Hospital Advisory Committee Copy

Wakari Board Room - zoom link available if required

07/06/2022 09:00 AM - 12:00 PM

	7.1.2	SDHB Output Trends, FTE Trends and Productivity	COO	11:15 AM-11:30 AM	64
	7.2	Financial Performance Summary	COO	11:30 AM-11:58 AM	77
8.	Closing Karakia			11:58 AM-12:00 PM	

APOLOGIES

At the time of publication no apologies had been received.

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)~~	Removed 09.12.2021	
	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		
	02.11.2021	Wife, Alison Douglass, Barrister	Has had involvement with SDHB when representing patients.	
	25.06.2021	Director and Shareholder, Kiwood Limited	Nil (farm forestry plot).	
	09.12.2021	Member, Transition Unit's Funding Flows and Incentives Expert Panel (appointed December 2021)		
	09.12.2021	Member: Transition Unit's Primary and Community Expert Panel (appointed October 2021)		
	09.12.2021	Member: Transition Unit's Review of the Primary Care Capitation Formula Expert Panel (appointed October 2021)		
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.	
	24.02.2022	Representative, Southland Inter-Agency Forum	No foreseeable conflict apart from advocacy.	
Lyndell Kelly	09.12.2019 Updated 04.12.2021	~~Employed as Specialist, Radiation Oncology,~~ Locum SMO, Southern DHB	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~~	Updated 29/10/2021	
	25.06.2021	~~Trustee, New Zealand Brain Tumour Trust~~	Updated 29/10/2021 (Resigned as Trustee)	
	04.12.2021	Trustee, Healthcare Otago Charitable 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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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		
	~~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~~	Stood down 29.03.2022	
	~~09.12.2019~~	~~*Shareholder in Te Kaika~~		
	24.06.2021	Te Rau Ora Directorship		
	24.06.2021	Needle Exchange Services Trust (NEST) member		
	28.08.2021 (Updated 23.02.2022)	Chair, NZ Drug Foundation		
	23.02.2022	Chair, Needle Exchange Services Trust (NEST)		
	23.02.2022	Board Member, Mental Health and Wellbeing Commission		
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	Employment: Associate Professor, University of Otago	Updated 08.12.2021	
	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)~~	Removed 08.12.2021	
	17.08.2020	Health Research Council Fellow		
	14.01.2022	Sister-in-law, Charge Nurse Manager, Wakari, SDHB		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Andrew Connolly (Advisor)	21.01.2020 (updated 02.06.2021)	Employee, Counties Manukau DHB. Currently seconded to Ministry of Health as Acting Chief Medical Officer		
	21.01.2020 (updated 02.06.2021)	Clinical Advisor to the Board, Waikato DHB		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	Advisor to Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020 (Updated 28.01.2021)	Chair, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		
	18.06.2021	Treasury: Health Reform Challenge Panel		
	26.08.2021	Advisor to Health Transition Unit on Finance/Procurement		
Benjamin Pearson (Crown Monitor)	21.07.2021	Consultant Paediatrician, South Canterbury DHB		
	13.01.2022	Chief Medical Officer, 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	
Mata CHERRINGTON	18.03.2022	Chair, Community Trust South	Nil
	18.03.2022	Associate, Centre for Social Impact	Nil
	18.03.2022	~~Director, Hiringa Oranga o Awarua Ltd~~	~~Possible conflict when contracts with Southern DHB come up for renewal~~. Removed 10.05.2022
	18.03.2022	Director, MATA Consultancy Ltd	Nil
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 Māori 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	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017 (updated 21.04.2022)	Nephew, ~~Tax Advisor, Treasury~~, Senior Treasury Official in Grant Robertson's office.	
	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)
	19.02.2022	Helix Enterprises Limited (Director and Shareholder)	Nil. Family owned investment entity.
John EASTWOOD	19.01.2022	Clinical Director Localities, Interim Health New Zealand	Conflict with matters related to establishment of Localities. Possible conflict with matters related to the Health Reforms and the establishment of Māori Health Authority and Health New Zealand
	19.01.2022	Clinical Professor Department of Preventative and Social Medicine, University of Otago	Conflict with matters related to Department of Preventative and Social Medicine, and possible conflict with matters related to the three UoO Clinical Schools and the University of Otago
	19.01.2022	Adjunct Professor University of New South Wales	Nil
	19.01.2022	Clinical Professor University of Sydney, Sydney, Australia	Nil
	19.01.2022	Executive Clinical Advisor Sydney Local Health District, Sydney, Australia	Nil
	19.01.2022	Director Early Years Research Group, Ingham Institute of Applied Medical Science, Liverpool, New South Wales, Australia	Nil
	19.01.2022	Director of Centre of Research Excellence for Health and Social Care Integration, Sydney, Australia	Nil
	19.01.2022	Co-Chair Sydney Institute for Women Children and their Families, Sydney Local Health District	Nil
	19.01.2022	Co-Chair International Foundation of Integrated Care - Australia	Nil
	19.01.2022	Co-Chair International Foundation of Integrated Care - Aotearoa Steering Committee	Nil
	19.01.2022	Member Royal Australasian College of Physicians Policy and Advocacy Committee (CPAC)	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
	19.01.2022	Executive Member of the International Society of Social Paediatrics and Child Health (ISSOP)	Nil
	19.01.2022	Consultant to the World Health Organization, Geneva	Nil
	19.01.2022	Fellow of the New Zealand College of Public Health Medicine	Nil
	19.01.2022	Fellow of the Australasian Faculty of Public Health Medicine	Nil
	19.01.2022	Fellow of the Royal Australasian College of Physicians	Nil
	19.01.2022	Fellow of the Royal Australasian College of Medical Administrators	Nil
	19.01.2022	Fellow and Certified Health Executive of the Australasian College of Health Services Managers	Nil
	19.01.2022	Wife - General Practitioner at Mosgiel Health Centre, Mosgiel	Possible conflict with any SDHB contract negotiations with the General Practice
	19.01.2022	Wife - Contracted medical educator for the Royal New Zealand College of General Practice	Nil
	19.01.2022	Member of the Medical Assurance Society (MAS)	Nil
David GOW	07.12.2021	Private Clinic, Mercy Hospital	
	07.12.2021	Wife employed by SDHB as Nurse Consultant for Quality Improvement	
Andrew LESPERANCE	20.12.2021	Son, employee, HR Department, Ministry of Health (working with IT team recruitment)	
	20.12.2021	Director, Secretan Family Trust	
	20.12.2021	Former Director, North Island PHO (resigned when appointed to SDHB)	
	20.12.2021	Daughter, Project Co-ordinator, Ministry of Education	
	20.12.2021	Son, student, University of Otago (accounting major)	
Hywel LLOYD	16.06.2021	GP, Mosgiel Health Centre	
	16.0.2021	Wife, Nurse, Paediatric Outpatients	
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~~	Removed 10.03.2022

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	10.03.2022	Daughter is a junior doctor at Middlemore Hospital and is undertaking a PhD.	PhD is in the field of general surgery and may involve engagement with general surgeons at SDHB in coming years.
	23.07.2020	~~Wife, Chief Data Architect, Inde Technology~~ - resigned (updated 10.03.2022)	Inde is part of WSP's Digital Health Collective, the consultancy service supporting the NDH Digital Infrastructure and Digital Facility Services
	10.03.2022	50% shareholder in wife's company *Ava Technology Solutions Limited*	Will avoid engaging with Southern Health system and the only health businesses that will be pursued will be private entities. No approach to public health will be made without the express pre-approval of the future HNZ and with the potential for conflicts noted. She will also expressly avoid recruiting from the Southern Health System.
Nigel TRAINOR	17.05.2021	Daughter, Sonographer (works part-time for Dunstan Hospital)	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 4 April 2022, 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
	Assoc Prof Moana Theodore	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
	Mr Hamish Brown	Chief Operating Officer
	Ms Kaye Cheetham	Chief Allied Health Scientific and Technical Officer
	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 AND OPENING KARAKIA

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting. Associate Professor, Dr Moana Theodore, provided an opening Karakia.

2.0 APOLOGIES

Apologies were noted from Mr Andrew Lesperance, Executive Director, Planning, Funding and Population/Public Health and Professor John Eastwood, Chief Medical Officer. An apology was also noted from Crown Monitor, Mr Roger Jarrold, who advised he would need to leave the meeting between 9.30 and 10.00am.

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES (tab 4)

It was resolved:

"That the minutes of the meeting held on 1 February 2022 be approved and adopted as a true and correct record of the meeting."

5.0 MATTERS ARISING

There were no matters arising from the minutes that were not covered in the Agenda. The Chief Operating Officer (COO), Mr Hamish Brown, responded to members queries in relation to:

- The Outpatient Clinics for General Medicine.
- Direct admissions by General Medicine Physicians, by-passing the Emergency Department (ED). The admissions have risen from 59% to 69%
- Re-appointment of staff impacted by the COVID vaccination pass mandate.
- Neurosurgery recruitment.

Mr Chris Fleming, CEO, joined the meeting at 9.05am.

6.0 REVIEW OF ACTION SHEET

The Committee considered the action sheet (tab 6) and attached information papers and the verbal update from the COO, Mr Hamish Brown.

Centralisation of RMO Rostering

An update was included with the action sheet (tab 6.1) providing a brief on the centralisation of RMO Rosters. The COO advised that the Omicron COVID outbreak has slowed progress. A further update will be included in the COO Report for the June 2022 meeting.

Ophthalmology Wait Times

Members considered the report on the risk associated with Ophthalmology patients being overdue for a follow-up appointment (tab 6.2). The COO advised on the work done to significantly reduce the waitlist and success with recruitment. An update was also provided on the barriers to recruitment due to difficulty with getting people into the country as most District Health Boards have lost their preferred provider status with Immigration New Zealand.

Ms Tanya Basel, Executive Director People and Culture (EDPC) joined the meeting at 9.10am.

The EDPC, Ms Tanya Basel, advised that the preferred provider status lapsed due to the long delay with the borders closed and Southern DHB now needs to go through a process to reapply for that. The lack of pathway for residency at the current time is a further barrier.

The Chair acknowledged the progress made with Ophthalmology wait times and the assurance that it should continue to reduce. The Board Chair commended the COO and the team on the effective response and progress made within a short period of time and advised he would like to have seen the progress reflected in the wider Board papers.

Gynaecology Waiting List and Surgical Thresholds

Members considered the update on the Southland Gynaecology Outpatient Waiting List and the updated table of actions for recovery and sustainability (tab 6.3). The COO noted the positive progress with the urgent case numbers and advised that he would like to have seen more progress on the overall numbers, which have increased slightly. The COO noted the pressure on the Senior Medical Officer (SMO) team and the impact with the shortage of Midwives.

Associate Professor, Dr Moana Theodore, noted the increase in waiting times and the impact of that on women. The COO acknowledged the impact on women and outlined actions being taken, but advised that compliance is a long way off. The COO concurred with comments from Crown Monitor, Mr Ben Pearson, in relation to the referral boundaries and scope for a centralised system across the district. The HAC Chair reflected the need for the system to provide what works best for the patient and advised the need for change under the pending new health system. In response to concerns around the Oncology Service wait list, it was noted that additional funding will be provided by the Ministry of Health (MoH) from September 2022. The Dunedin figures are not included in the report and the COO provided an update on the district view in relation to gynaecology.

Recruitment

Members considered the report on recruitment included with the action sheet (tab 6.4). The COO raised concern around the accuracy of the figures provided and advised reconciliation work is ongoing to ensure accurate information is provided in future reports. A forensic analysis of the Registered Nurse and Registered Midwife workforce was undertaken, which indicated 60 vacancies rather than the 400 reported. The EDPC advised on work being undertaken to clean up the recruitment system and the Request for Recruitment (RFR) may be driving some of the numbers. There are challenges with no correlation between the financial and the recruitment system and the lack of a position control system. Work will be done over the next three months to clear historical vacancies out of the system. The Board Chair advised the need for management to provide a paper for the Board advising of the concerns with the system and what is being done to identify and mitigate the issues. The EDPC is to provide a report as outlined and include information related to the Human Resource Information System (HRIS). The CEO advised that the system issues experienced also existed in other DHBs he has worked in. Further work will be done prior to the next meeting to improve the data available to assist with regional and national convergence in the future. The HAC Chair noted the paucity of information around workforce and advised the need to look at a different model of care for services where recruitment has been an ongoing issue for a number of years. Discussion was held on the impact of staff being paid more than one FTE and candidates turning down job offers for more highly paid positions elsewhere.

7.0 PRESENTATION – ORTHOPAEDIC SURGERY SOUTHERN DHB 2022

The following staff joined the meeting at 9.45am:

- Dr Janine Cochrane, General Manager (GM), Dunedin Surgical Services and Radiology, Dunedin Hospital.
- Ms Sharon Jones, Director of Nursing, Dunedin Surgical Services and Radiology, Dunedin Hospital.
- Mr Michael Chin, Clinical Director, Orthopaedics, Dunedin Hospital

Members received the presentation (tab 7.1) highlighting key issues and proposed solutions and the following highlights were noted in discussion following the presentation:

- Members thanked the team for the presentation, noting it provides them with a better understanding of what is happening within the area of Orthopaedics and why.
- The barriers to achieving a Saturday list were noted and there is currently no date for commencement of acute theatre as recruitment is not yet complete. The full complement of Anaesthetic Technicians is not available and there is a shortage nationally.

- Mr Chin advised that the Day Surgery facilities in Dunedin are marginal, particularly for more complex surgery. There is a definite move to short stay surgery and there is ability to manage people as outpatients if well prepared.
- There is an increase in the use of Outpatient Arthroplasty overseas, particularly in the UK and USA.
- There is the potential for more Day Surgery to be done with good facilities.
- Other services are currently using the main Operating Theatres, due to the poor state of the current Day Surgery Theatres. The dire shortage of nursing staff is impacting and the current recruitment into Nursing Programmes across the district are insufficient to keep up the current level of nursing staff. Changes to the Nursing Programme are likely to further impact on the shortages.
- There is no immediate solution around recruitment to the final Spinal Surgeon vacancy in Southland and it is a challenge to get somebody with the appropriate skills to complement the team.
- The Spinal Surgeon vacancy is not currently advertised and it is challenging for the Surgeons travelling from Dunedin to Southland as they are often limited in what they can do due to bed closures.
- The Chief Allied Health, Scientific and Technology Officer (CAHSTO), Kaye Cheetham, provided a comprehensive update on the work being done to recruit to and mitigate the shortage of staff in the areas of Anaesthetic Technicians and Physiotherapists. The CAHSTO is to provide a paper for the next HAC meeting on providing Scholarships to attract Anaesthetic Technicians to the Southern district and retain them.
- The Chief Nursing and Midwifery Officer and the Director of Nursing, provided an update on the challenges with the Ward 3 situation at Dunedin Hospital, where Wards were consolidated into one large Ward to make room for ICU.
- The COO provided a brief update on progress with the Central Sterile Services Department (CSSD) and the work being done with the Building and Property team. Further discussion is to take place at the Finance Audit and Risk Committee.
- Crown Monitor, Mr Ben Pearson, advised that South Canterbury DHB has the capacity to deliver around 130 joints per year, but no contracts have been issued beyond July 2022. The GM Surgical and Radiology Services is to investigate this.
- Mr Chin responded to a query from the Board Chair around work on Enhanced Recovery after Surgery (ERAS), acknowledging the need to reduce length of stay and noting the need to have the staff to support the process.
- The HAC Chair commended and thanked the team for their presentation and the initiatives being taken to address the key areas of concern and noted the hard work going in to make a difference despite the challenging times.

Dr Janine Cochrane, Ms Sharon Jones and Mr Michael Chin left the meeting at 10.27am.

A brief five minute break was held commencing at 10.27am.

8.0 PRESENTATION – TELEHEALTH

The following staff joined the meeting at 10.30am:

- Simon Donlevy, General Manager, Southland/Deputy Chief Operating Officer
- Matthew Pettersson, Project/Change Manager - Telehealth

The COO introduced the team and members received the presentation (tab 7.2), highlighting key issues and the following was noted in discussion following the presentation:

- Members noted their thanks for the excellent presentation.
- The Project/Change Manager Telehealth, is to provide information for the next meeting showing the number of patient contacts that have traditionally been face to face that could be via telehealth.
- The Board Chair acknowledged the standard of the presentation and the attention to patient time. As the DHB with the largest geographical area in the country, Southern DHB should be leaders in Telehealth.
- The main challenges with advancing Telehealth within Southern are attitudes and staff change and a willingness to accept feeble objections to it.
- The system currently captures clinician location, but not specifics of clinician time saved by using Telehealth.
- The National Health Service (NHS) in the UK has overcome the challenge of integrating the clinical information systems to the Telehealth Technology. However, it is more of a challenging for NZ currently with 20 individual DHBs.
- The team responded to concerns raised by Associate Professor, Moana Theodore, relating to ethnicity data captured on page 62 of the agenda papers. The team have reached out to the Māori Health Directorate to address the findings and further work is being done to identify Māori participation and barriers. Research is being undertaken and initiatives looked at by digital service providers to address digital inequity.
- Advice was received on the limitation of Telehealth in specialties such as ENT, Ophthalmology and Oncology and the need for first specialist appointments (FSA) to be face to face. In some cases Telehealth can take more clinician time.
- Advice was received on the growing public awareness of telehealth and WellSouth Primary Health Network (PHN) are about to launch an advertising campaign that will further raise awareness.
- Crown Monitor, Mr Roger Jarrold, urged Southern DHB to embrace Telehealth and promote it, given the substantial amount of money required for the new information technology business case. He noted the value of hubs for people to Telehealth from.
- The COO thanked the team for the presentation and acknowledged the significant opportunities for Telehealth across Southern DHB. He noted the learnings from COVID and the need to have the right clinical workflows and business rules in place, along with the resources to support Telehealth.
- The HAC Chair acknowledged the progress made and advised she would like to see a move to having no option for a face to face appointment for any appointments that can be done by Telehealth.

Mr Simon Donlevy, General Manager, Southland/Deputy Chief Operating Officer and Mr Matthew Pettersson, Project/Change Manager – Telehealth left the meeting at 11.12am.

The HAC Chair advised that there are to be no presentations to the final Southern DHB HAC meeting, scheduled for 7 June 2022, as the time is needed to discuss where the Committee is to leave the various issues being considered.

9.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Chief Operating Officer's (COO) Report

The COO report (tab 8.1) was taken as read and the COO, Mr Hamish Brown, drew the Committee's attention to the following items:

- The complex operating environment that management and staff have been working in with the complexities of COVID, vacancies and COVID absenteeism, whilst juggling acute flow and care within the environment. The COO noted his thanks to the Senior Leadership Team, across both sites, for their support over the past couple of months, noting the achievements, despite the difficult environment.
- Of the 82 Nursing Entry to Practice (NETP) Nurses who joined the team, 68 are now out of their time.
- The increased number of beds that have been open across the district.
- The installation of the new Magnetic Resonance Imaging (MRI) machine in Dunedin.
- The reduction in ESPI 2 and ESPI 5 cases.
- There are still significant challenges across the hospitals, but the team are working hard to address those challenges.
- An update on case weight delivery (cwd), finishing 180 cwd behind for the month of February 2022.
- The improved position overall despite the challenges.
- Outsourcing has continued, despite the providers facing many of the same challenges as Southern DHB.
- The increased number on the Orthopaedic Outpatient Waitlist, with an aging population and the burden of disease being significant.
- The increasing presentations to ED and high acuity. There is potential for Geriatricians to do Emergency Medicine to help reduce acuity, discharge more or work with people in their home to prevent the presentations. The CMO is keen to use the Medical Assessment Unit (MAU) as part of a virtual care pilot to help reach out to Rest Homes and General Practice to keep the frail elderly from having to come in to the ED setting.
- The Board Chair commended the COO on the modestly positive changes, achieved under the current challenging circumstances. An update was provided on the discrepancy in the data for Ophthalmology, noting that the activity is not captured in the discharges as a lot of it is Outpatient or coded under different activity. Most of the improvement in the area of Ophthalmology is in the Outpatient area.
- The recruitment campaign, with the final video and material almost ready for sign-off by the recruitment agency.
- The business case for increased bed capacity is reliant on involvement by the Southern Institute of Technology. In the interim more beds have been opened on the surgical floor, using a team based model. Conversations are in progress and students are in place, but there are insufficient registered staff to cover the night shift and weekends. There are a number of Enrolled Nurses graduating from SIT in April 2022. The employment of Health Care Assistants is working well in Surgical and a number of other areas, enabling Registered Nurses to work to the top of scope. A request was made for an update to be provided for the June 2022 meeting.
- In response to concerns raised regarding surgical performance and cwd compared to 2021, the CEO advised he would arrange for an update to be provided for the Board meeting to be held on 5 April 2022. The COO advised that work is being done to actively lift elective performance after 25 April 2022.
- Clarification was provided on the recovery approach for long waiting patients on the waitlists outlined on page 15 of the COO report and discussion was held on the treatment of these patients into the future. Members expressed concern at the lengthy waiting lists, with one example noted of a person advised of a wait time of 40 weeks for a FSA. ELT members will keep working to address this issue.

Southern DHB Output Trends, FTE Trends and Productivity

The Southern DHB Output Trends, FTE Trends and Productivity report (tab 8.1.1) was taken as read and the COO, Mr Hamish Brown, drew the Committee's attention to the following:

- The Business Analyst team provided the report in response to a paper from the Technical Advisory Service (TAS) that looked at overall productivity of all DHBs.
- The table on page 94 of the agenda and reports compares Southern DHB's productivity to the national productivity growth.
- A follow up report will be provided showing a more in depth analysis.

Financial Performance Summary

The COO presented the Specialist Services financial results (tab 8.2) for the period ended 28 February 2022 and highlighted the following:

- The adverse result of $950K for the month, with the main contributor being outsourcing ($600K).
- The year-to-date result is unfavourable by $7,352K.
- Further discussion on the finances will take place at the Finance Audit and Risk Committee (FARC) meeting on 4 April 2022.
- The HAC Chair queried what action management is taking in relation to the high Annual Leave Liability, particularly in relation to the Resident Medical Officers (RMOs), with leave taken at 68% of levels budgeted. The COO acknowledged the concerns and noted the challenges with balancing the ongoing operational need against future service delivery. The National COO group has discussed the approach to annual leave with a view to having a consistent approach nationwide. With the borders opening, there are now more CME and other leave requests coming through and these are being monitored carefully.

***It was resolved**:*

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

10.0 NEXT MEETING

The final meeting of the Southern DHB HAC is to be held on 7 June 2022.

11.0 CLOSING KARAKIA

Associate Professor, Dr Moana Theodore, provided a closing Karakia and the meeting closed at 11.43am.

Confirmed as a true and correct record:

Chair: _____ Date: _____

HOSPITAL ADVISORY COMMITTEE

ACTION SHEET

As at 16 May 2022

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
September 2021 February 2022 April 2022	**RMO Rostering** (Minutes Item 8.0 6.0 and 6.0)	An update on the proposed centralisation of RMO rostering following the presentation at the April 2022 meeting.	COO	Paper as appended to the action sheet 5.1.	Complete
November 2021 February 2022	**Ophthalmology** (Minutes Item 8.0)	An update on Ophthalmology wait times following the presentation at the April 2022 HAC meeting.	COO	Paper as appended to the action sheet 5.2.	Complete
December 2021 February 2022	**Gynaecology Waiting List and Surgical Thresholds** (Minutes Item 8.0 and 6.0)	An update on the Gynaecology Waiting List and Surgical Thresholds following the presentation at the April 2022 HAC meeting.	COO	Paper as appended to the action sheet 5.3.	Complete
February 2022	**ED Presentation** (Minutes Item 7.0)	Budget amounts for proposed resource indicated by the ED presentation team to be provided for discussion at the FARC meeting on 1 February 2022.	COO	Analysis complete and will be provided for the June FARC meeting.	June 2022
April 2022	**Action Sheet –** Recruitment (Minutes Item 6.4)	Following discussion on the inaccuracies with the HR report on recruitment, a report is to be provided advising on the concerns with the system and	EDPC	A verbal update will be provided at the meeting by the EDPC.	7 June 2022

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		what is being done to identify and mitigate the issues. The report is to include information related to the HRIS. Work is to be done to improve the data available to assist with regional and national convergence in the future.			
April 2022	**Orthopaedic Surgery Presentation** (Minutes Item 7.0)	A report is to be provided advising on providing Scholarships to attract Anaesthetic Technicians to the Southern District and retain them.	CAHSTO	Paper as appended to the action sheet 5.4.	Complete
April 2022	**Orthopaedic Surgery Presentation** (Minutes Item 7.0)	The GM Surgical and Radiology Services is to investigate contracting of joint surgery to SCDHB, who has the capacity to provide 130 joints per year.	COO/ GM Surg & Radiology	SCDHB have been contacted and advised that their annual capacity is 75 joints. At present any joints done at SCDHB would be under the Inter District Flow status. It is not yet clear what the arrangements will be going forward under HNZ.	Complete
April 2022	**Telehealth Presentation** (Minutes Item 8.0)	The Project/Change Manager Telehealth is to provide information for the next HAC meeting showing the number of patient contacts that have traditionally been face to face that could be via Telehealth.	COO/ Project Manager Telehealth	Paper as appended to the action sheet 5.5.	Complete
April 2022	**COO Report** (Minutes Item 9.0)	An update on increased bed capacity in Southland is to be	COO/GM Southland	An additional four beds have been opened in the Rehab	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		provided for the next HAC meeting.		ward in Southland on 27 April in what is being termed the 'NEW' (Nurse Education Ward) area. Up to a further six beds will be opened as recruitment allows.	

RMO Rostering (Minutes Item 8.0 6.0 and 6.0)	An update on the proposed centralisation of RMO rostering was provided for the April 2022 HAC meeting.

The RMO Unit Manager has been working with various stakeholders regarding the possible centralisation of RMO rosters to the RMO Unit. A discussion paper was presented to the surgical directorate to discuss with clinical leads which we are still waiting feedback from.

The RMO office pressures centring around recruitment, rostering and educational constraints e.g., College/Medical Council requirements have also been discussed amongst Medical Directors, with a plan to further develop a brief document with the Chief Medical Officer to be used as the precursor to a wider planning meeting to improve processes and practices in operational, educational and clinical governance.

FOR INFORMATION

Item: Ophthalmology Update

Proposed by: Hamish Brown, Chief Operating Officer

Meeting of: Hospital Advisory Committee, 07 June 2022

Recommendation

That the Hospital Advisory Committee notes this update provided by Brad Aitcheson, Service Manager.

Purpose

1. To update the Hospital Advisory Committee on the risk associated with Ophthalmology patients being overdue for a follow up appointment.

Background

Overdue patients

The ophthalmology service updated the Hospital Advisory Committee on 1 February 2022 in regard to the overdue patients. At that time (23 January 2022), it was reported that 3093 patients were greater than 1.5 on the acuity scoring system and 73 patients were listed as 'Do Not Delay' patients – meaning a total of 3166 patients were overdue.

In the April 2022 update – the service reported 2046 patients greater than 1.5 on the acuity scoring system and 11 patients listed as 'Do Not Delay'– meaning a total of 2057 patients remained overdue.

Currently, as of 12 May 2022, the ophthalmology service has **1126 patients greater than 1.5 on the acuity scoring system and 10 patients listed as 'Do Not Delay'– meaning a total of 1136 patients remain overdue.** This is summarised in Table 1.

Patients classified as Do Not Delay indicate the highest risk category. This is when the medical staff feel that harm may come to the patient if not seen on time. This is essentially a safety net to ensure the patients most in need are booked the soonest.

Table 1

Overdue Eye Department patients summary as at 12 May 2022.

	Summary		
	Total Over 1.5	DND's	Total
January	3093	73	3166
March	2046	11	2057
April	1126	10	1136

This **reduction of 2030 overdue patients** since January 2022 is attributed to the use of Sequre Medical locum agency, other approved SMO locums and eye department staff undertaking additional shifts.

A breakdown of volumes seen by locums is demonstrated in Table 2.

Table 2

Locum type – 1 February 2022 – 12 May 2022

Locum	Qty
Sequre	879
SMO Locums	536
Orthoptist	117
Total	1532

Recruitment

The service currently has an Ophthalmologist vacancy for which they are recruiting. An interview occurred in April 2022. This candidate has been invited to New Zealand for a face to face interview. If he is offered the role and accepts, likely start date would be early to mid-2023.

The recently appointed optometrist had to leave suddenly for personal family reasons – currently recruiting.

The UK based orthoptist is due to start mid-June 2022.

There are some pending vacancies within the administration team.

Community update

Initial forums were held with community optometrists in Queenstown, Wanaka and Te Anau to explore the opportunity of undertaking the diabetic monitoring of patients domiciled in their community. Currently, Ophthalmic photographers travel to these regions to undertake the imaging and the images are then medically reviewed in Dunedin.

This is the first phase of outsourcing appropriate work to the community optometrists before we progress into a larger outsourcing opportunity. It is anticipated that issues are worked through in this first phase and will inform second phase implementation (including IT constraints, communication, funding, geographic cover).

COVID

Covid-19 infection and isolating continues to impact staffing and HAC should note the continued risk to delivery around this.

Discussion

2. The **locum use continues to be effective in reducing risk** in a short space of time.

3. Staffing instability (recruitment and Covid requirements) continue to impact service delivery and is monitored closely.

4. A reduction in patients requiring hospital Eye Department support is necessary in the short term and part of the longer-term planning. Support by the community Optometrists is critical to support a sustainable service. This strategy is supported by the SMOs.

Next Steps & Actions

Complete contract for Sequre, continue Locums to cover the gap in staffing. Explore continuation of Sequre contract for 2022/2023 financial year (via IAP if appropriate).

Continue recruitment for SMOs.

Continue work on moving appropriate patients to the community for their ongoing care.

Southland Gynaecology Outpatient Waiting List

Overall, waiting lists have further deteriorated since the last HAC report in February 2022 with a further 80 patients added to the waiting list. The Service is overall 0.8 FTE (20%) unfavourable and had impacts of COVID of 0.25FTE and 0.35FTE for March and April with a further SMO away in May with COVID. Overall sick leave for YTD is 0.27 FTE (excluding COVID). 0.8 FTE Maternity leave commenced mid-April. The impact of COVID on Senior Medical Officer (SMO) together with uncovered maternity leave have been the primary drivers of the deterioration as gynae clinics are the only deferrable activity.

The actions listed below will have a positive effect on the waitlist over the next 1-3 months as they're implemented, however a total recovery may take between 12 and 24 months. There has been a positive response from GPs with a special interest in gynaecology and their additional clinics will assist greatly with the routine patient backlog and it is anticipated that this model, assuming it to be successful, will be proposed to continue following the recovery of waiting times as patients remain in the community to receive treatment. The two newly created Clinical Nurse Specialist roles, once fully operational, will see follow-up patients and perform minor operations and free up SMOs to see the more complex patients. Timing of the recruitment of SMOs, both in order to facilitate recovery but also to provide maternity cover, remains a challenge with one candidate commencing in September and a further candidate at the reference checking stage also targeting a September commencement date.

Waiting Time by Priority

Southland Gynaecology patients days waiting by priority for an FSA																
Priority	**0-39**	**40-79**	**80-119**	**120-159**	**160-199**	**200-239**	**240-279**	**280-319**	**320-359**	**360-399**	**400-439**	**440-479**	**480-519**	**520-559**	**560-600**	**Grand Total**
SURG	33	47	40	48	53	34	31	49	85	39	27	5	4	1	1	**497**
ROU	44	49	60	28	40	34	21	38	46	26	29	14	13	4	4	**450**
URG	30	3	1		2	1		1								**38**
Grand Total	**107**	**99**	**101**	**76**	**95**	**69**	**52**	**88**	**131**	**65**	**56**	**19**	**17**	**5**	**5**	**985**

Urgent Priority Waiting Time – further detail

Urgent patients days waiting and booked status							
Priority	**0-39**	**40-79**	**80-119**	**160-199**	**200-239**	**280-319**	**Grand Total**
booked	12	2		1	1		16
unbooked	18	1	1	1		1	22
Grand Total	**30**	**3**	**1**	**2**	**1**	**1**	**38**

Recovery and Sustainability

No.	Area of focus	Action	Progress/timeframe
1	Administration processes	Review of administration processes to ensure acuity based booking and good process.	Completed March 2022.
2	Clinic roster	Introduction of a three-month roster for clinic booking. This will improve the booking process.	Completed May 2022.
3	SMO locum	12 month fixed term role as part of IAP funding. Candidate confirmed.	September 2022 to start.
4	SMO maternity leave	Have a preferred candidate and checking referees.	September start planned.

5	Clinical Nurse Specialist (CNS) clinic role	Permanent CNS started in April and is training. Second fixed term role will start in July. These roles will see ward, clinic follow ups, run the early pregnancy clinic and undertake some minor procedures (see below) which will free up the SMOs for Gynae clinic.	One CNS commenced 25 April 2022 with the second commencing July. Please see below for the scope of the CNS.
6	District triaging	Same criteria for accepting referrals to be adopted on both sites. Decline rate is higher in Dunedin than Southland which signals that potentially more patients are being accepted in Southland however may reflect referral patterns. Consistent guidelines and triage will remove this variable and potentially result in fewer patients in Southland being accepted.	On-going discussion - note no agree criteria for either site. Dunedin has a higher decline rate.
7	Primary care and minor operations	GPs to see routine patients in their clinics (see detail below) and reduce ESPI 2 waitlist (1-2 clinics per week). They should be able to see 8-16 patients per week. GPs will be supported by the on-call SMO.	Applications close 20 May 2022. Three good applicants so far.
8	District approach	Discuss opportunities for collaboration to improve and standardise care to our patients alongside creating efficiencies.	Fortnightly district team meetings from April 2022.
11	Recruitment	Engaging with a recruitment agency to attempt to address our inability to consistently recruit into the service.	International recruitment campaign commenced April 2022.

Patients anticipated to be seen and treated by CNS and GP Resource (excluding follow-up)

GP possible patients				
Count of Patient_Id	Column Labels			
Row Labels	ROU	SURG	URG	Grand Total
Pelvic and perineal pain	33	22		55
Endometriosis, unspecified	33	16		49
Pain localised to other parts of lower abdomen	10	3	1	14
Endometriosis of uterus	3	3		6
Other specified abnormal uterine and vaginal bleeding		4	1	5
Postmenopausal bleeding	1	3		4
Other endometriosis	2	1		3
Pain in a joint, pelvic region and thigh	1			1
Grand Total	**83**	**52**	**2**	**137**

Possible CNS patients			
Count of Patient_Id	Column Labels		
Row Labels	ROU	SURG	Grand Total
Insertion of contraceptive device	16	7	23
Other contraceptive management	5	13	18
Surveillance of contraceptive device	8	8	16
General counselling and advice on contraception	9	4	13
Female infertility, unspecified	4		4
Contraceptive management, unspecified	1	3	4
Presence of contraceptive device	3		3
General counselling and advice on procreation	3		3
Counselling, unspecified	3		3
Other specified counselling	1		1
Other specified surgical follow-up care	1		1
Grand Total	**54**	**35**	**89**

Southern District Health Board
Piki Te Ora

FOR APPROVAL

6.4

Item:	Anaesthetic Technician (AT) Scholarships
Proposed by:	Kaye Cheetham Chief Allied Health Scientific and Technical Officer
Meeting of:	07 June 2022

Recommendation

That the HAC approves Option 1 in the attached paper and introduces Six AT Scholarships in 2023

Purpose

1. To seek HAC's approval to commence scholarships for the Anaesthetic Technician Workforce.

Specific Implication For Consideration

2. Financial

    - As per proposal attached.

3. Quality and Patient Safety

    -

4. Operational Efficiency

    - Adopting scholarships will enable a more consistent pipeline for the AT workforce which will result in theatres being fully staffed improving operational efficiency
    - Service manager will spend less time on costly recruitment and relocation of UK Anaesthetic Technicians

5. Workforce

    Scholarships will support retain local approach and see a more consistent approach to the supply of AT's in order to meet workforce demand.

6. Equity

    - There will be the opportunity to specifically target Māori applicants to the AT workforce in line with AHS&T pro-equity recruitment guideline.

Background

7. Paper provided as per the HAC action from the 04 April 2022 meeting.

Discussion

Next Steps & Actions

Recommend adopting option 1 commencing, six Anaesthetic technician scholarships in 2023.

Appendices

Appendix 1 – Authored by Tracy Hogarty, Director of Allied Health Scientific & Technical Dunedin

Introduction

Registered Anaesthetic Technicians (ATs) are a vulnerable workforce with limited availability throughout New Zealand alongside an international workforce shortage. Southern DHB has experienced significant delays with filling vacancies, currently there are: Dunedin 7 FTE and Southland 3.2FTE vacant. Both sites are dependent on agency staff (locums) to meet service needs. This is not a sustainable nor cost-effective long-term approach.

Locum costs:

2018	$155,668
2019	$834,992
2020	$468,890
2021`	$596,249

Permanent recruitment is predominantly from overseas (United Kingdom), however on average this nets **two** staff per annum, whereas attrition is **three** staff per annum. Therefore, the overall solution is to train and retain our AT workforce. This paper provides an update on the AT Workforce Training Plan with clear recommendations to recruit and maintain a consistent workforce pipeline.

Current Training Plan

Southern DHB currently has two AT training pathways, the 3-yr Diploma and the 2-yr Post Graduate Certificate Registered Nurse Anaesthetic Technician (RNAT) pathway. AUT will support both pathways until the end of 2023. From 2022 AUT commence a 3-year bachelor in perioperative practice.

Table one: Southern DHB Anaesthetic Technician Training Plan

	2022	**2023**	**2024**	**2025**
Dunedin Trainees	7	3	X	X
	(2x Yr 1)			
Southland Trainees	4	3	X	X
	(1x Yr 1)			
Total Trainees	**11**	**6**	**-**	**-**
New Graduates	**6**	**6**	****TBC**	****TBC**
		Student DHB Clinical Placements		
BHSc PeriOp Students	Year 1 Degree	Year 2 of Degree	**Yr 3 Students	**Yr 3 Students

Note:

Table one. In 2021, 4x new graduates were offered permanent, registered AT roles. In 2022, there are 11 trainees. 6x AT Trainees are completing the Diploma, and 5x Trainees are completing the Post Graduate Certificate. In 2023, 6x AT trainees will complete training. In 2024, Bachelor Health Science Perioperative (BHSc PeriOp) Year 3 students will become the new graduate workforce. Ongoing, Bachelor graduates will be the new AT workforce.

Changes from 2023

The training model for the anaesthetic technician workforce has changed. The apprenticeship in house Diploma model part funded by Health Workforce NZ is no longer available. The pathway is now a bachelor's degree in perioperative practice. The three years of full-time study include 1200 clinical hours. The programme is offered either on-site in South Auckland or via online learning. A second campus in Christchurch is also being explored. The degree removes the employment barrier to training positions, which has previously limited graduate numbers. However, unlike the current training pathway, where trainees can work under three levels of supervision, the degree candidates will be entirely at level one supervision*. (* *The practitioner providing supervision must be in the same room as the trainee under supervision).* This direct supervision means that students will not be able to contribute the same service delivery as the current trainees.

The AUT Perioperative Practice degree has two intakes per year, in February and July. The cohort size will only be limited by the number of clinical placement spaces available in New Zealand hospitals. AUT reports there is extremely strong support for these throughout the motu, with a significant number of applicants for the July 2022 cohort. Expected intake for July is 70/80 places. The university is extremely flexible with their mode of delivery, indicating if six students were based at Southern; they would be happy to send a lecturer to Southern, when required to work with students, to remove the need for the students to travel to attend block courses in Auckland or Christchurch. The risk remains with having a predominantly Auckland based model. How will we get a consistent flow of graduates to Dunedin and Invercargill?

To create a sustainable workforce, after reviewing the data available we have drawn the following conclusions:

- Based on current data average attrition of staff per annum = 3
- On average we have been attracting 2 overseas trained AT's per year
- We are starting with 7 current vacancies in Dunedin and 3 in Invercargill
- We have 4 trainees completing in Dec 2022
- Our training capacity for students is 4x students Dunedin and 2x students in Southland

Southern DHB Anaesthetic Technician Workforce Plan

Dunedin Anaethetic Technicians	Dec-21	Jun-22	Dec-22	Jun-23	Dec-23	Jun-24	Dec-24	Jun-25	Dec-25	Jun-26	Dec-26
Attrition average 3 p.a.		2.0	1.0	2.0	1.0	2.0	1.0	2.0	1.0	2.0	1.0
Employ All Qualified Trainees			-4.0		-5.0						
Employee Overseas ATs (1xAT/6 months)		-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0
Adjusted Projected Vacancies	6.2	7.2	3.2	4.2	**0.8**	**0.2**	**0.2**	**0.8**	**0.8**	**1.8**	**1.8**
New Graduates required to clear vacancies					1.0		1.0		2.0		
NDH, Outpatient Building, DSU, AT 1.0FTE											
NDH, Inpatient Building, Theatres, AT 4.0FTE											

Southland Anaesthetic Technicians	Dec-21	Jun-22	Dec-22	Jun-23	Dec-23	Jun-24	Dec-24	Jun-25	Dec-25	Jun-26	Dec-26
Attrition average 1 p.a.		1.0		1.0		1.0		1.0		1.0	
Employ All Qualified Trainees			1.0		3.0						
Employee Overseas ATs (1xAT/12 months		-1.0		-1.0		-1.0		-1.0		-1.0	
Adjusted Projected Vacancies	3.0	3.0	2.0	2.0	**1.0**	**1.0**	**1.0**	1.0	1.0	1.0	1.0
New Graduates required to clear vacancies					1.0		2.0		2.0		
Fifth Theatre Southland, AT 1.0FTE											

This proposal will consider the logistics of how we as an employer could develop and sustain our future AT workforce through scholarships and bonding. Alongside this the following recommendations need also be considered.

Actions & Recommended Workforce Strategies -

In addition to the 'training our own' approach there needs to be ongoing actions

- Maintain ongoing financial support for AT overseas advertising campaign
- Maintain relocation package for ATs and managers to ensure alignment across the district
- Service and Surgical Radiology Directorate support for requests to over-recruit new graduates when they are available and reduce the risk of each site carrying prolonged unfilled vacancies
- In Dec 2023, convert 3x 1.0FTE fixed term trainee roles to permanent, registered AT roles. Appoint Anaesthetic Technicians 2.0FTE Dunedin and 1.0FTE Southland
- 2024, appoint a Clinical Coach Anaesthetic Technician on each site to support the professional development and consolidation of knowledge for new graduates.

Scholarship

We have two primary issues with this workforce:

- Attraction
- Retention

A funded scholarship goes part way to achieving both outcomes. Most health scholarships require a period of bonding which largely guarantees a workforce for a fixed period of time.

Scholarships come in many forms:

Option one: **Attraction of Local People**

Attraction based scholarships would target local people and offer a financial level of support across Year 2 and Year 3 of training with a bonding requirement to the DHB following graduation. To support work readiness paid work experience as an AT assistant could be provided for two months per year – to fit in with course semester break

For example:
We could target local schools and specific communities for local candidates and offer a fixed amount per year to support the study programme dependant on successful completion.
This person would be bonded for one year after completion of the programme.

Option two: **Attraction of People from Outside the District**

The more conventional approach appears to be offering 50% of year three fees, up to a fixed amount, to people already in the programme with a bonding period of 12 months. The person is required to commence work within 3 months of graduating.

The preferred is option one and we are proposing SDHB offers six scholarships to Year 3 and Year 4 students in 2024.

Pros and Cons

Option one would mean we supported our local people and could be more targeted in our recruitment to the scholarships which in time could mean we improved equity in our workforce.

The risks here are that the yearly payment of the scholarship may not be financially significant enough to support programme completion. Ideally attached to this scholarship would be provision on some DHB based employment over holiday periods. This would improve work readiness of the graduates as they would become very familiar with the local environment reducing orientation when graduated.

The other risk here is non completion of the programme.

Option two could attract people from anywhere who may or may not choose to stay in the community they are bonded to. Potentially one would assume these people are less invested in the local community and less likely to stay beyond the bond timeframe of one year.
These people have demonstrated achievement across the previous two years and are therefore more likely to complete the programme.

Costs:

Option one:	Year 2	Year 3
Scholarship	$2,000	$2,000
No. of Scholarships	6	6
Total	$12,000	$12,000
Scholarship Total		**$24,000**

Option two:	Year 3
Scholarship	$4,000.00
No. of Scholarships	6
Scholarship Total	**$24,000**

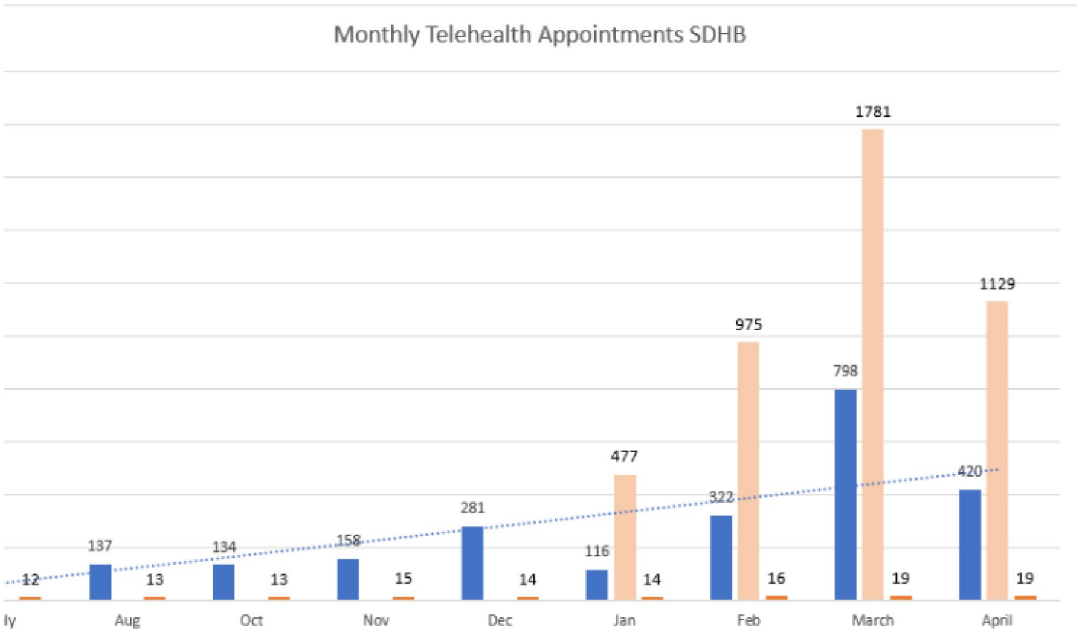
Work experience as an Anaesthetic Technician Assistant		
AT Assistant 1.0FTE base salary	$46,560	$46,560
No. of AT Assistants	6	6
2 months work experience/student	2	2
12-moth base salary cost	$46,560	$46,560
Total base salary costs		**$93,120**

Telehealth Presentation (Minutes Item 8.0)	The Project/Change Manager Telehealth is to provide information for the next HAC meeting showing the number of patient contacts that have traditionally been face to face that could be via Telehealth.	COO/ Project Manager Telehealth	An update is to be provided within the COO report.

The number of Telehealth appointments that have been reported in SDHB for the calendar month of April versus the total number of follow-up appointments is shown below. Telehealth naturally lends itself more to follow-up appointments as opposed to First Specialist Assessments (FSA) as it is perceived that the clinical risk of not seeing the patient face to face is less once a diagnosis has been made and treatment commenced. There are no absolute metrics that can determine how many telehealth could or should be undertaken but for follow-up appointments this may be conservatively 50% of all appointments and for FSA 20% though, as before, the FSA would need to be carefully selected.

Telehealth challenges how care has been delivered and it remains uncomfortable for many clinical staff and this, coupled with our current systems not being designed for digital communications act as barriers. It would not be expected that we will reach the percentages figures as above in the foreseeable future but improvements in infrastructure, education, experience and support for the platform will continue and the uptake will continue to rise until a tipping point arrives where Telehealth is seen as a normal way that healthcare is delivered.

April numbers



Total follow up appointments
8285

Total completed via Telehealth
158 *(1.9% of total follow-up appointments)*

Total completed via Phone
1129 *(13% of total follow-up appointments)*

There has been a considerable drop-off in telehealth appointments in April though the trend remains positive. The explanation for the April result is not clear and the coming months will determine the overall trend.

FOR INFORMATION

Item: Chief Operating Officer (COO) – April 2022 report

Proposed by: Hamish Brown, COO

Meeting of: Hospital Advisory Committee, 07 June 2022

Recommendation

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

Purpose

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

1. Equity

Initiatives underway:

Initiative	April Update
Dunedin fourth floor outpatients	Planning day on 23rd May to design how to imbed the agreed pro-equity changes regarding phone contact with Māori and Pacifica patients prior to outpatient appointments. This will include determining a workstream for outpatients around equity.
ERAS (Early Recovery after Anaesthesia) - for Orthopaedics Dunedin	Engagement of the Māori Health Directorate in this important work underway to reduce length of stay and improve outcomes for patients getting joint surgery.
High Tech imagining equity Radiology waiting times for CT by ethnicity Radiology waiting times for MRI by ethnicity	Education for Dunedin schedulers complete, Southland planned for early June. Monthly reporting of waiting times by ethnicity has improved waiting times for Māori and Pacific. CT Dunedin and Southland - The median and average waiting times for Māori and Pacific are similar to all ethnicities. This is an improvement from March 2022. MRI Dunedin and Southland - The median and average waiting times for Māori and Pacific are similar to all ethnicities. This is an improvement from March 2022.
Respiratory and Cardiology – outpatients pro-equity	4th floor outpatient project to phone all Māori and Pacific patients one week prior to their new or follow-

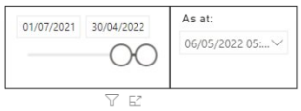
	up appointment shows early promising results compared to Feb-Apr 2021. Cardiology Unable to attend rates Follow-ups dropped from 13% to 8% New patients increase from 6% to 16% (so we are looking at this). Overall drop in cardiology from 11% to 9% Respiratory unable to attend rates Follow-ups dropped from 14 to 12% New patients dropped from 23% to 15% Overall drop in respiratory 18% to 13%.
ESPI 2 and 5 Waitlist	A breakdown of all patients including long wait patients by ethnicity to identify Māori and Pacific patients – this is in alignment with planned care taskforce initiates and some waitlists (e.g., Cardiothoracic) are already reported this way.

2. Surgical Performance – Case Weight Discharges

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

The 'service provider' view in the case weight discharge (CWD) table is the target set for the hospitals. For the April 2021/22 financial year to date we are 1,176.1 CWD and 1,376 discharges **behind plan**. Dunedin is –620.9 caseweights and –1,156 discharges behind plan and Southland is –556.1 caseweights and –221 discharges behind plan. This represents the nature of the work at both sites.

The 'population' view in the case weight discharge (CWD) table is an overall target which includes both the SDHB hospital delivered CWD and the net CWD delivered for us by other DHBs. The most up to date data from the Ministry of Health shows that for April year to date we are –1,125.0 CWD behind this target and –1,366 discharges behind target. This represents the small outflow from Southern Hospitals.



YTD CASEWEIGHTS

	YTD Service Provider View			- YTD IFL			+ YTD OFL			YTD Population View			Previous FYTD Service Provider View		Previous FYTD Population View	
PUC	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Target	Variance	Actuals	Year on Year Variance	Actuals	Year on Year Variance
Non Surgical PUC																
Non Surgical PUC with Surgical DRG	1,109.7	997.0	112.7	6.5	22.8	-16.3	537.2	510.9	26.3	1,640.4	1,485.1	155.3	1,184.5	-74.8	1,536.0	104.5
PUC Total	**1,109.7**	**997.0**	**112.7**	**6.5**	**22.8**	**-16.3**	**537.2**	**510.9**	**26.3**	**1,640.4**	**1,485.1**	**155.3**	**1,184.5**	**-74.8**	**1,536.0**	**104.5**
Surgical PUC																
S00.01 General Surgery	2,386.8	2,500.7	-113.8	22.5	2.1	20.4	142.1	202.5	-60.3	2,506.4	2,701.0	-194.6	2,814.6	-427.8	2,981.6	-475.1
S05.01 Anaesthesia Services	4.8	0.0	4.8				6.8		6.8	11.6	0.0	11.6	8.4	-3.6	8.4	3.2
S15.01 Cardiothoracic	1,138.1	1,189.6	-51.4	3.6	15.7	-12.1	42.3	19.0	23.3	1,176.9	1,192.9	-16.0	1,204.2	-66.1	1,211.7	-34.9
S25.01 Ear Nose and Throat	922.1	1,145.9	-223.8	6.3	1.3	5.0	13.2	17.3	-4.1	928.9	1,161.9	-233.0	1,080.7	-158.6	1,096.4	-167.5
S30.01 Gynaecology	779.0	949.0	-170.1	1.9	1.3	0.6	131.0	78.6	52.4	908.1	1,026.3	-118.2	861.3	-82.3	1,012.3	-104.2
S35.01 Neurosurgery	402.0	311.9	90.1		33.9	-33.9	141.6	146.7	-5.1	543.6	424.7	119.0	356.5	45.4	494.9	48.8
S40.01 Ophthalmology	642.1	994.1	-352.0	0.8	0.6	0.3	11.7	5.7	6.0	653.0	999.3	-346.3	825.1	-183.0	839.8	-186.8
S45.01 Orthopaedics	3,470.9	4,014.1	-543.2	262.5	233.3	29.2	235.6	98.2	137.4	3,444.1	3,879.0	-435.0	3,520.4	-49.5	3,329.9	114.2
S55.01 Paediatric Surgical Services	93.5	157.9	-64.4				75.0	69.2	5.8	168.5	227.1	-58.6	107.0	-13.5	231.8	-63.3
S60.01 Plastic & Burns	429.4	560.7	-131.3	3.5	2.0	1.5	42.3	161.0	-118.7	468.2	719.7	-251.6	462.5	-33.1	499.3	-31.1
S70.01 Urology	1,068.0	922.3	145.8	1.6	2.2	-0.7	14.6	31.3	-16.6	1,081.1	951.3	129.8	994.2	73.8	1,019.3	61.8
S75.01 Vascular Surgery	853.9	733.2	120.7	0.4	9.1	-8.8	7.8	24.8	-16.9	861.4	748.9	112.5	710.7	143.2	720.2	141.1
PUC Total	**12,190.6**	**13,479.4**	**-1,288.8**	**303.1**	**301.6**	**1.5**	**864.2**	**854.3**	**10.0**	**12,751.7**	**14,032.1**	**-1,280.4**	**12,945.6**	**-755.0**	**13,445.5**	**-693.8**
PUC Total	**13,300.4**	**14,476.5**	**-1,176.1**	**309.6**	**324.4**	**-14.8**	**1,401.4**	**1,365.1**	**36.3**	**14,392.2**	**15,517.2**	**-1,125.0**	**14,130.1**	**-829.7**	**14,981.5**	**-589.3**

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	390	459	-69	2	7	-5	108	122	-14	496	574	-78
PUC Total	**390**	**459**	**-69**	**2**	**7**	**-5**	**108**	**122**	**-14**	**496**	**574**	**-78**
Surgical PUC												
S00.01 General Surgery	1,295	1,426	-131	11	7	4	71	74	-3	1,355	1,493	-138
S05.01 Anaesthesia Services	19	0	19				4		4	23	0	23
S15.01 Cardiothoracic	180	192	-12	1	2	-1	6	4	2	185	194	-9
S25.01 Ear Nose and Throat	1,016	1,362	-346	6	2	4	17	26	-9	1,027	1,386	-359
S30.01 Gynaecology	877	908	-31	3	2	1	63	42	21	937	947	-10
S35.01 Neurosurgery	109	94	15		10	-10	44	50	-6	153	134	19
S40.01 Ophthalmology	1,132	1,840	-708	1	1	0	14	6	8	1,145	1,845	-700
S45.01 Orthopaedics	1,479	1,720	-241	24	33	-9	112	76	36	1,567	1,763	-196
S55.01 Paediatric Surgical Services	136	167	-31				74	66	8	210	233	-23
S60.01 Plastic & Burns	441	545	-104	3	2	1	25	69	-44	463	612	-149
S70.01 Urology	983	853	130	4	3	1	9	20	-11	988	870	118
S75.01 Vascular Surgery	427	294	133	2	5	3	4	3	1	429	292	137
PUC Total	**8,094**	**9,401**	**-1,307**	**55**	**66**	**-11**	**443**	**436**	**7**	**8,482**	**9,770**	**-1,288**
PUC Total	**8,484**	**9,860**	**-1,376**	**57**	**73**	**-16**	**551**	**558**	**-7**	**8,978**	**10,344**	**-1,366**

For the month of April 2022 service provider delivery was –212.0 cw and -83 discharges behind plan. The population view for the same period was –208.6 cw and -95 discharges behind plan.

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	25.6	89.3	-63.8		2.1	-2.1	51.1	51.1	0.0	76.7	138.4	-61.7
PUC Total	**25.6**	**89.3**	**-63.8**		**2.1**	**-2.1**	**51.1**	**51.1**	**0.0**	**76.7**	**138.4**	**-61.7**
Surgical PUC												
S00.01 General Surgery	195.7	222.0	-26.2	9.0	0.2	8.8	20.2	20.2	0.0	206.9	242.0	-35.1
S05.01 Anaesthesia Services	0.2		0.2				0.0		0.0	0.2		0.2
S15.01 Cardiothoracic	91.0	106.7	-15.7		1.4	-1.4	1.9	1.9	0.0	92.9	107.2	-14.4
S25.01 Ear Nose and Throat	71.3	102.7	-31.4	1.2	0.1	1.1	1.7	1.7	0.0	71.9	104.3	-32.4
S30.01 Gynaecology	74.4	85.0	-10.7		0.1	-0.1	7.9	7.9	0.0	82.2	92.8	-10.5
S35.01 Neurosurgery	35.6	28.0	7.6		3.1	-3.1	14.7	14.7	0.0	50.3	39.6	10.7
S40.01 Ophthalmology	44.2	81.3	-37.2				0.6	0.6	0.0	44.7	81.9	-37.2
S45.01 Orthopaedics	328.8	360.7	-31.9	14.2	20.4	-6.2	9.8	9.8	0.0	324.5	350.2	-25.7
S55.01 Paediatric Surgical Services	11.1	14.1	-3.0				6.9	6.9	0.0	18.0	21.1	-3.0
S60.01 Plastic & Burns	43.2	50.3	-7.1		0.2	-0.2	16.1	16.1	0.0	59.3	66.2	-6.9
S70.01 Urology	92.4	82.7	9.7	0.8	0.2	0.6	3.1	3.1	0.0	94.8	85.6	9.2
S75.01 Vascular Surgery	63.2	65.7	-2.5		0.8	-0.8	2.5	2.5	0.0	65.6	67.3	-1.7
PUC Total	**1,051.1**	**1,199.3**	**-148.2**	**25.2**	**26.5**	**-1.3**	**85.4**	**85.4**	**0.0**	**1,111.4**	**1,258.3**	**-146.9**
PUC Total	**1,076.7**	**1,288.7**	**-212.0**	**25.2**	**28.5**	**-3.4**	**136.5**	**136.5**	**0.0**	**1,188.1**	**1,396.7**	**-208.6**

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	23	37	-14		0	0	5	12	-7	28	49	-21
PUC Total	**23**	**37**	**-14**		**0**	**0**	**5**	**12**	**-7**	**28**	**49**	**-21**
Surgical PUC												
S00.01 General Surgery	121	112	9	1	0	1	5	7	-2	125	119	6
S05.01 Anaesthesia Services	3		3							3		3
S15.01 Cardiothoracic	12	15	-3		0	0	1	0	1	13	16	-3
S25.01 Ear Nose and Throat	104	110	-6	2	0	2	1	3	-2	103	112	-9
S30.01 Gynaecology	73	73	0		0	0	3	4	-1	76	77	-1
S35.01 Neurosurgery	2	7	-5		1	-1	5	5	0	7	11	-4
S40.01 Ophthalmology	83	136	-53				4	1	3	87	137	-50
S45.01 Orthopaedics	121	138	-17	2	3	-1	6	8	-2	125	143	-18
S55.01 Paediatric Surgical Services	11	13	-2				11	7	4	22	20	2
S60.01 Plastic & Burns	30	44	-14		0	0	2	7	-5	32	51	-19
S70.01 Urology	85	69	16	1	0	1	1	2	-1	85	70	15
S75.01 Vascular Surgery	28	24	4		0	0		0	0	28	24	4
PUC Total	**673**	**742**	**-69**	**6**	**5**	**1**	**39**	**44**	**-5**	**706**	**781**	**-75**
PUC Total	**696**	**779**	**-83**	**6**	**6**	**0**	**44**	**56**	**-12**	**734**	**829**	**-95**

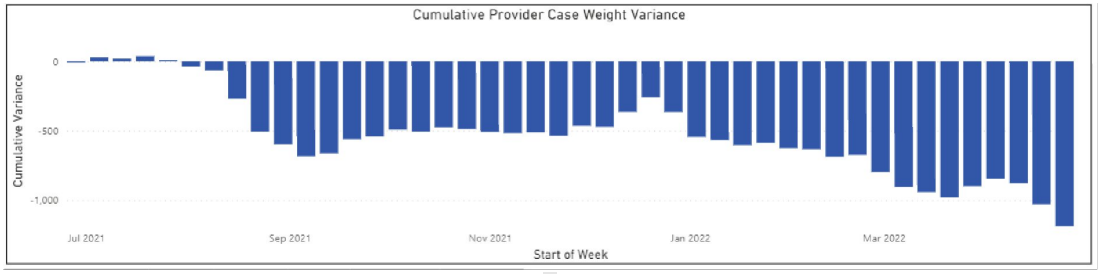
The large variance to YTD target reflects the impact that the August 2021 COVID-19 lockdown has had on surgical delivery (550CW in August alone) in the months following. Surgical delivery (across all streams) was ramped up as quickly as possible for the remainder of September as lockdown restrictions were lifted. Additional spending on outsourcing and the fact that Dunedin was able to consistently fill their theatre lists across this period resulted in the district provider view being only -383.4 CW behind target by the end of December (Dunedin -1.2 CW behind target and Southland –382.2 CW behind target).

In both Dunedin and Southland performance across March and April has been affected by cancellations. Fifty operations were postponed due to bed availability (high occupancy of acute patients) and fifty-eight were cancelled due to covid and staff sickness. Actual bed closures have been minimal across April however 10 beds remain closed on the Dunedin Surgical wards due to nursing vacancy and 10 Beds closed in Dunedin 6ATR as a result of COVID preparations. With the reduced capacity, theatre time is prioritised for non-deferrable and urgent patients and when beds are available, they are used for long waiting elective patients. Southland has been more affected than Dunedin by workforce shortages for perioperative nurses and anaesthetic technicians and this continues to have an impact on the ability to fully utilise the operating theatres.

Key Actions

1. **Theatre utilisation** is being maintained by adding as many day cases as possible to ensure services are maintained.
2. **Tight coordination of operating lists** through this period to ensure appropriate clinical prioritisation and reduce on the day cancellations and the resulting impact on patients and staff.
3. **Utilising private hospital beds** for overnight stays rather than cancel lists.
4. **Increase bed capacity** – four of ten additional medical beds were opened in the AT&R ward in Southland on 27th April and these have been used to take medical outliers who would normally have used surgical ward beds. The remaining six beds will be opened as recruitment of new staff permits.
5. **Recruitment campaign** - HainesAttract have developed an advertising concept specifically for Southland called "Fit in. Stand out" which includes video and still photos. This international campaign went live in mid-April and the Recruitment Manager will provide click through statistics in late May. SDHB is also participating in the national critical care recruitment programme being conducted by TAS.
6. **Improved coordination of planned activity** - The planned care team have begun initiatives to improve coordination of theatre resources, inpatient beds, and allied health staff to improve flow and reduce the number of cancellations. These initiatives include, where possible, booking elective operations 6 weeks in advance. These improvements are continuing but have been hampered by the number of cancellations due to bed closures.
7. **Progression of the 5th Operating theatre planning** – this has moved through concept stage and is being costed by the Quantity Surveyor.
8. **Increase Southland day cases** – the pathway for day cases is being reviewed in Southland. Typically, laparoscopic cholecystectomies and simple ankle joint operations have a one-night length of stay and the new pathway will support suitable patients to be discharged on the day of surgery.
9. **Increase Dunedin Orthopaedic delivery** – The Orthopaedic service are working to create a ring-fenced 4-bed high throughput arthroplasty pod which will reducing both length of stay and the number of cancellations due to bed block for orthopaedic joint patients. It is founded on well-established ERAS principles.

Cumulative weekly caseweight variance to plan



5

Improvement Action Plan (IAP) funding update

The 2021/22 IAP is a MOH funded initiative targeted to provide additional activity and reduce the number of long waiting patients. Southern and the MOH have agreed targets for inpatients (ESPI 5), outpatient (ESPI 2), diagnostics and ophthalmology follow-ups. The additional funding available is $5,680,929.

For the third quarter we applied for $4,406,758 of IAP funding and this has been **approved** by the MOH and payment will be received in the June payment schedule. For April we have earned $203,251 and there is $1,115,030 of funding remaining.

IAP target and actual volumes and funding earned								
	Target volume	Quarter 3 delivery	Quarter 4 delivery	Target remaining	IAP funding total	Funding earned quarter 3	Funding earned quarter 4	Funding remaining
ESPI 5	363	349	2	12	$ 3,589,104	$3,500,282	$12,689	$ 76,133
ESPI 2	404	174	16	214	$ 205,207	$ 94,696	$16,592	$ 93,919
Diagnostics	1,400	1,175	63	162	$ 650,000	$ 425,000	$63,000	$ 162,000
Ophthalmology	1,500	972	197	331	$ 537,300	$ 348,170	$70,565	$ 118,564
Colonoscopies	450	37	12	401	$ 699,318	$ 57,499	$40,405	$ 601,413
Total	**4,117**	**2,707**	**290**	**1,120**	**$ 5,680,929**	**$4,425,648**	**$203,251**	**$ 1,052,030**

Key actions:

1. **ESPI 2 and 5** – waitlists and delivery are monitored weekly, and we are on target to achieve the full amount.

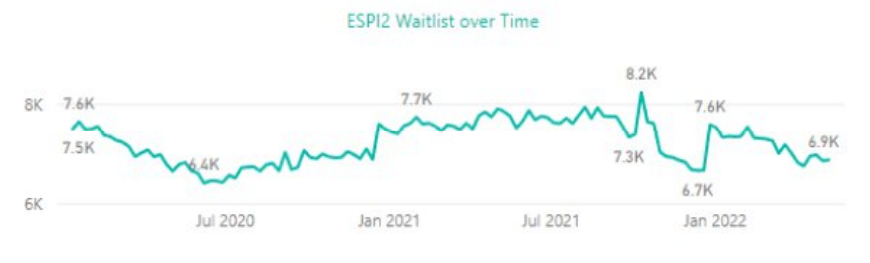
2. **Ophthalmology and Diagnostics** – Sequre is booked for May and June for follow-up clinics, and we will achieve the full amount of funding.

3. **Colonoscopies** – there is some risk of us not receiving the full funding as capacity to do additional clinics is limited. Options are being discussed with the service manager and clinical leader to better define the risk to revenue.

4. **Funding for 2022/23** - the MoH has said there will be IAP funding for 22/23 but have not released the details yet. In preparation for this we are working with managers on proposals for the funding. In addition to paying for locums and additional clinics there is a focus on proposals, for both medicine and surgery, that will improve patient flow and free up SMO capacity e.g., Orthopaedic Arthroplasty Nurse, TAVI Nurse Coordinator, Cardiology Coordinator, Clinical Nurse Specialist roles in Vascular, ENT and Rheumatology.

3. Outpatient Performance ESPI 2

The following chart shows the total number of outpatient appointments on our waiting over time. The waitlist has decreased by 711 since December 2021 when it was 7,583 to its current 6,872. The decrease can be attributed to the outpatient service managing to maintain a high level of service, holding additional clinics as part of the IAP funding and a lower than usual number of referrals being received.



ESPI 2 'breaches' (defined as those patients who had to wait longer than the Ministry target of 120 days). The number of ESPI 2 breaches is currently 2,145 which is a decrease of 329 from February when it was 2,474.

ESPI 2 (FSA) Breaches by Speciality and Directorate

Breaches down by speciality and site to highlight the key areas of ESPI non-compliance are listed below. The national narrative around ESPI compliance is that it is unachievable in the short to medium term and the focus will shift to managing clinical risk and long waiting patients. This is consistent with messaging from the planned care taskforce.

In the February HAC report the ESPI 2 split by site was Dunedin (45%) and Southland (55%). Dunedin breaches have decreased by 11 from 1,092 in February and Southland breaches have decreased by 248. In Southland, ENT has run additional clinics and Orthopaedics and General Surgery have run additional clinics and employed locums to decrease their waitlists.

All specialities	DN	Sthld	Total	
Neurosurgery	121	0	121	6%
Cardiothoracic	1	0	1	0%
Orthopaedics	261	41	302	14%
Haematology	24	0	24	1%
Gynaecology	56	626	682	32%
Vascular	37	0	37	2%
Cardiology	9	3	12	1%
Urology	6	6	12	1%
ENT	54	107	161	8%
Plastics	181	0	181	8%
Respiratory	4	0	4	0%
General Surgery	91	149	240	11%
Dermatology	99	61	160	7%
Renal Medicine	0	3	3	0%
Neurology	38	0	38	2%
Ophthalmology	16	25	41	2%
General Medicine	4	4	8	0%
Rheumatology	45	22	67	3%
Diabetes	1	2	3	0%
Endocrinology	1	2	3	0%
Gastroenterology	1	7	8	0%
Oncology	0	0	0	0%
Paed Medicine	0	6	6	0%
Paed Surgery	0	0	0	0%
Radiation Oncology	0	0	0	0%
Anaesthesia	31	0	31	1%
Total	**1081**	**1064**	**2145**	**100%**
% by site	**50%**	**50%**	**100%**	

Surgery	
Neurosurgery	121
Orthopaedics	302
Vascular	37
ENT	161
Plastics	181
General Surgery	240
Urology	12
Ophthalmology	41
Paed Surgery	0
Anaesthesia	31
Breach share	**52.5%**

Medicine	
Haematology	24
Gynaecology	682
Cardiology	12
Respiratory	4
Dermatology	160
Renal Medicine	3
Neurology	38
Diabetes	5
Rheumatology	67
General Medicine	8
Endocrinology	3
Gastroenterology	8
Oncology	0
Paed Medicine	0
Radiation Oncology	0
Breach share	**47.3%**

Orthopaedic Outpatient Waitlist and ESPI 2 (FSA) Breaches

The overall waitlist has increased by 31 patients since the February report and is now 788. The number of breaches has increased by 3 over the same period to remain stable at 302. Due to a long-term vacancy on the Southland site, all spinal patients are being seen on the Dunedin site.

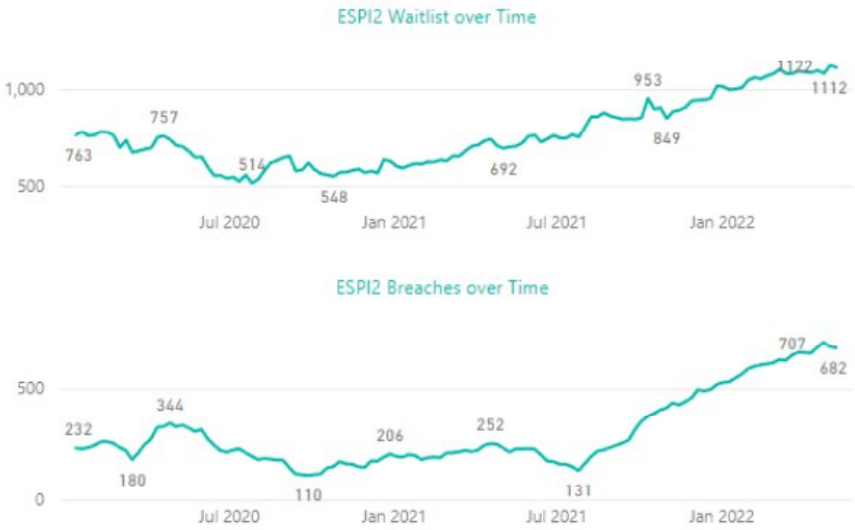
HAC should note the following actions:

1. An Orthopaedic Senior Medical Officer has been employed to fill a long-term vacancy on the Southland site and will start in August 2022. The FTE from this vacancy is being used to employ a locum to see FSA's and cover acute call and is having a positive impact on the ESPI 2 waitlist.
2. Discussions with Clutha Health to reduce their Orthopaedic Outpatient clinics from monthly to one every three months are continuing. This will add an additional 10 FSA and 8-10 follow-ups per month to Dunedin. The aim is to shift resources to ensure patients wait a similar time across the district.
3. On the Dunedin site additional outpatient clinics are being provided by the Fellow and Orthopaedic Surgeons.

Gynaecology Outpatient Waitlist and ESPI 2 (FSA) Breaches

The overall waitlist has increased by 32 patients since the February report and is now 1,112. The number of breaches has increased by 57 over the same period and is currently 682.

Actions being taken to address the challenges for both sites are covered in **paper 5.3** as appended to the action sheet.



ENT Outpatient Waitlist and ESPI 2 Breaches

The overall waitlist has decreased by 120 patients since the February report and is now 762. The number of breaches has decreased by 136 over the same period and is now 161.

HAC should note the following actions:

1. A greater number of referrals for skin lesions go to General Practitioners with a Sub-specialty Interest (GPSI's) in primary care, this is working well and supported by health pathways and contributes to our minor procedure targets.
2. Southland have been able to secure a SMO for a 12-month position from June 2022 which will improve service delivery on that site.
3. Dunedin has senior registrars and recently employed a SMO so are able to see an increased number of patients.
4. The Southland ENT Surgeon, who is no longer under supervision, has been holding additional clinics.

4. Inpatient Performance ESPI 5 (surgery)

The inpatient wait list is currently 4,812 which is a decrease of 90 since February when it was 4,722. On both sites there has been reduced theatre capacity due to staff vacancies and sickness resulting in theatre closures and acute patients have restricted access to elective beds. The total waitlists and breach numbers for all services have either held steady or slightly increased. A notable exception is dental surgery in Southland, who have made use of additional mobile bus visits and have decreased both their waitlist and breach numbers.

HAC should note the following actions:

1. On the Dunedin site planned care capacity has been limited by the number of available inpatient beds and has purposefully been aligned with that constraint to reduce the number of on the day cancellations. This has been managed with input and support of surgeons in order to maintain available theatre capacity for urgent and non-deferable patients.

2. The number of day surgery cases have been increased on both sites when possible.

3. As part of a ten additional bed project in Southland, four additional beds were opened in the AT&R ward on 27th April and have been taking medical outliers that would usually have been in the surgical ward. As staffing recruitment permits, the remaining six beds will open.

4. Outsourcing continues to be maximised within constraints of our private partners and will continue into June.

ESPI 5 breaches by speciality

In the February HAC report the ESPI 2 split by site was Dunedin (70%) and Southland (30%). Dunedin breaches have decreased by 265 from 1,945 in February and Southland breaches have increased by 284. Over the past two months Southland has been affected to a greater degree than Dunedin by the impact of COVID-19.

Surgery	DN	Sthld	Total	
Neurosurgery	30	0	30	1%
Orthopaedics	733	321	1054	37%
Vascular	91	0	91	3%
ENT	154	391	545	19%
Plastics	182	0	182	6%
General Surgery	178	83	261	9%
Gynaecology	66	67	133	5%
Urology	63	38	101	4%
Paediatric Surgery	0	0	0	0%
Dental Surgery	0	63	63	2%
Ophthalmology	163	170	333	12%
Cardiothoracic	20	0	20	1%
Max Fax	0	0	0	0%
Total	**1680**	**1133**	**2813**	**100%**
% by site	**60%**	**40%**	**100%**	

Orthopaedic ESPI 5 Breaches

The high number of breaches in the orthopaedics service reflects the impact of high demand and the continued pressure of acute care during the COVID-19 peak and plateau. This has restricted access to beds especially HDU and ICU. On both sites all opportunities to do additional outsourcing with current providers are being taken.

HAC should note the following:

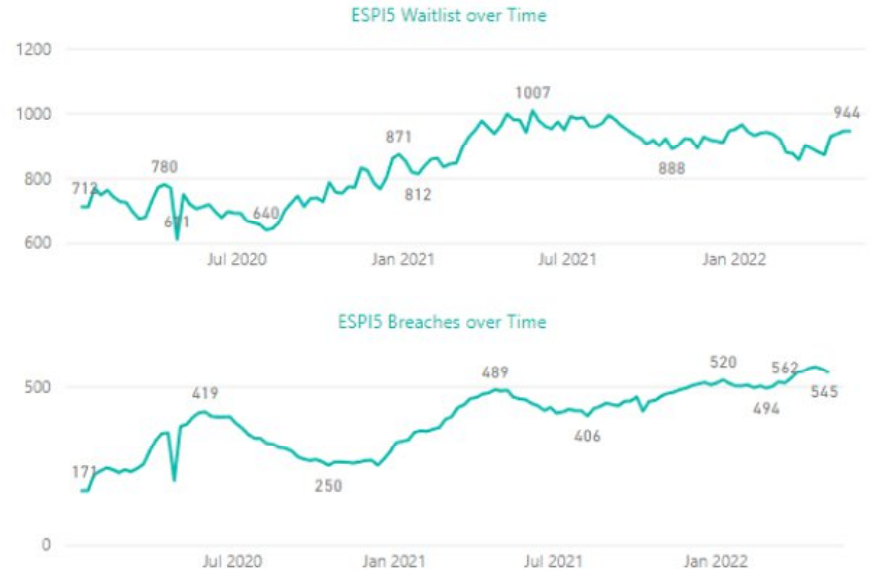
1. An additional Saturday acute theatre is being run on the Dunedin site when current staffing shortages permit.
2. Negotiations are being finalised for a long-term contract with a Dunedin Private provider.
3. On the Dunedin site the 4-bed pod plan to ring fence beds for orthopaedic patients will start end of May and this will reduce cancellations and improve throughput.
4. Continued outsourcing as required. For example, over the past 12 months forty-seven joints have been operated on at South Canterbury DHB and they have indicated they would like this to continue past 1 July 2022.
5. IAP funding is planned to be used for 22/23 for Arthroplasty Nurses on both sites to improve patient flow, early discharges and throughput.

ENT ESPI 5 Breaches

Since the February HAC report the total ENT waitlist has increased by 89 to now be 944 and the number of breaches has increased by 46 to 545. The ENT service faces similar challenges to other services with reduced theatre time and cancelled lists due to bed block nursing shortage.

HAC should note the following:

1. There has been an increase in the number of skin lesions being undertaken by the primary care.
2. A locum surgeon in Southland has been appointed for 12 months from June 2022.
3. On the Dunedin site the outsourced contract is currently being negotiated and will provide additional long-term capacity.



General Surgery ESPI 5 Breaches

The overall waitlist has decreased by 7 since the February HAC report to 499. The number of breaches over the same time period has decreased by 24 to 261. The sustained reduction in theatre capacity has resulted in General Surgery operating only on urgent and cancer cases and non-urgent cases are waiting longer.

HAC should note the following:

1. On the Southland site a new Colorectal Surgeon started in February.
2. A locum surgeon in Southland has extended their contract to June 2023 and are doing additional outpatient clinics.
3. Interviews for Clinical Nurse Specialist role (part of IAP funding) in Southland are complete and a preferred candidate has been chosen. When appointed this role will have a positive effect on throughput through the service with improved discharged planning and reduced length of stay.

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

ESPI 5 (Surgery Long Waiting) Patients

For April, the number of patients (defined as patients ready and able to be booked for an operation) is 653.

ESPI 5 waiting over 365 days						
Date	**Normal**	**Planned**	**Staged**	**Booked**	**Total**	**% booked**
Oct-21	404	128	70	58	602	12%
Nov-21	420	132	66	43	618	11%
Dec-21	455	134	66	61	655	10%
Jan-22	480	131	64	32	675	9%
Feb-22	559	133	68	43	760	9%
Mar-22	592	143	60	26	795	8%
Apr-22	653	140	61	30	854	7%

The services that continue to be challenging are ENT, Plastics, General Surgery, Orthopaedics, Ophthalmology and Vascular Surgery.

ESPI 5 by service waiting over 365 days						
Service	**Normal**	**Planned**	**Staged**	**Booked**	**Not booked**	**Total**
ENT	98	23	1	2	122	124
Dental Surgery	6	3	0	0	9	9
General Surgery	65	10	4	1	79	80
Gynaecology	7	11	0	2	18	20
Neurosurgery	9	0	0	0	9	9
Orthopaedics	354	76	12	16	442	458
Plastics	26	5	44	6	75	81
Ophthalmology	44	5	0	0	49	49
Urology	2	4	0	0	6	6
Cardiothoracic	3	0	0	0	3	3
Vascular Surgery	39	3	0	3	42	45
Total	**653**	**140**	**61**	**30**	**854**	**884**

HAC should note the following:

1. Outsourcing is being maximised and will continue throughout June (normally limited outsourcing occurs in June)
2. Waitlists are being audited to ensure they are current e.g., patients are categorised appropriately, removed with due process or if they have gone private and care is transferred if necessary.
3. Weekly ESPI meetings with the General Manager for Surgery, Service Managers and Planned Care Manager are on-going and focus on plans to book the long wait patients when possible or look for outsourced alternatives.

4. On the Dunedin site an Outsourcing and Waitlist Registered Nurse for General Surgery, Plastics and Urology commenced in April and will focus on both outpatient and inpatient long waiting patients.

ESPI 2 (Outpatient) Long Waiting Cases

ESPI 2 waiting over 365 days				
Date	**Not booked**	**Booked**	**Total**	**% booked**
Oct-21	91	21	112	19%
Nov-21	55	13	68	19%
Dec-21	69	19	88	22%
Jan-22	100	13	113	12%
Feb-22	149	14	163	9%
Mar-22	156	42	198	21%
Apr-22	221	30	251	12%

ESPI 2 by service waiting over 365 days				
Service	**Not booked**	**Booked**	**Total**	**% booked**
ENT	1	6	7	86%
General Surgery	19	7	26	27%
Gynaecology	123	1	124	1%
Neurosurgery	42	1	43	2%
Orthopaedics	1	2	3	67%
Plastics	10	2	12	17%
Vascular Surgery	10	0	10	0%
Rheumatology	15	11	26	42%
Total	**221**	**30**	**251**	**12%**

HAC should note the following:

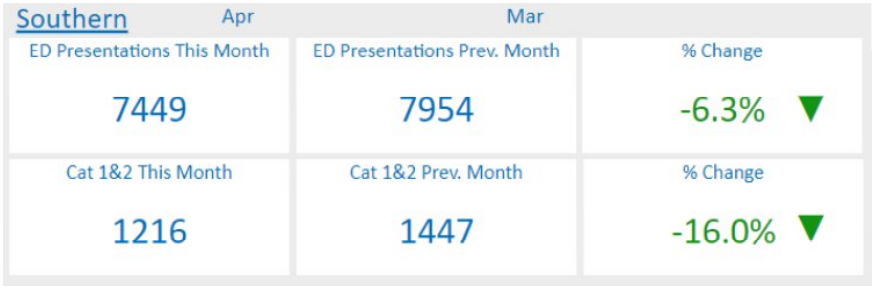
1. Additional clinics are being provided using the IAP (Improvement Action Plan) funding to provide additional clinic and locums.
2. Waitlists are being audited to ensure they are current e.g., data is entered correctly and appropriately, DNA guidelines are followed, and appointment outcomes recorded in a time manner.
3. Weekly ESPI meetings with the General Manager for Surgery, Service Managers and Planned Care Manager are on-going and focus on plans to book the long wait patients.

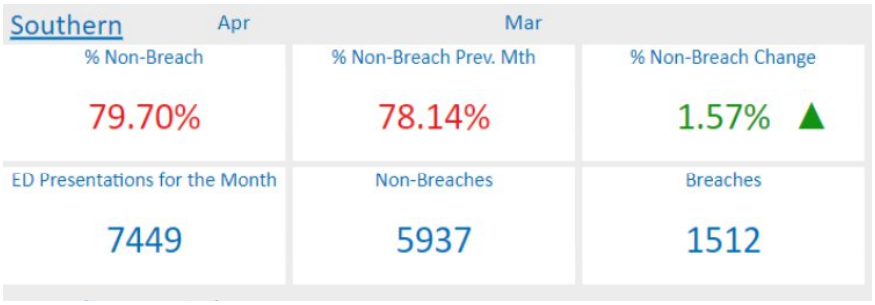
5. Emergency Departments

The Emergency Departments in both Southland and Dunedin are continuing to experience variable but sometimes significant patient volumes. This, coupled with the effect of COVID on the operation of the department and the significant periods of bed block that are being experienced has led to these areas being a challenging and high risk environment. Through the month of April however presentations dropped, and the number of the highest acuity patients also fell. ***COO Note*** - In May however Dunedin in are experiencing exceedingly high attendance numbers with a record 175 presentations experienced in on one day. Southland presentations have peaked at 128 in May.

The lack of beds available in aged residential care because of their recruitment difficulties and the effect of COVID has a significant impact on patient flow across the hospitals and accordingly on the Emergency Department.

April 2022





Strategies for improving patient flow in the Emergency Department(s) continue and HAC should note the following:

1. Patient flow manager is commencing in Southland on the 23rd of May. They will inevitably have a particular focus on flow through the Emergency Department however most actions will likely be applied external to the department. The establishment of a formal escalation plan for Southland will be the early focus for this role.
2. The Dunedin hospital-wide escalation plan remains the key strategy when the ED becomes overloaded or bed blocked and has been used with effect.

3. Staffing of the Emergency departments is increased, where possible, in response to challenges associated with bed block, acuity and volumes of patients to try and maintain as safe an environment as possible.
4. Emergency Q implementation is planned as a pilot in Southland.
5. A weekend discharge pilot programme is in place to improve discharge rates over the weekend.
6. Four additional beds have been opened in the Rehab ward in Southland Hospital which has allowed improved patient flow and a further six beds will be opened as staffing allows.
7. The Emergency departments continue to work with the speciality areas to try and ensure good response times and early decision-making for referrer patients.
8. The 7th floor MAU in Dunedin continues to operate to pull patients out of the ED.
9. Longer term measures include the expansion of the Emergency Department at Southland Hospital and the establishment of the MAU proximate to the ED combined with Generalism in Dunedin which will further enhance the early senior decision-making.
10. Integrated Ops Center. A project brief has been worked up and some project support has been seconded.

6. Radiology

April saw a slight decrease in CT performance but remains around 90% (target is 95%). The change appears to be mostly driven by Southland/Lakes. Although fewer than normal levels of outpatients were booked at Dunedin in April owing to COVID related staff shortages, Dunedin appears to have slightly improved on its March result. May has seen reasonably consistent scanning.

The second MRI was blessed on Monday 9th May and the first patient was scanned on that day. The team has been undertaking application training and building capacity on the machine. There is still a significant amount of backlog on the waiting list and pressure around waiting times. The long days continue on Machine 1 and we will continue to outsource at Pacific Radiology circa 10 scans per week with a review at the end of June.

The district result for MRI in April was 42%. Improvement performance for the MOH target of 85% of patients receiving an MRI scanned and report within 42 days will take some months to achieve. We are targeting significantly improved results by the end of August.

The tracking of CT and MRI waiting times by ethnicity is carried out monthly and currently there are no significant differences between Māori and Pacific with 'other'.

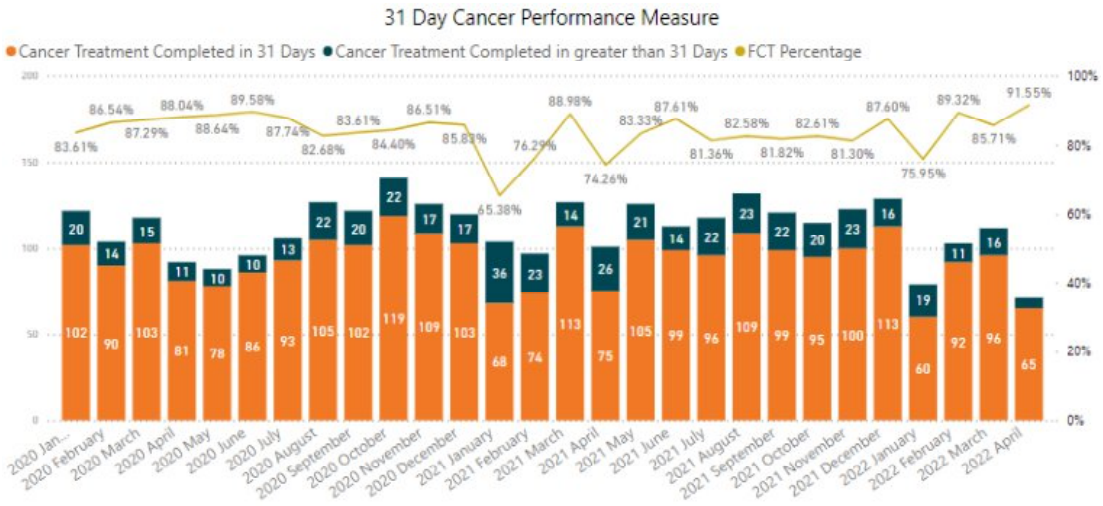
Direct access for Head CT will start on 30 May 2022. This was a collaborative project between Neurology, Radiology, HealthPathways and a GP Liaison (funded through IAP). Outcomes in terms of referral numbers will be monitored by Radiology and Neurology over the next few months to ensure the changes are as intended.

7. Oncology

Wait times continue to track well across 3 services.

The average decision to treatment varies by cancer type with Head and neck average sitting out at 27.6 days and Brain/Central Nervous System (CNS) averaging 5 days or less.

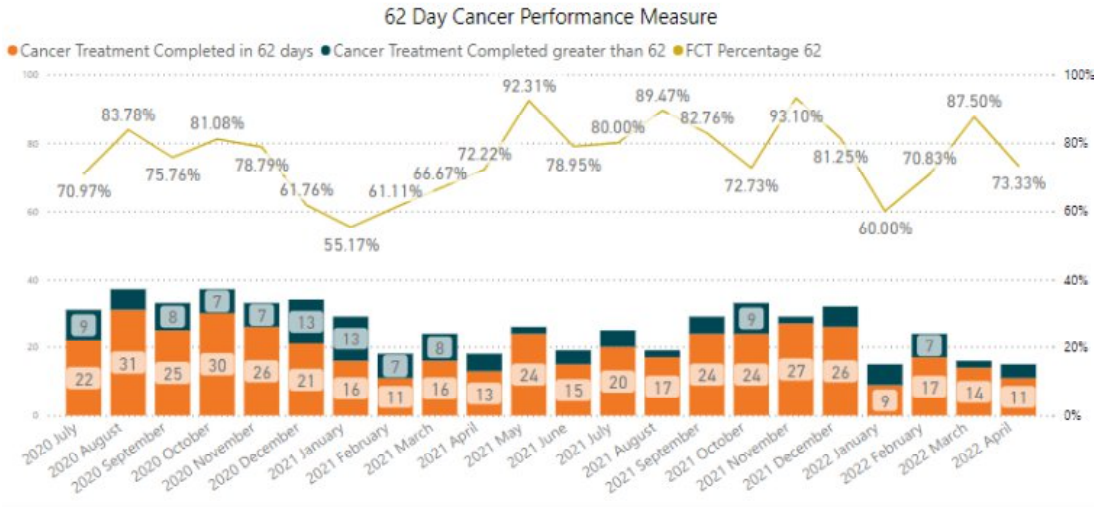
Overall, 91.55% of patients receiving treatment with 31 days in April.



Start of Quarter	FCT Percentage
1 January 2020	85.76%
1 April 2020	88.77%
1 July 2020	84.51%
1 October 2020	85.53%
1 January 2021	77.74%
1 April 2021	82.06%
1 July 2021	81.94%
1 October 2021	83.92%
1 January 2022	84.35%
1 April 2022	91.55%
Total	**83.95%**

Faster cancer treatment also continues to track well with 73.33% treatments completed with 62 days from referral.

There is some variance between cancer types with Brain/CNS average sitting around 88% and Haematology referrals averaging 42 days to treatment.



Start of Quarter	FCT Percentage 61
1 July 2020	77.23%
1 October 2020	74.04%
1 January 2021	60.56%
1 April 2021	82.54%
1 July 2021	83.56%
1 October 2021	81.91%
1 January 2022	72.73%
1 April 2022	73.33%
Total	**76.22%**

- Wait times for Radiation oncology have improved over 60% in the period from 1 July 21 to date with wait times within 2 weeks targeted timeframes for category 2 (urgent) cases.
- Medical Oncology wait times continue to remain steady with those curable intent cancers waiting less than 2 weeks (median to 80th percentile).
- Haematology service continues to be under some pressure due to staff vacancies but despite this all category 3 (semi-urgent) continue to be seen within 4-6 weeks (80th percentile).

8. Endoscopy

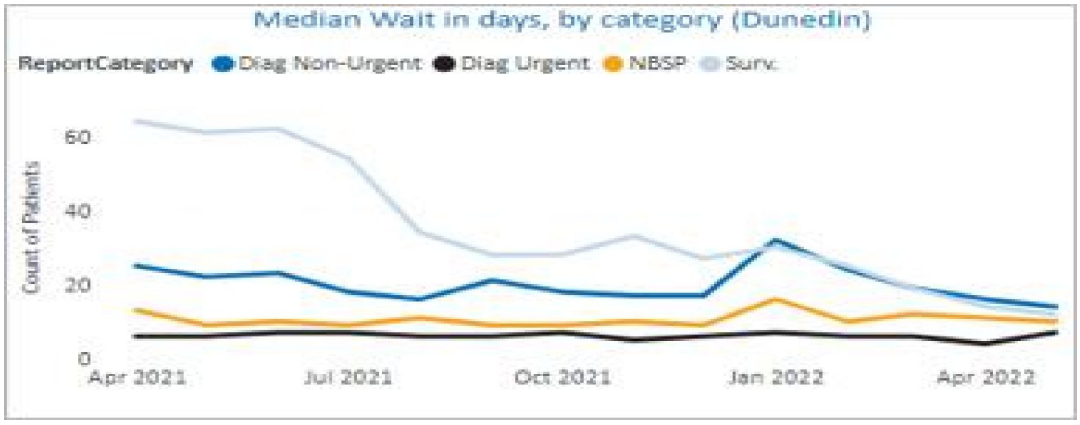
- Transition to the new bowel screening register scheduled for early April (funded externally).

- Gastro not currently required to relocate to Day Surgery Unit to allow ICU to expand into gastro recovery space as part of COVID planning. Still remains a possibility if required but currently not indicated.
- Recruitment underway for 0.5 FTE gastroenterologist for Southland; a preferred candidate has been identified.

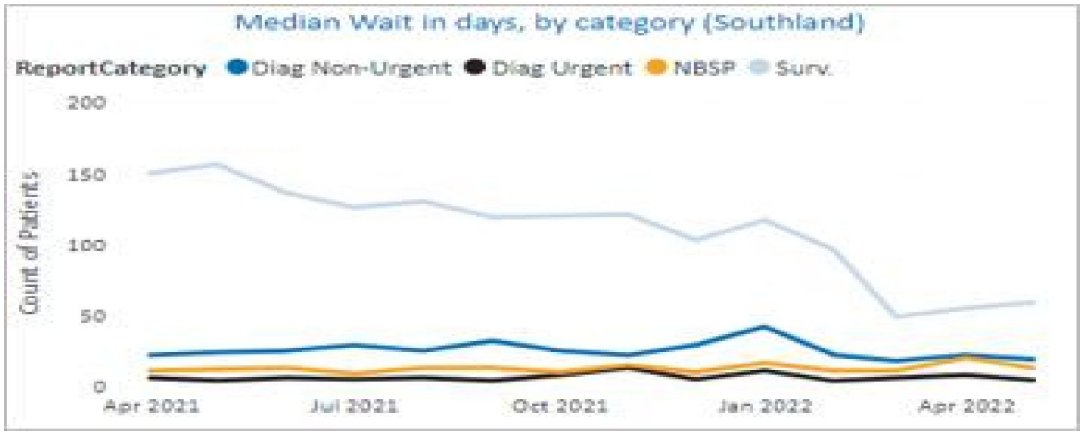
The Ministry wait time indicators are as follows:

Target	**Dunedin**	**Southland**
Urgent: 90% within 14 days	**85.7%**	**72.7%** (**100%** within 30days)
Non-urgent: 70% within 42 days	**84.5%**	**72.6%**
Surveillance: 70% within 84	**97.8%**	**63.2%**
NBSP: 95% within 45 days	**92.5%**	**91.3%**

Dunedin



Southland



9. A summary of key operational challenges

Risks are covered in the Audit and Risk reporting.

HAC should note the following key operation challenges.

1. April activity has been dominated by the continued response to COVID-19 and the forecast peak of hospitalisations. Southern infection rates have displayed a longer and more sustained peak.
2. Both Dunedin and Invercargill hospitals have been affected by high occupancy and staff absenteeism despite having more beds open than March. Rural Hospitals and Aged Residential Care have displayed a similar trend.
3. The pressure on beds and staff across the region as increased however lessons learnt through COVID has seen a greater degree of collaboration, resource sharing than previously achievable.
4. All Teams have been focussed on managing clinical risk and continuing to deliver high quality care in this complex environment and the HAC should recognise the commitment and dedication of its workforce.

10.Case weight, Discharges and Volumes

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,556	**8,978** Actual YTD vs 10,344 Plan YTD, as at April 2022.

Note the above discharges exclude improvement action plan volumes.

Item: Integrated Operations Centre (IOC)

Proposed by: Hamish Brown / Megan Boivin

Meeting of: 19 May 2022

Update on Current progress:

Within the Strategic Change Plan, there are two focus areas Systems for Success and System Improvements that have specific key deliverables that we are providing an update on:

1. Establishment of an Integrated Operations Centre
2. Hospital Escalation Planning / Standard Operating Procedures

Progress has not been as comprehensive as first anticipated due to resources being allocated towards the management of COVID-19, however this has also presented us with an opportunity to establish networks across the system and look at how we can best integrate our systems.

In March we successfully appointed a project manager (funded by the MoH) to work with the Patient Flow Operations Manager Dunedin. They have focused on defining the scope of the physical environment required for the establishment of an IOC, in addition to working with the team on 8Medical in relation to improving discharge processes.

The physical environment scope has been completed; however, we are yet to secure a suitable location. The initial location proposed by the COO, was perceived to be a good idea by many of us, however unfortunately from a Building and Property perspective it was not a suitable solution.

The appointment of the Southland Patient Flow Operations Manager has been made and they commenced on 23 May 2022.

The Dunedin Hospital Escalation Plan has had some minor changes earlier this year, however we are going to review this once the Southland plan has been fully developed to ensure we have close alignment.

Attached in appendix 1, is the overall scope for the IOC's for both Dunedin and Southland, noting that this is not all about physical location although it certainly is an enabler, the key function however is coordination and systems approach to patient movement.

Appendix one

Background

In 2014 Southern DHB set about to establish Operations Centres at Southland and Dunedin Hospitals, with the aim to achieve two key functions:

1. Consolidation of the hospital wide schedule of activity plus proactive planning to overcome the foreseeable conflicts between the activities.

2. The day-to-day monitoring and tactical response to problems in the process flow of the hospitals.

A change management process was undertaken to establish an IOC on both the Dunedin and Southland Hospital sites, this was to provide site specific support and coordinate day to day activity, in addition to providing robust clinical operational management, and encompassing the principles from the CCDM programme to match capacity and demand and support contemporary models of care and patient flow. The aim was to apply the Operations Management Principles of – forecasting, planning, and demand-capacity matching. Establishing an IOC was also to reduce risk at the most vulnerable time of the day – out of hours, ensuring only appropriate clinical tasks are performed at night by providing the right care by the right person at the right time outside of normal working hours.

At this time there was the establishment of Charge Duty Managers on each site, who led the team of Duty Managers, the CCDM / TrendCare team were later integrated into the IOC, and the RMO unit also became part of the IOC from a District perspective.

Several of the other components of expected deliverables and identified outcomes never progressed. These were the

1. Development of a forecasting platform to bring together the acute and elective flow, annual process for a fully integrated production plan from the front door to then back door of the hospital and into the community, and

2. Transport coordination.

It was identified that there would need to be investment in additional roles to ensure the IOC functioned as outlined above, however this investment could not be secured at the time.

Since 2014 the organisation has seen a number of roles established to meet some or all of the requirements above, however due to them not being part of a coordinated approach into an IOC the level of integration normally achieved by an IOC

It is now **time to move forward** and implement an IOC that functions in a contemporary way 24/7, we need to leverage off the Patient Flow Taskforce work and take the organisation into the future and prepare for the transition into the New Dunedin Hospital. Paul Shallard, Delotte New Zealand writes, "*The vision for the Integrated Operations Centre (IOC) is to identify what is happening in our health systems at a glance, in order to provide real-time visibility and inform data-led decision-making. This means optimising demand and supply across the Southern Health system to ensure patient and staff safety. The design and approach for the IOC is to build fit for purpose facilities, a forward-looking centre that will continue to evolve to meet the changing needs of patients and staff across the health system.*" Patient flow and patient access problems are identified issues in all hospitals internationally, and the coordination of such via an IOC is the contemporary approach.

Integrating services together in a common centre type arrangement enables the hospital to bring all the components from a systems perspective rather than an individual service perspective. This does not mean all components sit within the IOC, the IOC has a key role in the coordination and bringing teams together to support clinical and operational decision making across the organisation

from a tactical viewpoint. An IOC does not just focus on today but looks to learn from yesterday and project forward, to match capacity and demand.

Ward staff and support services such as cleaners and orderlies often have little insight into the effects of delayed discharge on the flow of patients into the hospital. Difficulty in accessing ward beds for emergency department patients contributes to longer waiting periods in the emergency department and higher rates of patients not waiting to be seen. Delays and postponements of elective and diagnostic procedures result in backlogs for theatre time and potential harm for patients and results in additional costs to the health system.

An IOC should be in a central location from which the day's activities can be coordinated, in the best interests of the whole system and therefore in the patients' best interests. The ideal would be to establish fit for purpose facilities that can accommodate all of the Operations Teams within one location on each site. Each IOC should be replicated ensuring either site has the ability to coordinate the system in the event that one of the IOC's is out of commission.

Technology is a key aspect to the IOC, without an organisational view, it is impossible to ensure a systems view is achieved. One of the features of an IOC is to have several dashboards / screens that provide a visual overview in real time, that allow for informed decision making and forecasting

The complexity of managing a hospital while still aiming to keep the patient journey within an acceptable timeframe is hindered by the lack of visible and real time information illuminating where the constraints / delays are occurring. Failure to do so inevitably results in teams working in silos with inward looking approaches to patient movement and processes which do not work seamlessly together.

The IOC is not limited to being hospital centric, the intention is that they have a system wide view of the Southern Health system, including the rural hospitals, mental health, community, primary and hospital services. This will take time to be fully inclusive of all, and a phased approach to the development will be required.

Example of possible setup:

Next Steps & Actions

Phase 1: by 30 June 2022

Determine the requirements for the **physical environment** for an IOC on both the Dunedin and Southland sites, and then progress to relocating to the more suitable environment. The Dunedin site is not easily accessible for the teams and is not large enough to accommodate all existing team members.

The Southland site will be reassessed once the Patient Flow – Operations Manager commences on 23 May 2022, she will move into the current location and the TrendCare / CCDM coordinator will be relocated, noting that this space is extremely small and does not have the space to have the visual management tools displayed.

Establish a wider reach into the Southern DHB daily operations to be inclusive of Mental Health Services and their regular huddles around resource and bed management. There are opportunities to further align functionality 24/7, inclusive of the CCDM principles and the proposed dashboards.

Development of **Standard Operating Procedures** for patient flow across the District, and Operation of the Hospitals 24/7 across the District, there are a number of processes / procedures established but not documented, which results in confusion and lack of standardisation. Without these, we cannot analyse where there are opportunities for improvement.

Agree a standardised set of **metrics**, definitions that are used in real time, this is in addition to the metrics already developed by the Patient Flow Taskforce, they will all be able to be reported at service and ward level, they will be presented as part of the Performance and Accountability Framework.

Phase 2: by 30 September

The IOCs on both sites will have relocated into suitable locations.

Establishment of **district wide transport coordination** / patient movement function – there are efficiencies that can be gained by having a district wide view of all patient movements. Currently at times there are road ambulances that could be more efficiently used for backloads and multiple loads. The move to an electronic system that St John are also implementing will be enabler for this function across the district. Patient transport is a priority area for the Ministry of Health, in particular in terms of ensuring we have a coordinated approach to utilising the resources available.

Future opportunities

Greater IT integration with real-time tracking and reporting.

Greater coordination of activity extending beyond traditional secondary care boundaries.

Notes on SDHB Output Trends, FTE trends, and Productivity

Prepared by: Courtney McElwain, Grant Paris (SDHB Management Accountants)

Date 16 May 2022

Introduction and Summary

This report is a follow up from the first report presented at the last meeting, attempting to further identify and analyse trends in productivity. Follow this analysis a process is required to understand what actions need to occur to reverse the trends outlined. For example; a recent audit of 300 clinical records showed that 77 of the audit sample resulted in DRG changes suggesting approximately 76CW could be recovered. A process will be established to improve clinical documentation.

The analysis is based only on caseweights for Dunedin Hospital and Invercargill Hospital. We have not included Lakes in the analysis. The source of the data was the NMDS (National Minimum Data Set) data reports obtain via the Southern DHB reporting system.

National data exists at a Ministry of Health level that suggests the trends contained within this report are not isolated to Southern DHB implying a more systemic issue.

Conclusion

In summary we have identified that;

1. Elective caseweights have decreased consistently over the period reviewed although the decrease in caseweights is less than the decrease in discharges identified in lasts months report. The decrease has accelerated over the COVID period and is yet to recover.

2. Acute caseweight are increasing at a higher rate than electives are decreasing. These also decreased over the COVID period.

3. Overall caseweights have increased. (marginally).

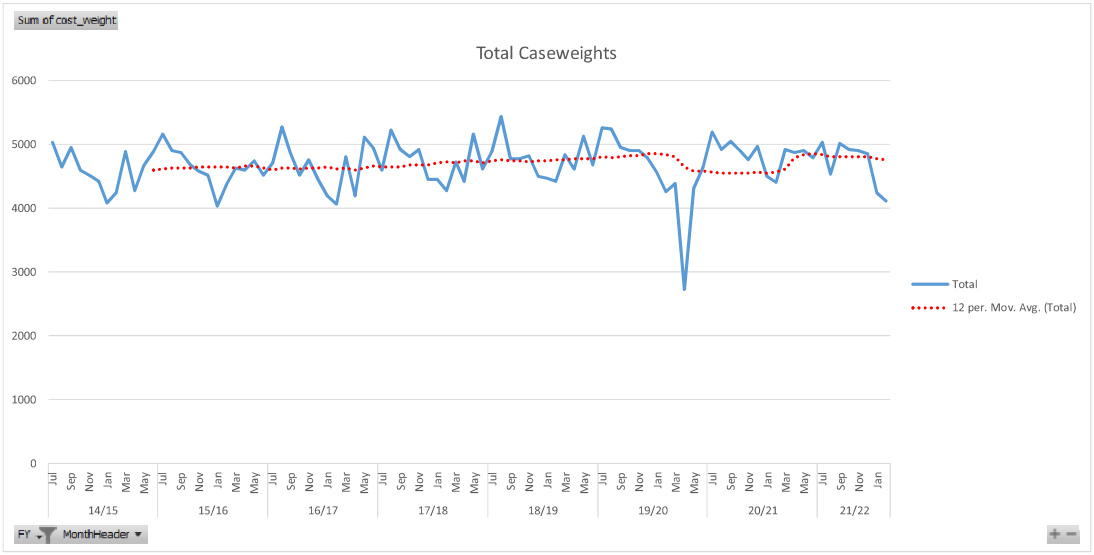
4. Acute length of stay is increasing.

Anecdotally the decrease in electives is due to;

- capacity constraints (bed nights available, theatre space)
- inability to staff beds (although this has improved)
- increasing acute caseweights utilising the existing capacity
- COVID has been the causal factor over recent years however this does not explain the reduction in periods prior to this.
- we have looked at the change in WEIS caseweight changes from year to year and this does not appear to have had a material impact.

Caseweight drill down by specialty

We have started at the overall level and intend to drill down into specific areas for further analysis.

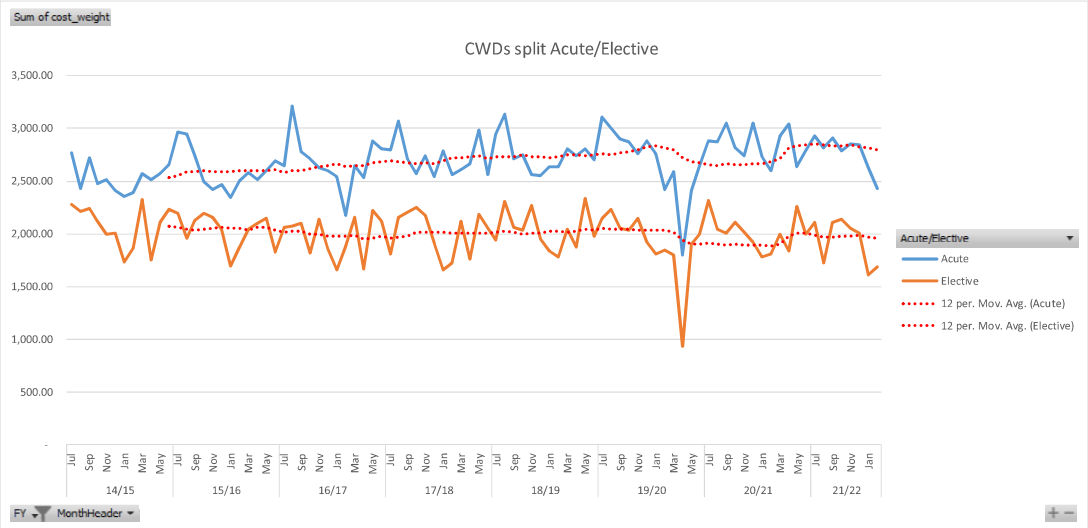


Total caseweights has a slight positive trend from 14/15 through to 21/22 with a defined drop during the first covid lockdown in March 2020. Prior to covid, total casweights were on the incline and post covid this appears to be trending downwards. The average caseweights from July-Dec 2021 was a 180 increase on the same period in 2014.

The year on year average shows a consistent increase until 19/20 which was the first full covid lockdown. The 21/22 year data only goes up to February and is not reflective of an entire year.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Sum of cost weight	**55,258**	**55,638**	**55,940**	**56,626**	**57,400**	**54,976**	**58,241**	**37,633**
Avg CWD per month	4,605	4,637	4,662	4,719	4,783	4,581	4,853	4,704
% change		0.69%	0.54%	1.23%	1.37%	-4.22%	5.94%	-3.07%

From the previous report we know that there was a decrease in elective discharges. The next chart illustrates the split between acute and elective caseweights.



Acutes show an increasing trend while electives show a decreasing trend, however the decrease shown above is not as severe as the decrease in all elective discharges (in previous report). Prior to covid elective caseweights were trending relatively flat, post covid this continues but at a lower level.

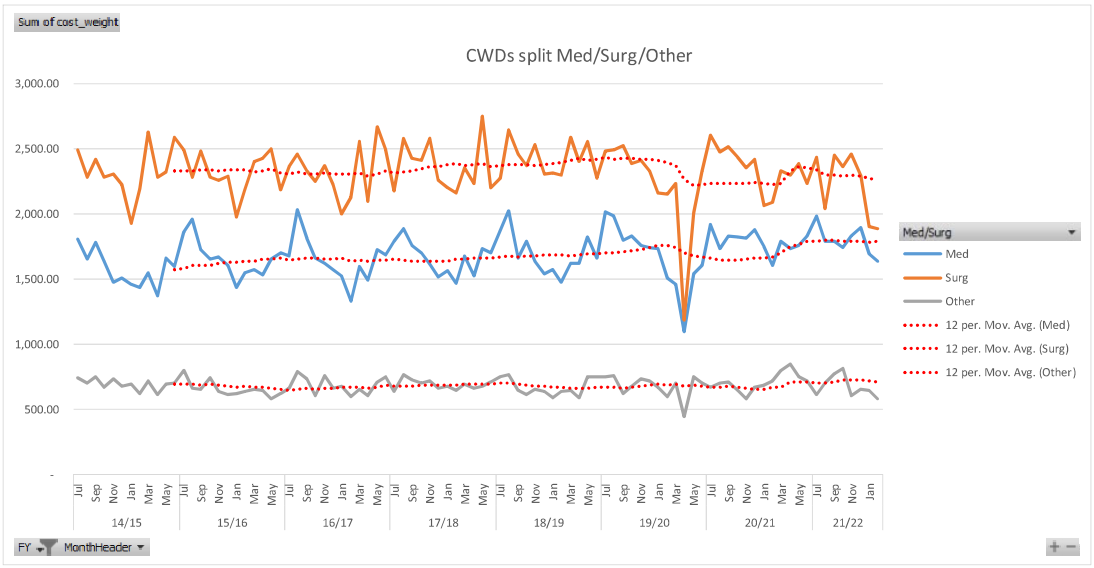
There is a drop of approx. 120 caseweights in the Jul-Dec 2021 period compared to the same period in 2014. Acutes have an average 300 caseweight increase across the same time periods. Acutes have increased at a higher rate than the electives have dropped creating the overall positive trend in the first chart.

Acute	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**
Total	30,390	31,268	32,167	32,605	32,990	32,150	34,139	22,204
Average	2,532	2,606	2,681	2,717	2,749	2,679	2,845	2,776
% change		2.9%	2.9%	1.4%	1.2%	-2.5%	6.2%	

Elective	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**
Total	24,868	24,370	23,773	24,022	24,410	22,827	24,101	15,429
Average	2,072	2,031	1,981	2,002	2,034	1,902	2,008	1,929
% change		-2.0%	-2.5%	1.0%	1.6%	-6.5%	5.6%	

Elective caseweights show drops in the average caseweight per month from 14/15 with another sharp drop in 19/20 due to covid. There was slight recovery in 20/21 however 14/15 elective levels have not been recovered.

Below is the split of combined acutes and electives by specialty:



Surgical caseweights pre-covid were trending upwards however took a large hit with covid and have not recovered and also look to be trending downwards post-covid. Medical CWDs have a continued increase post covid and appear to have resumed their previous trend. The surgical caseweights experienced a greater drop during covid than the medical caseweights.

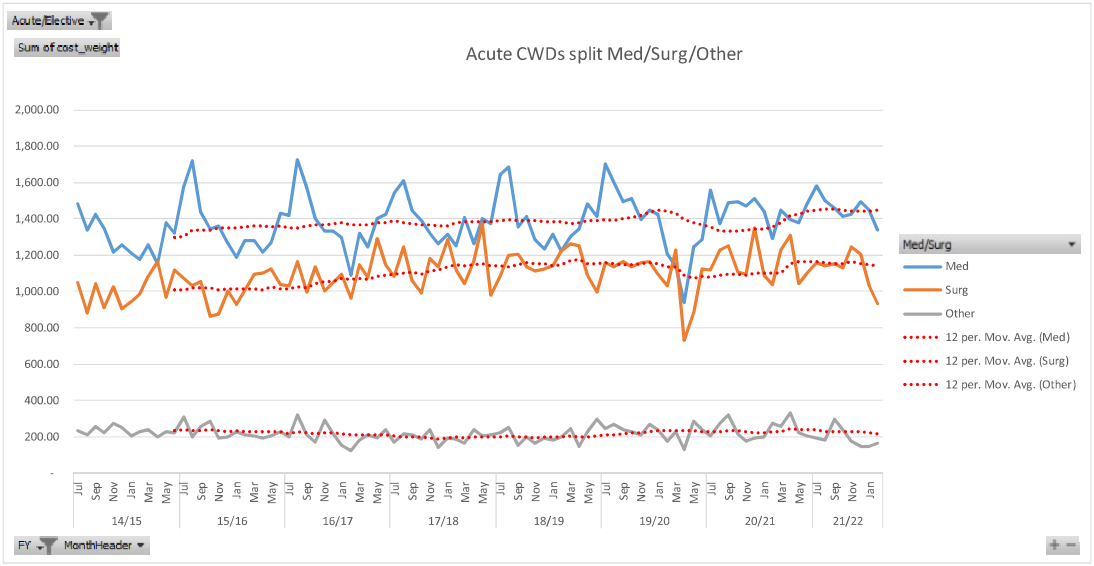
Medical CWDs	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Total	18,940	19,943	19,755	19,956	20,325	20,100	21,481	14,371
Average	1,578	1,662	1,646	1,663	1,694	1,675	1,790	1,796
% Change		5.29%	-0.94%	1.01%	1.85%	-1.10%	6.87%	0.36%

Surgical CWDs	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Total	27,990	27,807	27,963	28,370	29,050	26,724	28,246	17,863
Average	2,333	2,317	2,330	2,364	2,421	2,227	2,354	2,233
% Change		-0.65%	0.56%	1.45%	2.40%	-8.00%	5.70%	-5.14%

Other CWDs	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Total	8,328	7,888	8,221	8,301	8,026	8,152	8,514	5,399
Average	694	657	685	692	669	679	709	675
% Change		-5.28%	4.22%	0.97%	-3.31%	1.57%	4.44%	-4.88%

The tables above show there is a clear drop in covid, some recovery and another drop in 21/22.

The following charts are split down to acutes and electives then by area.

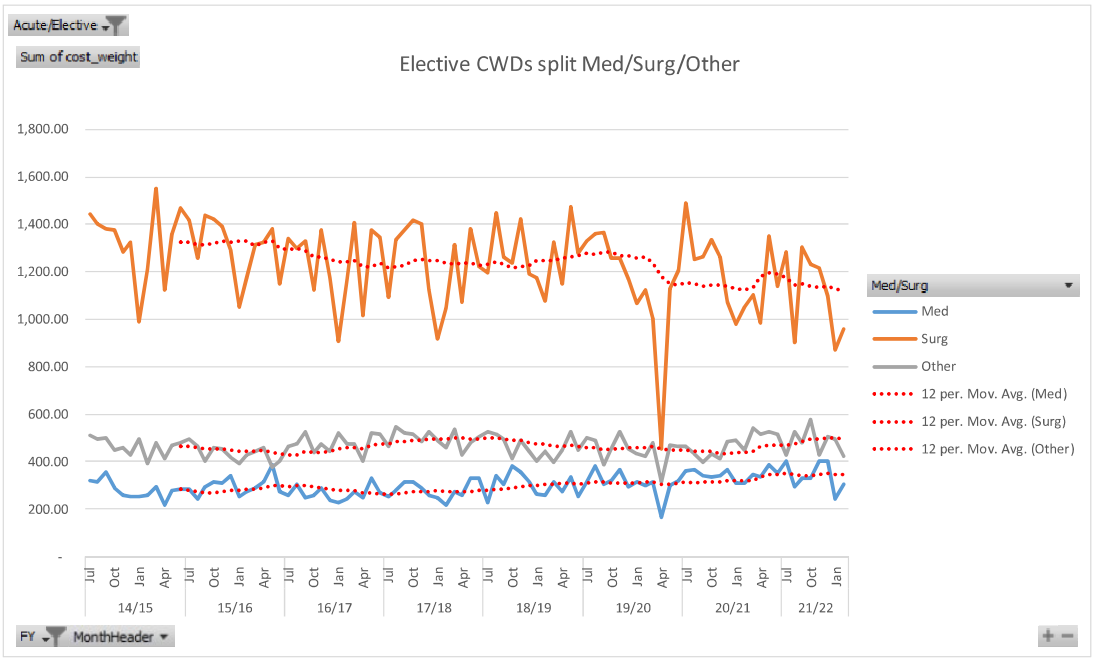


Medical and surgical acute caseweights both show an increasing trend with surgical acutes increasing at a steeper/faster rate.

Acutes - Medical	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Total	15,559	16,368	16,568	16,587	16,699	16,396	17,327	11,667
Average	1,297	1,364	1,381	1,382	1,392	1,366	1,444	1,458
% increase		5.20%	1.23%	0.11%	0.68%	-1.81%	5.67%	1.00%

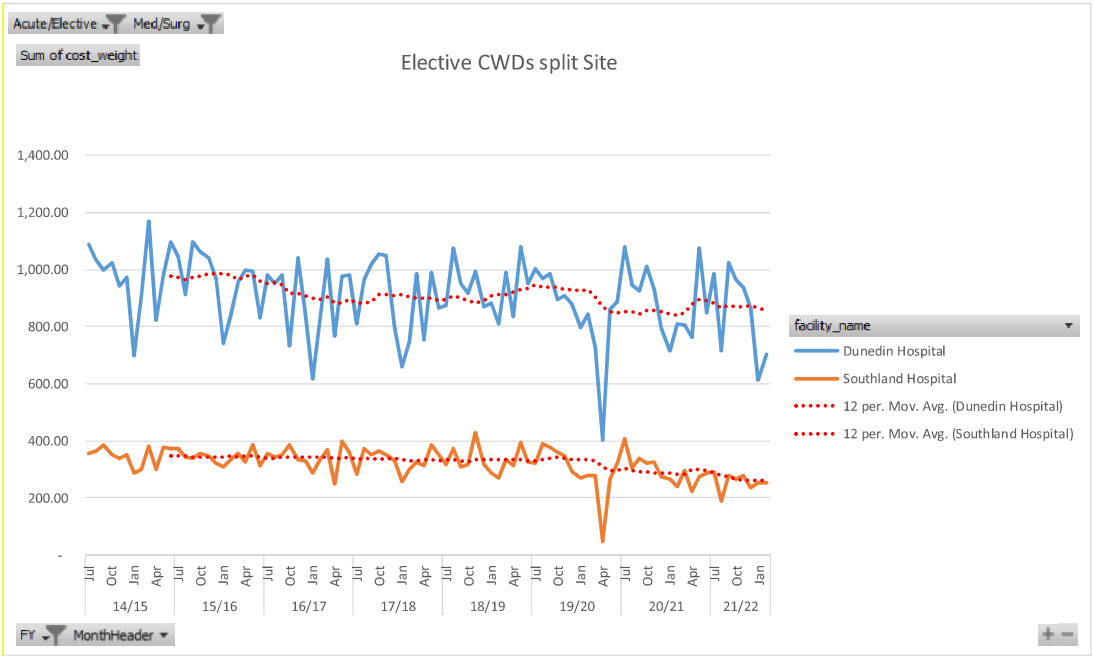
Acutes - Surgical	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Total	12,076	12,201	13,101	13,672	13,823	13,001	13,962	8,999
Average	1,006	1,017	1,092	1,139	1,152	1,083	1,163	1,125
% increase		1.03%	7.38%	4.36%	1.10%	-5.95%	7.39%	-3.32%

Acutes - Other	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Total	2,755	2,699	2,497	2,345	2,468	2,753	2,851	1,538
Average	230	225	208	195	206	229	238	192
% increase		-2.01%	-7.48%	-6.10%	5.24%	11.54%	3.57%	-19.05%

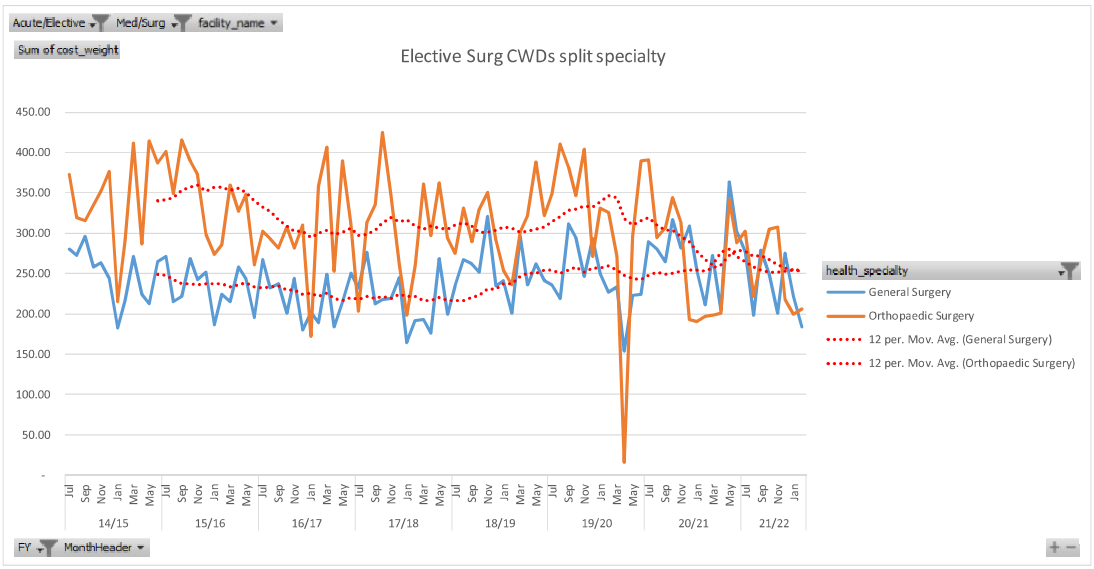


The decline in elective caseweights is strongly driven by surgical whereas med and other shows a slight increasing trend, although much smaller overall.

We have split electives by site in order to assess whether one site has more of an issue over the other however they are both showing a decline in electives, Dunedin slightly steeper.



General surgery and orthopaedic surgery carry the highest total caseweights within elective surgical caseweights. The following chart tracks the caseweights for these two specialties.



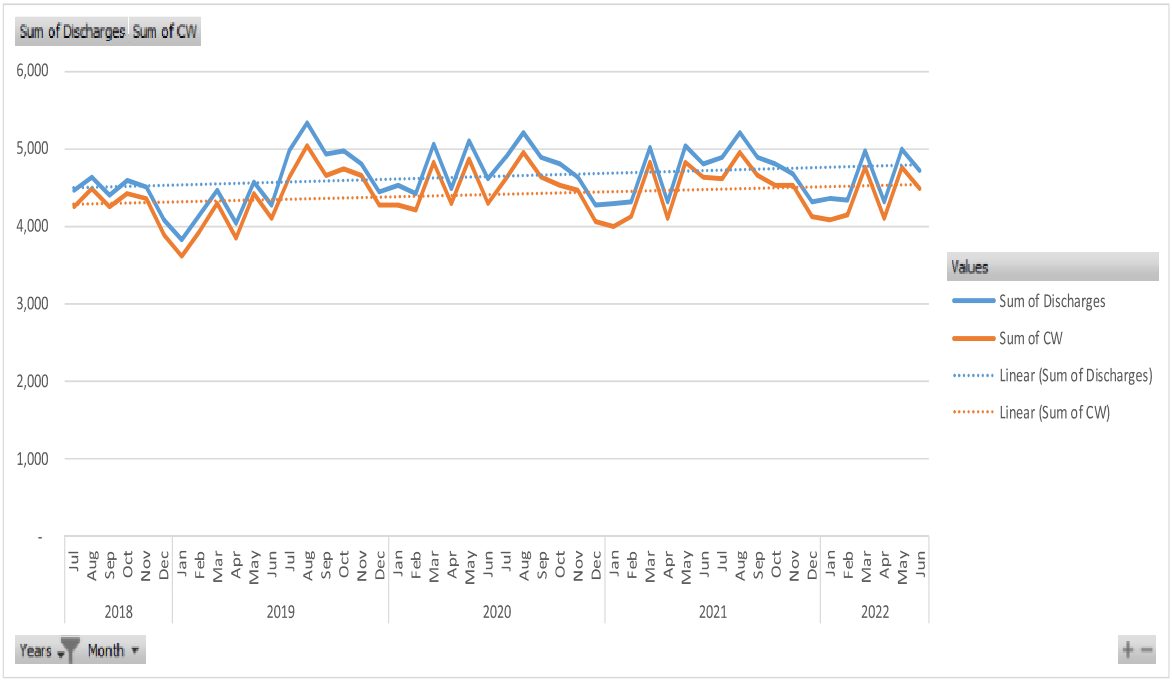
Orthopaedic surgery shows a decline whereas general surgery shows an increase which is driven by the 19/19 year onwards.

General surgery	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
General Surgery	2,984.2	2,793.5	2,650.6	2,597.8	3,045.8	2,910.9	3,350.4	1,884.7
Avg cwds per month	248.7	232.8	220.9	216.5	253.8	242.6	279.2	235.6
% change		-6.4%	-5.1%	-2.0%	17.2%	-4.4%	15.1%	-15.6%

Orthopaedic surgery	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Orthopaedic Surgery	4,077.6	4,082.1	3,668.0	3,656.9	3,690.3	3,792.3	3,258.0	2,026.3
Avg cwds per month	339.8	340.2	305.7	304.7	307.5	316.0	271.5	253.3
% change		0.11%	-10.15%	-0.30%	0.91%	2.77%	-14.09%	-6.71%

Note that 21/22 is not a full year. Caseweights associated with orthopaedic surgery have dropped approx. 800 from their height in 2014-2016 with the largest drops occurring in 16/17 and 20/21. General surgery has seen large increases in both 18/19 and 20/21.

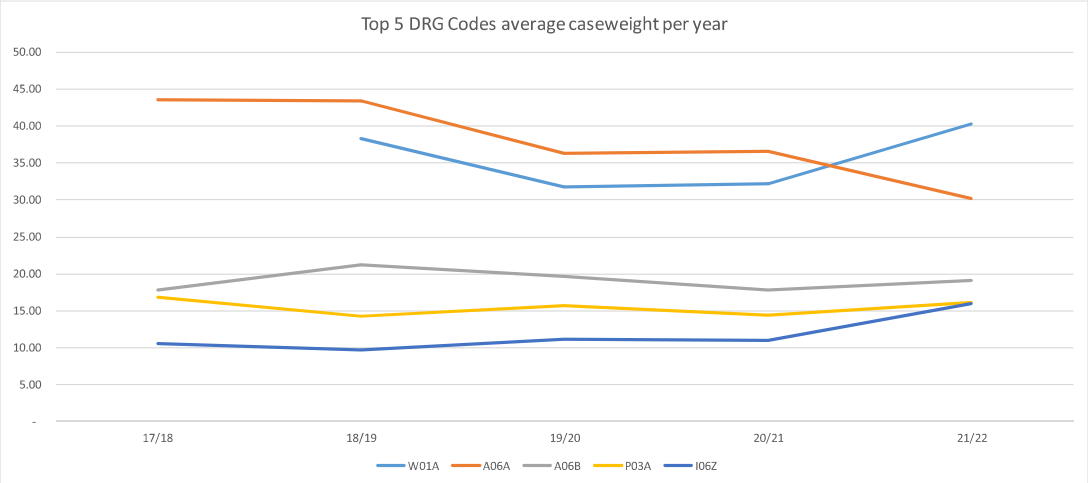
Target caseweights by year



The target caseweights shows a slight increasing trend with peaks/troughs in all the same months each year. Note that this data only goes back to 2018.

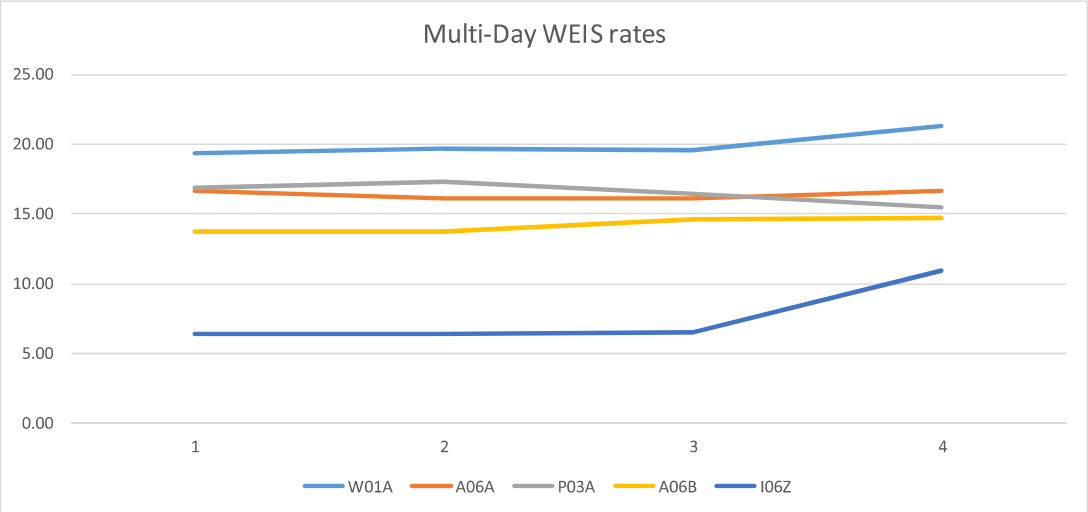
Average caseweight per DRG & WEIS

We reviewed the WEIS numbers from 2018 to 2021 and although there does appear to be a slight decrease in the weights per DRG across the years this will have less of an impact than increases in LoS and the quantity of procedures. We reviewed the average caseweight by DRG and noted no significant drops in the average caseweight per procedure. The below chart shows the movement in the 5 DRGs with the highest average caseweights in 21/22.



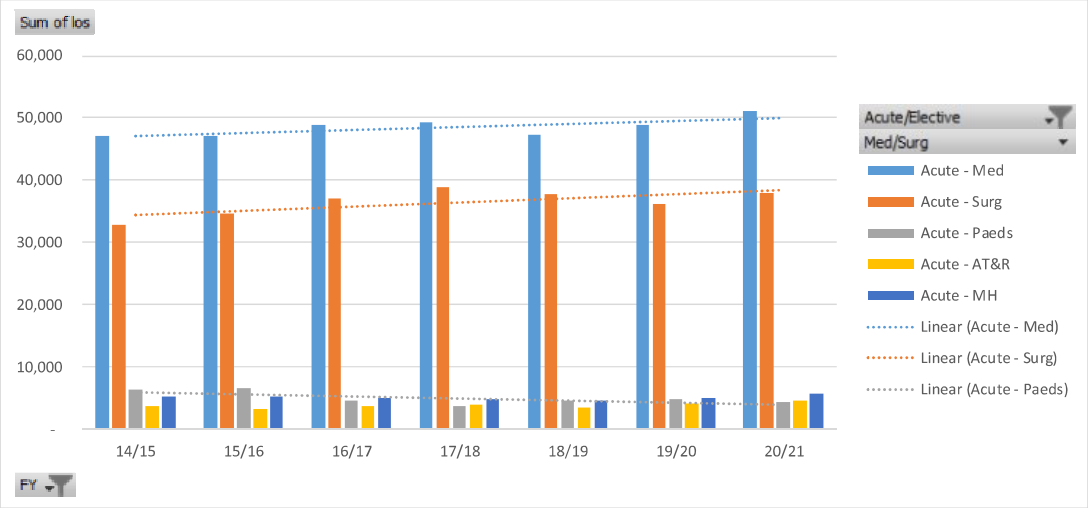
W01A	Tracheostomy for Multiple Significant Trauma
A06A	Tracheostomy W Ventilation >=96hrs W Catastrophic CC
A06B	Ventilation >=96hrs and OR Proc (W/O Tracheostomy or W/O Cat CC)
P03A	"Neonate, AdmWt 1000-1499g W Significant OR Proc W Multiple Major Problems"
I06Z	Spinal Fusion for Deformity

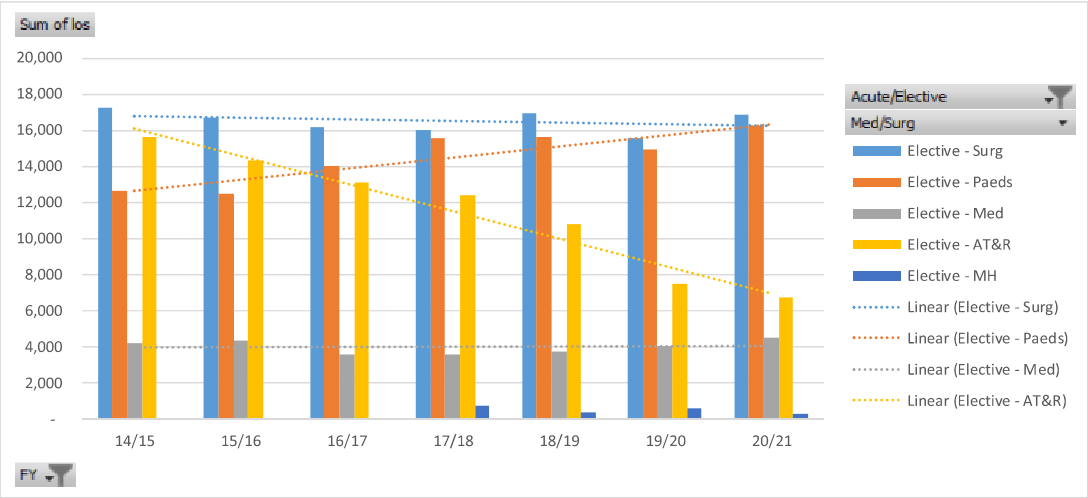
The below is the multi-day WEIS for each of the above DRGs.



Length of Stay (LoS)

We have reviewed the total LoS per year split by acute/elective and by each specialty. Acutes in medical and surgical are showing an increasing trend while Elective Surg LoS is decreasing, as is AT&R however Paeds is also showing a strong increasing trend in LoS.





We reviewed the LoS of the four highest acute specialties. 20/21 is showing an increase of approx. 12,000 bed nights over and above the lowest year of 15/16 in these four specialties.

Row Labels	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Emergency Medicine	2,441	2,522	2,820	2,882	2,744	3,116	3,535
General Medicine	27,400	26,493	27,863	29,951	28,468	31,289	33,676
General Surgery	13,633	13,814	14,578	16,905	15,882	15,269	16,167
Orthopaedic Surgery	10,623	10,881	11,984	11,590	11,508	10,997	12,405
Grand Total	**54,097**	**53,710**	**57,245**	**61,328**	**58,602**	**60,671**	**65,783**

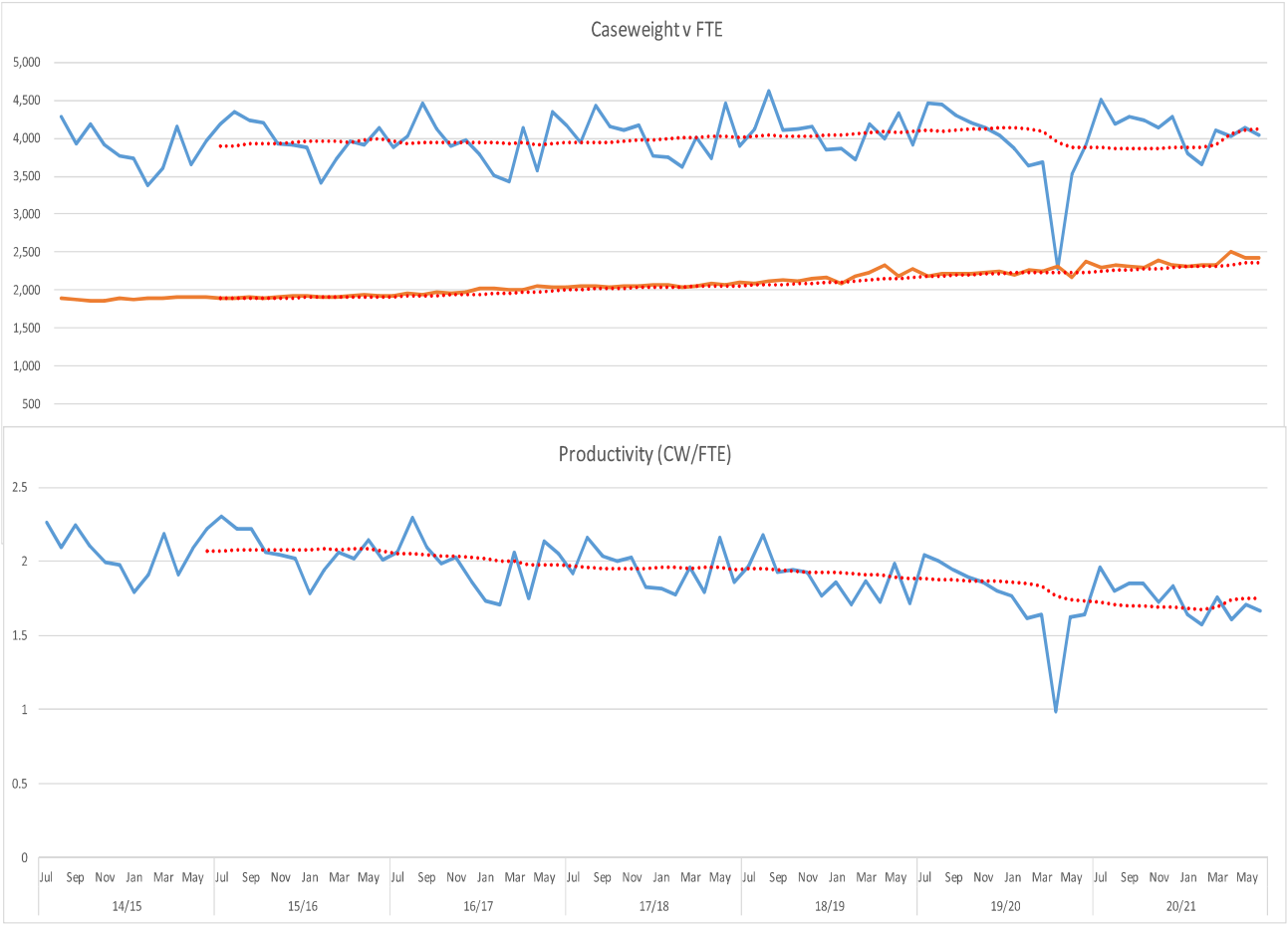
The total LoS split by acute and elective is shown below:

	Acute		Elective			
Row Labels	Sum of los	Count of cost weight	Sum of los	Count of cost weight	Average LoS per acute discharge	Average LoS per elective discharge
14/15	80,033	32,846	21,367	18,258	2.44	1.54
15/16	81,540	33,707	21,084	18,467	2.42	1.60
16/17	86,121	34,522	19,773	18,210	2.49	1.75
17/18	88,101	34,859	19,587	18,734	2.53	1.78
18/19	85,230	35,740	20,640	18,964	2.38	1.73
19/20	85,055	35,553	19,642	15,948	2.39	1.81
20/21	88,940	38,071	21,340	16,434	2.34	1.78

LoS overall has increased almost 9000 bed nights since the lowest year in 2014/15. The average length of stay for acute discharges has decreased while the average length of stay for elective discharges has increased.

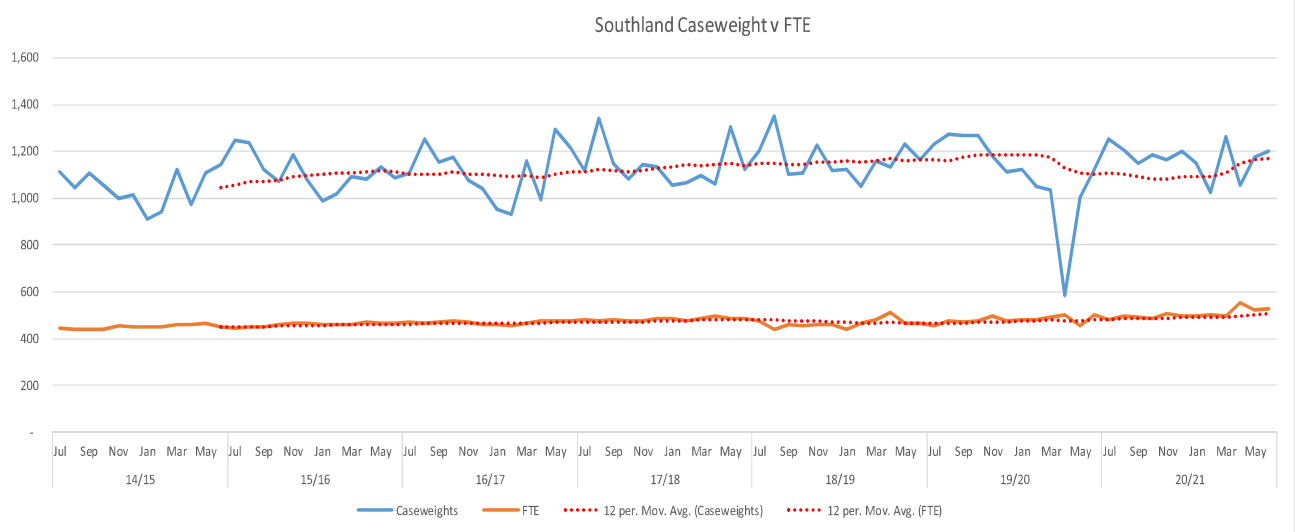
Productivity – Overall

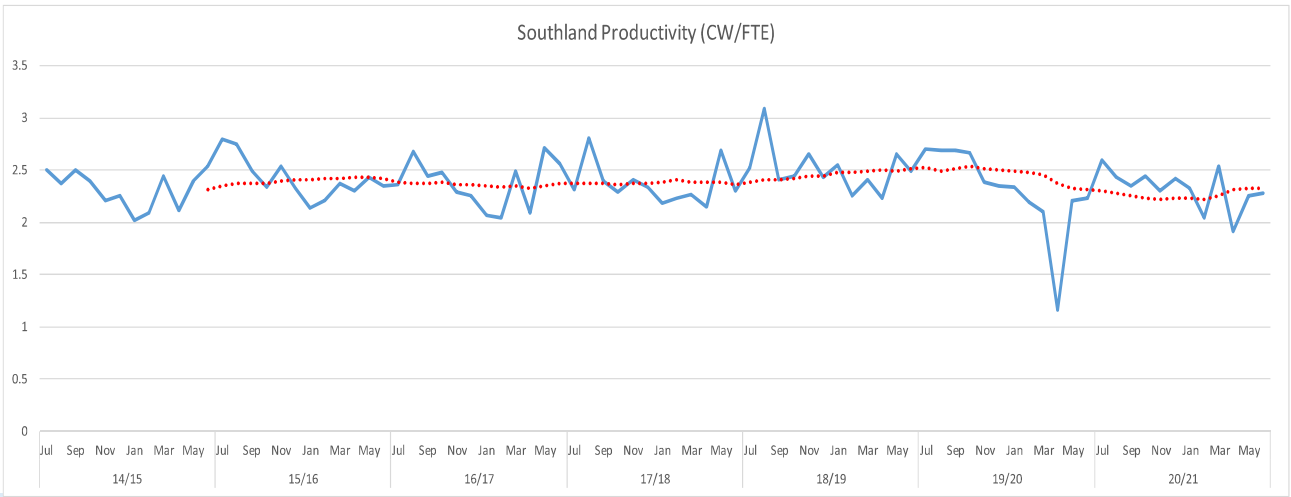
The following charts only include the FTE from the MWCD, SSRD and DCOD directorates and the caseweight data is only the medical and surgical PUC's



	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Caseweights	45,253	46,110	45,926	46,451	47,415	45,282	48,093
FTE	2,023	2,041	2,111	2,227	2,295	2,361	2,480
Productivity	22.37	22.59	21.75	20.86	20.66	19.18	19.39
% change		1.0%	-3.7%	-4.1%	-0.9%	-7.2%	1.1%

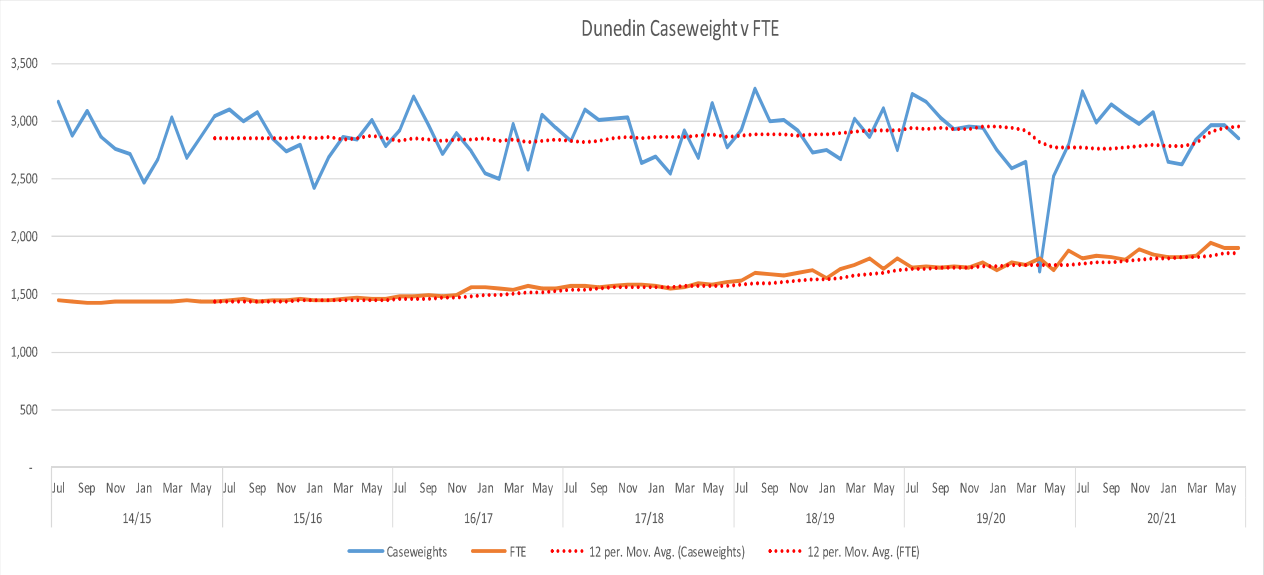
Productivity – Southland

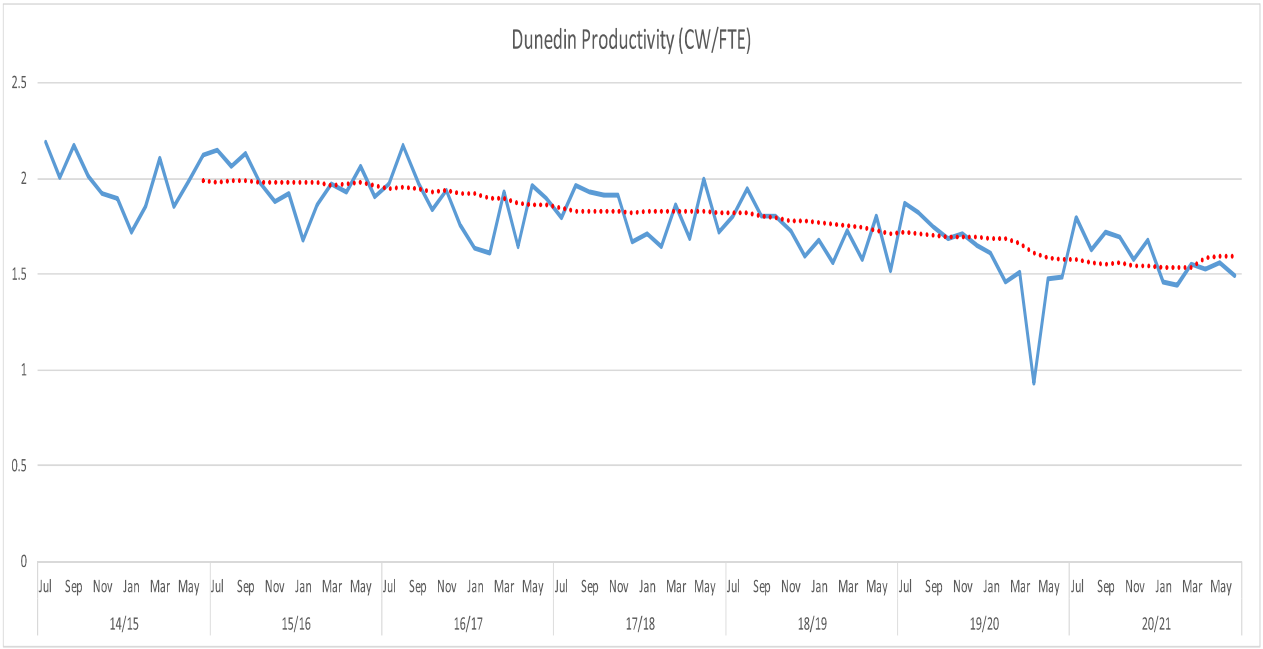




	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Caseweights	12,033	12,861	12,719	12,876	13,127	12,753	13,544
FTE	481	493	500	521	495	512	532
Productivity	25.00	26.08	25.46	24.70	26.54	24.89	25.47
% change		4.3%	-2.4%	-3.0%	7.5%	-6.2%	2.3%

Productivity – Dunedin





	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Caseweights	33,220	33,248	33,207	33,575	34,288	32,529	34,549
FTE	1,542	1,548	1,612	1,706	1,800	1,849	1,948
Productivity	21.55	21.48	20.60	19.68	19.05	17.59	17.73
% change		-0.3%	-4.1%	-4.5%	-3.2%	-7.6%	0.8%

FOR INFORMATION

Item: Financial Report for the period ended 30 April 2022

Proposed by: Grant Paris, Management Accountant

Presented by: Hamish Brown, Chief Operating Officer

Meeting of: 07 June 2022

Recommendation

That the Hospital Advisory Committee notes the Financial Report for the period ended 30 April 2022.

Purpose

1. To provide the Hospital Advisory Committee with the financial performance for the month and year to date ended 30 April 2022.

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 provide commentary on relationships between cost and productivity.

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: **April 2022**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **18 May 2022**

Overview

Results Summary for Specialist Services

1. April 2022 Result

The Chief Operating Officer (COO) portfolio encompasses the delivery of services across Surgical and Radiology, Medicine, Women's and Children's from Dunedin, 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
47,006	47,347	(341)	Revenue	484,678	473,385	11,293	568,129
27,664	26,913	(751)	Less Workforce Costs	270,742	258,745	(11,997)	313,371
12,890	12,671	(220)	Less Other Costs	134,741	127,001	(7,740)	153,123
6,452	**7,763**	**(1,311)**	**Net Surplus / (Deficit)**	**79,195**	**87,639**	**(8,443)**	**101,636**

For April 2022, the COO portfolio had a contribution to non-clinical and overhead costs of $6.45m, which is $1.31m unfavourable to budget. The year-to-date unfavourable variance is $8.44m for the 10 months to the end of April 2022.

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.

Volumes – care delivered by SDHB (includes outsourcing and IDF inflows)

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

Apr-22				Apr-21	YEAR ON YEAR		YTD 2021/22				YTD Apr-21	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,345	**1,315**	**30**	**2%**	**1,423**	**(78)**	**Acute**	**14,613**	**14,218**	**395**	**3%**	**14,797**	**(184)**
888	*870*	*18*	*2%*	981	(93)	Otago	*9,692*	9,392	300	3%	9,928	(236)
457	*445*	*12*	*3%*	442	15	Southland	*4,921*	4,826	95	2%	4,869	52
222	**255**	**(33)**	**-13%**	**342**	**(120)**	**Elective**	**3,178**	**2,865**	**313**	**11%**	**3,444**	**(266)**
190	224	(34)	-15%	295	(105)	Otago	*2,776*	2,518	258	10%	3,004	(228)
32	31	1	3%	47	(15)	Southland	*402*	347	55	16%	440	(38)
1,567	**1,570**	**(3)**	**0%**	**1,765**	**(198)**	**Total Medical Caseweights**	**17,791**	**17,083**	**708**	**4%**	**18,241**	**(450)**
						Surgical Caseweights						
999	**1,169**	**(170)**	**-15%**	**1,343**	**(344)**	**Acute**	**11,585**	**12,105**	**(520)**	**-4%**	**12,218**	**(633)**
680	822	(142)	-17%	969	(289)	Otago	*7,890*	8,458	(568)	-7%	8,464	(574)
319	347	(28)	-8%	374	(55)	Southland	*3,695*	3,647	48	1%	3,754	(59)
1,052	**1,199**	**(147)**	**-12%**	**1,101**	**(50)**	**Elective**	**12,189**	**13,480**	**(1,291)**	**-10%**	**12,945**	**(756)**
811	891	(80)	-9%	847	(36)	Otago	*9,291*	10,020	(729)	-7%	9,680	(389)
241	308	(67)	-22%	254	(13)	Southland	*2,898*	3,460	(562)	-16%	3,265	(367)
2,051	**2,368**	**(317)**	**-13%**	**2,444**	**(394)**	**Total Surgical Caseweights**	**23,775**	**25,585**	**(1,811)**	**-7%**	**25,163**	**(1,389)**
						Maternity Caseweights						
66	**80**	**(14)**	**-18%**	**148**	**(82)**	**Acute**	**927**	**883**	**44**	**5%**	**1,008**	**(81)**
45	59	(14)	-24%	108	(63)	Otago	*682*	644	38	6%	737	(55)
21	21	0	0%	40	(19)	Southland	*245*	239	6	3%	271	(26)
335	**323**	**12**	**4%**	**412**	**(77)**	**Elective**	**3,702**	**3,489**	**213**	**6%**	**3,813**	**(111)**
209	193	16	8%	224	(15)	Otago	*2,239*	2,091	148	7%	2,324	(85)
126	130	(4)	-3%	188	(62)	Southland	*1,463*	1,398	65	5%	1,489	(26)
401	**403**	**(2)**	**0%**	**560**	**(159)**	**Total Maternity Caseweights**	**4,629**	**4,372**	**257**	**6%**	**4,821**	**(192)**
						TOTALS						
2,410	**2,564**	**(154)**	**-6%**	**2,914**	**(504)**	**Acute**	**27,125**	**27,206**	**(81)**	**0%**	**28,023**	**(900)**
1,613	1,751	(138)	-8%	2,058	**(445)**	Otago	18,264	18,494	(230)	-1%	19,129	**(865)**
797	813	(16)	-2%	856	**(59)**	Southland	8,861	8,712	149	2%	8,894	**(33)**
1,609	**1,777**	**(168)**	**-9%**	**1,855**	**(247)**	**Elective**	**19,069**	**19,834**	**(765)**	**-4%**	**20,202**	**(1,133)**
1,210	1,308	(98)	-7%	1,366	**(156)**	Otago	14,306	14,629	(323)	-2%	15,008	**(702)**
399	469	(70)	-15%	489	**(90)**	Southland	4,763	5,205	(442)	-8%	5,194	**(431)**
4,019	**4,341**	**(322)**	**-7%**	**4,769**	**(751)**	**Total Caseweights**	**46,194**	**47,040**	**(846)**	**-2%**	**48,225**	**(2,031)**
						TOTALS excl. Maternity						
2,344	**2,484**	**(140)**	**-6%**	**2,766**	**(422)**	**Acute**	**26,198**	**26,323**	**(125)**	**0%**	**27,015**	**(817)**
1,568	1,692	(124)	-7%	1,950	**(382)**	Otago	17,582	17,850	(268)	-2%	18,392	**(810)**
776	792	(16)	-2%	816	**(40)**	Southland	8,616	8,473	143	2%	8,623	**(7)**
1,274	**1,454**	**(180)**	**-12%**	**1,443**	**(170)**	**Elective**	**15,367**	**16,345**	**(978)**	**-6%**	**16,389**	**(1,022)**
1,001	1,115	(114)	-10%	1,142	**(141)**	Otago	12,067	12,538	(471)	-4%	12,684	**(617)**
273	339	(66)	-19%	301	**(28)**	Southland	3,300	3,807	(507)	-13%	3,705	**(405)**
3,618	**3,938**	**(320)**	**-8%**	**4,209**	**(592)**	**Total Caseweights excl. Maternity**	**41,565**	**42,668**	**(1,103)**	**-3%**	**43,404**	**(1,839)**

Total caseweight delivery within the Provider Arm however was 212 case weights less than plan. This is due to a combination of minor bed closures due to staff availability, including staff sickness, acute activity and the continued use of Ward 7A for COVID patients (and the subsequent impact on the 6th floor) continuing through the autumn months in response to COVID surge.

Planned Care Intervention

The total elective caseweights delivered in the table above can be reconciled to the service provider case weight report in the FARC Public report as follows:

Actuals	
Elective case weights excluding maternity actuals for April: (Medical 222 + Surgical 1,052)	1,274
Minus: elective medical case weights actuals for April:	-222
Add: medical case weights which count for elective plan for April:	25
Equals: Total elective Planned Care Interventions for April:	1,077
Plan	
Elective case weights excluding maternity plan for April: (Medical 255 + Surgical 1,199)	1,454
Minus: elective medical case weights plan for April:	-255
Add: medical case weights which count for elective plan for April:	+90
Equals: Total elective Planned Care Interventions target for April:	1,289
Variance Actual Delivery to Plan Care Intervention Target	**(212)**

Appendix 1: Financial Report for the Hospital Advisory Committee

On this basis we delivered 212 case weights (CWD) less than the elective plan for the month of April. In March, delivery was 325 case weights less than plan and year to date to April 2022 was 1,177 case weights less than plan.

Appendix 1: Financial Report for the Hospital Advisory Committee

April 2022 Financials

Monthly							Year to date				Annual
Actuals	Budget	Variance	Actuals	Budget	Variance		Actuals	Budget	Variance	Variance	Budget
$000s	$000s	$000s	FTE	FTE	FTE		$000s	$000s	$000s	FTE	$000s
						REVENUE					
						Government & Crown Agency Sourced					
867	802	65				MoH Revenue	8,822	8,023	799		9,628
0	0	0				IDF Revenue	0	0	0		0
977	968	9				Other Government	8,175	9,602	(1,428)		11,590
1,845	**1,771**	**74**				**Total Government & Crown**	**16,997**	**17,626**	**(629)**		**21,218**
						Non Government & Crown Agency Revenue					
(8)	166	(174)				Patient related	513	1,656	(1,143)		1,987
179	178	1				Other Income	1,686	1,779	(92)		2,134
171	**343**	**(173)**				**Total Non Government**	**2,199**	**3,434**	**(1,236)**		**4,121**
44,990	45,232	(242)				Internal Revenue	465,482	452,325	13,158		542,790
47,006	**47,347**	**(341)**				**TOTAL REVENUE**	**484,678**	**473,385**	**11,293**		**568,129**
						EXPENSES					
						Workforce					
						Senior Medical Officers (SMO's)					
6,723	6,797	73	266	266	0	Direct	64,905	66,142	1,237	11	80,024
421	351	(70)				Indirect	3,958	3,506	(452)		4,207
267	106	(161)				Outsourced	2,673	1,398	(1,276)		1,696
7,411	**7,254**	**(157)**	**266**	**266**	**0**	**Total SMO's**	**71,537**	**71,046**	**(491)**	**11**	**85,927**
						Registrars / House Officers (RMOs)					
4,038	4,414	376	340	337	(3)	Direct	41,379	40,723	(656)	(4)	49,650
291	233	(58)				Indirect	2,316	2,330	14		2,796
28	21	(8)				Outsourced	253	273	20		331
4,357	**4,667**	**310**	**340**	**337**	**(3)**	**Total RMOs**	**43,948**	**43,326**	**(622)**	**(4)**	**52,777**
11,768	**11,921**	**153**	**606**	**603**	**(3)**	**Total Medical costs (incl outsourcing)**	**115,485**	**114,372**	**(1,113)**	**7**	**138,704**
						Nursing					
11,510	10,852	(659)	1,404	1,338	(66)	Direct	112,555	102,276	(10,279)	8	123,580
42	1	(41)				Indirect	128	10	(118)		12
34	3	(31)				Outsourced	296	31	(265)		37
11,587	**10,856**	**(731)**	**1,404**	**1,338**	**(66)**	**Total Nursing**	**112,980**	**102,317**	**(10,663)**	**8**	**123,629**
						Allied Health					
2,334	2,392	58	303	314	11	Direct	22,680	23,916	1,237	17	29,150
78	25	(53)				Indirect	564	421	(144)		472
32	45	13				Outsourced	872	453	(419)		544
2,444	**2,462**	**18**	**303**	**314**	**11**	**Total Allied Health**	**24,116**	**24,790**	**674**	**17**	**30,165**
						Support					
158	184	27	34	38	4	Direct	1,628	1,905	277	4	2,294
0	1	1				Indirect	4	9	6		11
0	0	0				Outsourced	1	0	(1)		(0)
158	**185**	**28**	**34**	**38**	**4**	**Total Support**	**1,632**	**1,914**	**282**	**4**	**2,306**
						Management / Admin					
1,682	1,475	(208)	297	270	(27)	Direct	16,339	15,210	(1,129)	(10)	18,397
14	9	(5)				Indirect	92	86	(6)		104
11	5	(5)				Outsourced	97	55	(41)		66
1,707	**1,489**	**(218)**	**297**	**270**	**(27)**	**Total Management / Admin**	**16,528**	**15,352**	**(1,177)**	**(10)**	**18,567**
27,664	**26,913**	**(751)**	**2,645**	**2,564**	**(81)**	**Total Workforce Expenses**	**270,742**	**258,745**	**(11,997)**	**26**	**313,371**
3,606	3,271	(335)				**Outsourced Clinical Services**	36,563	32,453	(4,110)		38,618
14	0	(14)				**Outsourced Corporate / Governance Services**	81	0	(81)		0
3	0	(3)				**Outsourced Funder Services**	42	0	(42)		0
7,173	7,551	378				**Clinical Supplies**	79,125	76,311	(2,814)		92,441
999	830	(169)				**Infrastructure & Non-Clinical Supplies**	8,814	8,570	(243)		10,313
						Non Operating Expenses					
1,070	1,018	(52)				Depreciation	9,824	9,667	(157)		11,750
0	0	0				Capital charge	(0)	0	0		0
0	0	0				Interest	0	0	0		0
25	0	(25)				Provider Payments - Personnel Health	293	0	(293)		0
12,890	**12,671**	**(220)**				**Total Non Personnel Expenses**	**134,741**	**127,001**	**(7,740)**		**153,123**
40,554	**39,584**	**(970)**				**TOTAL EXPENSES**	**405,483**	**385,746**	**(19,736)**		**466,493**
6,452	**7,763**	**(1,311)**				**Net Surplus / (Deficit)**	**79,195**	**87,639**	**(8,443)**		**101,636**

Appendix 1: Financial Report for the Hospital Advisory Committee

3. *Revenue*

- Revenue was $0.34m lower than budget mainly due to the reduction in Planned Care funding for volumes not achieved ($1.164m) partially offset by revenue received from the Crown to offset the NZNO, PSA & MERAS MECA settlements ($0.529m).

- Patient Related Revenue was $0.17m unfavourable to budget continuing the year to date trend driven by non-resident income being less than budget due to current COVID border restrictions.

- Other Government revenue was on budget in April which was against the year to date run rate. This has resulted in this being $1.4m unfavourable year to date. While ACC has remained under budget due primarily to lower Orthopaedic ACC revenue (driven by lower capacity), this was offset by additional backdated revenue from the Dental School.

- MoH Revenue was $0.06m favourable relating to the release of revenue for service improvement projects (Endocrinology, Respiratory and Rheumatology)

4. *Workforce Costs*

Monthly result

Workforce costs (personnel plus outsourcing) were $0.75m unfavourable to budget in April 2022 with full time equivalent (FTE) 81 unfavourable to budget.

FTE

The FTE for the April accounts was based on the following pay dates;

- Nursing pay run –10th and 24th April.
- Medical, Allied, Support and Admin – 3rd and 17th April.

FTE is 81 over budget in April summarised in the following table.

Although FTE is 81 over budget, 65 FTE relate to nursing of which 50 FTE relates to known underbudgeting of stat leave due to limitations within the budget model. There a still a significant number of vacancies within the Hospital. The table below while not meant to be an exact reconciliation highlights some of the reasons for this.

					Adjust for restated BAU variance						
Staff Type	Actual FTE April 22	Budget FTE April 22	Monthly Variance	%	COVID *	Savings Plans not met (excl vacancies) **	Annual Leave Taken less than budgeted ***	Overtime ****	CCDM FTE approved post 2021/22 budget setting	Monthly adjusted Variance to est vacancy level	YE Budget FTE
SMO	266	266	0	0%	0		11	4		16	264
RMO	340	337	(3)	(1%)			10	(3)		5	336
Nursing	1,404	1,338	(66)	(5%)	9	33		22	60	59	1,317
Allied	303	314	11	3%			10	7		28	325
Support	34	38	4	10%			1			5	38
Mgmt / Admin	297	270	(27)	(10%)	5		10	2		(10)	277
	2,645	**2,564**	**(81)**	**(3%)**	**15**	**33**	**42**	**33**	**60**	**102**	**2,557**

* Assume COVID FTE not part of Business as Unusual (BAU) FTE. Variance would have been higher if no COVID so reduce unfavourable variance
** Savings plan not being met. Loaded as negative FTE budgets. If removed, variance more favourable
*** Annual leave not taken to levels budgeted. Exclude Nursing as staff would be covered if on annual leave.
**** Assume major % of this to cover vacant roles

Appendix 1: Financial Report for the Hospital Advisory Committee

Senior Medical Officer (SMOs)

SMO FTE was on budget for the month and 11 FTE favourable year to date. Leave taken was 11 FTE under budget for the month, which was higher than the ytd average (6 FTE). This has resulted in ordinary time being higher than usual.

Direct payroll costs are $0.07m favourable in April as per the table below. This is offset by outsourced costs which are $0.16m unfavourable.

Ordinary time	On budget despite FTE being 6.5 unfavourable due to vacancies offset with use of locums and overtime
Overtime	$306k 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 and vacancies.
Training	$201k favourable due to less staff away on training days. (7.5FTE)
Sick Leave	$49k favourable due to less staff taking sick leave.
Leave	57% leave taken in month which is lower than other months (equivalent to 11FTE). With a number of staff away with COVID, leave isn't able to be taken currently.

Indirect payroll costs are $0.07m unfavourable for the month due to Professional Memberships ($0.04m) Recruitment ($0.02m) and Parental Leave ($0.01m). YTD costs are $0.45m unfavourable mostly driven by Professional Memberships ($0.28m) and Parental Leave ($0.15m).

RMOs

RMOs were $0.31m favourable for the month and 3FTE over budget. Leave taken continues to be low at 70% of levels budgeted (68% year to date).

The unfavourable FTE variance is driven by

Ordinary Time	17.3FTE over budget for the month (7.2FTE year to date).
Leave Taken	70% leave taken in month (in line with prior months). This is equivalent to 10 FTE which is driving up ordinary time.
Overtime	Overtime is 3 FTE under budget (1FTE over budget year to date).
Training	3 FTE favourable due to less staff away on training days. Consistent YTD.

Indirect payroll costs are $0.06m unfavourable for the month driven by Parental Leave ($0.03m), Relocation ($0.01m) and Training ($0.02m). **YTD costs are on budget**.

Nursing

Nursing was $0.66m unfavourable and 66 FTE unfavourable in April.

To fully interpret the Nursing FTE position, we need to look at the components making up the 66 FTE unfavourable variance to understand the components that make it up.

Appendix 1: Financial Report for the Hospital Advisory Committee

Payroll Component	Actual FTE MTD	Budget FTE MTD	Variance FTE MTD
10010 - Ordinary Time	1,018.63	1,038.52	19.89
10011 - Overtime	35.90	13.76	(22.14)
10021 - Leave Earned (including non-Stat Time in Lieu)	115.08	111.37	(3.71)
10022 - Statutory (including Stat Time in Lieu)	158.58	108.44	(50.14)
10023 - Sick Leave	41.63	30.90	(10.73)
10024 - Accident Leave	1.97		(1.97)
10025 - Other Leave	15.40	16.57	1.17
10026 - Training (including CME)/ Study Leave	15.32	18.28	2.96
10027 - Long Service Leave	1.41		(1.41)
10029 - Leave Taken (including non-Stat Time in Lieu)	81.84	119.18	37.34
10099 - Leave Taken Contra (including non-Stat Time in Lieu)	(81.98)	(119.18)	(37.20)
Grand Total	**1,403.78**	**1,337.84**	**(65.94)**

As shown above, ordinary time which represents "normal" hours worked is 20FTE less than budget. This broadly aligns with our vacancy factor within nursing.

Combining Ordinary and Statutory FTE together to remove the impact of timing differences between budget and actuals in the stat days, we have then looked at the responsibility centres with variances > 2 FTE (tabled below). This highlights significant variances across a wide range of responsibility centres some of which are resulting in bed closures.

The total positive and negative FTE variances can't be netted to give an overall statement about the number of nursing positions vacant as it fails to take into account;

- Positions that have been approved over and above the current budget (e.g., ED PIN, Increased CCDM over Budget), or
- Budgeted savings that are not driving the favourable variances (i.e., the favourable FTE variances are due mainly to the inability to recruit sufficient numbers of nurses, not because efficiencies have been put in place to run the wards at these lower numbers).

Appendix 1: Financial Report for the Hospital Advisory Committee

Responsibility Centre	Actual FTE MTD	Budget FTE MTD	Variance FTE MTD	Comments
6818110 - General Manager Operations	0.20	(27.11)	(27.31)	Savings Valuing PT / Positive Shifts / Generalism
6812511 - Ward 8 Medicine	78.06	62.85	(15.21)	Increased recruitment over budget for CCDM. Patient Watches
6812365 - Emergency Department (ED)	67.94	56.93	(11.01)	Pin notice increase
6808007 - COVID COO	7.37		(7.37)	COVID
6812510 - Ward 7C Cardiology/Nephrology	28.29	21.78	(6.51)	COVID ward. New model of care being used
6812508 - Ward 7A Respiratory/Thoracic/Cardiac	38.84	33.14	(5.70)	Extra beds open
6803507 - National Bowel Screening Programme	5.52		(5.52)	Offsets budget in Gastro
6812504 - Ward 4A General Surgery	35.41	30.03	(5.38)	
6822542 - Medical Ward	54.91	50.70	(4.21)	2 FTE increase in CCDM over budget
6815213 - Nursing Resource Unit	20.46	16.87	(3.59)	Covering increased sick leave and vacancies
6812505 - Ward 4C General Surgery/Urology	33.97	30.84	(3.13)	
6808042 - General Manager Surgical Services & Radi	2.16	(0.88)	(3.04)	Savings
6813653 - Ophthalmology Outpatients	9.22	6.21	(3.01)	
6812502 - Ward 3 Surgical	63.00	60.46	(2.54)	increase budget to address patient watches
6818132 - Service Manager General Surgery, Orthopae	7.33	9.35	2.02	
6822365 - Emergency Department (ED)	43.20	45.29	2.09	Vacancies
6813660 - 4th floor outpatients	8.34	10.62	2.28	
6822366 - Neonatal (NICU) Unit	15.52	17.89	2.37	Vacancies
6813653 - Oncology/Haematology Outpatient Service	17.25	19.68	2.43	
6812514 - Childrens Unit	20.20	23.07	2.87	Closed beds
6816250 - Patient Transport		3.04	3.04	Actuals in ICU
6813652 - Renal Unit/Nephrology	14.66	19.33	4.67	Vacancies
6813505 - Gastroenterology 8th Floor	15.29	20.18	4.89	Offset bowel screening
6822543 - Surgical Ward	55.24	61.77	6.53	9 FTE budgeted for medical overflow into ATR beds
6825213 - Nursing Resource Unit	8.14	15.16	7.02	VRM vacancies
6822350 - Maternity Ward	18.38	25.50	7.12	Vacancies
6812364 - Te Puna Wai Ora - Southern Critical Care (IC	82.33	91.22	8.89	FTE yet to be recruited for second
6812350 - Maternity Ward	33.79	46.23	12.44	Vacancies
Grand Total	**1,177.21**	**1,146.96**	**(30.25)**	

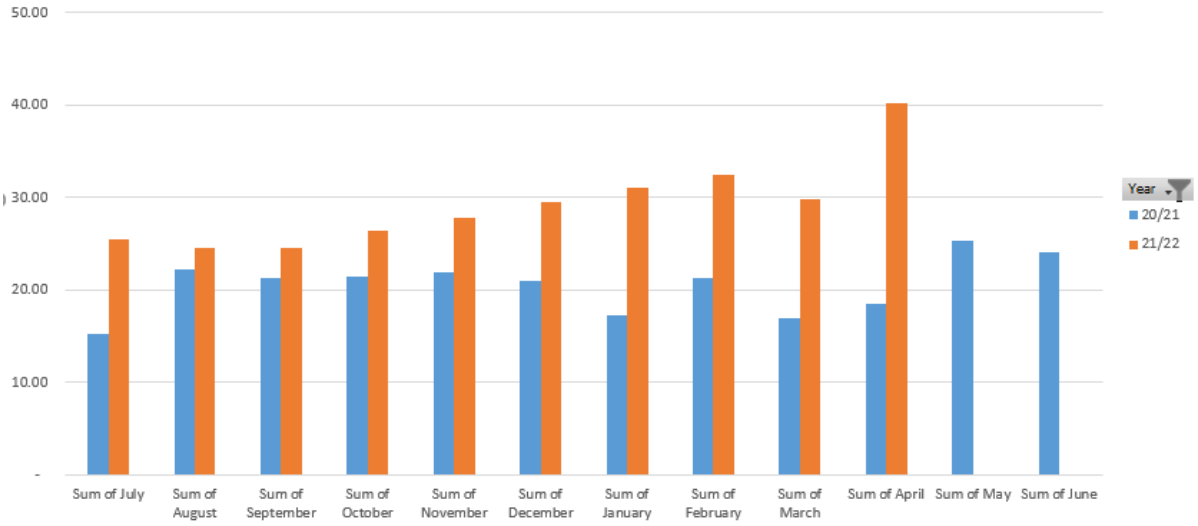
As shown below CCDM is budgeted in April at 94.03FTE which is 98% of the full year budget that has been budgeted from May 2022.

CCDM Allocation to cost centres

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

Patient watches remain an area of focus with watch hours 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.

Appendix 1: Financial Report for the Hospital Advisory Committee



Allied Health

Allied Health costs were on budget for the month and 11FTE favourable to budget in April. Direct payroll costs were $0.05m favourable and 11 FTE favourable, offset by indirect costs that were $0.05m unfavourable driven by Professional Memberships ($0.04m) and Training ($0.01m).

The favourable FTE variance was driven by vacant roles in:

- Radiology service 6.6FTE favourable due to delays in recruitment of new MRT graduates.
- Dunedin Ophthalmology Outpatients 3FTE favourable is offset with nursing as HCAs employed but budgeted under Technicians.
- Dunedin Anaesthesia Service and Southland Perioperative anaesthetic technicians are 5.2FTE favourable, partially offset by outsourced costs which are $0.03m unfavourable.

Support

Support Staff costs and FTE were under budget for the month due to continued vacancies in Sterile Services at both sites.

Management and Administration

Management/Admin costs were $0.22m unfavourable and 27FTE over budget in April.

The variance is partly driven by annual leave not taken as only 59% of leave was taken to budget.

Leave Taken	59% leave taken in month (high when comparted to prior months). This is equivalent to 10 FTE
Overtime	Overtime is 2 FTE over budget. This includes cover for leave not budgeted.

Appendix 1: Financial Report for the Hospital Advisory Committee

Ordinary	Base FTE is over budget due to 6FTE in Clinical Admin Southland (ongoing resourcing issues), 2 FTE in Oncology (offset by Radiation Oncology investment budgeted in Allied Health), 4.6 COVID FTE not budgeted.

The below table shows cost centres with an FTE variance <> 1.5FTE. The monthly negative variance of 23FTE has increased from the year to date variance of 7FTE due to;

- An increase in COVID FTE of 5.3FTE.
- An increase due to less leave being taken during the month of approx. 10FTE (only 59% of budgeted leave taken compared to 80% year to date). 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.
- Southland Clinical Admin increased by 3FTE due to the regional admin restructure (offset in Cardiology and Gastroenterology).
- Deputy COO Southland increase of 4FTE due to Tier 2&3 Restructure and is offset in other costs centres both within & outside of Chief Operating Officer Directorate.

Row Labels	Actual FTE MTD	Budget FTE MTD	Variance FTE MTD	Variance FTE YTD
6828002 - Clinical Administration - Southland	46.2	39.1	(7.0)	(4.0)
6808061 - Deputy COO Southland Hospital	5.5		(5.5)	(0.9)
6808007 - COVID COO	5.3		(5.3)	(0.7)
6808000 - Executive Director Specialist Services	7.5	5.0	(2.5)	(1.5)
6808045 - General Manager Medicine and Womens & Childrens Health		(2.3)	(2.3)	(2.2)
6813659 - Ophthalmology Outpatients	8.8	6.8	(2.0)	(0.2)
6813654 - Radiation Oncology Outpatients	11.1	9.3	(1.8)	(1.4)
6808041 - General Manager Medicine, Womens & Childrens	9.3	7.7	(1.6)	0.3
6818132 - Service Manager General Surgery, Orthopaedics & Plastics Dunedin	4.1	2.5	(1.5)	(0.9)
6813511 - Cardiology Labs	7.1	8.7	1.6	0.5
6803507 - National Bowel Screening Programme	0.1	2.0	1.9	1.2
6803509 - National Bowel Screening South Island	0.7	4.0	3.3	3.0
Total Variances >1.5 or <-1.5FE	**105.5**	**82.9**	**(22.6)**	**(6.9)**

5. *Outsourced Clinical Services Costs*

Outsourced services were $0.3m unfavourable in April driven by Outsourced Surgical Services as shown below.

Appendix 1: Financial Report for the Hospital Advisory Committee

Object	Account Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
3615	Laboratory Service	(1,486)	(1,492)	6	(14,998)	(14,917)	(81)
3620	Laboratory Sendaway Tests	0	(0)	1	0	(4)	4
3630	Breast screening	(71)	(113)	42	(1,013)	(1,152)	139
3640	Radiology Service	(223)	(162)	(61)	(1,730)	(1,650)	(81)
3642	CT Scans	(14)	(58)	45	(110)	(594)	484
3646	Lithotripsy		(6)	6	(21)	(64)	43
3647	MRI Scans	(88)	(33)	(55)	(687)	(335)	(352)
3650	Other Radiology Procedures	(97)	(35)	(63)	(606)	(352)	(254)
3651	Audiology	3	(2)	5	(24)	(20)	(4)
3653	Ophthalmology	(96)	(43)	(53)	(603)	(440)	(163)
3665	Surgical	(1,084)	(728)	(356)	(10,627)	(6,863)	(3,764)
3675	Vascular Assessments	(140)	(75)	(65)	(960)	(762)	(198)
3677	Out Sourced Clinical Services - Accommodatior	(4)		(4)	(8)		(8)
3690	Outsourced Clinical Services - Other	(308)	(524)	216	(5,177)	(5,301)	124
		(3,606)	**(3,271)**	**(335)**	**(36,563)**	**(32,453)**	**(4,110)**

The $0.3m unfavourable variance in Outsourced Clinical Services is due to:

- Increased surgical outsourcing to try to meet monthly planned activity and address catch ups where possible in CWD delivery and address surgery waiting lists, as measured by ESPI 5 - patients waiting longer than four months for surgery.
- Saving of $0.1m loaded as part of the budget saving initiative (full year impact $1m).
- Increased Radiology outsourcing due to IAP supported activity (funded).
- The above was partially offset by a $0.35m favourable variance due to no cancer patients being sent to St Georges Hospital in Christchurch combined with over accruals being written back.

6. *Clinical Supplies (excluding depreciation)*

Clinical supplies were favourable to budget by $0.38m in April and $2.81m unfavourable year to date.

Although the monthly variance was out of line with the year to date trend, it was not unexpected given the 7% reduction in actual caseweights to plan in April.

With the exception of Blood costs and Air Ambulance which do not necessary correlate with volumes, clinical supplies decreased reflecting the lower surgical activity and bed closures.

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

Appendix 1: Financial Report for the Hospital Advisory Committee

Object	Account Description	$000 Monthly Actua	$000 Monthly Budge	$000 Monthly Varian	$000 YTD Actua	$000 YTD Budge	$000 Variance YTD
4010	Blood and Tissue Supplies	(778)	(645)	(133)	(9,453)	(8,465)	(988)
4025	Catheters	(130)	(186)	56	(1,527)	(1,892)	365
4190	Patient Consumables	(252)	(343)	91	(3,149)	(3,487)	338
4235	Sterilising Consumables	(44)	(129)	84	(605)	(1,309)	704
4290	Other Diagnostic Supplies	(166)	(73)	(93)	(1,558)	(747)	(811)
4315	Disposable Instruments	(99)	(287)	188	(1,327)	(2,576)	1,249
4320	Laparoscopic Equipment	(193)	(46)	(147)	(2,040)	(410)	(1,630)
4530	Hip Prostheses	(169)	(231)	62	(1,853)	(2,400)	547
4535	Knee Prostheses	(51)	(118)	67	(773)	(1,226)	453
4555	Screws, nails and plates	(159)	(215)	56	(2,373)	(2,188)	(186)
4590	Implants and Prostheses - Other	(8)	(85)	77	(98)	(862)	764
4955	Air Ambulance	(604)	(408)	(196)	(6,327)	(4,155)	(2,172)
		(7,173)	**(7,551)**	**378**	**(79,125)**	**(76,311)**	**(2,814)**

1) Blood & Tissue Supplies continue to track over budget and were $0.13m over budget for the month, partly offset by the Haemophiliac rebate of $0.02m. The main driver in non-haemophiliac costs is Intragam costs. This is an Immunoglobulin product used primarily in haematology and neurology. It is demand driven and usage is tightly controlled using clinical criteria.

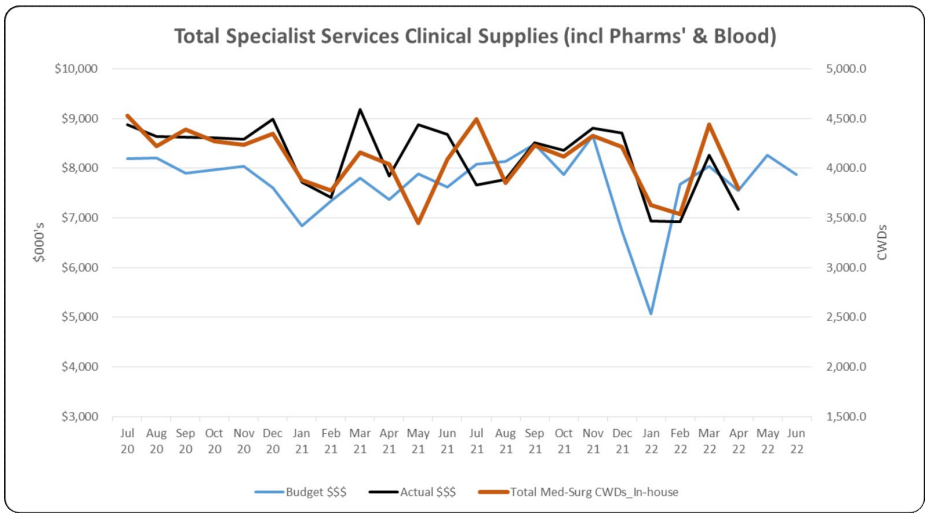
2) Air ambulance was $0.20m over budget for the month and $2.17m YTD.

   - In April there were 66 flights, made up of 19 fixed wing and 47 helicopter. Drivers of the unfavourable variance were;
     - 9 of the flights were for transferring COVID patients,
     - 4 flights due to Christchurch covering neurosurgical call and
     - 1 flight was due to no road ambulance being available.

   - Helicopter charges have **incurred a 10% price increase.**

3) Laparoscopic instruments are offset by disposable instruments although these accounts are unfavourable year to date. This coding issue between actuals and budget has occurred with the switch to the new Oracle financial system (FPIM) when a change of classification for some items using the national catalogue resulted.

We have graphed clinical supplies against Medical / Surgical and Maternity caseweights as below, with the planned CWD and Budget shown out to June 2022. This reflects a reduction in dollars and caseweights delivered in April as expected.



Appendix 1: Financial Report for the Hospital Advisory Committee
Infrastructure and Non-Clinical (excluding depreciation)

Infrastructure and Non-Clinical supplies were over budget in April by $0.17m and unfavourable $0.24m year to date. Monthly variances <> $10k are shown below:

Object	Account Description	$000 Monthly Actua	$000 Monthly Budge	$000 Monthly Varian	$000 YTD Actua	$000 YTD Budge	$000 Variance YTD
5040	Patient Meals (Outsourced)	(349)	(337)	(13)	(3,494)	(3,410)	(84)
5045	Cleaning Supplies	(20)	(38)	18	(181)	(384)	203
5158	Maintenance - Mechanical Materials	(10)	0	(10)	(85)	0	(85)
5159	Maintenance - Outsourced	(64)	(14)	(50)	(159)	(140)	(19)
5250	Staff Travel - Domestic	(128)	(91)	(37)	(937)	(850)	(87)
5325	Hardware - Minor Purchases	(22)	(4)	(18)	(117)	(41)	(77)
5355	Telecommunications - Line Rentals	(1)	(47)	47	(149)	(473)	324
5620	Other Equipment - Minor purchases	(44)	(24)	(20)	(456)	(237)	(219)
5650	Stock Adjustments	(39)	0	(39)	(144)	0	(144)
5670	Postage, Courier & Freight	(18)	(35)	18	(167)	(464)	297
		(999)	**(830)**	**(169)**	**(8,814)**	**(8,570)**	**(243)**

April had a higher variance than the year to date average due to the following;

- Outsourced maintenance was high due to $52k of COVID costs associated with sealing off doors / installing new doors and building walls associated with the 6ATR, 6C and 6A transition and Paediatrics.
- Pharmaceutical stock adjustments were higher than usual. This is variable month to month based on stock holding.
- Travel costs is above the year-to-date average and includes additional expenditure for a locum sonographer in Southland.

7. *Non-operating Expenses & Provider Payments*

These costs relate to depreciation charges for clinical equipment and are slightly unfavourable to budget.

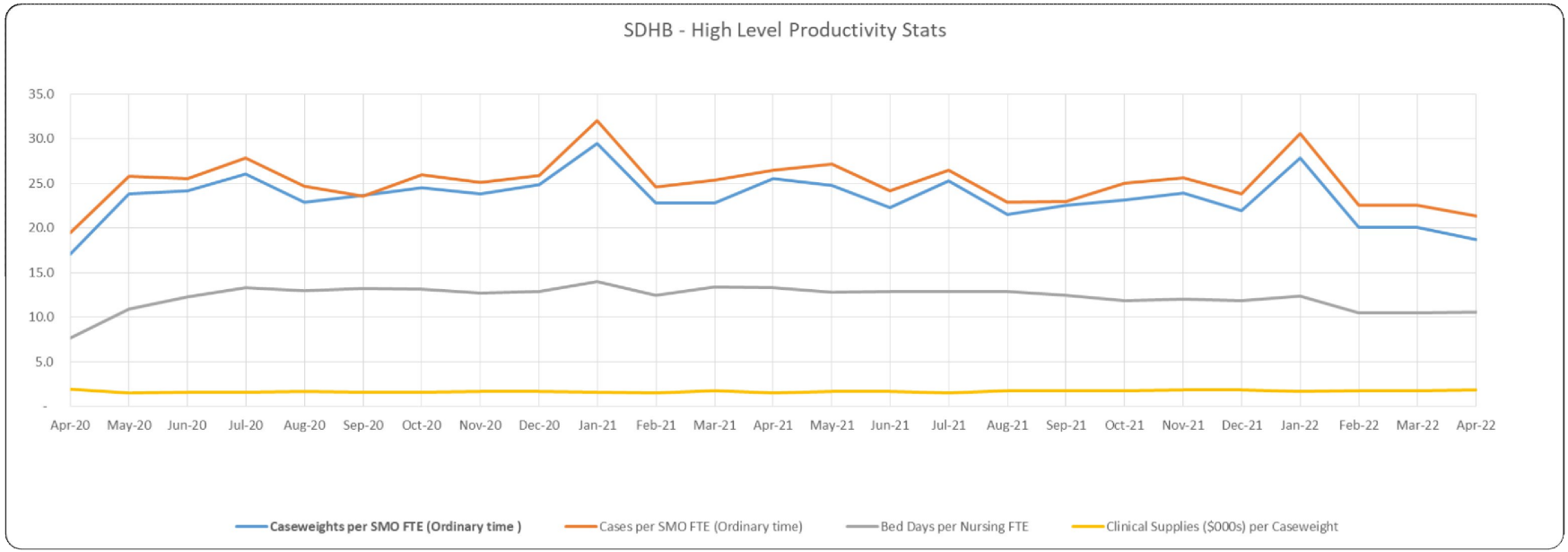
Object	Account Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
5962	Depreciation - Clinical Equipment	(1,016)	(975)	(42)	(9,369)	(9,230)	(139)
5967	Depreciation - General Equipment	(54)	(44)	(10)	(455)	(437)	(18)
		(1,070)	**(1,018)**	**(52)**	**(9,824)**	**(9,667)**	**(157)**

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 25 months with the exception of;

- April 20 where delivery was impacted by COVID,
- January 2021 & 2022 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,
- February –April 2022 shows a decrease in productivity driven by bed closures, reduced theatre, COVID ward set-up and industrial action / strike preparation for PSA Allied Health.



Appendix 1: Financial Report for the Hospital Advisory Committee

Productivity Statistics

Medical/Surgical/Maternity

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Average
Caseweights	4,604.1	4,643.6	4,534.1	4,976.5	4,363.7	4,687.3	4,629.3	4,729.9	4,637.8	4,067.2	3,920.6	4,346.1	3,820.4	4,458.5
Cases	4,776.0	5,089.0	4,921.0	5,224.0	4,649.0	4,774.0	5,012.0	5,072.0	5,018.0	4,464.0	4,254.0	4,734.0	4,365.0	4,796.3
Caseweights per Case	1.0	0.9	0.9	1.0	0.9	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Bed Days	11,172.0	11,177.0	11,265.0	11,455.0	11,308.0	11,139.0	10,638.0	10,780.0	10,888.0	9,860.0	9,138.0	10,447.0	9,707.0	10,690.3
Cases (excl Day Case)	2,882.0	3,015.0	2,964.0	3,174.0	2,821.0	2,781.0	2,886.0	2,920.0	2,913.0	2,609.0	2,413.0	2,633.0	2,547.0	2,812.2
ALOS	3.9	3.7	3.8	3.6	4.0	4.0	3.7	3.7	3.7	3.8	3.8	4.0	3.8	3.8
SMO FTE (Ordinary Time)	180.3	187.5	203.6	197.2	203.0	207.8	200.3	198.2	211.0	146.2	194.0	214.8	204.4	196.0
Nursing FTE (Ordinary Time)	839.6	872.4	876.7	888.7	878.3	892.8	897.2	894.9	919.2	794.6	886.3	899.3	914.1	881.1
Clinical Supplies ($000's)	7,848.7	8,872.2	8,684.3	8,549.7	8,664.3	9,403.6	9,308.2	9,771.9	9,690.7	7,847.3	7,934.0	9,136.0	8,189.0	8,761.5
Depreciation Clinical Supplies	937.8	943.9	898.2	889.2	884.7	884.4	953.1	972.5	982.5	906.0	1,011.0	870.0	1,016.0	934.6
Clinical Supplies less Depreciation ($000's)	6,911.0	7,928.3	7,786.1	7,660.5	7,779.6	8,519.2	8,355.1	8,799.4	8,708.2	6,941.3	6,923.0	8,266.0	7,173.0	7,827.0
Caseweights per SMO FTE (Ordinary Time)	25.5	24.8	22.3	25.2	21.5	22.6	23.1	23.9	22.0	27.8	20.2	20.2	18.7	22.7
Cases per SMO FTE (Ordinary Time)	26.5	27.1	24.2	26.5	22.9	23.0	25.0	25.6	23.8	30.5	21.9	22.0	21.4	24.5
Bed Days per Nursing FTE (Ordinary Time)	13.3	12.8	12.8	12.9	12.9	12.5	11.9	12.0	11.8	12.4	10.3	11.6	10.6	12.1
Clinical Supplies per Caseweight	1.7	1.9	1.9	1.7	2.0	2.0	2.0	2.1	2.1	1.9	2.0	2.1	2.1	2.0

As expected, a reduction in all the volume metrics (caseweights, cases, bed days) has resulted in a drop in the productivity metrics (bed days per nursing FTE, caseweights per SMO FTE) as staffing numbers have remained close to the normal average. This was not unexpected in the current COVID environment

Quality measures such as average length of stay and clinical supplies per caseweight have not changed however which is pleasing to note.