	**136.5**	**0.0**	**1,583.0**	**1,682.0**	**-99.0**

Period: 3 | Financial Year: 2022 | As at: 7/10/2021

MTD DISCHARGES

	MTD Service Provider View			- MTD IFL			+ MTD OFL			MTD Population View		
PUC	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance
Non Surgical PUC												
Non Surgical PUC with Surgical DRG	39	50	-11		1	-1	12	12	0	51	61	-10
PUC Total	**39**	**50**	**-11**		**1**	**-1**	**12**	**12**	**0**	**51**	**61**	**-10**
Surgical PUC												
S00.01 General Surgery	143	158	-15		0	0	7	7	0	150	165	-15
S05.01 Anaesthesia Services	3	0	3		0	0	0	0	0	3	0	3
S15.01 Cardiothoracic	21	21	0		0	0	0	0	0	21	21	0
S25.01 Ear Nose and Throat	106	148	-42	1	0	1	3	3	0	108	150	-42
S30.01 Gynaecology	113	98	15		0	0	4	4	0	117	102	15
S35.01 Neurosurgery	10	10	0		1	-1	5	5	0	15	14	1
S40.01 Ophthalmology	107	215	-108		0	0	1	1	0	108	216	-108
S45.01 Orthopaedics	152	184	-32	1	4	-3	8	8	0	159	188	-29
S55.01 Paediatric Surgical Services	12	18	-6		0	0	7	7	0	19	25	-6
S60.01 Plastic & Burns	48	59	-11		0	0	7	7	0	55	66	-11
S70.01 Urology	114	92	22		0	0	2	2	0	116	94	22
S75.01 Vascular Surgery	39	32	7		1	-1	0	0	0	39	32	7
PUC Total	**868**	**1,036**	**-168**	**2**	**6**	**-4**	**44**	**44**	**0**	**910**	**1,072**	**-162**
PUC Total	**907**	**1,085**	**-178**	**2**	**8**	**-6**	**56**	**56**	**0**	**961**	**1,133**	**-172**

During September Dunedin have been able to consistently fill their theatre lists, but we have continued to face workforce shortages in Southland and this is having an impact on

our ability to fully utilise our operating theatres. This is a key risk to operational performance. We have vacancies comprising circa 30% of our perioperative nursing workforce in Southland and we have anaesthetic technician vacancies. Whilst we have had some success with recruitment, we are facing delays with getting overseas recruits and we have further retirements pending. We have approached our HR colleagues about a Haines Attract style campaign, and the Haines Attract team have visited a number of teams in Southland who are experiencing workforce shortages. We are now awaiting a proposal from Haines Attract with some lateral thinking to attract the skills that we need into the Southland region.

Another constraint at Southland hospital is inpatient beds. A cross disciplinary team have developed a model utilising nursing trainees to resource 10 beds in the assessment, treatment and rehabilitation area (AT&R), and we have confirmed with the training institution that they can supply the necessary trainees from the start of February. We have confirmed with our medical colleagues that these will be inpatient medical beds, which will allow the medical outliers (which typically average 6-8 per day) who are in the surgical ward to be relocated there, and this in turn will provide additional surgical beds which will remove this constraint and allow for more surgery to be delivered.

Further work has occurred on the development of our 'production plan'. The production plan is currently a rudimentary model which quantifies how much of our annual planned care surgical target we believe we will be able to achieve and what additional initiatives we believe are required in order to achieve this target. We have developed the production plan on the basis of what would have been delivered pre-wind down for the nursing strike and pre-the impact of the COVID lockdown and we have then identified what mitigations we can take to get back to the planned number. We have then added in the impact of nursing strike wind down and COVID lockdown and added further mitigations to see how close we can get to the planned care surgical target.

Based on our workings we believe that prior to COVID we would have been circa 1,000 case weight discharges (CWD) short of the annual target of 17,600 CWD, without initial mitigations being undertaken. This is primarily due to lower productivity because of nurse ward vacancies and our inability to fully recruit into the Southland perioperative team. We then identified initiatives that will improve our delivery capability. The key initiatives are adding 10 inpatient beds at Southland hospital (planned to be 'on stream' in February 2022), and additional acute surgical list time in Dunedin (planned to start in early 2022, currently in discussion with our anaesthesia colleagues to reach consensus on how these will be staffed). With these initiatives and on the assumption of minor improvement to surgical throughput as a consequence of care capacity demand management (CCDM) investment (noting that this initiative is primarily about quality rather than capacity), our calculations suggest we can offset our underlying productivity losses pre-COVID.

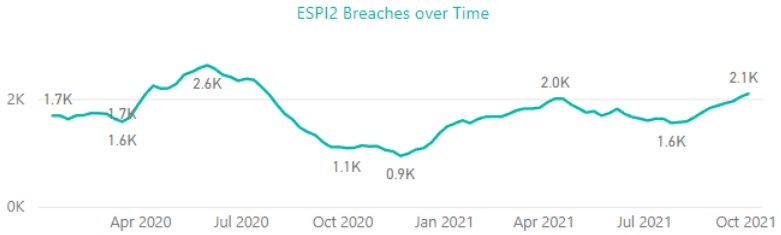
However, when we introduce the productivity loss caused by COVID shutdowns, further mitigations then become necessary. These are largely focused on external outsourcing, as there are minimal opportunities to further add to our internal surgical capacity beyond the initiatives noted above. We have made conservative assumptions about our ability to gain additional outsourced capacity in Dunedin and Southland and we have made conservative assumptions about our ability to gain outsourced capacity at the new Queenstown facility when it opens in early 2022. Based on our assumptions, we would still be short of our annual surgical target by circa 400 CWD. Our next step is to consider what additional outsourcing capacity we can get at Queenstown, and what additional outsourcing capacity we might be able to get outside of the district for some cases (noting that many of our cases are unsuitable to outsource because of their complexity and the ongoing requirements associated with the patients' post-surgical care). We are continuing to refine the model and to progress with the actions required to implement the initiatives identified in the model.

Production planning and production engineering are disciplines that we are keen to introduce at SDHB. These disciplines can logically be extended across most outpatient, procedure and inpatient services and would allow better forecasting and planning associated with our core hospital activities. We believe that Auckland DHB have dedicated roles, robust tools and a sound overall approach to the use of these disciplines and we are awaiting a drop in COVID alert levels to enable us to visit and to review their approach in more depth. We have also considered requesting virtual access to their key team and the tools but as they are dealing with significant disruption due to COVID we are holding off until it is appropriate to either visit virtually or in person.

3. Outpatient Performance ESPI 2

The following chart shows the total number of 'ESPI' outpatient appointments on our waiting list over time (i.e., total wait list including 'breach' and 'non-beach' patients). It shows growing wait lists coming out of the first 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 as is a period of stabilisation prior to the second COVID lockdown in August of this year. Since the start of the second lockdown to the beginning of October there has been a slight improvement in the waitlist numbers.

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). The number of breaches dropped after the first COVID lockdown – a concerted effort went into catching up the long waiting patients and by November those breaching had dropped from a peak of 2,600 during the first COVID lockdown to 900. However, there was a delayed growth in demand (as seen in the total wait list also) from early this calendar year. Our breach numbers peaked in April at 2,000 and we were again gaining some traction on getting the breach numbers down, but the latest COVID lockdown has led to our current breach numbers of 2,100.



As noted in the next section, the breach numbers are most prevalent in a small number of specialities and our plan for addressing these is also noted.

ESPI 2 Breaches by Speciality and Directorate

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

Our ESPI 2 performance has worsened in key specialities and several specialities in Southland account for a relatively large proportion of our overall breaches (e.g., 133 for orthopaedics Southland, 207 for general surgery in Southland, 449 for ENT in Southland and 319 for gynaecology in Southland). I.e., circa 59% 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.

All specialities	DN	Sthld	Total	
Neurosurgery	123	0	123	6%
Orthopaedics	180	133	313	15%
Haematology	11	0	11	1%
Gynaecology	32	319	351	17%
Vascular	56	9	65	3%
Cardiology	5	4	9	0%
Urology	3	7	10	0%
ENT	73	449	522	25%
Plastics	104	0	104	5%
Respiratory	4	0	4	0%
General Surgery	80	207	287	14%
Dermatology	17	22	39	2%
Renal Medicine	0	1	1	0%
Neurology	46	2	48	2%
Ophthalmology	7	32	39	2%
General Medicine	1	5	6	0%
Rheumatology	71	15	86	4%
Diabetes	1	4	5	0%
Endocrinology	23	8	31	1%
Gastroenterology	1	14	15	1%
Oncology	1	0	1	0%
Paed Medicine	1	15	16	1%
Paed Surgery	2	1	3	0%
Radiation Oncology	3	0	3	0%
Anaesthesia	6	0	6	0%
Total	**851**	**1247**	**2098**	**100%**
% by site	**41%**	**59%**	**100%**	

Surgery	
Neurosurgery	123
Orthopaedics	313
Vascular	65
ENT	522
Plastics	104
General Surgery	287
Urology	10
Ophthalmology	39
Paed Surgery	3
Anaesthesia	6
Breach share	**70%**

Medicine	
Haematology	11
Gynaecology	351
Cardiology	9
Respiratory	12
Dermatology	39
Renal Medicine	2
Neurology	46
Diabetes	5
Rheumatology	86
General Medicine	7
Endocrinology	31
Gastroenterology	14
Oncology	1
Paed Medicine	16
Radiation Oncology	3
Breach share	**30%**

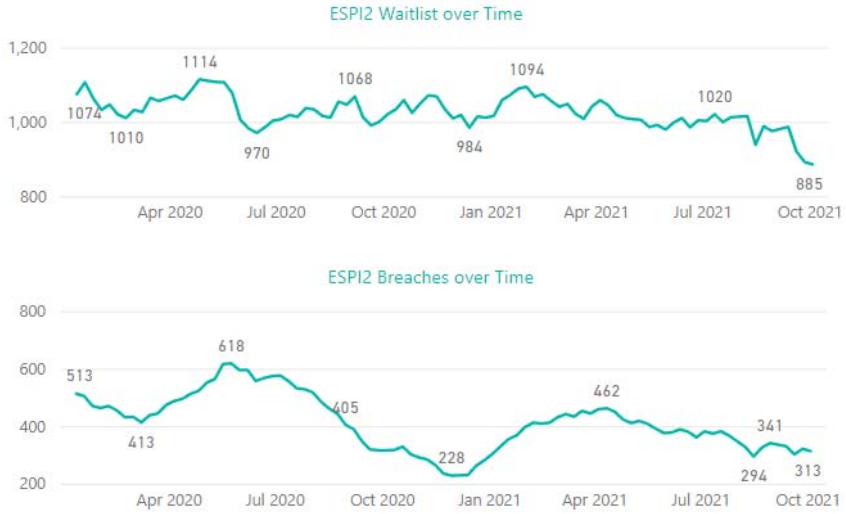
72% of our breaches are in 4 specialities – orthopaedics, gynaecology, ear, nose and throat (ENT) and general surgery.

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. Coming out of the second lockdown in August and September of this year the overall waitlist has

decreased to circa 885 and the number of breaches has remained relatively stable at circa 300. The approximate split between Dunedin and Southland is 180 in Dunedin and 133 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 in Southland. Breach numbers have recently improved in Southland – we have had breaches of circa 200 to circa 250 for some time – the current breach numbers of circa 133 are an improvement and are largely attributable to additional clinics that we have been able to undertake.

The use of the prioritisation tool in Dunedin and continuing to apply tight acceptance criteria in Southland (combined with additional clinics when we are able to resource these) is leading to a reduction of the breaches (and the total wait list) over time and we are continuing to apply these levers to manage the overall breaches on the wait list.



Gynaecology Outpatient Waitlist and ESPI 2 Breaches

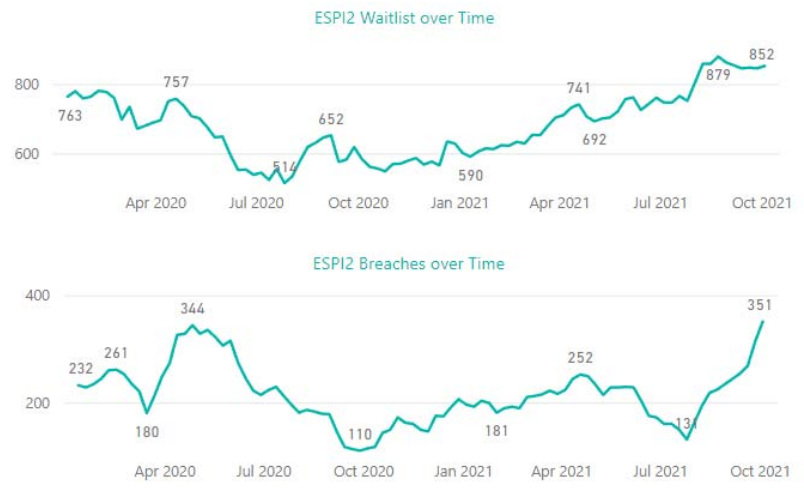
As noted earlier, the main challenges that we have are in the Southland service. The Southland service has regular Senior Medical Officer staffing (SMO) of 5.8 FTE. However, we have had regular gaps in this service for some time (maternity leave and vacancies). The service has used locums whenever it 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.

While SMO staffing remains a challenge, the Clinical Leader, who recently returned to the USA for personal reasons has been granted an emergency MIQ spot and will return to work at the start of November. Another SMO from the USA has accepted a role with a planned start date of later this year, however given the strain on MIQ spots, this could well be postponed until next year. SMO capacity was at crisis point earlier this month but with the

confirmed return of the clinical leader we believe we have sufficient capacity to manage urgent patients and a proportion of our less urgent patients. There continue to be risks with the overall staffing levels for this service.

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. Initiatives already taken include Dunedin clinicians coming to Southland and providing support for the Southland service and reaching out to the other South Island Chief Executives to see whether we can either send some of our more routine patients to other regions or there is available SMO capacity to come down to Southland to provide assistance.

In terms of future planning, 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 placed on this service. However, the next 4-6 months will require careful balancing of what we accept into the service given the available capacity within the service.



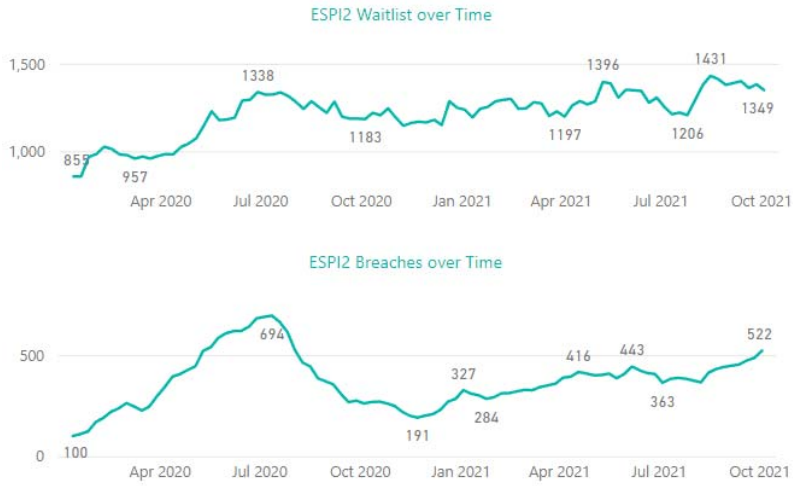
ENT Outpatient Waitlist and ESPI 2 Breaches

ENT remains a challenge with only a small decrease in the waitlist and an increase in the number of breaches. As noted previously the key challenge is in Southland, however since the August and September lockdown the number of breaches on both sites has increased,

Dunedin has increased to 73 breaches and Southland has 449 ESPI 2 breaches. The Southland service has carried vacancies for some time, one SMO who started recently is working under supervision, as required by the Medical Council, and is steadily taking on an increased workload. Another SMO who was offered a role with an expected start of September this year has withdrawn and recruitment for this role has re-recommenced.

The two district service managers are working together to determine how best to utilise Dunedin capacity to support Southland. They have also taken steps to raise thresholds to reduce what is accepted into the services given the lack of available capacity in Southland. Triaging of referrals for the whole district is undertaken in Dunedin.

The size of the wait list will need to be systematically worked down over time, but the most important initiative for achieving this is the steps that have been taken to reduce the rate at which referrals are being accepted given the capacity constraints that exist in the Southland service.



4. 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. Breaches have then been exacerbated by the latest COVID lockdown. 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) have increased from August to October by circa 400 patients.

As noted earlier, there are ongoing issues gaining access to elective theatre in Southland. A specific piece of work has started to address Southland specific surgical challenges, and this includes a plan to open 12 additional beds (10 beds initially) by February 2022 and a recruitment campaign to attract more perioperative staff. The beds will be staffed utilising a nurse training model. This is an innovative way to staff the beds given the challenges with vacancies and recruitment and is made possible through good collaboration with the local nurse training organisation. All parties consulted with appear enthusiastic about the

approach being taken. The additional beds will be internal medicine beds and will enable us to remove internal medicine outlier patients from the surgical ward. This in turn will enable more surgery to be undertaken. Once implemented together with our initiatives to improve perioperative staffing we believe we will see a meaningful uplift in Southland surgical delivery.

ESPI 5 breaches by speciality

Seventy-eight percent of our breaches are in the four specialties highlighted in red, below. In contrast to the ESPI 2 breach break-down by site in which Southland is the larger of the two, the ESPI 5 breach challenge is predominantly on the Dunedin site which accounts for 71% of our overall breaches.

Surgery	DN	Sthld	Total	
Neurosurgery	23	0	23	1%
Orthopaedics	654	199	853	40%
Vascular	74	0	74	3%
ENT	282	112	394	18%
Plastics	151	0	151	7%
General Surgery	148	56	204	9%
Gynaecology	17	19	36	2%
Urology	29	39	68	3%
Paediatric Surgery	2	0	2	0%
Dental Surgery	0	104	104	5%
Ophthalmology	160	88	248	11%
Cardiothoracic	0	0	0	0%
Max Fax	0	0	0	0%
Total	**1540**	**617**	**2157**	**100%**
% by site	**71%**	**29%**	**100%**	

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, the impact of high acute demand (also earlier in the calendar year) and the most recent lockdown in August and September. The Timaru hospital initiative planned to deliver 3 orthopaedic patients per week however with the recent lockdown and the tragedy that occurred with their orthopaedic surgeon this number decreased to circa 4 patients per month. The General Manager for Surgery is in negotiation with Mercy hospital and is seeking to increase the number of outsourced patients operated on there. A Service Improvement Manager will commence from 1 November and one of their priorities will be to finalise and complete the orthopaedic recovery plan for both Dunedin and Southland.

As noted earlier, outsourcing will be key to the recovery plan as we are constrained in terms of our secondary care capacity, relative to the size our waiting list. This service was particularly badly impacted by both COVID lockdowns, as practically none of the planned orthopaedic surgery is urgent, so their elective capacity was severely curtailed during the lockdowns. The size of the wait list is now a multi-year initiative to address.

As noted previously, the ability to catch up on these wait lists is a national problem. Locally, the General Manager Surgery and Radiology has been asked to work through raising the access criteria for surgery, but nationally some consideration is likely to be made about whether the current wait list might need tighter criteria applied to it retrospectively. No decisions have been made on this to date, but we are working with our Ministry colleagues and awaiting guidance about taking further steps to address the time our longest waiting patients have spent on the waiting list.

Our production planning has made conservative assumptions about the available theatre capacity that will be made available once Southern Cross Queenstown opens in early 2022. We are hoping to gain further theatre capacity and provided that we can identify suitable cases on our waiting list to be undertaken at Queenstown this will add additional capacity that can be used in our recovery plan. We are also continuing to utilise Timaru hospital per the arrangements we put in place earlier this year and will increase the utilisation of this if they are able to provide us with further capacity in the future.

ENT ESPI 5 Breaches

Although there was a slight decrease in breaches in August to 339, the impact of the COVID lockdown has had an impact and the numbers are starting to increase – we had 494 breaches at the start of October. Although we had successfully recruited 2 surgeons into Southland, one has pulled out and we will now need to reinstitute our recruitment. An immediate initiative has been to raise the threshold for what is accepted for surgery, and further work is required to determine whether the GP initiative (whereby GP's undertake suitable skin lesion work in a GP setting rather than in a secondary care setting) can be further extended. The General Manager – Surgery and Radiology has been asked to work with her strategy, primary and community colleagues to assess whether more of this diversion to primary care is a possibility.

General Surgery ESPI 5 Breaches

The recent lockdown has also affected General Surgery (although they were able to continue with their most urgent cases). Our experience from the last lockdown is that cancers did not get detected at the rate they usually would, so we are expecting some form of increase in urgent cases in the next few months, although this will be less than during the previous lockdown as the recent lockdown was of a shorter duration. Before the COVID lockdown we had believed that Dunedin's capacity for urgent cases was sufficiently under control that we could apply more capacity from the team to be applied to benign cases on an ongoing basis, starting in September. However, due to uncertainty about pending demand for urgent work and to ensure we have the ability to respond to this, we have put a hold on this initiative for now. When we do get this initiative underway it will assist us to systematically work the longest waiting patients off our wait list as this capacity will be directly applied to those on the wait list who have been given certainty and for whom surgery is still appropriate.

5. Recovery Approach for Long Waiting Patients on our Waitlists (Inpatient and Outpatient)

Our largest challenge (and primary focus) is patients waiting for inpatient surgery.

ESPI 5 (Surgery Long Waiting) Patients

COVID lockdowns and the challenges we have previously outlined in gaining access to either surgical lists or inpatient recovery beds has resulted in the number of patients waiting more than 1 year for surgery growing.

We have established a working group to provide a particular focus on these low urgency but long waiting cases with the intention of gaining access to surgery for these cases or otherwise appropriately removing these patients from the waiting lists. The team is already meeting to review these on a weekly basis, but the addition of a working group gives added emphasis and allows for broader solutions to be considered and implemented.

The key actions taken are as follows:

a. Where a patient has been given certainty, meets criteria and is waiting behind higher priority cases we are attempting to book these onto available theatre slots in the first instance. Some cases have been able to be completed in this manner.
b. Where a patient is long waiting and low complexity, we have booked these for outsourced surgery where this is possible. There are limitations to this, as a number of these patients are complex and need to be done in the public hospital.
c. We have had the long wait list clinically reviewed. And we are in the process of formulating process that will enable long waiting patients who tip over the 365 day threshold to be reviewed, so that all long waiting patients at any given time have been reviewed.
d. We have also undertaken an administrative review, and where patients are found to be a data quality error (left the district, had surgery privately, no longer want the surgery) we have cleansed the wait list accordingly.
e. And where patients need to meet conditions which they have not, and where appropriate to do so we have completed a 'transfer of care' to return these patients to their GP, with the provision for the GP to fast track them back onto the inpatient wait list if the criteria for them to access their surgery is met within 12 months. Reasons for patients to fall into this category include needing to lose weight or quit smoking before the surgeon is prepared to undertake surgery.

These actions have resulted in a number of patients being removed from the wait list. Over the 5 week period from which we initiated this intensive review with the Planned Care Manager, GM Surgery and Radiology and the Service Managers, 116 long waiting patients have been successfully moved off the waiting list. However, our net movement is considerably lower than this as 91 patients have subsequently tipped over the 365 day threshold. Noting that we have surgery dates for 13 of our long waiting patients, the net movement is therefore (+116 + 13 – 91 equals 38 net patient movement from the waiting list).

A table showing the net movement is as follows:

Additions and exits to inpatient waiting list for patients waiting over 365 days					
	13/09/2021				21/10/2021
	Patients waiting >365 days	Additions >365	Exits >365	Patients with surgery date	Waiting >365 days with no surgery date
Dental Surgery	0	1	0	1	0
E.N.T	31	9	8	4	28
ENT Surgical	21	3	9	1	14
General Surgery	15	4	4	0	15
Gynaecology	0	1	0	0	1
Neurosurgery	1	0	0	0	1
Ophthalmology	14	3	8	1	8
Orthopaedic Surgery	11	5	4	0	12
Orthopaedics	203	50	57	6	190
Plastic Surgery	18	3	5	0	16
Spec Paediatric Surg	0	1	0	0	1
Surgical Services	26	5	17	0	14
Urology	3	1	1	0	3
Vascular Surgery	32	5	3	0	34
Total	375	91	116	13	337

Next Steps

As we deal with COVID lockdowns and their aftermath, and the more subtle challenges that are also related (e.g., nursing roster gaps), our long waiting patient numbers have grown and an ongoing focus is required to systematically work them off the wait list as quickly as possible.

In addition to the actions taken (noted above), further actions need to be taken to achieve the required outcomes. These include:

- Transfer of care. We have a good transfer of care policy (which we developed earlier this year), and we need to ensure that it is applied consistently and systematically in all services. A transfer of care back to the GP will typically be a good option where a patient has a medical condition that needs treatment before they can have their surgery or must meet a specific health condition such as losing weight or stopping smoking. Having them on the wait list with no progress on these conditions is arguably not the best care that the wider system can give to the patient. When a transfer of care is initiated, the patient is returned to their GP but the GP can gain fast track access back to the inpatient wait list provided that the health condition is met within 12 months. We have asked our GM Surgery and Radiology and our Planned Care Manager to systematically work through the services (administrative teams and clinical leaders) to implement this approach and to review the long waiting patients with this lens applied.
- Reviewing the approach to patients being placed on the waiting list when conditions need to be met. The above is arguably an 'ambulance at the bottom of the cliff.' We have also asked our GM Surgery and Radiology and our Planned Care Manager to review with the services the conditions under which patients are added to the inpatient wait list in the first place. I.e., if there are conditions that will be challenging to meet before the patient can have their surgery, arguably, the patient should not be put on the inpatient wait list in the first place but should be returned

to the GP with clear instructions for the GP and the patient to follow before the patient becomes eligible for surgery.

- We are in the process of initiating better reporting for long waiting patients. Going forward, reporting will be provided which shows the long waiting patients (> 365 days) who have been successfully removed from the waiting list, long waiting patients who have tipped into the wait list and the net long waiting patients on the waiting list, by speciality. We will also institute processes so that those who tip on each month are clinically reviewed, so that we know that every long waiting patient has been reviewed, and we will initiate an administrative review for each patient that tips on as well. This will require manual reporting and process set up in the first instance (and this will be driven by the Planned Care Manager), but we will get it in place, and we will improve upon it over time. This is a logical inclusion for the Performance and Accountability framework.
- And we are planning a long wait list surgical list for General Surgery from early 2022. The service was preparing to start this weekly list prior to the latest COVID lockdown (as it had gotten on top of its urgent cancers) but now needs to further catch up before we can regularly institute this.
- Given the accumulations onto our wait lists we now also need to review the score at which surgery is agreed to, as we need to balance our available capacity between our existing wait list and ongoing additions to the wait list. The GM Surgery and Radiology and Planned Care Manager will work through this speciality by speciality.
- Patients waiting an excessively long time (we are using the marker of 600 days) are a much smaller number (56 cases, excluding deferred patients). These are sufficiently small numbers when broken down by service that we can reasonably expect a case by case explanation by Service Manager in our weekly meetings about the status of these cases and the steps being taken to remove them. We are setting up our weekly reporting on this basis.

Sub-Set Patients >= 600 days by Speciality (excluding deferred patients)

Speciality	NHI Count > 600
ENT - Otalaryngology (ORL)	5
General Surgery - Vascular	15
General Surgery	3
Orthopaedic Surgery	26
Plastic Surgery	5
Urology General	1
Other	1
Total	**56**

Whilst getting the total cases > 365 days down is challenging, as we are somewhat constrained by our internal theatre capacity (as many of these cases are too complex to complete in private surgery), the key to achieving this is applying available policies well (like the 'transfer of care' policy), ensuring that we outsource all available cases, ensuring that we appropriately prioritise available inpatient theatre for these cases and ensuring that our processes are set up optimally in the first place to minimise the number of cases which require pre-requisites to be achieved before they can receive surgery.

ESPI 2 (Outpatient) Long Waiting Cases

Our outpatient wait list is considerably more manageable with a total of 45 patients waiting > 365 days for their FSA appointment. The Planned Care Manager has weekly reporting and review work in place with the Service Managers, and rather than lose our focus on the inpatient surgical patients we are leaving the management and review of these patients at this level.

A breakdown of the additions, exits and total numbers > 365 days by speciality is outlined in the following table.

Additions and exits to outpatient waiting list for patients waiting over 365 days					
	13/09/2021				21/10/2021
	Patients waiting >365 days	Additions >365	Exits >365	Patients with outpatient appointment date	Waiting >365 days with no appointment date
ENT	6	9	5	6	4
Endcrinology	1	0	1	0	0
ENT surgical	5	9	4	6	4
General Surgery	14	7	9	3	9
Gynaecology	0	4	0	0	4
Haematology	0	1	0	0	1
Neurology	3	0	2	0	1
Neurosurgery	2	13	1	0	14
Ophthalmology	1	0	1	0	0
Orthopaedics	11	1	9	0	3
Vascular Surgery	3	6	3	1	5
Total	46	50	35	16	45

6 of these patients are in the medicine, women and children specialities. However, the majority (39) are win surgical specialities. With an ongoing focus, use of our 'acuity tool' and 'prioritisation tool' (for those specialities we have rolled this out to, which include the bigger specialities – Orthopaedics and General Surgery) we anticipate systematically dropping the number of patients waiting > 365 days back towards zero in the coming months. This is likely to be compromised, however, if endemic COVID constrains outpatient capacity.

6. Emergency Departments

Per the following table, demand in the month of September was lower than our year to date average, noting the impact of the COVID lockdowns was a reduction in ED demand, but to a lesser extent than during the COVID lockdown last year, and that we came out of the lockdown relatively early in September.

September 2021	Admit	Non-Admit	Admit %	Total Presentations	Average Presentation
Southland	627	2255	21.8	2882	96
Dunedin	983	2471	28.5	3454	115

Financial Year to September 2021	Admit	Non-Admit	Admit %	Total Presentations	Average Presentation
Southland	2026	7226	21.9	9252	100
Dunedin	3206	8040	28.5	11246	122

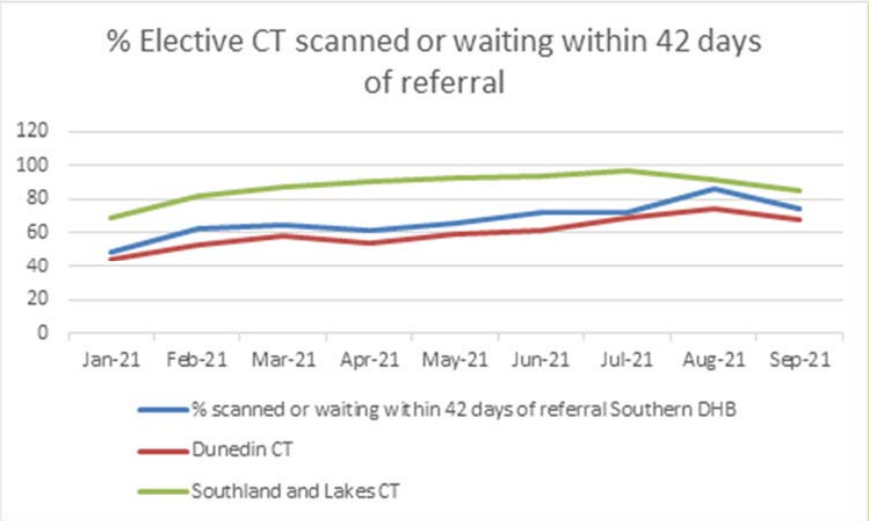
The minimum number of presentations at Dunedin during the month was 72 in a day and the maximum number was 135. The minimum number in Southland was 77 and the maximum was 116.

Key to improving flow and therefore ED performance in Dunedin is the implementation of the medical assessment unit, to be built next to the Emergency Department. Planning and de-canting work is now well underway. We have also tasked the Generalism project team with initiating the medical assessment unit approach utilising the existing medical assessment unit (on the 7th floor) so that we can get the most we can out of the generalist team whilst we wait for the new medical assessment unit to be built. This requires them to recruit the physiotherapists that were a part of the generalism business case and to implement, adapt and improve upon the medical assessment unit care model. They will cover this in their presentation on generalism. Good progress has been made with the recruitment of the SMO's for the 2 team generalism model, the establishment of service level agreements with the sub-specialities, and increasing the percentage of patients admitted under the generalist (as opposed to sub-specialist) team/s. This will be covered in the generalism presentation. There also appears to be a substantial improvement in the re-admission rate for general medicine admitted patients. Next logical steps whilst we await the construction of the new medical assessment unit are to trial / adapt and improve the medical assessment unit model using the existing medical assessment unit, and to commence with the reconfiguration of the wards in order to optimise the location of internal medicine patients and to minimise 'safari' ward rounds.

Key to improving flow and therefore ED performance in Southland is the development of the ED expansion space. Planning is now underway with the design consultants. One of the project managers on the building and property team has identified that the new 5th theatre could be built on top of the ED expansion space (this was previously thought not to be possible). This approach would lower the cost of the 5th theatre in Southland and would also reduce the amount of de-canting, shuffling and timeframes associated with the 5th theatre project. This concept is being worked up as the preferred option for the 5th theatre and will be presented as a brief business case in the coming months.

7. Radiology

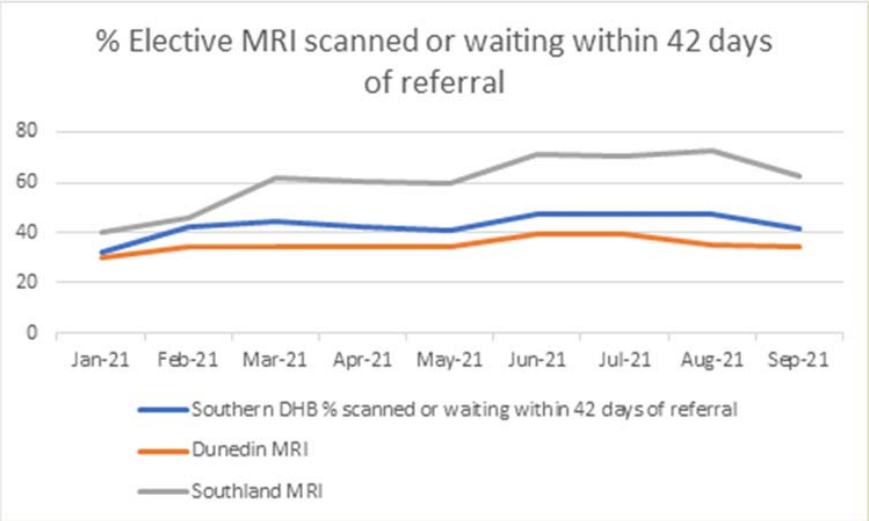
CT Performance (The target is that 95% of planned CT's are completed within 42 days).



The CT performance deteriorated in September due to the August COVID level restrictions. The team scanned at higher rates than during the previous lockdown, but this still resulted in a loss of capacity. 146 patients were postponed as a consequence of the COVID 19 lockdown, these have now been rescheduled and/or scanned. Notwithstanding the disruption, the overall performance against the target of circa 77% remains considerably higher than it has been historically and this will only improve with the full benefit of the additional sessions on the second scanner. The new CT scanner in Dunedin started scanning on the 20th of September. Patients prioritised for this scanner include procedures and interventional radiology. Whist we anticipate that demand will start to increase as we slowly and systematically lift our intervention rate to be more aligned to Southland and our other peers, we are also anticipating that we will continue to improve our performance against the elective target.

Another initiative that we have underway is increasing GP direct access to CT. A GP has been identified to work with the Radiology team to increase direct GP access to High Tech imaging with an initial focus on CT. This is a 9 month project and is due for completion in June 2022.

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



The September result dropped due COVID restrictions, particularly at Southland where planned evening sessions were unable to proceed until the return to level 2. A total of 199 patients were postponed, all of whom have now been rescheduled. Overall performance continues to be circa 40-44%, primarily due to capacity constraints in Dunedin.

The second MRI scanner for the Dunedin site has been ordered with an estimated 26-week delivery timeframe. The design work for the location of the new MRI machine is underway. In a similar manner to the CT, we anticipate a significant lift in performance once the new MRI machine is installed and commissioned.

8. Oncology

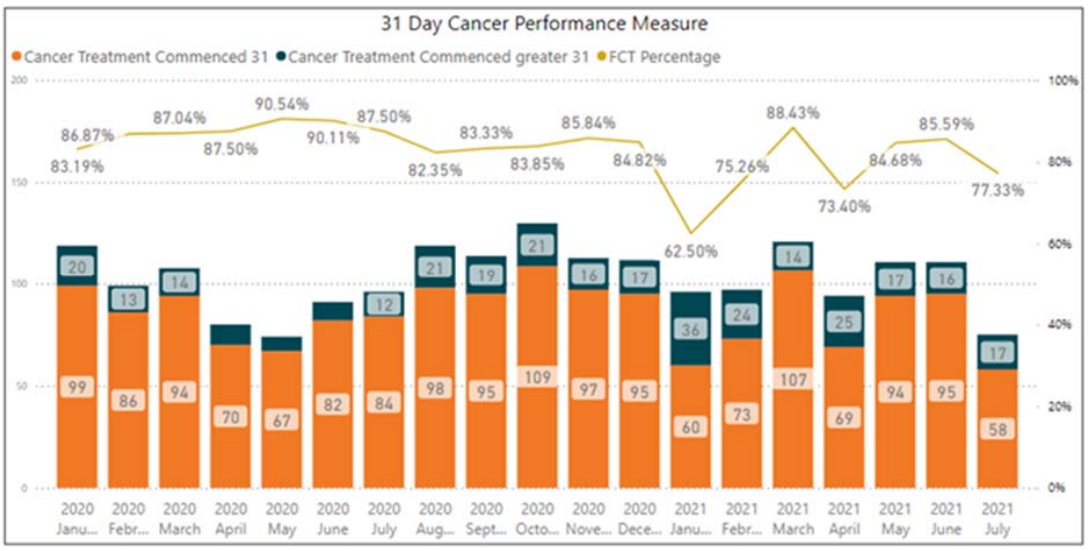
The radiation oncology wait list remains at circa 80 (a significant reduction from its peak of 160 four months ago), and the consequential wait times are much more satisfactory, e.g., median wait time of 4 weeks for semi-urgent patients compared to 6-8 weeks previously. We are continuing to utilise outsourcing to both St Georges in Christchurch and to Ikon in Wellington to minimise the impact of the additional volumes of FSA's being seen causing a wait for treatment on our LINAC machines. Our medical oncology and haematology wait lists have seen modest improvement as well.

As noted in regular, weekly reporting to the Board we have had good success with recruitment, with several medical oncology SMO's, a haematology SMO, circa 5 RMO's (trainee doctors) across all 3 services and clinical nurse specialist roles all successfully recruited into. We also have 2 suitable candidates soon to be interviewed for the additional physics roles that are being invested in this year.

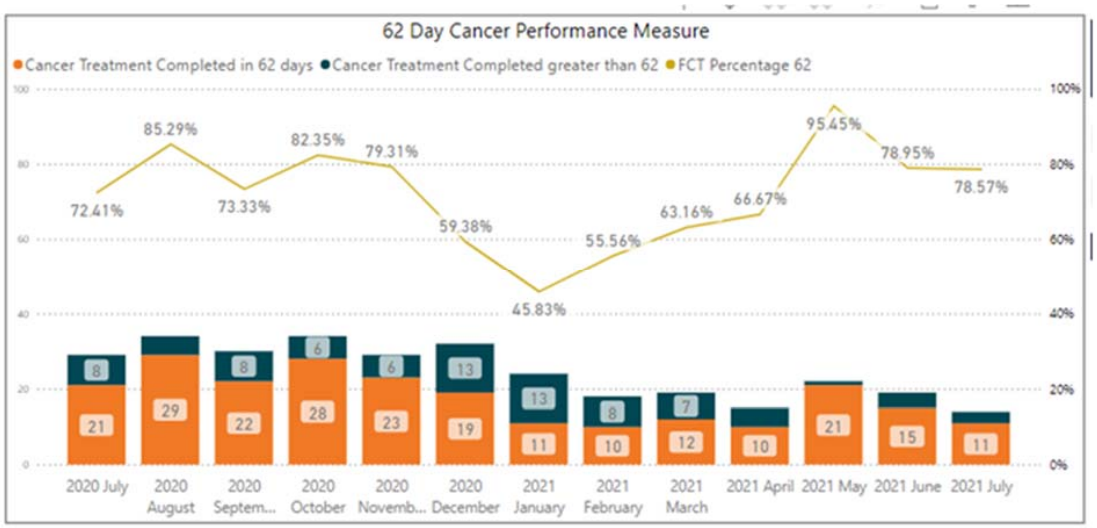
Our focus is now on the completion of the Ernst & Young benchmarking study. The study is using a combination of empirical (observation based), qualitative and quantitative data analysis to determine whether our services are under resourced relative to our peers in the other cancer centres and will then recommend immediate opportunities to us that would allow ourselves to align our level of resourcing if we are below par. The report is on schedule to be completed in November. An early version will be presented to the ELT and an updated version will then be presented to the Board (targeting the November Board meeting in December).

Unfortunately, we are having reporting challenges which is limiting our ability to report on August and September faster cancer treatment results. Per our previous report, the additional focus that we have placed upon reporting has improved our 62 day FCT reported results in the last quarter from circa 71% historically to circa 79% for the last quarter. We believe that the current quarter, once finalised, will reflect a similar level of performance (i.e., circa 80%).

31 day performance to July 2021



62 day performance to July 2021



9. Endoscopy

The *real time wait list* continues to show good performance, with the average and median wait times in all categories sitting inside the waiting times targets across the district. The only category not achieving the target wait times is surveillance patients in Invercargill where our recovery plan is ongoing and has been disrupted due to the latest COVID lockdown.

Surveillance waiting times in Invercargill continue to be the subject of a recovery plan with priority being given to colonoscopy (as opposed to gastroscopy), additional weekend lists, clinical review of the waiting list (in line with new surveillance guidelines) and patients being offered appointments in Dunedin as capacity increases on that site.

The Ministry wait time indicators are as follows:

Ministry of Health Colonoscopy Wait Time Indicators		
	Recommended	Maximum
Urgent	90% within 14 calendar days	100% within 30 calendar days
Non-urgent	70% within 42 calendar days	100% within 90 calendar days
Surveillance	70% within 84 days	100% within 120 days
NBSP	95% within 45 working days	

Noting these timeframes, the performance per our real time wait list is as follows.

Real time waitlist - combined

Priority new	No of Waiting Patients	Average waiting time	Median Wait time	Longest Wait
Diag Urgent	9	11.67	6.00	65
Diag Non-Urgent	128	31.59	25.00	141
Diag Planned and Staged	1	175.00	175.00	175
NBSP	42	8.40	7.50	27
SURV	331	66.57	34.00	265

Real time waitlist - by region

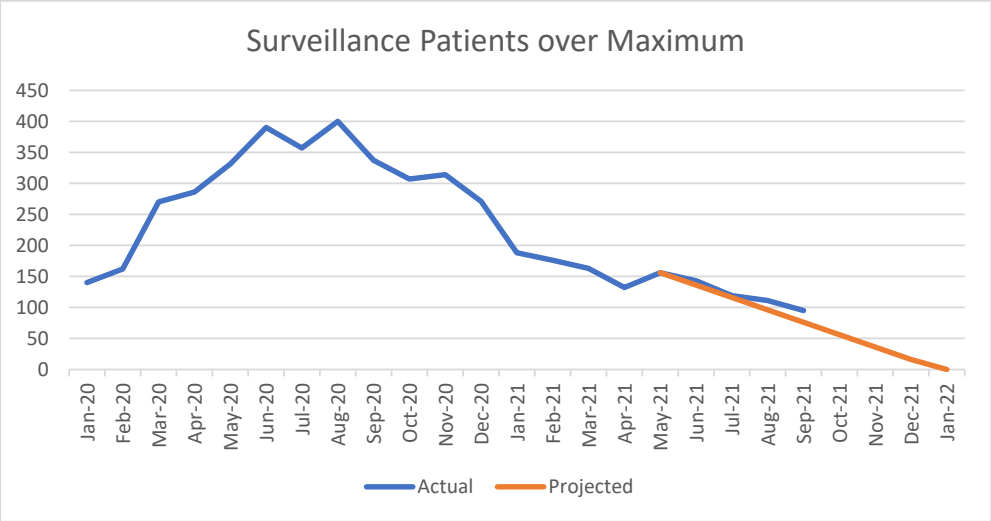
Hospital	No of Waiting Patients	Average waiting time	Median Wait time	Longest Wait
Southland				
SURV	190	99.38	97.00	265
NBSP	9	11.33	9.00	27
Diag Planned and Staged	1	175.00	175.00	175
Diag Non-Urgent	67	39.28	34.00	141
Diag Urgent	4	4.25	4.00	8
Dunedin				
SURV	141	22.35	13.00	167
NBSP	33	7.61	7.00	23
Diag Non-Urgent	61	23.13	20.00	68
Diag Urgent	5	17.60	7.00	65

Maximum Wait time Breach

Hospital	Urg >30	Non urg >90	SURV >120	NBSP > 45
Southland		5	75	
Dunedin	1		2	
Total	**1**	**5**	**77**	

The ‘planned and stage’ category is now substantitively removed (as requested) with only 1 pateint remaining in this category and no new patients being added to the category.

Despite COVID lockdown recovery of surveillance patients waiting over their maximum time in Southland remains broadly on target. We still anticipate that these patients will be caught up by end of January 2022.



The split of the non urgent wait list shows that the majority of patients are waiting with the 42 day target timeframe.

Non Urgent Waitlist Split

Hospital	Upto 42 days	43 to 49 days	50 to 59 days	60 to 69 days	70 to 79 days	80 to 89 days	90 days or greater	Total
Southland	38	11	5	5	1	2	5	67
Dunedin	53	3	2	3				61
Total	**91**	**14**	**7**	**8**	**1**	**2**	**5**	**128**

The overall Ministry of Health Colonoscopy Waiting Time Indicator for the month of September was not met for urgent or non-urgent patients but was met for Surveillance and National Bowel Screening. Urgent patients represent a small cohort and the two week timeframe means that patient factors often influence this category. Non-urgent patients have been deprioritised to allow recovery of surveillance patients and the impact of the COVID lockdown has impacted on overall performance. It is expected that non-urgent performance will be quickly recovered.

Performance on Ministry Targets - Region combined

End of Month	Diag Urgent 14 days(90%)	Var Urgent	Non Urgent 42 days (70%)	Var Non Urgent	NBSP 45 Days (95%)	NBSP Var	Surv 84 Days (90%)
30 November 2020	100.00%	10.00%	79.40%	9.40%	100.00%	5.00%	16.67%
31 December 2020	92.86%	2.86%	91.34%	21.34%	98.68%	3.68%	39.18%
31 January 2021	78.38%	-11.62%	75.38%	5.38%	98.46%	3.46%	46.27%
28 February 2021	88.89%	-1.11%	85.06%	15.06%	100.00%	5.00%	42.86%
31 March 2021	94.23%	4.23%	89.66%	19.66%	97.96%	2.96%	48.40%
30 April 2021	92.68%	2.68%	80.68%	10.68%	96.94%	1.94%	59.12%
31 May 2021	90.20%	0.20%	82.63%	12.63%	98.98%	3.98%	61.08%
30 June 2021	84.31%	-5.69%	87.50%	17.50%	98.82%	3.82%	59.02%
31 July 2021	86.89%	-3.11%	80.27%	10.27%	100.00%	5.00%	63.80%
31 August 2021	92.73%	2.73%	86.03%	16.03%	100.00%	5.00%	72.49%
30 September 2021	85.37%	-4.63%	61.07%	-8.93%	98.31%	3.31%	86.90%

Performance on Ministry Targets - by region

Region	Dunedin						Southland					
End of Month	Diag Urgent 14 days (90%)	Var Urgent	Non Urgent 42 days (70%)	Var Non Urgent	NBSP 45 Days (95%)	NBSP Var	Diag Urgent 14 days (90%)	Var Urgent	Non Urgent 42 days (70%)	Var Non Urgent	NBSP 45 Days (95%)	NBSP Var
30 November 2020	100.00%	10.00%	84.62%	14.62%	100.00%	5.00%	100.00%	10.00%	69.81%	-0.19%	100.00%	5.00%
31 December 2020	100.00%	10.00%	90.40%	20.40%	98.11%	3.11%	83.33%	-6.67%	93.51%	23.51%	100.00%	5.00%
31 January 2021	78.95%	-11.05%	78.91%	8.91%	100.00%	5.00%	77.78%	-12.22%	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%	93.83%	23.83%	98.55%	3.55%	95.45%	5.45%	82.83%	12.83%	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%	97.22%	2.22%
31 May 2021	87.80%	-2.20%	81.15%	11.15%	98.39%	3.39%	100.00%	10.00%	84.62%	14.62%	100.00%	5.00%
30 June 2021	82.05%	-7.95%	87.90%	17.90%	100.00%	5.00%	91.67%	1.67%	86.96%	16.96%	96.88%	1.88%
31 July 2021	77.78%	-12.22%	86.93%	16.93%	100.00%	5.00%	100.00%	10.00%	70.34%	0.34%	100.00%	5.00%
31 August 2021	90.00%	0.00%	90.84%	20.84%	100.00%	5.00%	96.00%	6.00%	79.59%	9.59%	100.00%	5.00%
30 September 2021	84.62%	-5.38%	78.16%	8.16%	97.30%	2.30%	86.67%	-3.33%	37.10%	-32.90%	100.00%	5.00%

10.A summary of key operational challenges

Whilst risks are covered comprehensively in the Audit & Risk Committee reporting there are a number of operational challenges that are worth summarising in our HAC Committee report. Some of these challenges have been included in earlier commentary. These are worth noting again for emphasis.

Midwifery in Dunedin and Southland.

Vacancies are an ongoing challenge for both the Southland and Dunedin midwifery services. These vacancies have been an issue for some time now and a shortage of midwives is also a national challenge. We are currently utilising registered nurses to work alongside midwives to support the provision of postnatal care. Our General Manager Operations is working with the union (MERAS) and with the Director of Nursing and the staff in the midwifery team to optimise the arrangements that are in place whilst continuing to recruit into these key vacancies.

Obstetrics and Gynaecology in Southland

As noted earlier in this report we have a number of vacant Senior Medical Officer positions in this service. We have been fortunate to be able to get an MIQ slot for our clinical leader and are expecting him back in the service soon. Over November and December, we will be carrying circa 2 vacancies from a team of circa 5 (i.e., 40%). This situation improves from December, where our vacant FTE drops to circa 0.5 (i.e., 10%). We believe we have enough cover in the service to continue to provide our acute service and to manage a proportion of our planned care workload, but we will need to continue to manage the demands on the service carefully until the recently confirmed appointments into the service are on-board and we now need to plan the recovery of the backlogs that have accumulated in this service.

Perioperative Staffing in Southland

As noted earlier in our report, perioperative staffing in Southland remains a key operational challenge for us and we have asked our HR colleagues for help to improve our targeting and attraction via a Haines Attract style campaign. The challenges associated with these vacancies are leading to some rostered shifts not being able to be filled when sickness or overnight acute case load is too high. This in turn is leading to circa 1 half day list not being able to be resourced on a regular basis.

The teams are working hard on mitigating the impacts of these operational challenges as much as practically possible. However, there remain unmitigated challenges for these services.

11. Case weight, Discharges and Volumes

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,556	**2,673** Actual YTD vs 3,354 Plan YTD, as at September 2021

Note the above discharges exclude improvement action plan volumes.

Refer to Appendix 1 - Volume variances, this paper had been provided to the Board.

FOR INFORMATION – Appendix 1

Item: July 2021 internal elective volumes compared to July 2020

Proposed by: Patrick Ng, Executive Director, Specialist Services

Meeting of: 05 October 2021

Recommendation

It is recommended that the Board notes the key reasons for volume variances between July 2021 and July 2020.

Summary

Dunedin Case Weight Discharges (CWD) for Elective Surgery, Acute Surgery and Medical Inpatients were down by -1.3% in 2021 and this was also reflected in inpatient bed nights used, which were down by -2.1%. Surgery (elective and acute surgery) was also down by -2.1% whilst surgical minutes were down by -8%, suggesting that we delivered more CWD for the theatre minutes we used in July 2021. Overall, underlying internal CWD delivery was similar in July 2021 to July 2020, but we could have delivered +104 CWD more surgery if we had used the same theatre minutes in 2021 that we used in 2020.

Southland Case Weight Discharges (CWD) for Elective Surgery, Acute Surgery and Medical Inpatients were up by +1.3% in 2021. Inpatient bed nights had -0.6% growth once medical inpatient CWD growth was accounted for. Surgery (elective and acute surgery) was down by 5.5% whilst surgical minutes were down by +5.4% which is directionally similar. However, there was a high level of overall substitution in Southland, with -107 CWD of elective surgery lost but more than offset by increased acute surgery and medical inpatient CWD. Overall, high acute and medical demands directly impacted on Southland's elective surgical performance when July 2021 is compared to July 2020. In Southland we could have delivered +32 CWD more surgery if we had used the same theatre minutes that we used across elective and acute surgery in July 2020.

Purpose

1. To clarify what drove performance in each year so that a valid comparison can be made between July volumes delivered in 2021 compared to July 2020.

Background

On face value the elective case weight delivery (CWD) was higher in July 2020 than what was achieved in July 2021 and a piece of analysis work has been undertaken to explain the key differences between the two July months.

This report has focused on comparing internally delivered volumes (elective surgery, medical case weights and acute surgery). Outsourced surgery was higher last year than this year, primarily in Dunedin, as last year we sought to catch up from the COVID lockdown and we maximised what we could get done before the private hospitals filled their lists back up. To improve the comparability of the two years we have focused on the

change in internal elective delivery by backing out the impact of the additional outsourcing work which was completed in 2020.

Other differences between the two July months include there being an extra working day in July 2020 and additional catch-up lists being run in the weekends in July 2020.

Dunedin Explanation:

Internal elective case weight delivery was -50 CWD this year compared to last year. The explanations are captured in the following bridge.

Bridge (elective internal):		
a Weekend Lists in 2020	-15	-1%
b 1 Less Working Day 2021	-41	-3%
c Unexpected Loss OT 6	-30	-2%
d Other	36	2%
	-50	-3%

a) Weekend lists completed in July 2020 explained -15 CWD of difference between years.

b) An additional working day in July 2020 explained an additional -41 CWD.

c) In July 2021 operating theatre 6 was out of commission for a week which had a -30 CWD impact.

There is a further +36 CWD that we aren't able to explain between the years (d).

However, total CWD across elective surgery, acute surgery and medical inpatients was -44 CWD on total volume of 3,428 CWD, translating into a 1.3% reduction in CWD volume overall. This is due to combined acute surgical and medical CWD increasing slightly (6 CWD) year on year.

We then cross referenced this to the theatre minutes that were used in July 2021 and July 2020, and we have also cross referenced this to the inpatient bed days used in both years.

In terms of the elective theatre minutes used, there is an overall reduction in theatre minutes used in July 2021 compared to July 2020 of -8.0% across elective and acute surgery.

In comparison, elective surgery and acute surgery were down a total of -43 CWD on 2020 volumes of 2,046 CWD, indicating a CWD deterioration of -2.1%. This suggests that we delivered more surgery for our theatre minutes in 2021 compared to 2020, which is both a slight productivity gain, but also an opportunity cost as we would have delivered more surgery if we had used the same theatre minutes that we used last year. The opportunity cost translates into +104 CWD of additional activity that could have been delivered if we had used the same number of theatre minutes as we used last year.

In cross referencing to the inpatient bed nights used, we found that once we had accounted for the extra medical inpatient stay case weights, there was an underlying reduction in bed nights used of -147 bed nights. On 2020 volumes of 7007 bed nights this translates into a reduction in bed nights used of -2.1%.

Overall conclusions for Dunedin:

Overall, on a CWD basis there is a -1.3% productivity loss compared to 2020 across elective surgery, acute surgery and medical inpatient case weights, including known differences which are accounted for in the bridge included in this analysis. There is also a reduction of inpatient bed nights of -2.1%, which is directionally consistent. However, the elective and acute CWD were -2.1% less in July 2021 compared to July 2020, whilst the theatre minutes used were -8.0% less July 2021 compared to July 2020.

This leads us to conclude that underlying productivity across elective surgery, medical case weights and acute surgery was marginally lower in 2021 than in 2020 once the key differences explained in the bridge are taken into account, but CWD delivered for the theatre minutes used was actually slightly higher in 2021 than in 2020. There is an opportunity cost, as if we had used the same theatre minutes that we used in July 2020, we would have delivered a further +104 CWD of activity.

Once key differences are explained, internal CWD productivity is very comparable between July 2021 and July 2020, but we do need to note the opportunity cost of the theatre minutes not used compared to July 2020.

The differences noted above are shown in the following table.

Dunedin 2021 July Internal Volume Delivery Compared to Dunedin 2020

	Elective Surgical	Elective Medical	Total Elective Delivery (CWD Actual)	Acute Surgical	Non-Elective Medical	Total Non-Elective (CWD)	Total Activity CWD
CWD July 2020	1,217	332	**1,548**	829	1,051	**1,880**	**3,428**
CWD July 2021	1,066	356	**1,422**	861	1,025	**1,886**	**3,308**
	-151	25	**-126**	32	-26	**6**	**-120**
Outsource Change	76		**76**				**76**
Net Intenal Delivery Change	**-75**	**25**	**-50**	**32**	**-26**	**6**	**-44**

Bridge (elective internal):

a	Weekend Lists in 2020	-15	-1%
b	1 Less Working Day 2021	-41	-3%
c	Unexpected Loss OT 6	-30	-2%
d	Other	36	2%
		-50	-3%

Differences 2021 to 2020 (elective) **-50**

Difference 2021 to 2020 acute **6**

Total Variance for all Case Weight Discharge Activity (2021 compared to 2020)	**-44**
Overall Productivity Change 20201 to 2020 in CWD:	**-1%**

Cross Refence 1:

Elective Theatre Minutes 2021	71,603		
Elective Theatre Minutes 2020	81,316		
Change in Theatre Minutes:	-9,713		
Percentage Change:	-12%		
Bridged Elective Productivity (-75 CWD X 70 minutes)	-5,700	(Explained elective surgical minutes lost).	
Residual Productivity Gain / Opportunity Cost	-4,013	-5%	(Residual surgical minutes lost).
Opportunity Cost in Lost CWDs	**-54**		

Acute Theatre Minutes 2021	53,347	
Acute Theatre Minutes 2020	54,561	
Additional Acute Theatre Minutes:	-1,214	
Percentage Change:	-2%	
Bridged Acute Productivity (32 CWD x 65 minutes)	2,080	
Residual Productivity Gain / Opportunity Cost	- 3,294	
Opportunity Cost in Lost CWDs	- **47**	

Total Residual Productivity Gain / Opportunity Cost (in minutes)	-	**7,307**
Overall reduction in surgical minutes used (elective and acute) 2021 compared to 2020		**-8%**
Total Lost CWDs Due To Productivity Reduction	-	**104**

Cross Reference 2:

Total Inpatient Bed Nights 2020	7,007
Total Inpatient Bed Nights 2021	6,856
Change in Inpatient Bed Nights	-151
Percentage Change:	-2%
Change in Bed Nights Associated with Medical CWD (4 days ALOS X -1 CWD):	-4
Change in Bed Nights net of Medical Case Weight Change:	-147
Net Change in Inpatient Bed Nights July 2021 to July 2020 (elective & acute surgery):	**-2%**
Note: Outsourcing volumes were lower in 2021 than in 2020	*-76*

Southland Explanation:

There is, however, a more significant elective productivity loss in Southland, primarily due to higher medical and acute CWD activity leading to reduced elective CWD activity.

Internal elective case weight delivery was -107 CWD this year compared to last year. Compared to last years' volumes of 478 CWD this translates into a -22.4% reduction in activity. Acute and Medical CWD volumes were +120 more than last year and on last years' volumes of 840 this is a +14.2% increase. This translates into a total CWD variance across elective surgery, medical case weights and acute surgery of +12 CWD on volumes of 1,319, which is an overall increase of activity of +0.9%.

In terms of the reduction in underlying internal elective activity in 2021 compared to 2020, it is explained by the following bridge.

a Weekend Lists in 2020	-8	-2%
b 1 Less Working Day 2021	-12	-3%
c Other (note - primarily explained by acute and medical)	-87	-18%
	-107	-22%

a) Weekend lists completed in July 2020 explained 8 CWD of difference between years.

b) An additional working day in July 2020 explained an additional 12 CWD.

Whilst there was a deterioration of -107 CWD for elective surgery in 2021 compared to 2020, there was an increase in acute surgery and medical inpatient, which led to an overall CWD increase in July 2021 compared to July 2020 of +12 CWD. This indicates that the lost elective surgery CWD were (slightly) more than offset by other additional activity in acute surgery and medical inpatient CWD.

We then cross referenced this to the theatre minutes that were used in July 2021 and July 2020, and we have also cross referenced this to the inpatient bed days used in both years.

The overall movement on theatre minutes (elective and acute) was -2,502 minutes on 2020 volumes of 46,224 minutes, representing a -5.4% reduction in minutes used. Elective and acute surgery CWD were down -41. On July 2020 volumes of 751 CWD this represents a reduction of -5.5%. For Southland the reduction in surgical CWD therefore appears well aligned to the reduction in theatre minutes that were used.

In cross referencing to the inpatient bed nights used, we found that 2,613 bed nights were used in July 2020 and 2,757 bed nights were used in July 2021. This translated into a +5.5% increase in bed nights used year on year. However, after accounting for additional medical inpatient CWD delivered in July 2021 compared to July 2020 we find that there is a -0.5% change in bed use year on year.

Overall conclusions for Southland:

Overall, on a CWD basis there is a +0.9% productivity **gain** compared to 2020 across elective surgery, acute surgery and medical inpatient case weights, including accounting for known differences in July 2021 compared to July 2020. There is a -0.6% change to inpatient bed nights used once the additional inpatient medical CWD is accounted for. The elective and acute surgical CWD were -5.5% less in July 2021 than in July 2020, and this is consistent with the -5.4% reduction in theatre minutes in July 2021 compared to July 2020.

This leads us to conclude that underlying CWD productivity across elective surgery, medical case weights and acute surgery was marginally higher in 2021 than in 2020, particularly once key differences explained in the bridge are taken into account. There is also an opportunity cost, as if we had used the same theatre minutes that we used in July 2020, we would have delivered a further +32 CWD of activity.

However, the key observation for Southland is that acute CWD and medical inpatient CWD (driven by demand) were substituted for elective CWD, leading to lost elective CWD of -107 CWD when July 2021 is compared to July 2020.

Southland 2021 July Internal Volume Delivery Compared to Dunedin 2020

	Elective Surgical	Elective Medical	**Total Elective Delivery (CWD Actual)**	Acute Surgical	Non-Elective Medical	Total Non-Elective (CWD)	**Total Activity CWD**
CWD July 2020	438	40	**478**	313	528	**840**	**1,319**
CWD July 2021	321	45	**366**	384	576	**960**	**1,326**
	-117	4	**-112**	71	49	**120**	**8**
Outsource Change	5		**5**				**5**
Net Intenal Delivery Change	-112	4	**-107**	71	49	**120**	**12**
Bridge (elective):							
a Weekend Lists in 2020			-8	-2%			
b 1 Less Working Day 2021			-12	-3%			
c Other (note - primarily explained by acute)			-87	-18%			
			-107	-22%			
Differences 2021 to 2020 (elective)							**-107**
Difference 2021 to 2020 (non-elective)							**120**
Total Variance for all Case Weight Discharge Activity (2021 compared to 2020)							**12**
Overall Productivity Change 20201 to 2020:							**1%**
Cross Refence 1:							
Elective Theatre Minutes 2021		17,956					
Elective Theatre Minutes 2020		25,877					
Change in Theatre Minutes:		-7,921					
Percentage Change:		-31%					
Elective Productivity Bridge (112 CWD X 60 minutes)		-6,720	(Explained elective surgical minutes lost).				
Residual Productivity Gain / Opportunity Cost		-1,201	-5%	(Residual surgical minutes lost).			
Opportunity Cost in Lost CWDs		**-20**					
Acute Theatre Minutes 2021						25,766	
Acute Theatre Minutes 2020						20,347	
Change in Theatre Minutes:						5,419	
Percentage Change:						27%	
Bridged Acute Productivity Bridge (71 CWD x 65 minutes)						4,615	
Residual Productivity Loss / Opportunity Cost						804	
Opportunity Cost in Lost CWDs						**12**	
Total Residual Productivity Gain / Opportunity Cost (in minutes)						-	**397**
Overall reduction in surgical minutes used (elective and acute) 2021 compared to 2020							**-5%**
Total Lost CWDs Due To Productivity Reduction						-	**32**
Cross Reference 2:							
Total Inpatient Bed Nights 2020							2,613
Total Inpatient Bed Nights 2021							2,757
Change in Inpatient Bed Nights							144
Percentage Change:							6%
Change in Bed Nights Associated with Medical CWD (3 days ALOS X 53 additional CWD):							159
Change in Bed Nights net of Medical Case Weight Change:							-15
Net Change in Inpatient Bed Nights July 2021 to July 2020 (elective & acute surgery):							**-1%**
Plus Productivity Change in Outsourcing:							*-5*

Recommendation

It is recommended that the Board notes that:

Underlying internal elective delivery was broadly comparable between July 2021 and July 2020 for Dunedin once known differences (per the bridge in the analysis) are taken into account. However, we have delivered slightly more CWD for the theatre minutes that were used than we did in 2020 and there is an opportunity cost – if we had used the same theatre minutes as we did in 2020, we could have delivered an additional +107 CWD across elective and acute surgery.

Underlying internal elective delivery was significantly lower (-107 CWD) in July 2021 compared to July 2020 for Southland. However, there is a direct substitution of both acute surgery CWD and medical inpatient CWD taking up what would otherwise have been elective surgical CWD resources (theatres and beds). I.e., acute and medical demands directly impacted on Southland elective surgical performance when July 2021 is compared to July 2020.

FOR INFORMATION

Item: Financial Report for the period ended 30 September 2021

Proposed by: Grant Paris, Management Accountant

Presented by: Patrick Ng, Chief Operating Officer

Meeting of: 1 November 2021

Recommendation

That the Hospital Advisory Committee notes the Financial Report for the period ended 30 September.

Purpose

1. To provide the Hospital Advisory Committee with the financial performance for the month and year to date ended 30 September 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: **September 2021**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **14 October 2021**

Overview

Results Summary for Specialist Services

1. September 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 Mental Health and Addiction Services and the support services of Building and Property, Information Technology, Finance and Management.

Month				Year To Date			Year End
Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000	Budget $000
47,042	47,379	(337)	Revenue	137,952	142,101	(4,149)	568,129
25,050	25,362	312	Less Workforce Costs	75,098	75,995	896	313,707
14,592	13,688	(903)	Less Other Costs	40,012	40,138	126	153,124
7,401	**8,329**	**(928)**	**Net Surplus / (Deficit)**	**22,842**	**25,969**	**(3,127)**	**101,299**

For September 2021, Specialist Service had a contribution to non-clinical and overhead costs of $7.4m, which is $0.9m unfavourable 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.

Appendix 1: Financial Report for the Hospital Advisory Committee

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

Elective case weights excluding maternity actuals for September:	1,678
Minus: elective medical case weights actuals for September:	-318
Add: medical case weights which count for elective plan (from HAC report) for September:	104
Equals: total elective case weight actuals delivered against plan for September	1,464
Elective case weights excluding maternity plan for September:	1,785
Minus: elective medical case weights plan for September	-313
Add: medical case weights which count for elective plan (from HAC report) for September	+108
Equals: total elective case weight plan for September	1,580

On this basis we delivered 116 case weights (CWD) less than the elective plan for the month of September.

Sep-21				Sep-20	YEAR ON YEAR		YTD 2021/22				YTD Sep-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,416	1,487	(71)	-5%	1,508	(92)	Acute	4,530	4,575	(45)	-1%	4,494	36
960	982	(22)	-2%	1,054	(94)	Otago	2,977	3,018	(41)	-1%	3,047	(70)
456	505	(49)	-10%	454	2	Southland	1,553	1,557	(4)	0%	1,447	106
318	313	5	2%	341	(23)	Elective	1,004	932	72	8%	1,065	(61)
285	275	10	4%	304	(19)	Otago	894	819	75	9%	949	(55)
33	38	(5)	-13%	37	(4)	Southland	110	113	(3)	-3%	116	(6)
1,734	1,800	(66)	-4%	1,849	(115)	Total Medical Caseweights	5,534	5,507	27	0%	5,559	(25)
						Surgical Caseweights						
1,180	1,231	(51)	-4%	1,318	(138)	Acute	3,607	3,752	(145)	-4%	3,714	(107)
818	857	(39)	-5%	941	(123)	Otago	2,506	2,607	(101)	-4%	2,600	(94)
362	374	(12)	-3%	377	(15)	Southland	1,101	1,145	(44)	-4%	1,114	(13)
1,360	1,472	(112)	-8%	1,393	(34)	Elective	3,739	4,398	(659)	-15%	4,443	(704)
1,052	1,094	(42)	-4%	1,047	5	Otago	2,896	3,264	(368)	-11%	3,324	(428)
308	378	(70)	-19%	346	(38)	Southland	843	1,134	(291)	-26%	1,119	(276)
2,540	2,703	(163)	-6%	2,711	(172)	Total Surgical Caseweights	7,347	8,150	(804)	-10%	8,157	(811)
						Maternity Caseweights						
142	94	48	51%	127	15	Acute	388	286	102	36%	332	56
96	68	28	41%	111	(15)	Otago	295	208	87	42%	226	69
46	26	20	77%	16	30	Southland	93	78	15	19%	106	(13)
337	364	(27)	-7%	326	11	Elective	1,131	1,125	6	1%	1,090	41
197	219	(22)	-10%	216	(19)	Otago	668	675	(7)	-1%	720	(52)
140	145	(5)	-3%	110	30	Southland	463	450	13	3%	370	93
479	458	21	5%	453	26	Total Maternity Caseweights	1,519	1,411	108	8%	1,422	97
						TOTALS						
2,738	2,812	(74)	-3%	2,953	(215)	Acute	8,525	8,613	(88)	-1%	8,540	(17)
1,874	1,907	(33)	-2%	2,106	(232)	Otago	5,778	5,833	(55)	-1%	5,873	(95)
864	905	(41)	-5%	847	17	Southland	2,747	2,780	(33)	-1%	2,667	80
2,015	2,149	(134)	-6%	2,060	(46)	Elective	5,874	6,455	(581)	-9%	6,598	(724)
1,534	1,588	(54)	-3%	1,567	(33)	Otago	4,458	4,758	(300)	-6%	4,993	(535)
481	561	(80)	-14%	493	(12)	Southland	1,416	1,697	(281)	-17%	1,605	(189)
4,753	4,961	(208)	-4%	5,013	(261)	Total Caseweights	14,399	15,068	(669)	-4%	15,138	(739)
						TOTALS exd. Maternity						
2,596	2,718	(122)	-4%	2,826	(230)	Acute	8,137	8,327	(190)	-2%	8,208	(71)
1,778	1,839	(61)	-3%	1,995	(217)	Otago	5,483	5,625	(142)	-3%	5,647	(164)
818	879	(61)	-7%	831	(13)	Southland	2,654	2,702	(48)	-2%	2,561	93
1,678	1,785	(107)	-6%	1,734	(57)	Elective	4,743	5,330	(587)	-11%	5,508	(765)
1,337	1,369	(32)	-2%	1,351	(14)	Otago	3,790	4,083	(293)	-7%	4,273	(483)
341	416	(75)	-18%	383	(42)	Southland	953	1,247	(294)	-24%	1,235	(282)
4,274	4,503	(229)	-5%	4,560	(287)	Total Caseweights excl. Maternity	12,880	13,657	(777)	-6%	13,716	(836)

Appendix 1: Financial Report for the Hospital Advisory Committee

SDHB Monthly HAC Statement of Financial Performance - September 2021

Monthly					Year to date				Annual
Actuals	Budget	Variance	Variance		Actuals	Budget	Variance	Variance	Budget
$000s	$000s	$000s	FTE		$000s	$000s	$000s	FTE	$000s
				REVENUE					
				Government & Crown Agency Sourced					
912	802	110		MoH Revenue	2,557	2,407	150		9,628
0	0	0		IDF Revenue	0	0	0		0
957	1,001	(44)		Other Government	2,697	2,966	(269)		11,590
1,869	**1,804**	**66**		**Total Government & Crown**	**5,254**	**5,373**	**(119)**		**21,218**
				Non Government & Crown Agency Revenue					
301	166	135		Patient related	357	497	(139)		1,987
270	178	92		Other Income	623	534	89		2,134
571	**343**	**227**		**Total Non Government**	**980**	**1,030**	**(50)**		**4,121**
44,602	45,232	(630)		Internal Revenue	131,717	135,697	(3,980)		542,790
									0
47,042	**47,379**	**(337)**		**TOTAL REVENUE**	**137,952**	**142,101**	**(4,149)**		**568,129**
				EXPENSES					
				Workforce					
				Senior Medical Officers (SMO's)					
6,648	6,730	82	20	Direct	19,641	19,708	67	15	80,024
415	351	(64)		Indirect	1,102	1,052	(50)		4,207
305	156	(149)		Outsourced	822	468	(354)		1,696
7,368	**7,237**	**(131)**	**20**	**Total SMO's**	**21,565**	**21,228**	**(337)**	**15**	**85,927**
				Registrars / House Officers (RMOs)					
3,979	3,910	(69)	1	Direct	12,106	11,673	(433)	(5)	49,650
190	233	43		Indirect	439	699	261		2,796
0	30	30		Outsourced	53	91	39		331
4,169	**4,173**	**4**	**1**	**Total RMOs**	**12,597**	**12,463**	**(134)**	**(5)**	**52,777**
11,537	**11,411**	**(127)**	**21**	**Total Medical costs (incl outsourcing)**	**34,163**	**33,692**	**(471)**	**10**	**138,704**
				Nursing					
9,335	9,766	431	40	Direct	28,275	29,655	1,379	16	123,916
6	1	(5)		Indirect	11	3	(8)		12
6	3	(3)		Outsourced	11	9	(2)		37
9,346	**9,770**	**424**	**40**	**Total Nursing**	**28,297**	**29,667**	**1,370**	**16**	**123,965**
				Allied Health					
2,238	2,368	130	23	Direct	6,807	7,083	276	16	29,150
14	25	11		Indirect	111	76	(34)		472
106	45	(61)		Outsourced	333	137	(196)		544
2,358	**2,438**	**80**	**23**	**Total Allied Health**	**7,251**	**7,297**	**45**	**16**	**30,165**
				Support					
162	188	27	6	Direct	442	578	136	5	2,294
1	1	0		Indirect	(5)	3	8		11
0	0	0		Outsourced	0	0	0		(0)
162	**189**	**27**	**6**	**Total Support**	**437**	**581**	**144**	**5**	**2,306**
				Management / Admin					
1,617	1,540	(78)	(1)	Direct	4,895	4,716	(179)	(8)	18,397
17	9	(9)		Indirect	18	26	8		104
11	5	(5)		Outsourced	36	17	(19)		66
1,645	**1,554**	**(92)**	**(1)**	**Total Management / Admin**	**4,950**	**4,759**	**(191)**	**(8)**	**18,567**
25,050	**25,362**	**312**	**89**	**Total Workforce Expenses**	**75,098**	**75,995**	**896**	**38**	**313,707**
3,824	3,411	(413)		**Outsourced Clinical Services**	10,565	10,052	(513)		38,618
1	0	(1)		**Outsourced Corporate / Governance Services**	2	0	(2)		0
2	0	(2)		**Outsourced Funder Services**	2	0	(2)		0
8,519	8,487	(32)		**Clinical Supplies**	23,957	24,705	748		92,441
1,318	870	(449)		**Infrastructure & Non-Clinical Supplies**	2,701	2,637	(63)		10,314
				Non Operating Expenses					
926	920	(5)		Depreciation	2,785	2,743	(43)		11,750
0	0	0		Capital charge	0	0	0		0
0	0	0		Interest	0	0	0		0
14,592	**13,688**	**(903)**		**Total Non Personnel Expenses**	**40,012**	**40,138**	**126**		**153,124**
39,641	**39,050**	**(591)**		**TOTAL EXPENSES**	**115,110**	**116,132**	**1,022**		**466,830**
7,401	**8,329**	**(928)**		**Net Surplus / (Deficit)**	**22,842**	**25,969**	**(3,127)**		**101,299**

Appendix 1: Financial Report for the Hospital Advisory Committee

3. *Revenue*

Revenue was $0.34m unfavourable to budget in September due to:

1. Internal Revenue was $0.63m less than budget due to the under-delivery of Planned Care procedures.

2. Patient Related Revenue was $0.14m favourable to budget made up primarily of non-resident invoicing $0.2m for a long-term patient. Recovery of this debt is doubtful however, so an offsetting doubtful debt has been raised.

3. MoH Revenue was $0.1m favourable relating to prior months $0.05m public health side contract (cervical screening) and personal health side contract $0.05m (bowel screening).

4. Other income was $0.07m favourable for donations received by NICU which purchases will be made through capital expenditure.

4. *Workforce Costs*

Monthly result

Workforce costs (personnel plus outsourcing) were $0.31m favourable to budget in September 2021 with full time equivalent (FTE) 89 favourable to budget.

FTE

FTE is 89 under budget in September summarised in the following table. Budgeted FTE increases to 2,557FTE by June 2022 an increase of 120FTE. This is largely driven by a combination of additional Nursing FTE approved to address CCDM (Care Capacity Demand Management) requirements as well as FTE phased in to address approved investments such as the Medical Assessment Unit.

Staff Type	Actual FTE Sep21	Budget FTE Sep21	Monthly Variance	%	YE Budget FTE	
SMO	245	265	20	8%	264	
RMO	315	316	1	0%	336	
Nursing	1,197	1,238	40	3%	1,317	CCDM progressive increase
Allied	285	308	23	8%	325	
Support	33	39	6	15%	38	
Mgmt / Admin	274	272	(1)	(1%)	277	
	2,348	**2,437**	**89**	**4%**	**2,557**	

Appendix 1: Financial Report for the Hospital Advisory Committee

Senior Medical Officer (SMOs)

SMOs were $0.1m favourable and 20 FTE favourable for the month. Given the FTE variance, the dollar variance is less than expected due to additional clinic payments made that have no hours associated with them.

Direct payroll costs are $0.08m favourable in September as per the table below. This is partially offset by outsourced costs which are $0.1m unfavourable, due to outsourced vacancy cover in:

- Paediatrics
- Obstetrics and Gynaecology and
- General Medicine

Ordinary time	$121k favourable due to vacancies; offset with use of locums
Overtime	$262k unfavourable (we do not budget for overtime due to full rosters being budgeted): Monthly overrun is due to payments for additional clinics, call backs, SMO's covering RMO shifts.
Training	$136k favourable due to less staff away on training days.
Sick Leave	$133k favourable due to less staff taking sick leave.
Leave	76% leave taken in month (in line with prior months). Leave management actions continue.

RMOs

RMOs were on budget for the month both dollars and FTE. Leave taken continues to be low at 55% of levels budgeted.

Nursing

Nursing was $0.42m favourable and 40 FTE favourable in September

Nursing FTE

In September, an additional 51.83FTE were added to the budget for Care Capacity Demand Management (CCDM) which has resulted in the favourable variance for the month. This increases progressively to 95.7FTE by June 2022. 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.

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**

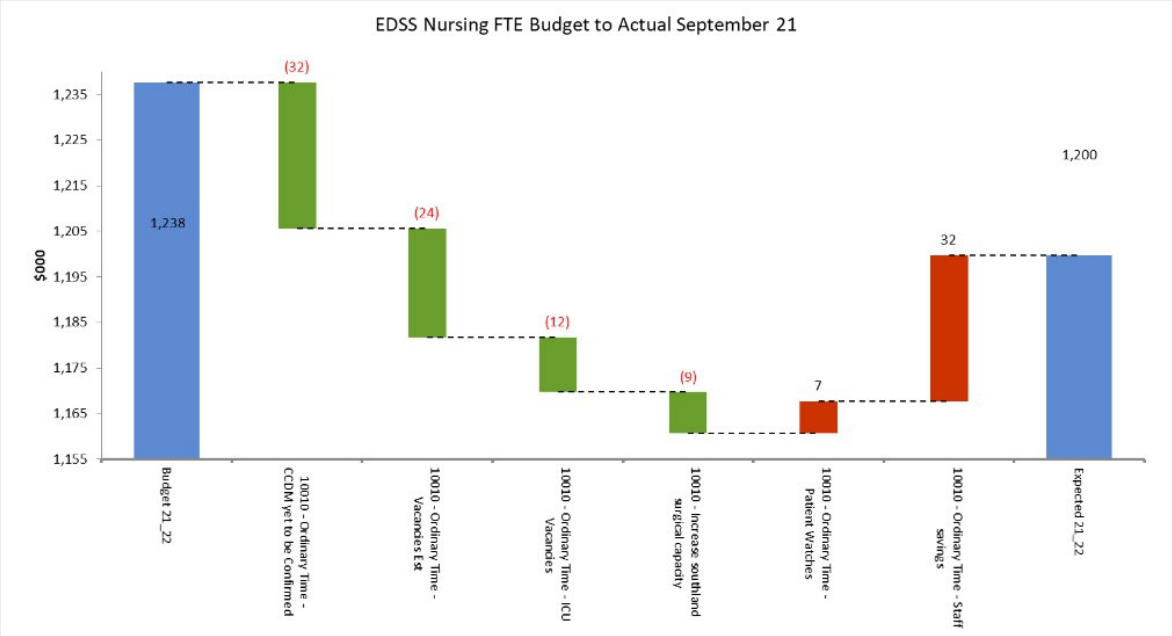
Drivers of the favourable variance include:

- Ordinary time is 45FTE favourable to budget reflecting new CCDM roles not yet recruited into and vacancies in areas such as the Critical Care Unit which continues to recruit to full staffing levels (12 FTE vacant).

Appendix 1: Financial Report for the Hospital Advisory Committee

- Overtime continues over budget (5FTE as staff cover for vacant shifts) but reduced compared to prior months. This has been positively impacted by covid due to less volumes through ED and reduced planned care.

- Favourable variances have also been offset partially by unrealised savings for Valuing Patient Time (-22 FTE), Positive shifts (-10 FTE)



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.

Allied Health

Allied Health costs were $0.08m favourable to budget in September. Direct payroll costs are $0.1m favourable and 23FTE favourable partially offset by outsourcing to cover vacancies.

The favourable FTE variance was driven by vacant roles in:

- Radiology service where additional staff for the second CT scanner are not in place currently.
- Dunedin Anaesthesia Service and Southland Perioperative which is partially offset by outsourced costs which are $0.06m unfavourable.

Support

Support staff were $0.02m favourable and 6FTE favourable in September due to vacancies in sterile services at both sites.

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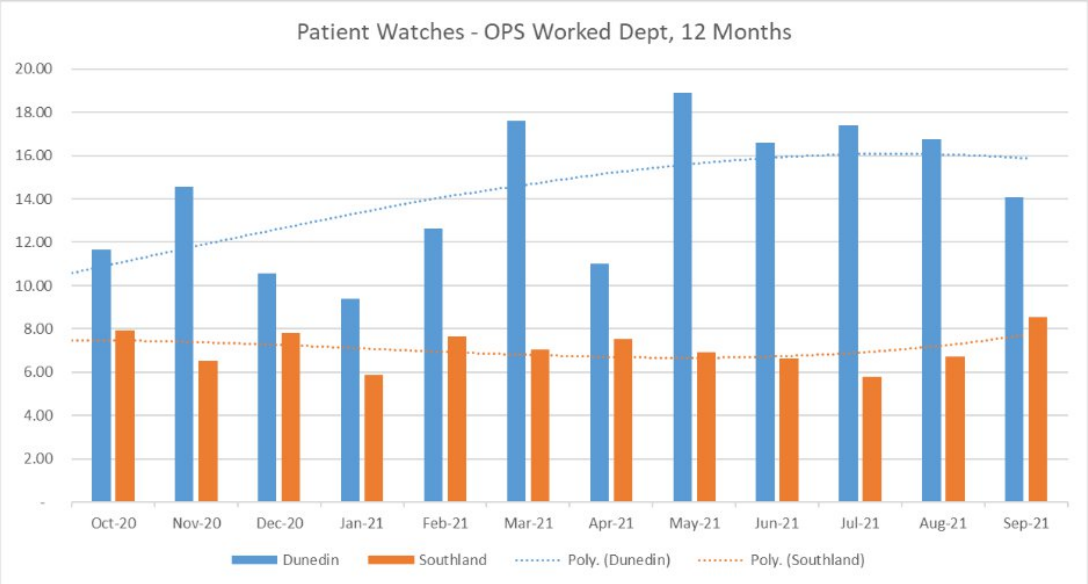
Management and Administration

Management/Admin dollars were $0.1m unfavourable and 1.5FTE over budget in September.

Majority of the variance is driven by annual leave not taken. Only 53% of leave was taken to budget. This was driven by the Level 4 lockdown which payroll impacts are included in the September accounts.

Most of this staff type (except for 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.



Appendix 1: Financial Report for the Hospital Advisory Committee

5. *Outsourced Clinical Services Costs*

Outsourced services were $0.4m unfavourable in September driven by Outsourced Clinical Services as shown below.

Account code	Actual $000's MTD	Budget $000's MTD	Variance $000's MTD	Budget $ Annual Budget
3665 - Outsourced Clinical Services - Surgical	1,061	810	(251)	7,804
3690 - Outsourced Clinical Services - Other	695	547	(148)	6,404
3650 - Outsourced Other Radiology Procedures	130	37	(93)	426
3615 - Outsourced Laboratory Service	1,499	1,492	(8)	17,900
3642 - Outsourced CT Scans	67	62	(5)	720
3677 - Outsourced Clinical Services - Accommodation	1		(1)	0
3620 - Outsourced Laboratory Send away Tests	0	0	0	5
3647 - Outsourced MRI Scans	34	35	1	406
3651 - Outsourced Audiology	0	2	2	24
3646 - Outsourced Lithotripsy	0	7	7	77
3630 - Outsourced Breast screening	111	121	10	1,396
3675 - Outsourced Vascular Assessments	65	80	14	924
3653 - Outsourced Ophthalmology	21	46	25	533
3640 - Outsourced Radiology Service	140	173	33	1,999
Grand Total	**3,824**	**3,411**	**(413)**	**38,618**

The $0.4m 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 clinical services: increased surgical outsourcing to meet / catch up CWD delivery.

Appendix 1: Financial Report for the Hospital Advisory Committee

6. *Clinical Supplies (excluding depreciation)*

Clinical supplies were unfavourable to budget by $0.03m in September 2021 and $0.75m year to date.

The monthly variances <> $50k are shown below:

Account code	Actual $000's MTD	Budget $000's MTD	Variance $000's MTD	Budget $ Annual Budget
4320 - Endoscopic Instruments	238	40	(197)	491
4530 - Hip Joint Prostheses	361	188	(173)	2,968
4955 - Air Ambulance	527	435	(92)	5,035
4105 - Dialysis Supplies	202	114	(89)	1,314
4290 - Diagnostic Supplies	161	78	(83)	906
4510 - Cardiac Implants	373	306	(67)	3,538
4555 - Orthopaedic Implants	295	229	(66)	2,651
4315 - Instruments - Minor Purchases	198	253	55	3,089
4535 - Knee Joint Prostheses	36	96	60	1,516
4235 - Sterilising Consumables	70	137	67	1,586
4590 - Implants and Prostheses - Other	10	90	80	1,045
4604 - Pharmaceuticals	2,120	2,625	506	23,476
Grand Total	**4,591**	**4,592**	**1**	**47,615**

1) Pharmaceuticals were $0.5m favourable to budget. The budget for 21/22 was increased by $3.7m annually as indicated by the Pharmac forecast. To date, we have not experienced the level of expenditure, the major area of favourable variance being in Oncology and Oncology/Haematology Outpatients. This is also the driver of the favourable year to date variance.

2) Hip Joint Protheses are $0.17 over budget relating to July and August clinical supply costs that were missing in those months, coming through to September. This is a result of delays in processing the backlog that resulted from the FPIM implementation.

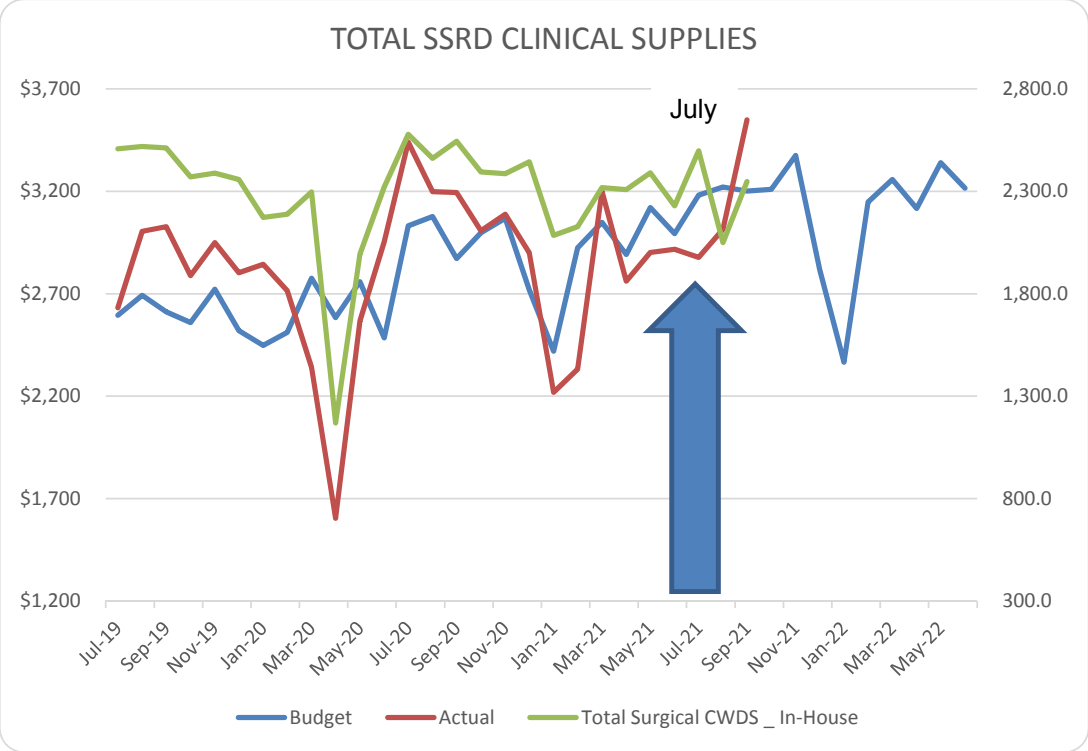
3) Air ambulance was $0.09m over budget for the month and $0.4m YTD, due to;

   - In September there were 40 flights costing on average $14k per flight. This includes one Neurosurgery flight at the lower cost fixed wing flight and a repatriation flight for $0.07m.
   - Helicopter charges incurred a 10% price increase, which has impacted the month unfavourably by $0.03m.

4) Cardiac Implants were $0.07m 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 there were 6 performed in September.

Appendix 1: Financial Report for the Hospital Advisory Committee

We have graphed clinical supplies against Medical / Surgical and Maternity caseweights as below, July had an increase of case weights but not a corresponding increase in costs. We are now seeing the costs come through in September.



Appendix 1: Financial Report for the Hospital Advisory Committee

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

Infrastructure and Non-Clinical supplies were $0.45m unfavourable in September and $0.06m unfavourable year to date. The monthly variances are tabled below, the major variances due to Patient Meals and Telecommunications allocations not processed in prior months which have been processed in September.

This unfavourable variance should therefore be viewed as a timing difference within Specialist Services and a correction of year to date balances.

Account code	Actual $000's MTD	Budget $000's MTD	Variance $000's MTD	Budget $ Annual Budget
5040 - Patient Meals (Outsourced)	605	337	(269)	4,094
5355 - Telecommunications - Line Rentals	140	47	(93)	568
5510 - Consultants Fees	47	4	(43)	53
5620 - General Equipment - Minor Purchases	57	24	(33)	285
5305 - ITC Services Outsourced	48	24	(25)	284
5526 - Accreditation Audit	33	10	(23)	118
5120 - Rents	19	4	(15)	50
5360 - Telecommunications - Local and Toll Charges	22	10	(12)	116
5158 - Maintenance - Mechanical	12		(12)	0
5665 - Stationery and Office Supplies	36	46	10	503
5045 - Cleaning Supplies	15	38	23	461
5250 - Business Related Travel and Accommodation Domestic	64	90	26	1,031
5670 - Postage Courier Freight	24	52	28	562
Grand Total	**1,318**	**870**	**(449)**	**10,314**

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.