BOARD MEETING

AGENDA

Thursday, 7 June 2012

10.30 am

Board Room, 1st Floor, Dunedin Hospital
201 Great King Street

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SOUTHERN DISTRICT HEALTH BOARD MEETING

Thursday, 7 June 2012, 10.30 am
Board Room, 1st Floor, Dunedin Hospital

A G E N D A

Confidential Session:

RESOLUTION:

That the Board move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 32, Schedule 3 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	***Reasons for passing this resolution:***	***Grounds for passing the resolution:***
Previous Public Excluded Board Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.
Review of Public Excluded Action Sheet	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i), 9(2)(j), and 9(2)(a).
Annual Plan 2012/13	Plan is subject to Ministerial approval	As above, sections 9(2)(f)(iv) and 9(2)(j).
Health Benefits Ltd Business Case	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Public Excluded Advisory Committee Reports a) Disability Support Advisory Committee and Community & Public Health Advisory Committee ▪ 6 June 2012 ▪ Home Based Support Services b) Hospitals Advisory Committee ▪ 2 May 2012 ▪ 6 June 2012 ▪ Southland & Dunstan Hospitals Boiler Upgrade c) Clinical Advisory Committee ▪ 2 May 2012 ▪ 6 June d) Audit & Risk Committee ▪ 7 June 2012 e) Iwi Governance Committee ▪ Māori Health Plan 2012/13	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Contract Approvals ▪ Southern PHO – After Hours Primary Care Initiatives	Commercial sensitivity	As above, section 9(2)(i).
Sentinel Events Report	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(j), 9(2)(a)
Risk Report	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Legal Issues	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
EMT Proposal for Change ▪ Verbal update	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	01.03.2012 06.12.2010	1. Member, South Island Neurosurgical Board **Son-in-law:** 2. Partner, Polson Higgs, Chartered Accountants. 3. Trustee, Corstorphine Baptist Community Trust	1. 2. Does some accounting work for Southern PHO. 3. Has a mental health contract with Southern DHB.
Paul MENZIES (Deputy Chairman)	10.02.2010 10.02.2010 06.10.2011	1. Wife a member on the Southland Child Youth Mortality Review Group. 2. Wife a member on the Child and Youth Health Advisory Committee. 3. Trustee, Southern PHO	1. Nil. 2. Nil. 3. Appointed as a trustee by Southern DHB. PHO is contracted to the DHB.
Neville COOK	04.03.2008 04.03.2008 04.03.2008 26.03.2008	1. Board Member, Invercargill Licensing Trust. 2. Board Member, Invercargill Licensing Trust Foundation. 3. Councillor, Environment Southland. 4. Trustee, Norman Jones Foundation.	1. Possible conflict with funding requests. 2. Possible conflict with funding requests. 3. Nil. 4. Possible conflict with funding requests.
Sandra Cook	01.09.2011	1. Te Runanga o Ngāi Tahu	1. Holds a "right of first refusal" over certain Crown properties. Also seen as a Treaty partner and affiliates may hold contracts from Southern DHB from time to time.
Kaye CROWTHER	09.11.2007 14.08.2008 14.08.2008 12.02.2009 05.12.2010 01.03.2012	1. Employee of WHK South. 2. Trustee of Plunket Foundation. 3. Trustee of Wakatipu Plunket Charitable Trust. 4. Corresponding member for health and family affairs, National Council of Women. 5. Member of advisory panel for No 10, Invercargill. 6. DHB representative on the Gore Social Sector Trial	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of WHK. 2. Nil. 3. Nil. 4. Nil.
Mary FLANNERY	17.11.2010 10.11.2011	1. Trustee, Rural Otago Primary Health Organisation 2. Associate Solicitor, Bodkins/AWS Legal, Alexandra. 3. Partner, Tayside Farm Partnership. 4. Director, New Zealand Irrigation Board	1. Was contracted to Southern DHB – contracts assigned to Southern PHO (will be wound up) 2. Nil 3. Nil 4. Nil
James Malcolm MACPHERSON	28.06.2005 09.03.2011 25.11.2010	1. Member Otago Polytechnic Council. 2. Contractor and Tutor, Otago Polytechnic. 3. Member Central Lakes Trust.	1. (OP has training interests in common with the DHB, no) 2. (personal interest.) 3. CLT is a community funder in its region, which includes

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	25.11.2010 25.11.2010 28.08.2007 09.03.2011 09.03.2011 09.03.2011 13.12.2001 22.04.2003	4. Member Roxburgh Gorge Trail Charitable Trust. 5. Part owner, Alexandra Medical Centre. 6. Co-Principal, Brilliant New Zealand Ltd. 7. Chairman, Jolendale Charitable Trust. 8. Shareholder, Medco Properties Ltd 9. Director, Centennial Health Ltd **Spouse - Susan Elizabeth Macpherson:** 10. GP Principal, Centennial Health Ltd, Alexandra. 11. Branch Medical Advisor, ACC, Alexandra.	Dunstan and Lakes District Hospitals, plus a wide range of community and primary services and service providers, and is a possible future funder. 4. Nil. 5. The AMC is tenanted by all of Alexandra's GPs and a pharmacy, and is also occasionally used by related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts. 6. BNZL is a consultancy which may have an involvement with health sector organisations. 7. Nil. 8. MPL will be responsible for the tenancy of all of Alexandra's current GPs and a pharmacy and may also house other related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts, real and theoretical. 9. & 10. Board discussions relating to primary health providers or primary referred services may involve conflicts of interest. Declare where appropriate and withdraw where prudent. 11. ACC is a major customer of the DHB. Remote possibility of an influence, no personal interest.
Tahu POTIKI	15.12.2007 03.04.2008 24.11.2009 03.06.2010	1. Director, Arataki Associates. 2. Representative to Te Runanga o Ngai Tahu. 3. Trustee of Ngai Tahu Charitable Trust. 4. Board Member, Relationship Services NZ. 5. Board Member, Environmental Science and Research	1. Contracted to Southern DHB, funded provider in the past ie Araiteuru Whare Hauora Ltd. 2. & 3. Treaty Partner - affiliated providers may contract to Southern DHB. Te Runanga o Ngai Tahu has right of first refusal on disposal of property. 4. No apparent conflict. 5. CRI involved in public health research.
Branko SIJNJA	07.02.2008 04.02.2009 22.06.2010	1. Director, Clutha Community Health Company Limited. 2. 0.5 FTE Director Rural Immersion Programme, Otago University School of Medicine. 3. Employee, Balclutha General Practitioners Limited	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.
Richard John THOMSON	13.12.2001	1. Managing Director, Thomson & Cessford Ltd. 2. Director, Susanna Shaya Imports Ltd 3. Chairperson and Trustee, Hawksbury Community Living Trust.	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	23.09.2003 29.03.2010 06.04.2011	4. Trustee, HealthCare Otago Charitable Trust. 5. Director, Composite Retail Group. 6. Councillor, Dunedin City Council.	2. Susanna Shaya Imports is a homeware importing company. It has no dealings with Southern DHB. 3. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 4. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 5. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009 01.05.2010 01.05.2010	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT).	1. May have some Southern DHB patients and staff as clients. 2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at March 2012

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
John Adams	27.05.2003 24.02.2004 23.11.2004 22.04.2008 18.02.2010	1. Dunedin School of Medicine (Dean). 2. Southern DHB Mental Health Service (staff member). 3. Ashburn Hall Charitable Trust (Trustee). 4. NZ Institute of Rural Health (Trustee). 5. Medical Council of New Zealand (Chair).	1. Possible conflicts between Southern DHB and University interests. 2. Possible differences in priorities and view between governance and employee. 3. The Ashburn Clinic is both a contractor to and provides similar services to the Southern DHB. 4. DHBs contract NZIRH to provide services. 5. At times, NZMC policy or opinion may conflict with or be critical of Southern DHB policy.
Steve Addison	21.02.2012	1. Mother-in-law (Anne Gover) Gore District Councillor 2. Father-in-law (Keith Gover) on Board of Gore Counselling Centre	
Vivian Blake	23.04.2007 08.02.2009	1. Executive Director on the Board of the Health Roundtable (HRT). 2. New Zealand Benchmarking Group (Chair).	1. The HRT facilitates benchmarking activity for 130 Australasian hospitals. 2. NZBG is the New Zealand Chapter of the Australasian Health Roundtable.
Richard Bunton	17.03.2004 29.04.2010	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Deputy Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	23.02.2010	8. Otago Rugby Union (Director).	6. No conflict. 7. No conflict. 8. No conflict.
Donovan Clarke	02.02.2011	1. Te Waipounamu Delegate, Te Piringa, National Maori Disability Advisory Group. 2. Director, Great Western Steakhouse, New Lynn, Auckland.	1. Nil. 2. Nil.
Tina Gilbertson	16.11.2011	Nil	
Carole Heatly	14.03.2012	Nil	
Robert Mackway-Jones	28.08.2007	1. Close association (wife) employed by Dunedin Hospital.	1. Reporting line to Purchasing Team leader.
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
Lynda McCutcheon	24.01.2012	Nil	
John Pine	17.11.201	Nil	
Leanne Samuel	01.07.2007 01.07.2007 01.07.2007 29.10.2009 01.10.2010	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member of Board of Studies at Southern Institute of Technology. 4. Southland Medical Foundation Inc (Member) 5. Member of National Elective Services Productivity and Workforce Programme Steering Group.	1. Southland Hospital Trust. 2. Nil. 3. Potential conflict if the DHB purchases services from this organisation. 4. Southland Trust. 5. Nil.
John Simpson		Nil	
David Tulloch	23.11.2010 02.06.2011	1. Southland Urology (Director) 2. Southern Surgical Services (Director) 3. UA Central Otago Urology Services Limited (Director)	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 3. Potential conflict if DHB purchases services.
Ian Macara (in attendance at EMT as CEO of the Southern PHO)	26.08.2010	Nil	

Minutes of the Southern District Health Board Meeting

Thursday, 3 May 2012, 10.00 am
Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Joe Butterfield	Chair
	Mr Paul Menzies	Deputy Chair
	Ms Sandra Cook	
	Mr Neville Cook	
	Mrs Kaye Crowther	
	Mrs Mary Flannery	
	Dr Malcolm Macpherson	
	Mr Tahu Potiki	
	Dr Branko Sijnja	
	Mr Richard Thomson	
	Mr Tim Ward	
In Attendance:	Mr Stuart McLauchlan	Crown Monitor
	Ms Carole Heatly	Chief Executive Officer
	Mrs Lexie O'Shea	Deputy Chief Executive Officer/Chief Operating Officer, Southland
	Mrs Vivian Blake	Chief Operating Officer, Otago
	Mr Robert Mackway-Jones	General Manager, Finance & Funding
	Mrs Leanne Samuel	Chief Nursing & Midwifery Officer
	Mr David Tulloch	Chief Medical Officer
	Mr Steve Addison	Public Relations and Communications Manager
	Ms Jeanette Kloosterman	Board Secretary (by videoconference)
	Ms Cherie Wells	CEO Support Manager (by videoconference)

1.0 APOLOGIES

There were no apologies.

2.0 CHAIR'S OPENING COMMENTS

The Chairman welcomed everyone to the meeting.

3.0 DECLARATION OF INTERESTS

It was resolved:

"That the Interests Register be noted."

4.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

"That the minutes of the 5 April 2012 Board meeting be approved and adopted as a true and correct record."

5.0 MATTERS ARISING

There were no matters arising from the previous minutes.

6.0 ACTION SHEET

The Board meeting action sheet (agenda item 6) was received.

7.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer presented her monthly report (agenda item 7), then took questions from members.

Wakatipu Age Related Care (ARC) Service Transition

It was noted that a new provider had been selected to take over ARC services in Queenstown.

It was resolved:

"That the Chief Executive Officer's report be received."

8.0 FINANCIAL REPORT

The General Manager, Finance & Funding presented the Financial Report for the period ended 31 March 2012 (agenda item 8) and answered members' questions on the financial statements.

The Board requested:

- That the General Manager, Finance & Funding liaise with the Audit & Risk Committee Chair on non-Provider Arm financial reporting to Board;
- That the cash forecast be reviewed.

It was resolved:

"That the Financial Report be received."

9.0 NATIONAL HEALTH BOARD AND SOUTHERN DHB JOINT ASSESSMENT OF SYSTEMS: DUNEDIN HOSPITAL

The Board considered a progress report on implementing the organisation-wide recommendations from the National Health Board (NHB) and Southern DHB assessment of systems at Dunedin Hospital (agenda item 9).

The Chief Executive Officer informed the Board that an additional column would be added to future reports indicating timelines and expected completion dates.

It was resolved:

"That the report be received."

10.0 ADVISORY COMMITTEE REPORTS

Disability Support Advisory Committee/Community & Public Health Advisory Committee

The minutes of the joint meeting of the Disability Support Advisory Committee (DSAC) and Community & Public Health Advisory Committee (CPHAC) held on 4 April 2012 (agenda item 10a), which were reported on verbally at the last meeting, were taken as read.

It was resolved:

"That the minutes be received."

Dr Macpherson, Chair of DSAC and CPHAC, gave a verbal report of the meeting held on 2 May 2012 and tabled a recommendation from the Committees on the draft Mental Health and Addiction Strategic Plan – *Raise Hope: Hapaia Te Tumanako.*

It was resolved:

"That the verbal report be received."

Mental Health and Addiction Strategic Plan

It was resolved:

"That the Board:

1. **Approve the Mental Health and Addiction Strategic Plan 2012-2015, and**

2. **Note that Planning & Funding will begin implementation of the plan."**

Staff were congratulated on the process used to develop the plan.

Hospital Advisory Committee

The minutes of the Hospital Advisory Committee (HAC) meeting held on 4 April 2012 (agenda item 11), which were reported on verbally at the last meeting, were taken as read.

It was resolved:

"That the minutes be received."

The Board received a verbal report from Mr Menzies, HAC Chair, on the meeting held on 2 May 2012 and recommendations from the Committee on an application for funding to the Invercargill Licensing Trust for the Chair in Neurosurgery and a ninth operating theatre at Dunedin Hospital were tabled.

The Chairman advised that, due to commercial sensitivity, these items would be considered with the public excluded and the Board's decision released at the end of the meeting.

It was resolved:

"That the verbal report be received."

Iwi Governance Committee

The minutes of the Iwi Governance Committee meeting held on 3 April 2012 (agenda item 12), which were reported on verbally at the last meeting, were taken as read.

It was resolved:

"That the minutes be received."

The Board received a verbal report from Mr Potiki on the meeting of the Committee held on 2 May 2012.

It was resolved:

"That the verbal report be received."

11.0 CONTRACTS REGISTER

The Funding contracts register (expenses) for April 2012 was circulated with the agenda (item 13) for members' information.

It was resolved:

"That the register be received."

CONFIDENTIAL SESSION

***At 10.40 am, it* was *resolved*:**

"That the public be excluded from the meeting for consideration of the following agenda items:

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Board Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Review of Public Excluded Action Sheet	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i), 9(2)(j), and 9(2)(a).
Annual Plan and Financials	Plan is subject to Ministerial approval	As above, sections 9(2)(f)(iv) and 9(2)(j).
Project Opportunities	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
HBL Update	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Public Excluded Advisory Committee Reports a) Disability Support Advisory Committee and Community & Public Health Advisory Committee ▪ 4 April 2012 ▪ 2 May 2012 b) Hospitals Advisory Committee ▪ 4 April 2012 ▪ 2 May 2012 ▪ Theatre 9 Business Case ▪ ILT Funding Application c) Clinical Advisory Committee ▪ 4 April 2012 ▪ 2 May 2012	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Contract Approvals ▪ University of Otago – School of Dentistry ▪ Adventure Development Ltd ▪ Health Workforce NZ - Postgraduate Nursing ▪ Medtronic Australasia Pty Ltd	Commercial sensitivity	As above, section 9(2)(i).
Sentinel Events Report	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(j), 9(2)(a)

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Risk Report	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Legal Issues	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
Staff Consultation – Verbal Update	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, section 9(2)(j).

The meeting adjourned for lunch at 12.20 pm and resumed at 12.45 pm.

Mr Menzies left the meeting at 1.10 pm.

***At 2.30 pm, it* was *resolved*:**

> ***"That the Board resume in open meeting and the following resolutions passed while the public were excluded be released to the public:***
>
> **Ninth Operating Theatre, Dunedin Hospital**
>
> That the Board seek approval from the South Island Regional Capital Committee and, subject to approval being granted, approve the commissioning of a ninth operating theatre in the Main Operating Theatre Suite at an estimated capital cost of $1.6m.
>
> **Chair in Neurosurgery – ILT Funding Application**
>
> That the Board support an application to the Invercargill Licensing Trust (ILT) for a grant towards the Chair in Neurosurgery at the University of Otago."

The meeting closed at 2.35 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 29 May 2012

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
043-2011/02 59-2011/05	**Alcohol Law Reform Bill** (Minute item 9.0)	That a draft policy statement on alcohol be developed and submitted to CPHAC to provide direction to future service provision in this area, including the issue of education. Timeframe to be provided for completion of the draft policy statement.	PHS GMFF	Being progressed as part of the South Island Public Health work stream. Not complete as yet.	
044-2011/02 60-2011/05	**Smokefree Environment Amendment Bill** (Minute item 9.0)	A draft policy statement on smokefree environments to be developed and submitted to CPHAC to provide direction to future service provision in this area. Timeframe to be provided for completion of the draft policy statement.	PHS GMFF	To be progressed as part of the South Island Public Health work stream. Southern DHB does have its own policy that was created in March 2010 and is due for review in 2012.	
90-2011/12	**Wakatipu Service Planning – CT Scanner** (Minute item 8.0)	Management to proceed with the review and submit a recommendation to the Board by the June 2012 meeting.	GMFF	Report included in agenda papers.	June 2012
105-2012/05	**Financial Report** (Minute item 8.0)	▪ GMFF to liaise with ARC Chair re non-Provider Arm reporting to Board; ▪ Cash forecast to be reviewed.	GMFF	Completed.	n/a
106-2012/05	**NHB/SDHB Joint Assessment of Systems – Dunedin Hospital** (Minute item 9.0)	Column to be added to report indicating timelines and expected completion dates.	CEO/ CEOSM	Next report due to be submitted to Board in July.	

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	07 June 2012

Summary:

The issues considered in this paper are:

- Monthly DHB activity.

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	No specific implications.
Workforce:	No specific implications.
Other:	No specific implications.

Document previously submitted to:	Not applicable, report submitted directly to Board. Detailed Provider Arm information contained in HAC agenda papers and Planning & Funding information in DSAC/CPHAC agenda papers.	**Date:** 05/05/12
Approved by Chief Executive Officer:		**Date:** 30/05/12

Prepared by: CEO Support Manager GM Planning & Funding Chief Operating Officers **Date:** 30/05/12	**Presented by:** Carole Heatly Chief Executive Officer

RECOMMENDATIONS:

1. **That the Board receive the report.**

CHIEF EXECUTIVE OFFICER'S REPORT

1. DHB FINANCIAL PERFORMANCE

As at 30 April 2012 the DHB year to date result is a deficit of $4.5m, which is $1.6m better than budget. April's result was aligned with budget, but the provider result is worse than forecast by $1.3m. The key year to date (YTD) variances are outlined in the Financial Report.

The YTD net Governance result remains favourable. The Funder result YTD is favourable to budget by $4.7m, however the actual result is in deficit. The April result is unfavourable by $0.3m. Key variances are outlined in the Financial Report.

The year-end forecast is projected as a deficit of $10.2m, with a deterioration projected for the Provider result of $4.4m.

2. PROVIDER ARM

Contract Performance

- Elective **caseweights** delivered (cwd) for Southern DHB were 11.2% (117.86 cwds) above plan for April 2012. Year to date case weighted volumes are 4% (465.4 cwds) above plan.
- Health Target Elective **discharges** delivered for Southern DHB were 48 above plan for April 2012. Year to date elective discharges are 183 above plan.

Financial Performance

- An unfavourable variance of $885k was recorded in the Provider Arm for the month of April 2012. YTD the result is unfavourable by $3,409k.
- Revenue for April 2012 was favourable against budget by $99k. Expenses for April 2012 were unfavourable against plan by $984k.

3. PLANNING AND FUNDING

Mental Health & Addictions Service Development

Sector and community stakeholders have been advised of the endorsement of *Raise HOPE: Hapaia te Tumanako 2012-2015* and invited to attend a First 100 Days Forum on August 10th.

The Mental Health and Addiction Planning Project is completed. The focus of the portfolio will be to implement the plan and develop a monitoring framework to facilitate ongoing evaluation.

Primary & Community

- **Pharmacy**

The proposed changes to the Pharmacy Services Agreement were consulted on during April. Agreements are in the process of being finalised and released to pharmacies.

- **Maternity**

A workshop was held in Balclutha for all providers of maternity services, consumers of services and attended by the team from the Ministry of Health leading the development of the Maternity Quality and Safety framework. The final draft plan for the implementation of the framework is due at the beginning of July.

- **Laboratories**

Work at a national level has recommenced to create and agree a national schedule of approved tests.

- **PHO Clinical Programmes Proposal**

The Initiating Insulin, Sexual Health and CVD risk assessments programmes are gathering momentum and reporting has commenced. Numbers are still relatively low but the programmes are targeting high needs, including Maori and Pacific Island, so total numbers of eligible people are not high.

Planning work has begun to extend the very successful "Year of Care" project across the district as the Year on Year programme. Stratification of the population is part of this project and the information gathered will be useful for a number of initiatives for the District Health Board. It is important to ensure this project is heavily linked to DHB activity with home based and community services work.

- **Replacement of Get Checked in General Practice**

The funding for the Diabetes Care Improvement package will remain in Primary Care for people with diabetes. Southern PHO has consulted with General Practice and the final feedback will be incorporated into a plan which will link with the Diabetes Strategy.

- **Free Under 6 Visits After Hours**

The principles of funding for this initiative are that the funding will be based on an eligible population and will go to those who are providing the service. Southern PHO has sought input from GPs around the District and SPHO are confident that coverage will be at least 60% at the beginning of July.

- **Diabetes**

Meetings have been held with consumers and interest groups around the district to hear their views about the future of diabetes services.

Pharmac consultation documents were widely distributed about funding for a single model of glucose meter, insulin pump and consumables.

Health of Older Persons

- **Ageing in Place Strategy**

A large amount of planning work has occurred in Home Based and Community Support Services. This is discussed in the excluded agenda.

- **Wakatipu ARC Service Transition**

The DHB has reached an agreement with Bupa Care Services to operate Lake Wakatipu Home and Hospital. The 36 bed age related residential care home and hospital will transfer to Bupa on 10 June 2012. Preparations are largely finalised with the existing provider, Bupa and the DHB to ensure a seamless transition for families and residents.

- **InterRAI Assessment Tool**

Implementation of the InterRAI assessment tool continues, with the initial roll-out phase ceasing as at 30 June 2012. As outlined previously, a direct impact of the ongoing InterRAI implementation has included a significant back-log of activity within the needs assessment service coordination service, including both new referrals and reviews of existing clients. A priority of management is to address and maintain service activity going forward, including the management of the current waiting lists for new referrals and reviews. A process mapping exercise for referral and assessment activities has been completed across the six sites which has identified a number of key bottlenecks that are now being resolved. Management are also progressing the development of a strategy to progress overdue reviews across the district.

- **Dementia Respite Services**

The DHB has completed a consultation exercise regarding the development of specific Dementia Day Care Services, such as level of need for day care services, referral processes, location and aspects of service delivery.

The DHB will finalise provider specific requirements for the service and will undertake an open Request for Proposal (RFP) for the service imminently. There has been new funding provided from Government budget allocations to introduce these services.

Public & Population Health

As outlined in the CPHAC/DSAC paper, a significant amount of activity is occurring in the following areas:

- Child and youth gateway assessment programme
- Family violence intervention programme
- Sexual health services
- Tobacco control plan

Hospital & Specialist Services

Work includes the finalisation of the CT scanner business case from the DHB's perspective. Planning work is also occurring with Ranfurly Hospital, radiology services and ophthalmology services. These were highlighted in the DSAC/CPHAC agenda.

Carole Heatly
Chief Executive Officer

30 May 2012

SOUTHERN DHB FINANCIAL REPORT

Financial Report as at: **30 April 2012**
Report Prepared by: **Robert Mackway-Jones, GM Finance & Funding**
Date: **26 May 2012**

Recommendations:

- **That the Board note the Financial Report**

Overview Section

Results Summary

Month				Year to Date				Annual
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000	Forecast $' 000	Budget $' 000
70	0	70	Governance	338	0	338	410	0
(301)	(1,161)	860	Funds	(4,432)	(9,133)	4,701	(6,204)	(10,981)
(1,331)	(445)	(886)	Provider	(451)	2,958	(3,409)	(4,381)	489
(1,562)	(1,606)	44	Net Surplus / (Deficit)	(4,545)	(6,175)	1,630	(10,175)	(10,492)

- April's result was in line with budget overall, but showed a continuing decline in financial performance by the provider-arm
- YTD, the result is now a deficit of $4.5m. This remains $1.6m better than budget
- April's result was $0.5m worse than previously forecast with the provider result being $1.3m worse than forecast
- Year-end forecasts have been revised with further deterioration projected for the provider-arm result
- The overall projected operational deficit is now $10.2m (was $9.2m last month).

YTD Key Variances

The ten largest (net) unfavourable variances are:

Category	Area	YTD $'m
Otago Medical Personnel / Outsourced Costs	Provider	(3.2)
Otago Allied Health Personnel (Excluding Mental Health) Costs	Provider	(1.3)
Otago Patient Treatment Disposable Costs	Provider	(1.1)
IDF Outflow expenditure	Funder	(0.7)
Aged Residential Care expenditure	Funder	(0.7)
Otago Management / Admin Personnel Costs	Provider	(0.7)
Southland Outsourced Clinical Services expenditure	Provider	(0.7)
Otago Outsourced Clinical Services expenditure	Provider	(0.6)
Southland Instruments & Equipment expenditure	Provider	(0.4)
Community Pharmaceutical expenditure	Funder	(0.4)

The 10 largest favourable variances are:

Category	Area	YTD $'m
NGO Personal Health expenditure & miscellaneous revenues	Funder	2.9
Mental Health Personnel (revenue not paid to DHB provider)	Funder	1.2
Otago Clinical Supplies expenditure (Patient Appliances, Implants & Prosthesis, Air Ambulance)	Provider	1.1
Primary Care expenditure	Funder	0.9
Southland Medical Personnel & Medical Outsourced Costs	Provider	0.8
NGO Mental Health expenditure	Funder	0.8
Southland Nursing Personnel (Excluding Mental Health) Costs	Provider	0.7
District Facilities expenditure	Provider	0.6
Cancer Drugs expenditure (PCT)	Funder	0.6
Home Based Support expenditure	Funder	0.5

These items have commentary and further detail provided in sections 2 and 3 of this report.

Year End Forecast Summary

Year-end forecasts have been updated and are summarised below:

$'000	Prior Forecast	Forecast	Budget
Governance result	376	410	0
Funder Result	(6,456)	(6,204)	(10,981)
Provider Result	(3,153)	(4,381)	489
Projected operating result	(9,233)	(10,175)	(10,492)
Building Valuation write-downs	Likely Nil	Likely Nil	
One off investments	Up to $0.7m	$0.3m	
Projected Net Surplus / (Deficit)	($10m)	($10.3m)	($10.5m)

The key issue is the projected continued decline in the provider-arm result.

Capital Expenditure

A summary table was provided in the HAC report.

Baseline (internally funded) capital expenditure is budgeted at $45.9m in 2011/12 which includes some carry-over of $15.7m from the prior year's allocations. Of the $45.9m; $25.5m has been committed ($16.3 has been paid) leaving a residual $20.4m available. Externally funded assets include the Dunedin Master Site Planning Project, the medium secure ID unit, Oral Health. Around $13m has been paid for these projects in the current financial year.

Total cash-flow for capital is $29.8m compared to a budgeted amount of $34.4m. As shown above, this is a timing issue.

Balance Sheet and Cashflow

An unused debt facility was drawn on in March ($6.65m) to provide cash for future capital investment. We also received $9.8m of equity for the externally funding capital works in April. Deficit support of $10m has been requested.

Detail Section

The DHB is required to report on its three operational arms. These are set out in the following sections and provide supporting detail for the key variances identified in the overview section.

1. YTD DHB Governance Results

Month				Year to Date			Annual
Actual	Budget	Variance		Actual	Budget	Variance	Budget
$' 000	$' 000	$' 000		$' 000	$' 000	$' 000	$' 000
546	517	29	Revenue	5,460	5,173	287	6,209
(225)	(236)	11	Less Personnel Costs	(2,436)	(2,356)	(80)	(2,827)
(251)	(281)	30	Less Other Costs	(2,686)	(2,817)	131	(3,382)
70	0	70	Net Surplus / (Deficit)	338	0	338	0

Summary Comment:
The net result remains favourable YTD.

Additional funding has been provided to the DHB to part fund most of the activities of HBL, the agency assessing national collective opportunities. The associated costs for this are part of the Other Costs. Overall non-personnel expenditure is well below budget YTD with fees paid to SISSAL/DHBNZ, provider audits and other DHB internal and external audits all lower than plan.

2. YTD DHB Funds Results

The summary tables below have been split to show the components of the DHB funder result that are paid to the DHB provider-arm and those paid to other providers.

The DHB funds financial statement sheet attached to this report shows the line by line split of expenditure into the DHB provider and all other providers (called NGOs).

Month of April	To / From Provider-arm			To / From NGOs			Total		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000
Revenue	35,895	35,915	(20)	29,843	29,396	447	65,738	65,311	427
Less Expenses									
Personal Health	(27,670)	(27,490)	(180)	(19,307)	(19,824)	517	(46,976)	(47,314)	338
Mental Health	(4,997)	(5,112)	115	(1,901)	(2,039)	138	(6,898)	(7,150)	252
Disability Support	(1,838)	(1,838)	0	(8,795)	(8,536)	(259)	(10,633)	(10,374)	(259)
Public Health	(822)	(935)	113	(1)	(14)	13	(823)	(949)	126
Maori Health	(23)	(23)	(0)	(139)	(143)	4	(163)	(167)	4
Other	(546)	(517)	(29)	0	0	0	(546)	(517)	(29)
Expenses	(35,895)	(35,915)	20	(30,143)	(30,556)	413	(66,039)	(66,471)	432
Net Surplus / (Deficit)	(0)	0	(0)	(300)	(1,160)	860	(301)	(1,160)	859

Year to Date (April)	To / From Provider-arm			To / From NGOs			Total			Annual
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Budget
	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000
Revenue	359,480	359,240	240	296,804	293,867	2,937	656,284	653,107	3,177	783,729
Less Expenses										
Personal Health	(276,284)	(274,987)	(1,297)	(192,650)	(195,311)	2,661	(468,934)	(470,298)	1,364	(564,492)
Mental Health	(49,887)	(51,118)	1,231	(19,544)	(20,334)	790	(69,431)	(71,451)	2,020	(85,752)
Disability Support	(18,378)	(18,378)	0	(87,650)	(85,789)	(1,861)	(106,028)	(104,167)	(1,861)	(124,876)
Public Health	(9,240)	(9,353)	113	(5)	(137)	132	(9,246)	(9,490)	244	(11,388)
Maori Health	(231)	(230)	(1)	(1,387)	(1,429)	42	(1,618)	(1,660)	42	(1,993)
Other	(5,460)	(5,174)	(286)	0	0	0	(5,460)	(5,174)	(286)	(6,209)
Expenses	(359,480)	(359,240)	(240)	(301,236)	(303,000)	1,764	(660,717)	(662,240)	1,523	(794,710)
Net Surplus / (Deficit)	0	0	0	(4,432)	(9,133)	4,701	(4,433)	(9,133)	4,700	(10,981)

Within the amounts classified as “NGO’s” some payments are made via inter district flows to other DHBs. These are either for specialist services or for regional services such as some of the mental health services, e.g. Odyssey House in Christchurch which is a specialist Child & Youth residential service. Some of the payments made to the provider also could be considered to be within the remit of the Committee’s, as some payments relate to the delivery of the programmes, such as the Before Schools Checks. This is provided by the DHB provide-arm via Public Health South and the Public Health Nurses in the Well Child Service. Hence, planning & funding (and consequently the Community Advisory Committee) have an interest in the successful performance of the programme as do the provider-arm staff (and consequently HAC) delivering the service.

Also, issues such as the variance show in mental health expenditure to the provider-arm ultimately will interest the Disability Advisory Committee. The variance arises from financial claw backs as FTE positions that receive funding for the FTE input are vacant; consequently the funder claws this money back from the provider and can reinvest it in other mental health services.

Summary Comment:
The YTD result is favourable to budget by $4.7m. The year-end forecast result is expected to be better than budget by $4.8m. However it is important to note the actual result is in deficit.

Key drivers of this YTD variance include:

- $2.9m of impacts for personal health revenues and expenditure including
  - $0.5m of revenue for personal health expenditure in 10/11
  - $0.4m of lower laboratory expenditure for non-schedule testing and share of national claims from un-coded NHI events
  - $0.7m of lower than budgeted pricing impacts
  - $0.6m of “duplicated” SIA budget
  - $0.2m of lower immunisation costs (excl HPV)
- $2.0m of other favourable mental health expenditure
- $0.9m of lower net payments to PHO, mainly SIA/HP payments
- $0.6m of below budget PCT expenditure (with $0.3m rebate from 10/11 and $0.3m in hospital services)
- $0.5m of below budget home support allocations
- ($0.7m) of unfavourable IDF wash-up provision for 11/12
- ($0.4m) of higher than budgeted community pharmaceuticals expenditure (with $0.9m unfavourable from community pharmacies schedule items and $0.5m favourable from hospital pharmacies dispensing community schedule items)
- ($0.7m) of net residential care / ageing in place expenditure
- ($0.9m) of renal and cardiology test volumes paid to provider-arm (medical outpatients)

The April result was a deficit of $0.3m, this compared to the prior forecast result for a deficit of ($1m). The improvement was primarily due to higher IDF revenue ($0.3m), lower IDF outflows ($0.2m), lower screening ($0.1m) and immunisation expenditure ($0.1m).

Revenue

YTD, revenue is $3.2m above budget however the bulk of this has associated cost offsets.

Item	$'m	Expense Line Offset (Y/N/Partial)
IDF's from Canterbury for ARC	0.5	Y, DSS ARC expenditure
IDF wash-up earthquake related personal health	0.5	N, Various but 10/11
IDF wash-up for current year	0.2	N,
Oral Health business case funding	0.7	Y, School Dental Services
Dementia Funding	0.5	Y, DSS ARC Rest Homes
Long Term Conditions funding	0.8	Y, DSS, Chronic Conditions
HBL activity funding	0.2	Y, Outsourced expenses
PHO Very Low Cost Access funding	0.1	Y, PHO Other
Maternity funding	0.1	P, Maternity Services
PHO Performance Management funding	(0.5)	Y, PHO Other
HEHA funding	(0.2)	Y, Public Health Nutrition
All other revenue variances	0.3	N
Total Revenue Variation	3.2	

Expenditure

Mental Health

The $2m YTD variance has $1.2m of funding not paid to the provider-arm where funded FTE positions have not been filled. Half of the residual $0.8m of below budget expenditure to NGO's relates to the residential bed funding line with the other half resulting from a number of other contractual changes. The variance in Alcohol & Drug Child & Youth services is offset against the Child & Youth line due to purchase unit changes within a contract.

Disability Support

Rest home level residential care services has a $1.1m unfavourable variance to April. This includes the pricing impact of the additional dementia funding of $0.5m leaving a residual deficit of $0.6m. Hospital level residential care is $1m over budget. Of this $1.6m there are offsets for this expenditure in the community services line and day programmes lines ($0.4m) plus some offset with the IDF funding from Canterbury ($0.5m). The net unfavourable variance is therefore $0.7m.

Home support allocations continue to be managed within budget; the favourable financial variance is $0.5m.

Personal Health

Some of the expenditure variances are impacting the bottom line; some of the more significant ones include:

- The PHO Health line has a $1.5m has a favourable variance of which $0.9m relates to SIA/HP funds to the PHO. The residual variance is due to a duplicated SIA budget.

- The rural support line contains the budget for a number of inflationary based adjustments to contracts that will progress over the course of the year. Some of the favourable variance in this line offsets the palliative care line which includes increased hospice funding approved as well as a number of other lines. The net favourable impact is around $0.7m. Although directly unrelated, both the GMS claiming and capitation expenditure are over budget (combined $0.5m) which dilutes the impact of this variation and the discretionary allowances budgeted in the minor personal health expense line.

- Laboratory expenditure is $0.4m below budget, claiming for non-schedule tests and other budgeted allowances are below planned level reflecting the demand driven nature of this service.

- The minor personal health expenditure line contains funding for primary care after hours support and workforce development. Workforce development funding has commenced from 1 November. The after-hours funding is being used for phone triage support and some of the ED volume in various hospitals is supported by this funding line as an interim step. This line also contains a number of small allowances for discretionary/special case expenditure that to date have not been required.

- A large rebate for PCT drugs ($0.3m) is reflected in the YTD result. Actual expenditure is tracking below budget; this expenditure is paid to the provider-arm.

- The community pharmaceuticals line is over budget by $0.4m, and the total budget is based on Pharmac forecasts. We estimate a split between schedule claiming to the hospital pharmacy and other community pharmacies, the community pharmacy proportion presents as unfavourable by $0.9m and the hospital pharmacy claiming component is favourable by $0.5m. This is always somewhat of an arbitrary split.

IDF Inflows/Outflows

Inflows
IDF revenue is $1.2m favourable to budget. This is represented by $0.5m from Canterbury DHB for ARC and a further $0.5m from Canterbury DHB relating to personal health costs (Labs, Pharms, GM subsidies etc.) as a result of resident movements following the Christchurch earthquake. The 11/12 volumes and revenue has a further $0.2m favourable variance with $0.3m relating to Canterbury DHB acute/arranged volumes.

Outflows
The default IDF wash-up position with other DHBs is unfavourable by $0.1m to the end of March. The financial accounts show a variance of $0.7m; this is because the budget was adjusted downwards by $0.8m ($0.6m YTD) for lower cardiology volumes than the default position.

For the nine (one month data lag); this component is tracking $0.3m unfavourably with all other services tracking unfavourably by $0.4m which is the value of the overall acute variance.

3. DHB Provider Summary Results

Month				Year to Date			Annual
Actual	Budget	Variance		Actual	Budget	Variance	Budget
$' 000	$' 000	$' 000		$' 000	$' 000	$' 000	$' 000
39,264	39,167	97	Revenue	391,587	391,156	431	469,551
(26,824)	(25,668)	(1,156)	Less Personnel Costs	(255,207)	(251,344)	(3,863)	(304,700)
(13,771)	(13,944)	173	Less Other Costs	(136,831)	(136,854)	23	(164,362)
(1,331)	(445)	(886)	Net Surplus / (Deficit)	(451)	2,958	(3,409)	489

Summary of Result:

- The provider result continues to track significantly worse than budget and the recent forecasts

- April's deficit of $1.3m was $1.3m worse than previously projected and is $0.9m worse than budget

- The forecast has been revised further and shows further expected deterioration with a forecast deficit at year-end of $4.4m which would be $4.9m worse than budgeted

As reported to HAC, the $3.4m unfavourable variance is split as follows:

- Dunedin / Otago sites; ($4.4m) unfavourable
- Southland sites; $0.0m unfavourable
- Shared services; ($1.0m) favourable

It should be noted that the Dunedin / Otago site results does contain some regional services such as Oncology. Equally, the shared services site report contains some revenue items that are not easily allocated. Hence the site splits are indicative rather than definitive.

From the overview section, the following variances are the key ones:

Category	YTD $'m
Otago Medical Personnel / Outsourced Costs	(3.2)
Otago Allied Health Personnel (Excluding Mental Health) Costs	(1.3)
Otago Patient Treatment Disposable Costs	(1.1)
Otago Management / Admin Personnel Costs	(0.7)
Southland Outsourced Clinical Services expenditure	(0.7)
Otago Outsourced Clinical Services expenditure	(0.6)
Southland Instruments & Equipment expenditure	(0.4)

Fortunately, some financial buffer is provided by the following items:

Category	YTD $'m
Otago Clinical Supplies expenditure (Patient Appliances, Implants & Prosthesis, Air Ambulance)	1.1
Southland Medical Personnel & Medical Outsourced Costs	0.8
Southland Nursing Personnel (Excluding Mental Health) Costs	0.7
District Facilities expenditure	0.6

Revenue

Overall revenue has a $0.4m favourable variation; however there are some larger underlying differences to budget as shown below:

Item	$'m	Expense Line Offset (Y/N/Partial)
Medium Secure ID Unit funding	(0.2)	Y, Salaries (nursing) & expenses
Mental Health funding (Internal Revenue)	(1.2)	Y, Salaries (Nursing, Allied mainly)
Community Pharms + PCT Claiming (Internal Rev)	(0.7)	Y, Pharmaceuticals
Renal / Cardiology funding (Internal Revenue)	0.9	N, but costs in existing budgets, offset is in funder result (no DHB consolidated impact)
Oral Health funding	0.7	P, Salaries and supplies
Non-Resident revenues	0.6	P, Clinical supplies & bad debts
SSC Kiwi saver subsidies	0.4	Y, Salaries
All other revenue variances	(0.1)	N
Total Revenue Variation	0.4	

Personnel Costs

April's FTE was 49 unfavourable to budget (32 unfavourable in March) driven by RMOs and Nursing. Whilst components of this FTE can be offset by cost decreases or revenue increases, this level of FTE places the DHB at risk not only for the current year, but the next financial year if the FTE levels were to continue (2012/13 budget = 3,606FTE). FTE levels have risen by 120 since the start of the financial year with a 73 FTE increase in the four months from January. The growth results from a combination of areas recruiting to vacancies, services planned starting later than

originally budgeted (eg medium secure ID unit) and some unbudgeted FTE positions in response to service demands.

A summary of salary variances and FTE by staff type is provided below:

Site FTE Variance Analysis

	Monthly FTE Variance				YTD FTE Variance			
Description	Otago	Southland	Shared	Total Provider	Otago	Southland	Shared	Total Provider
Medical	(16)	(7)	0	**(23)**	(11)	(4)	0	**(15)**
Nursing	(26)	(8)	(0)	**(35)**	8	3	0	**11**
Allied Health	(12)	19	(0)	**7**	1	18	(0)	**18**
Support	(5)	5	8	**8**	(2)	3	4	**5**
Mgmt / Admin	(5)	(7)	6	**(6)**	(4)	(1)	7	**1**
Total	**(65)**	**2**	**14**	**(49)**	**(8)**	**19**	**10**	**21**

Site $ Variance Analysis

	Monthly $000s Variance				YTD $000s Variance			
Description	Otago	Southland	Shared	Total Provider	Otago	Southland	Shared	Total Provider
Medical	(347)	(10)	(1)	**(357)**	(3,159)	(625)	(11)	**(3,795)**
Nursing	(328)	(162)	3	**(488)**	466	529	78	**1,073**
Allied Health	(235)	92	(3)	**(146)**	(990)	699	(19)	**(310)**
Support	(24)	(13)	0	**(37)**	(151)	1	63	**(87)**
Mgmt / Admin	(84)	(66)	19	**(131)**	(742)	(244)	239	**(746)**
Total	**(1,018)**	**(159)**	**18**	**(1,159)**	**(4,576)**	**361**	**350**	**(3,865)**

- **Medical** – largely due to increase in RMO numbers, with partial offset in Southland outsourcing costs.

- **Nursing** – 35 FTE over budget for the month as above, a component in each site. Hospitals are seen as being very busy. This is flowing on to a reduction in annual leave taken which is also adding to the negative $ variance.

- **Allied Health** – driven by Otago, with increasing FTE now being > budget. Vacancy factor that was previously relied upon has been eroded. Apparent issue with YTD annual leave not being taken to levels required adding to the YTD $ variance.

- **Management / Admin** – unfavourable $ variance driven by higher FTE levels, lump sum award settlement impacting YTD variances and YTD annual leave not being taken to budget.

As shown above there is a material negative FTE and $ variance for the month, that continues the recent trend. Although the YTD FTE position is favourable by 21 FTE, the YTD $ variance is now $3.8m over budget and forecast to further deteriorate. A significant component of the salary variances relates to annual leave (table below) which is $2.6m unfavourable to budget.

	Monthly Variance		YTD Variance		Budgeted YTD	
	FTE	$000s	FTE	$000s	FTE	Variance %
SMO	12.5	185,419	-2.8	- 414,028	35.4	-7.9%
RMO	-9.8	- 86,191	-5.7	- 499,835	35.3	-16.0%
Nursing	-10.0	- 52,922	-13.0	- 683,821	201.7	-6.4%
Allied	22.9	114,924	-13.0	- 651,035	100.2	-12.9%
Support	-9.3	- 32,934	-2.1	- 72,988	24.3	-8.4%
Mgmt / Admin	29.9	132,843	-8.1	- 358,340	92.3	-8.7%
		261,140		**- 2,680,047**		**-9.1%**

One factor that impacts the DHB from year to year is the level of annual leave taken to budget. The budgeting process assumes every employee will take their annual allocation of leave each year. Over the last few years standard allocations have increased from 4 to 5 weeks leave after 5 years service for most staff types. Leave management is now a focus to alleviate these on-going variances.

We currently have $28m of leave liabilities on the balance sheet. Of this, annual leave accounts for 22.7m (excluding joint clinical staff). The table below shows the dollar value by staff category and the hours. The table shows balances from February to April 2012. This establishes the baseline data for monitoring purposes.

We are investigating if the system can generate a historic report from April 2011, as the periods after January are likely to be the lowest point for leave balances. This is reflected in the "average weeks" column by staff category where all are either equal or less than one years entitlement for those staff groups. The DHB allows leave to be taken as it accrues (ie it has not vested to the employee yet); otherwise the likely holding could be one years entitlement (vested on employee anniversary date) plus accrued leave in the current year. The movement in April was an increase of $0.5m which will be an unfavourable variance in the monthly payroll accounts.

Employee Annual Leave Liability reports							
	Closing February	Closing March	Closing April	Movement April			
1. Medical SMO	4,306,511.47	4,533,500.00	4,573,400.46	39,900.46			
1. Medical MOSS	315,639.92	345,226.53	360,255.98	15,029.45			
1. Medical RMO	1,068,773.71	1,159,711.95	1,238,736.17	79,024.22			
1. Medical House Officers	144,665.43	164,712.58	196,368.50	31,655.92			
2. Nursing	9,070,253.47	9,236,123.22	9,417,105.14	180,981.92			
3. Allied	2,789,682.23	2,909,380.99	3,022,714.85	113,333.86			
4. Support	756,082.01	768,965.71	790,061.66	21,095.95			
5. Management Admin	3,066,432.81	3,120,091.66	3,126,347.90	6,256.24			
Totals	**21,518,041.05**	**22,237,712.64**	**22,724,990.66**	**487,278.02**			
Hours	Closing February	Closing March	Closing April	Movement April	YTD FTE	Avg Hours	Avg Weeks
Senior Doctors	47,909.44	48,983.66	49,192.52	208.86	198	249	6.2
RMO & House Officers	20,654.05	22,227.58	24,171.64	1,944.06	238	102	2.5
Nursing	250,551.08	254,773.89	258,684.19	3,910.30	1,536	168	4.2
Allied	81,856.81	85,752.62	88,590.85	2,838.23	667	133	3.3
Support	31,674.22	32,045.47	32,711.83	666.37	187	175	4.4
Management / Admin	100,721.59	102,845.66	103,579.28	733.62	687	151	3.8
Totals	**533,367.19**	**546,628.87**	**556,930.31**	**10,301.43**	**3,512.21**		

Robert Mackway-Jones:
YTD FTE less overtime generated FTE

Non Personnel Expenditure

Outsourced

YTD outsourced costs have over-run budget parameters by $0.4m.The outsourced medical line ($1.1m below budget) needs to be considered alongside the medical salary costs, and the favourable result for this line is positive as there are more permanent doctors recruited.

The outsourced clinical services line (over budget by $1.3m) relates to activity being undertaken outside of the provider arm facilities with private providers, the use of this line has once again contributed to the overspend for the month. The monthly overspend relates to the reduction of long wait patients with YTD overspend including outsourced radiology costs in both Otago and Southland.

Clinical Supplies

Clinical supplies costs overall are $0.3m above budget, however there are some large favourable and unfavourable variances in the underlying categories.

Treatment disposable costs are $0.9m higher than budget YTD. This result reflects higher than budgeted blood products ($330k), continence and hygiene supplies ($189k), renal supplies ($299k) and dressing costs ($177k) (treatment disposables).

Instruments and Equipment are $0.7m over budget YTD. Disposable instruments costs are over plan due to a move to more disposable use and laparoscopic type surgery there is a small offset with a change in coding from patient consumables. Minor clinical equipment also over YTD due to increased acute activity in main operating theatres and more ERCPs being performed in gastroenterology.

Pharmaceutical costs are $0.6m lower than plan which is offset by reduced revenue claiming from the funder. The bulk of the variance relates to PCT drugs.

Implants and prosthesis are favourable YTD by $0.2m due to lower hip and knee prostheses costs incurred compared to plan but this is still seen as a timing issue related to volume delivery.

Other clinical supplies are $0.4m lower than budget and mainly due to air ambulance transfer being lower than anticipated. Health promotion costs are also tracking below budget with a corresponding revenue decrease.

Infrastructure & Non-Clinical
This category overall is $0.7m below budget.

Facilities costs YTD are favourable by $0.7m. This is a result of lower than budgeted utility costs $431k (electricity, steam, gas and water), lower maintenance costs $313k, lower building and plant depreciation $231k, offset partially by increased insurance costs which are unfavourable YTD by $288k.

The YTD position for Information Technology Systems and Telecommunications is a $0.3m unfavourable variance against budget. Depreciation is $159k greater than budget YTD and telecommunication costs are $70k above budget due to mobile phone charges, repairs and maintenance and minor purchase costs being greater than plan.

YTD Professional fees and expenses are within planned parameters by $0.4m. Lower expenditure against consultant fees and affiliation fees than what was budgeted for.

YTD other operating expenses are on budget, the major variance in this area is the doubtful debt provision which is $0.3m over budget. While this has increased non-resident revenue, where the debt is uncollectable, there is a net cost to the DHB. Unrelated but offsetting, are underspends in stationery, printing, books and corporate training.

4. Year End Forecast Detail

Funder Forecast
The funder YE result projection is for a deficit of $6.2m. This is an improvement over the prior forecast by $0.2m.

Funder-arm Forecast	YTD	May	June	YE
Actual & Forecast Result	(4,432)	(1,381)	(391)	(6,203)
Funder Budget	(9,133)	(1,109)	(739)	(10,981)

The $4.8m projected improved result to budget is attributable to the key variances listed in the funder detail section. Items with some potential variability include acute IDF inflows and outflows and elective services funding dependent on all volume targets and ESPI compliance).

Some deterioration is projected to the current IDF position and increased immunisation costs in the last two months, which is why overall the forecast result is very close to the budget for the last two months.

Provider Forecast

The expected result has deteriorated further to a likely deficit of $4.4m

Provider-arm Forecast	YTD	May	June	YE
Actual & Forecast Result	(451)	(3,035)	(895)	(4,381)
Provider Budget	2,958	(1,969)	(500)	489

The provider forecast has a range of potential results from a deficit $3.8m (best case) through to $5.5m (worse case). Key areas that will impact this are;

- receipt of additional funding ($0.6m) for ESPI compliance and associated costs required to meet this target (funding is at risk if targets not met)
- movement in actuarial valuation from budget ($1m forecast = budget)
- the trend in FTE and associated payroll costs

The table below summarises the last 3 months of actual results and the 2 forecast months:

	Feb			March			April			May			June		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance	Forecast	Budget	Variance
Revenue	39,346	39,081	265	39,334	39,105	229	39,266	39,167	99	39,266	39,050	216	39,994	39,345	649
Medical	(8,270)	(7,403)	(867)	(8,881)	(7,893)	(988)	(7,939)	(7,583)	(356)	(8,703)	(8,246)	(457)	(7,942)	(7,704)	(238)
Nursing	(9,580)	(9,557)	(23)	(9,962)	(9,822)	(140)	(10,797)	(10,310)	(487)	(10,186)	(10,259)	73	(10,456)	(10,418)	(38)
Allied	(3,924)	(3,640)	(284)	(4,126)	(4,044)	(82)	(4,019)	(3,872)	(147)	(4,708)	(4,341)	(367)	(3,990)	(4,112)	122
Support	(735)	(764)	29	(786)	(791)	5	(819)	(782)	(37)	(832)	(839)	7	(797)	(806)	9
Management Admin	(3,505)	(3,063)	(442)	(3,253)	(3,290)	37	(3,253)	(3,122)	(131)	(3,412)	(3,416)	4	(3,270)	(3,198)	(72)
Total Personnel	(26,014)	(24,427)	(1,587)	(27,008)	(25,840)	(1,168)	(26,827)	(25,669)	(1,158)	(27,841)	(27,101)	(740)	(26,455)	(26,238)	(217)
Outsourced Costs	(1,587)	(1,511)	(76)	(1,299)	(1,581)	282	(1,839)	(1,558)	(281)	(1,833)	(1,531)	(302)	(1,838)	(1,560)	(278)
Clinical Supplies	(6,392)	(6,362)	(30)	(6,633)	(6,662)	29	(6,387)	(6,691)	304	(6,733)	(6,594)	(139)	(6,702)	(6,475)	(227)
Infrastructure	(5,429)	(5,587)	158	(5,670)	(5,957)	287	(5,544)	(5,695)	151	(5,894)	(5,798)	(96)	(5,894)	(5,603)	(291)
Total Expenses	(39,422)	(37,887)	(1,535)	(40,610)	(40,040)	(570)	(40,597)	(39,613)	(984)	(42,301)	(41,024)	(1,277)	(40,889)	(39,876)	(1,013)
Net Surplus/ (Deficit)	(76)	1,194	(1,270)	(1,276)	(935)	(341)	(1,331)	(446)	(885)	(3,035)	(1,974)	(1,061)	(895)	(531)	(364)

A couple or large items kick in during May & June. In May the impact of around $0.6m for the lump sum settlements in Allied and Nursing will be paid. The June projected result includes $1m of budgeted costs for increases in employee entitlement revaluations, this is primarily around grand-parented gratuity entitlement clauses in various agreements. The last 2 months will also seeing increasing activity in facilities maintenance where activity has been deferred due to the team being involved in other large capital projects.

5. Financial Statements

The following financial statements are attached:

- Governance result
- Provider-arm result
- Funder result
- Funder result with expenditure split between DHB provider and all other providers
- Balance Sheet
- Cashflow statement

Southern District Health Board

Apr-12

Part 1: DHB Governance and Funding Administration	Current Month Actual $(000)	Current Month Budget $(000)	Current Month Variance $(000)	Current Month Variance %	Year to Date Actual $(000)	Year to Date Budget $(000)	Year to Date Variance $(000)	Year to Date Variance %	Annual Budget $(000)
Part 1.1: Statement of Financial Performance									
REVENUE									
Government and Crown Agency sourced									
Internal - DHB Funder to DHB Provider	546	517	29 F	6%	5,460	5,174	286 F	6%	6,209
Other DHB's	-	-			-	-			-
Other Government	-	-			-	-			-
Government and Crown Agency Sourced Total	**546**	**517**	**29 F**	**6%**	**5,460**	**5,174**	**286 F**	**6%**	**6,209**
Other Income	-	-			-	-			-
REVENUE TOTAL	**546**	**517**	**29 F**	**6%**	**5,460**	**5,174**	**286 F**	**6%**	**6,209**
EXPENSES									
Personnel Expenses									
Medical Personnel	(13)	-	(13) U		(81)	-	(81) U		-
Nursing Personnel	(1)	-	(1) U		(8)	-	(8) U		-
Allied Health Personnel	-	-			-	-			-
Support Services Personnel	-	-			-	-			-
Management / Admin Personnel	(206)	(236)	30 F	13%	(2,342)	(2,356)	14 F	1%	(2,827)
Personnel Costs Total	**(219)**	**(236)**	**16 F**	**7%**	**(2,430)**	**(2,356)**	**(75) U**	**(3%)**	**(2,827)**
Outsourced Expenses									
Medical Personnel	-	-			-	-			-
Nursing Personnel	-	-			-	-			-
Allied Health Personnel	-	-			-	-			-
Support Personnel	-	-			-	-			-
Management / Administration Personnel	-	(1)	1 F		-	(14)	14 F		(17)
Outsourced Clinical Services	-	-			-	-			-
Outsourced Corporate / Governance Services	-	-			-	-			-
Outsourced Funder Services	(16)	(69)	53 F	77%	(144)	(690)	546 F	79%	(828)
Outsourced Services Total	**(16)**	**(70)**	**55 F**	**78%**	**(144)**	**(704)**	**560 F**	**80%**	**(845)**
Clinical Supplies									
Treatment Disposables	-	-			-	-		(216%)	-
Diagnostic Supplies & Other Clinical Supplies	-	-			-	-			-
Instruments & Equipment	-	-			-	-			-
Patient Appliances	-	-			-	-			-
Implants & Prosthesis	-	-			-	-			-
Pharmaceuticals	-	-			-	-			-
Other Clinical Supplies	-	-			-	-			-
Clinical Supplies Total	**-**	**-**			**-**	**-**		**(384%)**	**-**
Infrastructure & Non Clinical Expenses									
Hotel Services, Laundry & Cleaning	(1)	(3)	2 F	55%	(18)	(31)	14 F	44%	(37)
Facilities	-	-			-	-			-
Transport	(28)	(12)	(16) U	(129%)	(139)	(122)	(17) U	(14%)	(147)
IT Systems & Telecommunications	(5)	(7)	2 F	34%	(50)	(71)	21 F	29%	(85)
Interest & Financing Charges	(21)	(26)	5 F	18%	(214)	(262)	48 F	18%	(314)
Professional Fees & Expenses	(97)	(107)	10 F	9%	(1,271)	(1,071)	(200) U	(19%)	(1,285)
Other Operating Expenses	(11)	(15)	4 F	29%	(136)	(152)	16 F	10%	(183)
Democracy	(43)	(41)	(2) U	(6%)	(379)	(405)	26 F	6%	(486)
Subsidiaries & Joint Ventures	(35)	-	(35) U		(341)	-	(341) U		-
Infrastructure & Non-Clinical Supplies Total	**(241)**	**(211)**	**(30) U**	**(14%)**	**(2,547)**	**(2,114)**	**(433) U**	**(20%)**	**(2,537)**
Internal Allocations	-	-			-	-			-
Other	-	-			-	-			-
Total Expenses	**(476)**	**(517)**	**42 F**	**8%**	**(5,122)**	**(5,174)**	**52 F**	**1%**	**(6,209)**
Net Surplus/ (Deficit)	**70**	**-**	**70 F**		**338**	**-**	**338 F**		**-**
Zero Check	-	-			-	-			-
Interest Costs from CHFA	-	-			-	-			-
Capital Charge	-	-			-	-			-
Part 1.2 : Full Time Equivalent Numbers									
Medical Personnel	1	-			1	-			-
Nursing Personnel	-	-			-	-			-
Allied Health Personnel	-	-			-	-			-
Support Personnel	-	-			-	-			-
Management / Adminstration Personnel	24	22			22	22			22
Total Full Equivalents (FTE's)	25	22			23	22			22

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Southern District Health Board

Apr-12

Part 2: DHB provider	Current Month Actual $(000)	Current Month Budget $(000)	Current Month Variance $(000)	Current Month Variance %	Year to Date Actual $(000)	Year to Date Budget $(000)	Year to Date Variance $(000)	Year to Date Variance %	Annual Budget $(000)
Part 2.1: Statement of Financial Performance									
REVENUE									
Ministry of Health									
MoH - Personal Health	(20)	129	(149) U	(116%)	23	554	(532) U	(96%)	738
MoH - Mental Health	-	-			-	-			-
MoH - Public Health	10	24	(13) U	(56%)	105	238	(133) U	(56%)	286
MoH - Disability Support Services	766	741	25 F	3%	7,188	7,409	(220) U	(3%)	8,890
MoH - Maori Health	-	-			-	-			-
Clinical Training Agency	704	531	173 F	32%	5,394	5,315	79 F	1%	6,378
Internal - DHB Funder to DHB Provider	35,349	35,398	(48) U		354,020	354,065	(45) U		424,861
Ministry of Health Total	**36,810**	**36,823**	**(13) U**		**366,730**	**367,581**	**(851) U**		**441,153**
Other Government									
Other DHB's	19	25	(6) U	(24%)	258	246	12 F	5%	295
Training Fees and Subsidies	26	9	16 F	173%	191	93	98 F	105%	112
Accident Insurance	764	735	29 F	4%	7,151	7,268	(117) U	(2%)	8,793
Other Government	485	368	117 F	32%	3,907	3,684	224 F	6%	4,420
Other Government Total	**1,294**	**1,138**	**156 F**	**14%**	**11,508**	**11,291**	**216 F**	**2%**	**13,621**
Government and Crown Agency Total	**38,104**	**37,961**	**143 F**		**378,237**	**378,872**	**(635) U**		**454,774**
Other Revenue									
Patient / Consumer Sourced	256	253	3 F	1%	3,105	2,601	504 F	19%	3,089
Other Income	906	954	(47) U	(5%)	10,247	9,683	563 F	6%	11,688
Other Revenue Total	**1,162**	**1,206**	**(44) U**	**(4%)**	**13,352**	**12,284**	**1,068 F**	**9%**	**14,777**
REVENUE TOTAL	**39,266**	**39,167**	**99 F**		**391,589**	**391,156**	**433 F**		**469,551**
EXPENSES									
Personnel Expenses									
Medical Personnel	(7,939)	(7,583)	(357) U	(5%)	(80,187)	(76,392)	(3,795) U	(5%)	(92,355)
Nursing Personnel	(10,798)	(10,310)	(488) U	(5%)	(96,848)	(97,922)	1,073 F	1%	(118,599)
Allied Health Personnel	(4,018)	(3,872)	(146) U	(4%)	(38,431)	(38,121)	(310) U	(1%)	(46,574)
Support Services Personnel	(819)	(782)	(37) U	(5%)	(7,700)	(7,613)	(87) U	(1%)	(9,258)
Management / Admin Personnel	(3,253)	(3,122)	(131) U	(4%)	(32,043)	(31,297)	(746) U	(2%)	(37,911)
Personnel Costs Total	**(26,827)**	**(25,668)**	**(1,159) U**	**(5%)**	**(255,209)**	**(251,344)**	**(3,865) U**	**(2%)**	**(304,697)**
Outsourced Expenses									
Medical Personnel	(866)	(918)	52 F	6%	(8,112)	(9,208)	1,097 F	12%	(11,053)
Nursing Personnel	(28)	(2)	(25) U		(52)	(25)	(27) U	(107%)	(30)
Allied Health Personnel	(39)	(13)	(26) U	(193%)	(229)	(136)	(93) U	(69%)	(163)
Support Personnel	(36)	(22)	(14) U	(66%)	(209)	(221)	12 F	5%	(265)
Management / Administration Personnel	(3)	(2)	(1) U	(24%)	(123)	(23)	(99) U	(423%)	(28)
Outsourced Clinical Services	(777)	(524)	(253) U	(48%)	(6,367)	(5,071)	(1,296) U	(26%)	(6,023)
Outsourced Corporate / Governance Services	(89)	(77)	(12) U	(16%)	(776)	(800)	23 F	3%	(962)
Outsourced Funder Services	-	-			-	-			-
Outsourced Services Total	**(1,839)**	**(1,559)**	**(280) U**	**(18%)**	**(15,868)**	**(15,484)**	**(383) U**	**(2%)**	**(18,524)**
Clinical Supplies									
Treatment Disposables	(2,294)	(2,359)	65 F	3%	(23,709)	(22,775)	(934) U	(4%)	(27,645)
Diagnostic Supplies & Other Clinical Supplies	(138)	(150)	11 F	8%	(1,509)	(1,442)	(68) U	(5%)	(1,717)
Instruments & Equipment	(1,371)	(1,242)	(130) U	(10%)	(12,761)	(12,003)	(757) U	(6%)	(14,375)
Patient Appliances	(173)	(193)	20 F	10%	(1,634)	(1,907)	273 F	14%	(2,312)
Implants & Prosthesis	(824)	(850)	26 F	3%	(7,930)	(8,125)	194 F	2%	(9,730)
Pharmaceuticals	(1,411)	(1,626)	215 F	13%	(15,075)	(15,702)	626 F	4%	(18,728)
Other Clinical Supplies	(175)	(271)	96 F	36%	(2,212)	(2,615)	403 F	15%	(3,130)
Clinical Supplies Total	**(6,387)**	**(6,691)**	**304 F**	**5%**	**(64,831)**	**(64,568)**	**(263) U**		**(77,637)**
Infrastructure & Non Clinical Expenses									
Hotel Services, Laundry & Cleaning	(1,018)	(1,058)	40 F	4%	(10,458)	(10,623)	165 F	2%	(12,760)
Facilities	(1,679)	(1,789)	111 F	6%	(16,064)	(16,738)	674 F	4%	(20,332)
Transport	(410)	(328)	(82) U	(25%)	(3,282)	(3,161)	(121) U	(4%)	(3,814)
IT Systems & Telecommunications	(778)	(854)	76 F	9%	(8,723)	(8,432)	(290) U	(3%)	(10,140)
Interest & Financing Charges	(1,235)	(1,088)	(148) U	(14%)	(12,045)	(11,925)	(121) U	(1%)	(14,148)
Professional Fees & Expenses	(130)	(141)	11 F	8%	(1,073)	(1,437)	364 F	25%	(1,718)
Other Operating Expenses	(296)	(437)	141 F	32%	(4,487)	(4,486)	(1) U		(5,289)
Democracy	-	-			-	-			-
Subsidiaries & Joint Ventures	-	-			-	-			-
Infrastructure & Non-Clinical Supplies Total	**(5,545)**	**(5,695)**	**150 F**	**3%**	**(56,132)**	**(56,801)**	**669 F**	**1%**	**(68,202)**
Other Costs and Internal Allocations	-	-			-	-			-
Total Expenses	**(40,597)**	**(39,613)**	**(985) U**	**(2%)**	**(392,040)**	**(388,198)**	**(3,842) U**	**(1%)**	**(469,060)**
Net Surplus/ (Deficit)	**(1,331)**	**(445)**	**(886) U**	**(199%)**	**(451)**	**2,958**	**(3,410) U**	**(115%)**	**491**

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Southern District Health Board

Apr-12

Part 2: DHB provider	Current Month Actual $(000)	Current Month Budget $(000)	Current Month Variance $(000)	Current Month Variance %	Year to Date Actual $(000)	Year to Date Budget $(000)	Year to Date Variance $(000)	Year to Date Variance %	Annual Budget $(000)
Zero Check	-	-			-	-			-
Part 2.1 A: Supplementary Information to Statement of Financial Performance									
Depreciation - Clinical Equipment	(685)	(710)	25 F	4%	(6,842)	(6,941)	99 F	1%	(8,287)
Depreciation - Non Res Buildings & Plant	(615)	(680)	65 F	10%	(6,018)	(6,249)	231 F	4%	(7,609)
Depreciation - Motor Vehicles	(4)	(14)	10 F	71%	(39)	(104)	65 F	62%	(131)
Depreciation - Information Technology	(324)	(318)	(6) U	(2%)	(3,237)	(3,078)	(159) U	(5%)	(3,715)
Depreciation - Other Equipment	(55)	(61)	6 F	10%	(560)	(593)	33 F	6%	(715)
Total Depreciation	(1,683)	(1,783)	101 F	6%	(16,696)	(16,965)	269 F	2%	(20,458)
Interest Cost from Funder Loans	-	-			-	-			-
Interest Costs from CHFA	(456)	(399)	(56) U	(14%)	(4,126)	(4,065)	(61) U	(2%)	(4,877)
Financing Component of Operating Leases	(19)	(32)	13 F	40%	(246)	(326)	81 F	25%	(392)
Capital Charge	(753)	(649)	(104) U	(16%)	(7,604)	(7,460)	(144) U	(2%)	(8,792)
Part 1.2 : Full Time Equivalent Numbers									
Medical Personnel	474	451			468	452			452
Nursing Personnel	1,597	1,563			1,553	1,564			1,564
Allied Health Personnel	690	697			678	696			696
Support Personnel	191	199			190	195			196
Management / Administration Personnel	675	669			667	669			669
Total Full Time Equivalents (FTE's)	3,627	3,578			3,555	3,576			3,576

Southern District Health Board

Apr-12

Part 3: DHB Funds	Current Month Actual $(000)	Current Month Budget $(000)	Current Month Variance $(000)	Current Month Variance %	Year to Date Actual $(000)	Year to Date Budget $(000)	Year to Date Variance $(000)	Year to Date Variance %	Annual Budget $(000)
Part 3.1: Statement of Financial Performance									
REVENUE									
Ministry of Health									
MoH - Vote Health Non Mental Health	53,694	53,438	256 F		536,938	534,383	2,556 F		641,259
MoH - Vote Health Mental Health	6,946	6,945	1 F		69,456	69,448	8 F		83,338
PBF Adjustments	-	-			-	-			-
MoH Funding Subcontracts	2,822	2,983	(161) U	(5%)	29,199	29,826	(627) U	(2%)	35,791
Ministry of Health Total	**63,461**	**63,366**	**96 F**		**635,594**	**633,657**	**1,937 F**		**760,388**
Other Government									
IDF's - Mental Health Services	151	151			1,514	1,514			1,817
IDF's - All others (non Mental health)	2,125	1,794	331 F	18%	19,176	17,936	1,240 F	7%	21,524
Other Government Total	**2,276**	**1,945**	**331 F**	**17%**	**20,690**	**19,451**	**1,240 F**	**6%**	**23,341**
REVENUE TOTAL	**65,738**	**65,311**	**427 F**	**1%**	**656,284**	**653,107**	**3,177 F**		**783,729**
EXPENSES									
Outsourced Expenses									
Outsourced Funder Services	(546)	(517)	(29) U	(6%)	(5,460)	(5,174)	(286) U	(6%)	(6,209)
Payments to Providers									
Personal Health									
Child and Youth	(449)	(339)	(110) U	(32%)	(3,568)	(3,392)	(177) U	(5%)	(4,070)
Laboratory	(2,519)	(2,584)	65 F	3%	(25,421)	(25,841)	419 F	2%	(31,009)
Infertility Treatment Services	(94)	(94)			(940)	(940)			(1,128)
Maternity	(201)	(200)	(1) U	(1%)	(2,020)	(1,991)	(29) U	(1%)	(2,390)
Maternity (Tertiary & Secondary)	(1,428)	(1,456)	28 F	2%	(14,538)	(14,551)	14 F		(17,464)
Pregnancy and Parenting Education	(9)	(10)	1 F	13%	(81)	(99)	18 F	18%	(119)
Maternity Payment Schedule	-	-			-	-			-
Neo Natal	(672)	(672)			(6,720)	(6,720)			(8,064)
Sexual Health	(95)	(97)	2 F	2%	(954)	(969)	16 F	2%	(1,163)
Adolescent Dental Benefit	(223)	(264)	41 F	16%	(1,911)	(2,064)	153 F	7%	(2,539)
Other Dental Services	-	-			-	-			-
Dental - Low Income Adult	(147)	(77)	(70) U	(92%)	(888)	(764)	(125) U	(16%)	(917)
Child (School) Dental Services	(565)	(548)	(17) U	(3%)	(6,080)	(5,422)	(658) U	(12%)	(6,524)
Secondary / Tertiary Dental	(256)	(259)	3 F	1%	(2,561)	(2,577)	16 F	1%	(3,095)
Pharmaceuticals	(6,372)	(6,202)	(169) U	(3%)	(65,830)	(65,405)	(425) U	(1%)	(78,694)
Pharmaceutical Cancer Treatment Drugs	(338)	(352)	14 F	4%	(2,901)	(3,517)	616 F	18%	(4,220)
Management Referred Services	-	-			-	-			-
General Medical Subsidy	(132)	(102)	(30) U	(30%)	(1,387)	(1,067)	(320) U	(30%)	(1,344)
Primary Practice Services - Capitated	(3,307)	(3,255)	(51) U	(2%)	(32,759)	(32,553)	(207) U	(1%)	(39,063)
Primary Health Care Strategy - Care	(240)	(263)	23 F	9%	(2,501)	(2,626)	125 F	5%	(3,151)
Primary Health Care Strategy - Health	(150)	(469)	319 F	68%	(1,395)	(2,865)	1,471 F	51%	(3,195)
Primary Health Care Strategy - Other	(209)	(287)	78 F	27%	(2,365)	(2,881)	516 F	18%	(3,454)
Practice Nurse Subsidy	(15)	(18)	2 F	14%	(166)	(177)	11 F	6%	(211)
Rural Support for Primary Health Pro	(1,204)	(1,365)	162 F	12%	(12,464)	(13,654)	1,191 F	9%	(16,385)
Immunisation	(482)	(594)	111 F	19%	(1,817)	(2,145)	328 F	15%	(2,596)
Radiology	(406)	(400)	(6) U	(2%)	(4,057)	(3,996)	(61) U	(2%)	(4,796)
Palliative Care	(402)	(391)	(11) U	(3%)	(4,261)	(3,907)	(354) U	(9%)	(4,689)
Meals on Wheels	(55)	(58)	4 F	6%	(553)	(585)	31 F	5%	(702)
Domicilary & District Nursing	(1,502)	(1,444)	(58) U	(4%)	(14,721)	(14,440)	(281) U	(2%)	(17,328)
Community based Allied Health	(573)	(594)	21 F	4%	(5,730)	(5,939)	209 F	4%	(7,127)
Chronic Disease Management and Educa	(272)	(250)	(22) U	(9%)	(2,444)	(2,497)	54 F	2%	(2,997)
Medical Inpatients	(5,418)	(5,394)	(24) U		(54,013)	(53,940)	(73) U		(64,728)
Medical Outpatients	(3,426)	(3,332)	(94) U	(3%)	(34,264)	(33,320)	(945) U	(3%)	(39,984)
Surgical Inpatients	(10,052)	(10,056)	4 F		(100,521)	(100,563)	42 F		(120,676)
Surgical Outpatients	(1,726)	(1,703)	(23) U	(1%)	(17,076)	(17,027)	(49) U		(20,432)
Paediatric Inpatients	(621)	(621)			(6,212)	(6,212)			(7,454)
Paediatric Outpatients	(337)	(337)			(3,375)	(3,375)			(4,050)
Pacific Peoples' Health	(10)	(10)			(97)	(97)			(117)
Emergency Services	(1,533)	(1,533)			(15,330)	(15,329)	(2) U		(18,394)
Minor Personal Health Expenditure	(49)	(101)	52 F	52%	(445)	(1,006)	560 F	56%	(1,207)
Price adjusters and Premium	908	894	14 F	2%	9,010	8,936	74 F	1%	10,723
Travel & Accomodation	(341)	(364)	22 F	6%	(3,702)	(3,636)	(66) U	(2%)	(4,363)
Inter District Flow Personal Health	(2,055)	(2,115)	60 F	3%	(21,878)	(21,147)	(731) U	(3%)	(25,376)
Personal Health Total	**(46,976)**	**(47,314)**	**338 F**	**1%**	**(468,934)**	**(470,298)**	**1,364 F**		**(564,492)**

Printed: 1/06/2012 10:02 a.m.

Southern District Health Board

Apr-12

Part 3: DHB Funds	Current Month				Year to Date				Annual
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Budget $(000)
Mental Health									
Mental Health to allocate	-	-			-	-			-
Acute Mental Health Inpatients	(1,268)	(1,268)			(12,683)	(12,683)			(15,219)
Sub-Acute & Long Term Mental Health	(354)	(354)			(3,539)	(3,539)			(4,247)
Crisis Respite	(25)	(34)	8 F	24%	(254)	(336)	82 F	24%	(404)
Alcohol & Other Drugs - General	(293)	(346)	54 F	15%	(3,301)	(3,461)	160 F	5%	(4,153)
Alcohol & Other Drugs - Child & Youth	(48)	(107)	59 F	55%	(668)	(1,067)	399 F	37%	(1,282)
Methadone	(92)	(92)			(915)	(915)			(1,098)
Dual Diagnosis - Alcohol & Other Drugs	-	(7)	7 F	106%	(59)	(69)	10 F	14%	(83)
Dual Diagnosis - MH/ID	(9)	(5)	(3) U	(60%)	(85)	(53)	(32) U	(60%)	(64)
Eating Disorder	(14)	(14)			(139)	(140)	1 F		(168)
Maternal Mental Health	-	-			-	-			-
Child & Youth Mental Health Services	(776)	(724)	(52) U	(7%)	(7,434)	(7,239)	(195) U	(3%)	(8,688)
Forensic Services	(463)	(466)	3 F	1%	(4,624)	(4,662)	38 F	1%	(5,595)
Kaupapa Maori Mental Health Services	(120)	(147)	28 F	19%	(1,224)	(1,473)	250 F	17%	(1,768)
Kaupapa Maori Mental Health - Residential	24	(29)	53 F	185%	(109)	(288)	179 F	62%	(345)
Kaupapa Maori Mental Health - Inpati	-	-			-	-			-
Mental Health Community Services	(1,696)	(1,767)	71 F	4%	(17,048)	(17,667)	619 F	4%	(21,201)
Prison/Court Liaison	(78)	(42)	(36) U	(84%)	(382)	(421)	39 F	9%	(505)
Mental Health Workforce Development	-	(1)	1 F		(6)	(11)	6 F	51%	(14)
Day Activity & Work Rehabilitation S	(189)	(202)	14 F	7%	(1,866)	(2,018)	152 F	8%	(2,423)
Mental Health Funded Services for Older People	(34)	(34)			(318)	(338)	19 F	6%	(405)
Advocacy / Peer Support - Consumer	(34)	(59)	24 F	41%	(525)	(583)	58 F	10%	(700)
Other Home Based Residential Support	(338)	(307)	(32) U	(10%)	(3,132)	(3,067)	(64) U	(2%)	(3,681)
Advocacy / Peer Support - Families	(27)	(51)	24 F	48%	(477)	(505)	28 F	6%	(607)
Community Residential Beds & Service	(512)	(544)	32 F	6%	(5,009)	(5,416)	407 F	8%	(6,504)
Minor Mental Health Expenditure	(64)	(61)	(3) U	(5%)	(746)	(611)	(135) U	(22%)	(733)
Inter District Flow Mental Health	(489)	(489)			(4,887)	(4,887)			(5,864)
Mental Health Total	**(6,898)**	**(7,150)**	**252 F**	**4%**	**(69,431)**	**(71,451)**	**2,020 F**	**3%**	**(85,752)**
Public Health									
Alcohol & Drug	(39)	(39)			(388)	(388)			(465)
Communicable Diseases	(57)	(57)			(572)	(572)			(686)
Injury Prevention	(2)	(2)			(21)	(21)			(25)
Screening Programmes	(298)	(406)	108 F	27%	(3,866)	(4,058)	192 F	5%	(4,869)
Mental Health	(24)	(17)	(7) U	(43%)	(236)	(166)	(71) U	(43%)	(199)
Nutrition and Physical Activity	(77)	(114)	38 F	33%	(891)	(1,142)	252 F	22%	(1,371)
Physical Environment	(53)	(53)			(533)	(533)			(640)
Public Health Infrastructure	(150)	(138)	(13) U	(9%)	(1,504)	(1,377)	(126) U	(9%)	(1,653)
Sexual Health	(16)	(15)	(1) U	(5%)	(159)	(151)	(7) U	(5%)	(182)
Social Environments	(23)	(22)		(2%)	(226)	(221)	(5) U	(2%)	(265)
Tobacco Control	(83)	(84)	1 F	1%	(830)	(840)	10 F	1%	(1,008)
Well Child Promotion	(2)	(2)			(21)	(21)			(25)
Meningococcal	-	-			-	-			-
Public Health Total	**(823)**	**(949)**	**126 F**	**13%**	**(9,246)**	**(9,490)**	**244 F**	**3%**	**(11,388)**
Disability Support Services									
AT & R (Assessment, Treatment and Re	(1,905)	(1,918)	13 F	1%	(19,050)	(19,182)	132 F	1%	(23,018)
Information and Advisory	(1)	(1)		3%	(5)	(5)			(6)
Needs Assessment	(116)	(115)	(2) U	(2%)	(1,173)	(1,146)	(27) U	(2%)	(1,375)
Service Co-ordination	(126)	(126)			(1,260)	(1,260)			(1,512)
Home Support	(1,171)	(1,157)	(14) U	(1%)	(11,037)	(11,573)	536 F	5%	(13,888)
Carer Support	(164)	(168)	4 F	3%	(1,514)	(1,683)	169 F	10%	(2,019)
Residential Care: Rest Homes	(2,865)	(2,783)	(83) U	(3%)	(29,822)	(28,688)	(1,133) U	(4%)	(34,170)
Residential Care: Loans Adjustment	13	23	(10) U	(43%)	246	226	21 F	9%	271
Long Term Chronic Conditions	(140)	-	(140) U		(981)	-	(981) U		-
Residential Care: Hospitals	(3,330)	(3,266)	(64) U	(2%)	(33,672)	(32,657)	(1,015) U	(3%)	(39,189)
Ageing in Place	(115)	(114)	(2) U	(2%)	(1,117)	(1,137)	20 F	2%	(1,364)
Environmental Support Services	(96)	(98)	2 F	2%	(970)	(980)	10 F	1%	(1,179)
Day Programmes	(23)	(48)	25 F	52%	(244)	(351)	107 F	31%	(459)
Expenditure to Attend Treatment ETAT	-	-			-	-			-
Respite Care	(69)	(75)	6 F	8%	(723)	(749)	26 F	3%	(899)
Community Health Services & Support	(187)	(176)	(11) U	(6%)	(1,199)	(1,462)	264 F	18%	(1,844)
Inter District Flow Disability Support	(336)	(352)	16 F	4%	(3,507)	(3,519)	12 F		(4,223)
Disability Support Other	-	-			-	-			-
Disability Support Services Total	**(10,633)**	**(10,374)**	**(259) U**	**(2%)**	**(106,028)**	**(104,167)**	**(1,861) U**	**(2%)**	**(124,875)**
Maori Health									
Maori Service Development	(22)	(22)		1%	(220)	(223)	3 F	1%	(268)
Minor Maori Health Expenditure	(24)	(27)	3 F	11%	(241)	(272)	31 F	11%	(327)
Whanau Ora Services	(116)	(117)	1 F		(1,156)	(1,164)	8 F	1%	(1,398)
Maori Health Total	**(163)**	**(167)**	**4 F**	**2%**	**(1,618)**	**(1,660)**	**42 F**	**3%**	**(1,993)**
Total Expenses	**(66,039)**	**(66,471)**	**433 F**	**1%**	**(660,716)**	**(662,240)**	**1,524 F**		**(794,710)**
Net Surplus/ (Deficit)	**(301)**	**(1,161)**	**860 F**	**74%**	**(4,432)**	**(9,133)**	**4,701 F**	**51%**	**(10,981)**

Printed: 1/06/2012 10:02 a.m.

Southern District Health Board

Apr-12

Part 3.1: DHB Funds Expense Split	Year to Date Actual $(000)	Budget $(000)	Variance $(000)		Variance %	YTD Variance NGO	YTD Variance DHB Provider	Annual Budget $(000)
Part 3.1: Statement of Financial Performance								
REVENUE								
Ministry of Health								
MoH - Vote Health Non Mental Health	536,938	534,383	2,556	F				641,259
MoH - Vote Health Mental Health	69,456	69,448	8	F				83,338
PBF Adjustments	-	-						-
MoH Funding Subcontracts	29,199	29,826	(627)	U	(2%)			35,791
Ministry of Health Total	**635,594**	**633,657**	**1,937**	**F**				**760,388**
Other Government								
IDF's - Mental Health Services	1,514	1,514						1,817
IDF's - All others (non Mental health)	19,176	17,936	1,240	F	7%			21,524
Other Government Total	**20,690**	**19,451**	**1,240**	**F**	**6%**			**23,341**
REVENUE TOTAL	**656,284**	**653,107**	**3,177**	**F**				**783,729**
EXPENSES								
Outsourced Expenses								
Outsourced Funder Services	(5,460)	(5,174)	(286)	U	(6%)	-	(286)	(6,209)
Payments to Providers								
Personal Health								
Child and Youth	(3,568)	(3,392)	(177)	U	(5%)	(79)	(98)	(4,070)
Laboratory	(25,421)	(25,841)	419	F	2%	419	-	(31,009)
Infertility Treatment Services	(940)	(940)				-	-	(1,128)
Maternity	(2,020)	(1,991)	(29)	U	(1%)	(29)	-	(2,390)
Maternity (Tertiary & Secondary)	(14,538)	(14,551)	14	F		14	-	(17,464)
Pregnancy and Parenting Education	(81)	(99)	18	F	18%	18	-	(119)
Maternity Payment Schedule	-	-				-	-	-
Neo Natal	(6,720)	(6,720)				-	-	(8,064)
Sexual Health	(954)	(969)	16	F	2%	16	-	(1,163)
Adolescent Dental Benefit	(1,911)	(2,064)	153	F	7%	211	(58)	(2,539)
Other Dental Services	-	-				-	-	-
Dental - Low Income Adult	(888)	(764)	(125)	U	(16%)	(125)	-	(917)
Child (School) Dental Services	(6,080)	(5,422)	(658)	U	(12%)	82	(740)	(6,524)
Secondary / Tertiary Dental	(2,561)	(2,577)	16	F	1%	16	-	(3,095)
Pharmaceuticals	(65,830)	(65,405)	(425)	U	(1%)	(874)	449	(78,694)
Pharmaceutical Cancer Treatment Drugs	(2,901)	(3,517)	616	F	18%	361	255	(4,220)
Management Referred Services	-	-				-	-	-
General Medical Subsidy	(1,387)	(1,067)	(320)	U	(30%)	(320)	-	(1,344)
Primary Practice Services - Capitated	(32,759)	(32,553)	(207)	U	(1%)	(207)	-	(39,063)
Primary Health Care Strategy - Care	(2,501)	(2,626)	125	F	5%	125	-	(3,151)
Primary Health Care Strategy - Health	(1,395)	(2,865)	1,471	F	51%	1,471	-	(3,195)
Primary Health Care Strategy - Other	(2,365)	(2,881)	516	F	18%	516	-	(3,454)
Practice Nurse Subsidy	(166)	(177)	11	F	6%	11	-	(211)
Rural Support for Primary Health Pro	(12,464)	(13,654)	1,191	F	9%	1,191	-	(16,385)
Immunisation	(1,817)	(2,145)	328	F	15%	466	(138)	(2,596)
Radiology	(4,057)	(3,996)	(61)	U	(2%)	(61)	-	(4,796)
Palliative Care	(4,261)	(3,907)	(354)	U	(9%)	(354)	-	(4,689)
Meals on Wheels	(553)	(585)	31	F	5%	31	-	(702)
Domicilary & District Nursing	(14,721)	(14,440)	(281)	U	(2%)	(281)	-	(17,328)
Community based Allied Health	(5,730)	(5,939)	209	F	4%	209	-	(7,127)
Chronic Disease Management and Educa	(2,444)	(2,497)	54	F	2%	54	-	(2,997)
Medical Inpatients	(54,013)	(53,940)	(73)	U		-	(73)	(64,728)
Medical Outpatients	(34,264)	(33,320)	(945)	U	(3%)	(69)	(876)	(39,984)
Surgical Inpatients	(100,521)	(100,563)	42	F		42	-	(120,676)
Surgical Outpatients	(17,076)	(17,027)	(49)	U		(29)	(20)	(20,432)
Paediatric Inpatients	(6,212)	(6,212)				-	-	(7,454)
Paediatric Outpatients	(3,375)	(3,375)				-	-	(4,050)
Pacific Peoples' Health	(97)	(97)				-	-	(117)
Emergency Services	(15,330)	(15,329)	(2)	U		(2)	-	(18,394)
Minor Personal Health Expenditure	(445)	(1,006)	560	F	56%	560	-	(1,207)
Price adjusters and Premium	9,010	8,936	74	F	1%	74	-	10,723
Travel & Accomodation	(3,702)	(3,636)	(66)	U	(2%)	(66)	-	(4,363)
Inter District Flow Personal Health	(21,878)	(21,147)	(731)	U	(3%)	(731)		(25,376)
Personal Health Total	**(468,934)**	**(470,298)**	**1,364**	**F**		**2,660**	**(1,299)**	**(564,492)**

Printed: 1/06/2012 10:02 a.m.

Southern District Health Board

Apr-12

Part 3.1: DHB Funds Expense Split	Year to Date Actual $(000)	Budget $(000)	Variance $(000)		Variance %	YTD Variance NGO	YTD Variance DHB Provider	Annual Budget $(000)
Mental Health								
Acute Mental Health Inpatients	(12,683)	(12,683)				-	-	(15,219)
Sub-Acute & Long Term Mental Health	(3,539)	(3,539)				-	-	(4,247)
Crisis Respite	(254)	(336)	82	F	24%	-	82	(404)
Alcohol & Other Drugs - General	(3,301)	(3,461)	160	F	5%	82	78	(4,153)
Alcohol & Other Drugs - Child & Youth	(668)	(1,067)	399	F	37%	109	290	(1,282)
Methadone	(915)	(915)				399	(399)	(1,098)
Dual Diagnosis - Alcohol & Other Drugs	(59)	(69)	10	F	14%	-	10	(83)
Dual Diagnosis - MH/ID	(85)	(53)	(32)	U	(60%)	10	(42)	(64)
Eating Disorder	(139)	(140)	1	F		-	1	(168)
Maternal Mental Health	-	-				1	(1)	-
Child & Youth Mental Health Services	(7,434)	(7,239)	(195)	U	(3%)	(348)	153	(8,688)
Forensic Services	(4,624)	(4,662)	38	F	1%	-	38	(5,595)
Kaupapa Maori Mental Health Services	(1,224)	(1,473)	250	F	17%	-	250	(1,768)
Kaupapa Maori Mental Health - Residential	(109)	(288)	179	F	62%	179	-	(345)
Kaupapa Maori Mental Health - Inpati	-	-				-	-	-
Mental Health Community Services	(17,048)	(17,667)	619	F	4%	15	604	(21,201)
Prison/Court Liaison	(382)	(421)	39	F	9%	-	39	(505)
Mental Health Workforce Development	(6)	(11)	6	F	51%	6	-	(14)
Day Activity & Work Rehabilitation S	(1,866)	(2,018)	152	F	8%	128	24	(2,423)
Mental Health Funded Services for Older People	(318)	(338)	19	F	6%	-	19	(405)
Advocacy / Peer Support - Consumer	(525)	(583)	58	F	10%	48	10	(700)
Other Home Based Residential Support	(3,132)	(3,067)	(64)	U	(2%)	(138)	74	(3,681)
Advocacy / Peer Support - Families	(477)	(505)	28	F	6%	28	-	(607)
Community Residential Beds & Service	(5,009)	(5,416)	407	F	8%	407	-	(6,504)
Minor Mental Health Expenditure	(746)	(611)	(135)	U	(22%)	(135)	-	(733)
Inter District Flow Mental Health	(4,887)	(4,887)				-	-	(5,864)
Mental Health Total	**(69,431)**	**(71,451)**	**2,020**	**F**	**3%**	**791**	**1,230**	**(85,752)**
Public Health								
Alcohol & Drug	(388)	(388)				-	-	(465)
Communicable Diseases	(572)	(572)				-	-	(686)
Injury Prevention	(21)	(21)				-	-	(25)
Screening Programmes	(3,866)	(4,058)	192	F	5%	-	192	(4,869)
Mental Health	(236)	(166)	(71)	U	(43%)	120	(191)	(199)
Nutrition and Physical Activity	(891)	(1,142)	252	F	22%	24	228	(1,371)
Physical Environment	(533)	(533)				-	-	(640)
Public Health Infrastructure	(1,504)	(1,377)	(126)	U	(9%)	-	(126)	(1,653)
Sexual Health	(159)	(151)	(7)	U	(5%)	(7)	-	(182)
Social Environments	(226)	(221)	(5)	U	(2%)	(5)	-	(265)
Tobacco Control	(830)	(840)	10	F	1%	-	10	(1,008)
Well Child Promotion	(21)	(21)				-	-	(25)
Meningococcal	-	-				-	-	-
Public Health Total	**(9,246)**	**(9,490)**	**244**	**F**	**3%**	**132**	**113**	**(11,388)**
Disability Support Services								
AT & R (Assessment, Treatment and Re	(19,050)	(19,182)	132	F	1%	132	-	(23,018)
Information and Advisory	(5)	(5)				-	-	(6)
Needs Assessment	(1,173)	(1,146)	(27)	U	(2%)	(27)	-	(1,375)
Service Co-ordination	(1,260)	(1,260)				-	-	(1,512)
Home Support	(11,037)	(11,573)	536	F	5%	536	-	(13,888)
Carer Support	(1,514)	(1,683)	169	F	10%	169	-	(2,019)
Residential Care: Rest Homes	(29,822)	(28,688)	(1,133)	U	(4%)	(1,133)	-	(34,170)
Residential Care: Loans Adjustment	246	226	21	F	9%	21	-	271
Long Term Chronic Conditions	(981)	-	(981)	U		(981)	-	-
Residential Care: Hospitals	(33,672)	(32,657)	(1,015)	U	(3%)	(1,015)	-	(39,189)
Ageing in Place	(1,117)	(1,137)	20	F	2%	20	-	(1,364)
Environmental Support Services	(970)	(980)	10	F	1%	10	-	(1,179)
Day Programmes	(244)	(351)	107	F	31%	107	-	(459)
Expenditure to Attend Treatment ETAT	-	-				-	-	-
Respite Care	(723)	(749)	26	F	3%	26	-	(899)
Community Health Services & Support	(1,199)	(1,462)	264	F	18%	264	-	(1,844)
Inter District Flow Disability Support	(3,507)	(3,519)	12	F		12	-	(4,223)
Disability Support Services Total	**(106,028)**	**(104,167)**	**(1,861)**	**U**	**(2%)**	**(1,859)**	**-**	**(124,875)**
Maori Service Development	(220)	(223)	3	F	1%	3	-	(268)
Minor Maori Health Expenditure	(241)	(272)	31	F	11%	31	-	(327)
Whanau Ora Services	(1,156)	(1,164)	8	F	1%	8	-	(1,398)
Maori Health Total	**(1,618)**	**(1,660)**	**42**	**F**	**3%**	**42**	**-**	**(1,993)**
Total Expenses	**(660,716)**	**(662,240)**	**1,524**	**F**		**1,766**	**(242)**	**(794,710)**

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Southern District Health Board

Apr-12

Part 3.1: DHB Funds Expense Split	Year to Date					YTD Variance		YTD Variance	Annual
	Actual	Budget	Variance	Variance					Budget
	$(000)	$(000)	$(000)	%		NGO		DHB Provider	$(000)
Net Surplus/ (Deficit)	(4,432)	(9,133)	4,701 F	51%					(10,981)

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Southern District Health Board

Apr-12

Part 4: DHB Consolidated	Current Month Actual $(000)	Current Month Budget $(000)	Current Month Variance $(000)	Current Month Variance %	Year to Date Actual $(000)	Year to Date Budget $(000)	Year to Date Variance $(000)	Year to Date Variance %	Annual Budget $(000)
Part 4.1: Statement of Financial Performance									
REVENUE									
Ministry of Health									
MoH - Vote Health Non Mental Health	53,694	53,438	256 F		536,938	534,383	2,556 F		641,259
MoH - Vote Health Mental Health	6,946	6,945	1 F		69,456	69,448	8 F		83,338
PBF Adjustments	-	-			-	-			-
MoH Funding Subcontracts	2,822	2,983	(161) U	(5%)	29,199	29,826	(627) U	(2%)	35,791
MoH - Personal Health	(20)	129	(149) U	(116%)	23	554	(532) U	(96%)	738
MoH - Mental Health	-	-			-	-			-
MoH - Public Health	10	24	(13) U	(56%)	105	238	(133) U	(56%)	286
MoH - Disability Support Services	766	741	25 F	3%	7,188	7,409	(220) U	(3%)	8,890
MoH - Maori Health	-	-			-	-			-
Clinical Training Agency	704	531	173 F	32%	5,394	5,315	79 F	1%	6,378
Internal - DHB Funder to DHB Provider	-	-			-	-			-
Ministry of Health Total	**64,922**	**64,791**	**131 F**		**648,304**	**647,173**	**1,131 F**		**776,680**
Other Government									
IDF's - Mental Health Services	151	151			1,514	1,514			1,817
IDF's - All others (non Mental health)	2,125	1,794	331 F	18%	19,176	17,936	1,240 F	7%	21,524
Other DHB's	19	25	(6) U	(24%)	258	246	12 F	5%	295
Training Fees and Subsidies	26	9	16 F	173%	191	93	98 F	105%	112
Accident Insurance	764	735	29 F	4%	7,151	7,268	(117) U	(2%)	8,793
Other Government	485	368	117 F	32%	3,907	3,684	224 F	6%	4,420
Other Government Total	**3,570**	**3,083**	**487 F**	**16%**	**32,198**	**30,742**	**1,456 F**	**5%**	**36,962**
Government and Crown Agency Total	**68,492**	**67,874**	**618 F**	**1%**	**680,502**	**677,915**	**2,587 F**		**813,642**
Other Revenue									
Patient / Consumer Sourced	256	253	3 F	1%	3,105	2,601	504 F	19%	3,089
Other Income	906	954	(47) U	(5%)	10,247	9,683	563 F	6%	11,688
Other Revenue Total	**1,162**	**1,206**	**(44) U**	**(4%)**	**13,352**	**12,284**	**1,068 F**	**9%**	**14,777**
REVENUE TOTAL	**69,654**	**69,080**	**574 F**	**1%**	**693,853**	**690,199**	**3,655 F**	**1%**	**828,419**
EXPENSES									
Personnel Expenses									
Medical Personnel	(7,952)	(7,583)	(369) U	(5%)	(80,268)	(76,392)	(3,876) U	(5%)	(92,355)
Nursing Personnel	(10,799)	(10,310)	(489) U	(5%)	(96,857)	(97,922)	1,065 F	1%	(118,599)
Allied Health Personnel	(4,018)	(3,872)	(146) U	(4%)	(38,431)	(38,121)	(310) U	(1%)	(46,574)
Support Services Personnel	(819)	(782)	(37) U	(5%)	(7,700)	(7,613)	(87) U	(1%)	(9,258)
Management / Admin Personnel	(3,458)	(3,357)	(101) U	(3%)	(34,385)	(33,653)	(732) U	(2%)	(40,738)
Personnel Costs Total	**(27,046)**	**(25,904)**	**(1,142) U**	**(4%)**	**(257,640)**	**(253,700)**	**(3,940) U**	**(2%)**	**(307,524)**
Outsourced Expenses									
Medical Personnel	(866)	(918)	52 F	6%	(8,112)	(9,208)	1,097 F	12%	(11,053)
Nursing Personnel	(28)	(2)	(25) U		(52)	(25)	(27) U	(107%)	(30)
Allied Health Personnel	(39)	(13)	(26) U	(193%)	(229)	(136)	(93) U	(69%)	(163)
Support Personnel	(36)	(22)	(14) U	(66%)	(209)	(221)	12 F	5%	(265)
Management / Administration Personnel	(3)	(4)	1 F	23%	(123)	(38)	(85) U	(226%)	(45)
Outsourced Clinical Services	(777)	(524)	(253) U	(48%)	(6,367)	(5,071)	(1,296) U	(26%)	(6,023)
Outsourced Corporate / Governance Services	(89)	(77)	(12) U	(16%)	(776)	(800)	23 F	3%	(962)
Outsourced Funder Services	(16)	(69)	53 F	77%	(144)	(690)	546 F	79%	(828)
Outsourced Services Total	**(1,854)**	**(1,629)**	**(225) U**	**(14%)**	**(16,012)**	**(16,189)**	**177 F**	**1%**	**(19,369)**
Clinical Supplies									
Treatment Disposables	(2,294)	(2,359)	65 F	3%	(23,709)	(22,775)	(935) U	(4%)	(27,645)
Diagnostic Supplies & Other Clinical Supplies	(138)	(150)	11 F	8%	(1,509)	(1,442)	(68) U	(5%)	(1,717)
Instruments & Equipment	(1,371)	(1,242)	(130) U	(10%)	(12,761)	(12,003)	(757) U	(6%)	(14,375)
Patient Appliances	(173)	(193)	20 F	10%	(1,634)	(1,907)	273 F	14%	(2,312)
Implants & Prosthesis	(824)	(850)	26 F	3%	(7,930)	(8,125)	194 F	2%	(9,730)
Pharmaceuticals	(1,411)	(1,626)	215 F	13%	(15,075)	(15,702)	626 F	4%	(18,728)
Other Clinical Supplies	(175)	(271)	96 F	36%	(2,212)	(2,615)	403 F	15%	(3,130)
Clinical Supplies Total	**(6,387)**	**(6,691)**	**304 F**	**5%**	**(64,831)**	**(64,568)**	**(263) U**		**(77,637)**
Infrastructure & Non Clinical Expenses									
Hotel Services, Laundry & Cleaning	(1,019)	(1,061)	42 F	4%	(10,476)	(10,654)	178 F	2%	(12,797)
Facilities	(1,679)	(1,789)	111 F	6%	(16,064)	(16,738)	674 F	4%	(20,332)
Transport	(438)	(340)	(97) U	(29%)	(3,421)	(3,283)	(138) U	(4%)	(3,961)
IT Systems & Telecommunications	(783)	(861)	78 F	9%	(8,772)	(8,503)	(269) U	(3%)	(10,225)
Interest & Financing Charges	(1,257)	(1,114)	(143) U	(13%)	(12,259)	(12,187)	(72) U	(1%)	(14,463)
Professional Fees & Expenses	(227)	(248)	20 F	8%	(2,344)	(2,507)	164 F	7%	(3,003)
Other Operating Expenses	(307)	(453)	146 F	32%	(4,624)	(4,638)	15 F		(5,472)
Democracy	(43)	(41)	(2) U	(6%)	(379)	(405)	26 F	6%	(486)
Subsidiaries & Joint Ventures	(35)	-	(35) U		(341)	-	(341) U		-
Infrastructure & Non-Clinical Supplies Total	**(5,786)**	**(5,906)**	**120 F**	**2%**	**(58,679)**	**(58,915)**	**236 F**		**(70,739)**

Southern District Health Board

Apr-12

Part 4: DHB Consolidated	Current Month				Year to Date				Annual
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Budget $(000)
Payments to Providers									
Personal Health									
Child and Youth	(153)	(43)	(110) U	(257%)	(506)	(427)	(79) U	(19%)	(512)
Laboratory	(2,519)	(2,583)	65 F	3%	(25,415)	(25,835)	419 F	2%	(31,002)
Infertility Treatment Services	-	-			-	-			-
Maternity	(145)	(144)	(1) U	(1%)	(1,458)	(1,429)	(29) U	(2%)	(1,717)
Maternity (Tertiary & Secondary)	(42)	(70)	28 F	40%	(679)	(692)	14 F	2%	(833)
Pregnancy and Parenting Education	(6)	(8)	1 F	18%	(56)	(74)	18 F	24%	(89)
Maternity Payment Schedule	-	-			-	-			-
Neo Natal	-	-			-	-			-
Sexual Health	-	(2)	2 F	122%	-	(16)	16 F	99%	(19)
Adolescent Dental Benefit	(218)	(239)	21 F	9%	(1,596)	(1,807)	211 F	12%	(2,231)
Other Dental Services	-	-			-	-			-
Dental - Low Income Adult	(128)	(58)	(70) U	(122%)	(697)	(572)	(125) U	(22%)	(688)
Child (School) Dental Services	(2)	(59)	57 F	97%	(447)	(529)	82 F	16%	(653)
Secondary / Tertiary Dental	(139)	(141)	3 F	2%	(1,386)	(1,402)	16 F	1%	(1,684)
Pharmaceuticals	(5,957)	(5,774)	(183) U	(3%)	(61,996)	(61,121)	(874) U	(1%)	(73,554)
Pharmaceutical Cancer Treatment Drugs	-	-			361	-	361 F		-
Management Referred Services	-	-			-	-			-
General Medical Subsidy	(132)	(102)	(30) U	(30%)	(1,387)	(1,067)	(320) U	(30%)	(1,344)
Primary Practice Services - Capitated	(3,307)	(3,255)	(51) U	(2%)	(32,759)	(32,553)	(207) U	(1%)	(39,063)
Primary Health Care Strategy - Care	(240)	(263)	23 F	9%	(2,501)	(2,626)	125 F	5%	(3,151)
Primary Health Care Strategy - Health	(150)	(469)	319 F	68%	(1,395)	(2,865)	1,471 F	51%	(3,195)
Primary Health Care Strategy - Other	(209)	(287)	78 F	27%	(2,365)	(2,881)	516 F	18%	(3,454)
Practice Nurse Subsidy	(15)	(18)	2 F	14%	(166)	(177)	11 F	6%	(211)
Rural Support for Primary Health Pro	(1,128)	(1,290)	162 F	13%	(11,709)	(12,900)	1,191 F	9%	(15,479)
Immunisation	(415)	(548)	134 F	24%	(1,142)	(1,608)	466 F	29%	(1,969)
Radiology	(149)	(143)	(6) U	(4%)	(1,487)	(1,426)	(61) U	(4%)	(1,712)
Palliative Care	(402)	(391)	(11) U	(3%)	(4,261)	(3,907)	(354) U	(9%)	(4,689)
Meals on Wheels	(20)	(24)	4 F	15%	(206)	(237)	31 F	13%	(285)
Domicilary & District Nursing	(457)	(400)	(58) U	(14%)	(4,274)	(3,993)	(281) U	(7%)	(4,792)
Community based Allied Health	(162)	(183)	21 F	12%	(1,622)	(1,831)	209 F	11%	(2,197)
Chronic Disease Management and Educa	(100)	(79)	(22) U	(28%)	(731)	(785)	54 F	7%	(942)
Medical Inpatients	-	-			-	-			-
Medical Outpatients	(347)	(341)	(7) U	(2%)	(3,475)	(3,406)	(69) U	(2%)	(4,087)
Surgical Inpatients	(6)	(10)	4 F	43%	(55)	(98)	42 F	43%	(117)
Surgical Outpatients	(140)	(137)	(3) U	(2%)	(1,402)	(1,373)	(29) U	(2%)	(1,648)
Paediatric Inpatients	-	-			-	-			-
Paediatric Outpatients	-	-			-	-			-
Pacific Peoples' Health	-	-			-	-			-
Emergency Services	(147)	(147)			(1,469)	(1,467)	(2) U		(1,760)
Minor Personal Health Expenditure	(23)	(75)	52 F	69%	(188)	(749)	560 F	75%	(898)
Price adjusters and Premium	(58)	(72)	14 F	(20%)	(643)	(717)	74 F	(10%)	(861)
Travel & Accomodation	(337)	(359)	22 F	6%	(3,660)	(3,594)	(66) U	(2%)	(4,313)
Inter District Flow Personal Health	(2,055)	(2,115)	60 F	3%	(21,878)	(21,147)	(731) U	(3%)	(25,376)
Personal Health Total	**(19,307)**	**(19,824)**	**518 F**	**3%**	**(192,650)**	**(195,311)**	**2,661 F**	**1%**	**(234,526)**
Mental Health									
Mental Health to allocate	-	-			-	-			-
Acute Mental Health Inpatients	-	-			-	-			-
Sub-Acute & Long Term Mental Health	-	-			-	-			-
Crisis Respite	(9)	(18)	8 F	47%	(94)	(176)	82 F	47%	(212)
Alcohol & Other Drugs - General	(78)	(81)	3 F	4%	(695)	(804)	109 F	14%	(966)
Alcohol & Other Drugs - Child & Youth	(39)	(98)	59 F	61%	(576)	(975)	399 F	41%	(1,171)
Methadone	-	-			-	-			-
Dual Diagnosis - Alcohol & Other Drugs	-	(7)	7 F	106%	(59)	(69)	10 F	14%	(83)
Dual Diagnosis - MH/ID	-	-			-	-			-
Eating Disorder	(14)	(14)			(139)	(140)	1 F		(168)
Child & Youth Mental Health Services	(278)	(214)	(64) U	(30%)	(2,483)	(2,134)	(348) U	(16%)	(2,562)
Forensic Services	-	-			-	-			-
Kaupapa Maori Mental Health Services	-	-			-	-			-
Kaupapa Maori Mental Health - Residentual	24	(29)	53 F	185%	(109)	(288)	179 F	62%	(345)
Kaupapa Maori Mental Health - Inpati	-	-			-	-			-
Mental Health Community Services	(87)	(107)	20 F	18%	(1,048)	(1,063)	15 F	1%	(1,276)
Prison/Court Liaison	-	-			-	-			-
Mental Health Workforce Development	-	(1)	1 F		(6)	(11)	6 F	51%	(14)
Day Activity & Work Rehabilitation S	(129)	(141)	11 F	8%	(1,277)	(1,405)	128 F	9%	(1,687)
Mental Health Funded Services for Older People	-	-			-	-			-
Advocacy / Peer Support - Consumer	(1)	(25)	24 F	95%	(203)	(250)	48 F	19%	(301)
Other Home Based Residential Support	(304)	(265)	(39) U	(15%)	(2,790)	(2,652)	(138) U	(5%)	(3,182)
Advocacy / Peer Support - Families	(27)	(51)	24 F	48%	(477)	(505)	28 F	6%	(607)
Community Residential Beds & Service	(441)	(473)	32 F	7%	(4,297)	(4,705)	407 F	9%	(5,650)
Minor Mental Health Expenditure	(30)	(27)	(3) U	(11%)	(404)	(269)	(135) U	(50%)	(323)
Inter District Flow Mental Health	(489)	(489)			(4,887)	(4,887)			(5,864)
Mental Health Total	**(1,901)**	**(2,039)**	**138 F**	**7%**	**(19,544)**	**(20,334)**	**790 F**	**4%**	**(24,411)**

Southern District Health Board

Apr-12

Part 4: DHB Consolidated	Current Month				Year to Date				Annual
	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance	Budget
	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%	$(000)
Public Health									
Alcohol & Drug	-	-			-	-			-
Communicable Diseases	-	-			-	-			-
Injury Prevention	-	-			-	-			-
Mental Health	-	-			-	-			-
Screening Programmes	-	(12)	12 F		-	(120)	120 F		(144)
Nutrition and Physical Activity	-	(2)	2 F		7	(18)	24 F	139%	(21)
Physical Environment	-	-			-	-			-
Public Health Infrastructure	-	-			-	-			-
Sexual Health	(1)	-	(1) U		(7)	-	(7) U		-
Social Environments	-	-			(5)	-	(5) U		-
Tobacco Control	-	-			-	-			-
Well Child Promotion	-	-			-	-			-
Meningococcal	-	-			-	-			-
Public Health Total	**(1)**	**(14)**	**13 F**	**92%**	**(5)**	**(137)**	**132 F**	**96%**	**(165)**
Disability Support Services									
AT & R (Assessment, Treatment and Re	(308)	(321)	13 F	4%	(3,076)	(3,207)	132 F	4%	(3,849)
Information and Advisory	(1)	(1)		3%	(5)	(5)			(6)
Needs Assessment	(21)	(20)	(2) U	(10%)	(222)	(195)	(27) U	(14%)	(234)
Service Co-ordination	(3)	(3)			(33)	(33)			(40)
Home Support	(1,171)	(1,157)	(14) U	(1%)	(11,037)	(11,573)	536 F	5%	(13,888)
Carer Support	(164)	(168)	4 F	3%	(1,514)	(1,683)	169 F	10%	(2,019)
Residential Care: Rest Homes	(2,865)	(2,783)	(83) U	(3%)	(29,822)	(28,688)	(1,133) U	(4%)	(34,170)
Residential Care: Loans Adjustment	13	23	(10) U	(43%)	246	226	21 F	9%	271
Long Term Chronic Conditions	(140)	-	(140) U		(981)	-	(981) U		-
Residential Care: Hospitals	(3,330)	(3,266)	(64) U	(2%)	(33,672)	(32,657)	(1,015) U	(3%)	(39,189)
Ageing in Place	(113)	(112)	(2) U	(2%)	(1,095)	(1,115)	20 F	2%	(1,338)
Environmental Support Services	(96)	(98)	2 F	2%	(970)	(980)	10 F	1%	(1,179)
Day Programmes	(23)	(48)	25 F	52%	(244)	(351)	107 F	31%	(459)
Expenditure to Attend Treatment ETAT	-	-			-	-			-
Respite Care	(69)	(75)	6 F	8%	(723)	(749)	26 F	3%	(899)
Community Health Services & Support	(167)	(156)	(11) U	(7%)	(995)	(1,258)	264 F	21%	(1,600)
Inter District Flow Disability Support	(336)	(352)	16 F	4%	(3,507)	(3,519)	12 F		(4,223)
Disability Support Other	-	-			-	-			-
Disability Support Services Total	**(8,795)**	**(8,536)**	**(259) U**	**(3%)**	**(87,650)**	**(85,789)**	**(1,861) U**	**(2%)**	**(102,822)**
Maori Health									
Maori Service Development	(22)	(22)		1%	(220)	(223)	3 F	1%	(268)
Minor Maori Health Expenditure	(9)	(12)	3 F	26%	(89)	(120)	31 F	26%	(144)
Whanau Ora Services	(109)	(109)	1 F		(1,078)	(1,086)	8 F	1%	(1,304)
Maori Health Total	**(139)**	**(143)**	**4 F**	**3%**	**(1,387)**	**(1,429)**	**42 F**	**3%**	**(1,716)**
Internal Allocations	-	-			-	-			-
Total Expenses	**(71,216)**	**(70,686)**	**(530) U**	**(1%)**	**(698,398)**	**(696,373)**	**(2,026) U**		**(838,909)**
Net Surplus/ (Deficit)	**(1,562)**	**(1,606)**	**44 F**	**3%**	**(4,545)**	**(6,174)**	**1,629 F**	**26%**	**(10,490)**
Zero Check	-	-			-	-			-
Part 4.1 A: Supplementary Information to Statement of Financial Performance									
Depreciation - Clinical Equipment	(685)	(710)	25 F	4%	(6,842)	(6,941)	99 F	1%	(8,287)
Depreciation - Non Residential Buildings & Plant	(615)	(680)	65 F	10%	(6,018)	(6,249)	231 F	4%	(7,609)
Depreciation - Motor Vehicles	(4)	(14)	10 F	71%	(39)	(104)	65 F	62%	(131)
Depreciation - Information Techology	(324)	(318)	(6) U	(2%)	(3,237)	(3,078)	(159) U	(5%)	(3,715)
Depreciation - Other Equipment	(55)	(61)	6 F	10%	(560)	(593)	33 F	6%	(715)
Total Depreciation	(1,683)	(1,783)	101 F	6%	(16,696)	(16,965)	269 F	2%	(20,458)
Interest Cost from Funder Loans	-	-			-	-			-
Interest Costs from CHFA	(456)	(399)	(56) U	(14%)	(4,126)	(4,065)	(61) U	(2%)	(4,877)
Financing Component of Operating Leases	(19)	(32)	13 F	40%	(246)	(326)	81 F	25%	(392)
Capital Charge	(753)	(649)	(104) U	(16%)	(7,604)	(7,460)	(144) U	(2%)	(8,792)

Southern District Health Board

Apr-12

Part 4: DHB Consolidated	Current Month Actual $ (000)	Previous Month Actual $(000)	Movement $(000)	Current Budget $(000)	Current Year Opening Balance Sheet $(000)	Annual Budget $(000)
Part 4.2: Balance Sheet						
Current Assets						
Petty Cash	13	14	(1)	13	14	13
Bank	942	6,018	(5,076)	438	3,838	583
Short Term Investments	36,289	22,339	13,950	20,500	33,442	11,000
Short Term Investments	-	-	-	-	-	-
Prepayments	1,745	1,590	156	1,808	2,089	1,808
Accounts Receivable	11,175	6,819	4,356	9,666	6,559	9,865
Provision for Doubtful Debts	(1,813)	(1,813)	-	(1,492)	(1,426)	(1,492)
Accrued Debtors	21,491	20,885	606	19,894	19,197	19,896
Inventory / Stock	4,616	4,605	11	4,370	4,605	4,370
Assets Held for Resale	-	-	-	-	-	-
Current Assets Total	**74,459**	**60,456**	**14,003**	**55,197**	**68,317**	**46,043**
Non Current Assets						
Land, Buildings & Plant	238,882	238,759	123	239,999	229,596	240,663
Clinical Equipment	101,858	101,374	484	120,365	99,470	126,717
Other Equipment (incl Finance Leases)	12,879	12,869	10	13,748	12,670	13,962
Information Technology	31,947	31,909	38	35,407	30,489	36,164
Motor Vehicles	710	710	-	1,741	714	1,751
Provision Depreciation - Buildings & Plant	(15,655)	(15,040)	(615)	(15,951)	(9,642)	(17,311)
Provision Depreciation - Clinical Equipment	(76,888)	(76,273)	(615)	(89,014)	(75,683)	(90,360)
Provision Depreciation - Other Equipment	(11,272)	(11,218)	(54)	(11,311)	(10,718)	(11,433)
Provision Depreciation - Information Technology	(23,949)	(23,783)	(166)	(25,182)	(21,481)	(25,819)
Provision Depreciation - Motor Vehicles	(287)	(283)	(4)	(371)	(268)	(398)
WIP	18,860	15,967	2,894	13,759	8,304	17,506
Investment in Subsidiaries	-	-	-	-	-	-
Investment in Associates	326	326	-	238	326	238
Long Term Investments	-	-	-	-	-	-
Non Current Assets Total	**277,411**	**275,317**	**2,094**	**283,426**	**263,778**	**291,679**
Current Liabilities						
Accounts Payable Control	(3,605)	(2,470)	(1,135)	(4,926)	(2,849)	(4,822)
Accrued Creditors	(31,160)	(32,028)	868	(36,331)	(31,703)	(36,598)
Income Received in Advance	(2,864)	(1,566)	(1,299)	(2,419)	(1,168)	(2,419)
Capital Charge Payable	(3,012)	(2,259)	(753)	(649)	(796)	(598)
GST & Tax Provisions	(10,132)	(6,282)	(3,850)	(3,289)	(6,098)	(2,791)
Term Loans - Finance Leases (current portion)	(1,252)	(1,609)	356	(2,125)	(2,599)	(2,125)
Term Loans - Private (current portion)	-	-	-	-	-	-
Term Loans - Crown (current portion)	(28,045)	(11,045)	(17,000)	(4,459)	(5,249)	(4,229)
Payroll Accrual & Clearing Accounts	(13,622)	(12,786)	(836)	(18,393)	(11,889)	(10,818)
Employee Entitlement Provisions	(40,679)	(39,512)	(1,167)	(38,621)	(40,424)	(38,621)
Current Liabilities Total	**(134,373)**	**(109,557)**	**(24,816)**	**(111,212)**	**(102,775)**	**(103,022)**
WORKING CAPITAL	**(59,915)**	**(49,101)**	**(10,813)**	**(56,016)**	**(34,458)**	**(56,979)**
NET FUNDS EMPLOYED	**217,496**	**226,215**	**(8,719)**	**227,411**	**229,320**	**234,699**
Non Current Liabilities						
Long Service Leave - Non Current Portion	(3,069)	(3,069)	-	(3,348)	(3,069)	(3,348)
Retirement Gratuities - Non Current Portion	(10,492)	(10,492)	-	(10,088)	(10,520)	(10,088)
Other Employee Entitlement Provisions	(1,109)	(1,109)	-	(1,109)	(1,109)	(1,109)
Term Loans - Finance Leases (non current portio	(1,880)	(1,904)	25	(349)	(2,592)	(61)
Term Loans - Private (non current portion)	-	-	-	-	-	-
Term Loans - Crown (non current portion)	(74,611)	(91,587)	16,976	(90,891)	(91,274)	(90,891)
Custodial Funds	(3,758)	(3,725)	(32)	(3,857)	(3,830)	(3,857)
Non Current Liabilities Total	**(94,918)**	**(111,886)**	**16,968**	**(109,642)**	**(112,395)**	**(109,354)**
Crown Equity						
Crown Equity	(133,759)	(133,759)	-	(133,103)	(133,759)	(133,103)
Crown Equity Injection	(10,198)	(387)	(9,811)	(9,178)	-	(21,778)
Crown Equity Repayments	-	-	-	-	-	707
Trust and Special Funds (no restricted use)	(1,513)	(1,514)	1	(1,442)	(1,443)	(1,442)
Revaluation Reserve	(85,362)	(85,362)	-	(86,314)	(85,362)	(86,314)
Revaluation Reserve - Trust Assets	-	-	-	-	-	-
Retained Earnings - DHB Governance & Funding	1,664	1,734	(70)	2,082	2,002	2,082
Retained Earnings - DHB Provider	80,153	78,823	1,330	77,499	79,633	79,966
Retained Earnings - Funds	26,436	26,135	301	32,688	22,004	34,536
Crown Equity Total	**(122,578)**	**(114,329)**	**(8,249)**	**(117,768)**	**(116,925)**	**(125,346)**
NET FUNDS EMPLOYED	**(217,496)**	**(226,215)**	**8,719**	**(227,410)**	**(229,320)**	**(234,699)**
Zero Check	-	-	-	-	-	-
Part 4.3: Statement of Movement in Equity						
Total equity at beginning of the period	(114,329)	(116,442)		(118,896)	(116,925)	(114,764)
Net Results for Period	1,562	2,113		1,606	-	10,490
Revaluation of Fixed Assets	-	-		-	-	-
Equity Injections / Repayments	(9,811)	-		(478)	-	(21,071)
Other	-	-		-	-	-
Movement in Trust and Special Funds	-	-		-	-	-
Total Equity at end of the period	**(122,578)**	**(114,329)**		**(117,768)**	**(116,925)**	**(125,346)**

Board Cash Flow - Southern

Apr-12

Part 4: DHB Consolidated	Current Month			Year to Date			Annual
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Budget**
	$(000)	**$(000)**	**$(000)**	**$(000)**	**$(000)**	**$(000)**	**$(000)**
Part 4.4 Statement of Cashflows							
Operating Revenue							
Government and Crown Agency Revenue	64,828	67,743	(2,915) U	675,674	677,755	(2,081) U	813,386
Other Revenue Received	997	1,089	(92) U	11,508	10,413	1,095 F	12,453
Total Receipts	**65,825**	**68,832**	**(3,007) U**	**687,182**	**688,168**	**(986) U**	**825,840**
Payments for Personnel	(25,043)	(23,214)	(1,829) U	(255,680)	(250,076)	(5,604) U	(311,477)
Payments for Supplies	(10,353)	(11,450)	1,097 F	(110,046)	(110,304)	258 F	(132,975)
Interest Paid	(1,416)	(1,421)	5 F	(4,377)	(4,564)	187 F	(4,741)
Capital Charge Paid	-	(850)	850 F	(5,388)	(7,526)	2,138 F	(8,908)
GST (Net) & Tax	3,850	(219)	4,069 F	4,035	(176)	4,211 F	(512)
Payments to other DHBs	(2,889)	(2,955)	66 F	(30,717)	(29,552)	(1,165) U	(35,463)
Payments to Providers	(26,950)	(27,635)	685 F	(270,520)	(273,068)	2,548 F	(328,218)
Total Payments	**(62,801)**	**(67,744)**	**4,943 F**	**(672,693)**	**(675,266)**	**2,573 F**	**(822,294)**
Net Cashflow from Operating	**3,024**	**1,088**	**1,936 F**	**14,489**	**12,902**	**1,587 F**	**3,546**
Investing Activities							
Interest Receipts 3rd Party	165	186	(21) U	1,816	1,859	(43) U	2,231
Sale of Fixed Assets	-	-		32	-	32 F	-
Capital Expenditure							
Land, Buildings & Plant	(1,627)	(2,040)	413 F	(16,692)	(19,261)	2,569 F	(23,672)
Clinical Equipment	(1,826)	(669)	(1,157) U	(9,513)	(8,970)	(543) U	(15,322)
Other Equipment	(6)	(107)	101 F	(248)	(1,072)	824 F	(1,287)
Information Technology	(281)	(263)	(18) U	(3,213)	(4,135)	922 F	(4,713)
Motor Vehicles	-	(5)	5 F	(144)	(992)	848 F	(1,002)
Total Capital Expenditure	**(3,741)**	**(3,085)**	**(656) U**	**(29,810)**	**(34,430)**	**4,620 F**	**(45,995)**
Increase in Investments and Restricted & Trust Funds Assets	32	-	32 F	(72)	-	(72) U	-
Net Cashflow from Investing	**(3,543)**	**(2,899)**	**(645) U**	**(28,034)**	**(32,571)**	**4,537 F**	**(43,764)**
Financing Activities							
Equity Injections	9,811	478	9,333 F	10,198	9,178	1,020 F	21,071
New Debt							
Private Sector	-						-
CHFA	-			11,150	-	11,150 F	-
Repaid Debt							
Private Sector	(418)	(246)	(172) U	(2,594)	(2,932)	338 F	(3,400)
CHFA	-	-		(5,258)	(690)	(4,568) U	(920)
Other Non-Current Liability Movement							
Other Equity Movement	-	-		-	-		-
Net Cashflow from Financing	**9,393**	**232**	**9,161 F**	**13,496**	**5,556**	**7,940 F**	**16,751**
Net Cashflow	**8,874**	**(1,579)**	10,452 F	**(49)**	**(14,113)**	14,064 F	**(23,467)**
Plus Cash (Opening)	28,370	22,529	5,841 F	37,293	35,063	2,230 F	35,063
Cash (Closing)	**37,244**	**20,951**	**16,293 F**	**37,244**	**20,951**	**16,293 F**	**11,596**
Carry Forward Check							
Closing Cash made up of:							
Petty Cash	13	13		13	13		13
Bank (Overdraft)	942	438	(504) U	942	438	(504) U	583
Short Term Investments	36,289	20,500	(15,789) U	36,289	20,500	(15,789) U	11,000
Total Cashflow Cash (Closing)	**37,244**	**20,951**	**16,293 F**	**37,244**	**20,951**	**16,293 F**	**11,596**

Printed: 1/06/2012

Wakatipu Health Services Expert Panel Recommendations

	Expert Panel Recommendation	Targeted Completion Date	PROGRESS				COMMENT
			Scoping	Behind	On Track	Completed	
Enhancing Regional Service Planning							
1	The SDHB adapts the provision of clinical services across the region to ensure that as far as possible there is equity of access and comparable outcomes.	2012/13 2013/14	✓				SDR and TLA level intervention data has been modelled. This information is being discussed with clinical teams as part of 12/13 volume setting.
2	The SDHB develops a clinical services programme that defines pathways of care across the whole regions that are safe and as much as possible close to home.	2013/14			✓		Establishing a pathways work-stream leveraging from the SI pathways work championed by CDHB. Has a significant cost, however significant benefits. **Part of DHB quality planning approach.**
3	The SDHB delegates responsibility to a tier 2 manager of the Executive team for the services provided in the Central Otago/Lakes District, ensuring that services are provided: a. Independently of historic boundaries b. In a way that best meets the needs of the patient	Oct 11				✓	GMFF Robert Mackway-Jones assigned to lead strategic planning.
Retaining Hospital Services							
4	The SDHB retains and enhances services at LDH.	On-going			✓		Agreed. Enhancement that requires funding will need to be subject to prioritization across the SDHB region.
5	LDH retains an ED.	Oct 11				✓	Agreed.
6	LDH is retained on the current hospital site and is further developed as a health campus for the Wakatipu Basin.	On-going			✓		Agreed.
Clinical Workforce							
7	LDH maintains a minimum roster of eight medical FTEs, of which one or two could be registrars, supported by HWNZ.	Dec 11			✓		Agreement reached to employ 7 FTE senior medical staff and 1 FTE registrar. Registrar appointment targeted from mid-year along with training funding. Cover for 8 SMO on-going until then.
8	The SDHB pursues a partnership opportunity with the University of Otago to develop a centre of excellence for the training of rural health practitioners.	TBA	✓				Agreed. Building on the existing partnership with the University of Otago. Strategic planning workshop held early March 2012.
9	LDH expands the breadth of services that the medical and nursing teams can provide.	Mar 12			✓		Agreed. For medical see #10. A specialist diabetes nurse role has been established for the central Otago/Lakes area. The role commenced 5 March.
10	The SDHB encourages the development of special interests amongst hospital/non-hospital doctors and nurses in the Wakatipu Basin. Examples include GPs with special interests (GPSI) and senior medical officer with special interest (SMOSI) roles.	Mar 12			✓		Agreed. Completed for the orthopaedic service; has resulted in additional clinics being undertaken at LDH.
Enhancing Integration							

Wakatipu Health Services Expert Panel Recommendations

	Expert Panel Recommendation	Targeted Completion Date	PROGRESS				COMMENT
			Scoping	Behind	On Track	Completed	
11	The SDHB extends an open invitation to appropriate health providers to relocate to the LDH site, supporting the development of better integration of care on a health campus.	From Aug 12			✓		Agreed. **EOI for health providers to develop services on site or relocate was issued April 2012. This closes on 15 June with a number of responses already received.**
12	The SDHB facilitates (through an independent chair) a clinical services forum for ongoing dialogue on health services provision and planning in the Wakatipu Basin.	From Mar 12		✓			Agreed. Over time, benefits could be derived from linkage covering health service provision across the Central Otago/Lakes region in support of recommendations 1 & 2. **Deferred until later in the year.**
13	The SDHB encourages the further integration of services in the region, including sharing of resources, stronger clinical engagement between Dunstan and LDH and the development of clinical pathways and IT solutions. This would include a broader clinical forum covering the Central Otago/Lakes, or perhaps expanding to all rural health.	On-going			✓		Agreed. A collaborative group has been established between the medical officers at the Dunstan and Lakes facilities who have begun cross cover / shifts and swap shifts at the facilities and joint credentialing / training. Pathways links to item #2 where a permanent work-stream is to be established.
Improving Outpatient Services							
14	LDH expands the local and regional provision of outpatient services that better meets the needs of the Wakatipu region (including the coordination of private and public outpatient services).	Mar 12			✓		Agreed. Gastroenterology and Scoping Service and ENT clinics commenced March 12. Orthopaedic Service. As noted in item #10. **Respiratory Service commenced last week (June).**
Enhanced Community Services							
15	The SDHB encourages the development of increased capacity in aged residential care beds in the Wakatipu Basin, improving the ability to provide respite care and slow stream rehabilitation services.	From Aug 12	✓				Agreed. Links to recommendation 11.
16	LDH develops palliative care bed capacity on their campus as part of aged residential care facility developments.	2012/13			✓		**Additional outreach palliative services are now being provided in area by Hospice Southland.** **Planning & Funding have commenced service planning.**
Enhanced Diagnostic Support							
17	The SDHB supports the establishment of a CT scanner for the Central Otago region, located at LDH.	**June 12**			✓		**DHB planning document recommends a staged 2 site approach.**
18	Diagnostic services such as laboratory and radiology are best consolidated onto the LDH site.	From Aug 12	✓				Agreed. Links to recommendation 11.
Governance							

Wakatipu Health Services Expert Panel Recommendations

	Expert Panel Recommendation	Targeted Completion Date	PROGRESS				COMMENT
			Scoping	Behind	On Track	Completed	
19	The SDHB retains governance of LDH, including the funding and provision of health services.	Oct 11				✓	Agreed.
20	Queenstown Lakes District Council, in consultation with the Wakatipu Health Trust and Wakatipu Health Governance Reference Group, establishes a Community Reference Group.	Nov 11				✓	Panel now appointed.
21	The SDHB commits to engaging with the Community Reference Group early in the planning of any significant changes to clinical services.	On-going			✓		Agreed. Terms of reference established. Group meets monthly with GM Finance & Funding in attendance as the DHB tier 2 manager link.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CENTRAL OTAGO/LAKES DISTRICT SERVICE PLANNING – CT SCANNER**
Report to:	Board
Date of Meeting:	7 June 2012

Summary:

The issues considered in this paper are:

- Investment into increased CT scanning services in the Central Otago/Lakes District area .

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	Investment of: ▪ Up to $2.2m over next 7 years of funding (annualised) for a staged 2 site CT scanner approach
Workforce:	Public/Private partnership opportunity
Other:	Strategic planning context for Southern DHB

Document previously submitted to:		**Date:**
Approved by Chief Executive Officer:	Yes	**Date:** 31/05/12

Prepared by: Robert Mackway-Jones GM Finance & Funding **Date:** May 2012	**Presented by:** Robert Mackway-Jones GM Finance & Funding

RECOMMENDATIONS:

That the Board:

1. **Endorse the strategic context outlined in the paper;**
2. **Endorse the two site strategic approach for CT scanning capacity in the Central Otago/Lakes District area;**
3. **Note the detail of the public/private partnership at Lakes District Hospital site will need to be finalised and investment costs from this submitted at a later date;**
4. **Approve the investment proposed of up to $2.2m in operational costs over the next seven years to support CT scanner installations at Lakes District Hospital and Dunstan;**
5. **Note that the annualised operational cost in year 1 is $189k against a total budget provision of $300k.**

Central Otago / Lakes District Service Planning – CT Scanner

Background and Context

In May 2011, SDHB requested the National Health Board (NHB) lead an independent process to develop accelerated planning for future health care services for the Wakatipu Basin. A report from a NHB appointed panel was produced on 29 August 2011. One of the recommendations of the report was for the DHB to develop a business case by May 2012 for the provision of a CT scanner. The detail of the NHB report suggested that a CT scanner be established for the benefit of the Central Otago / Lakes area and be located at Lakes District Hospital.

The NHB report identified that funding, financing and ownership models would need to be considered in the business case with options including grants, fundraising or public / private partnerships. The panel recognised that the DHB would not be the primary funder of the CT scanner.

At its December meeting, the DHB Board requested that DHB management prepare:

- a terms of reference for the review of the location of the CT scanner
- appoint a panel for this review
- seek appropriate input from both Central Otago Health Services Limited (COHSL) and the Wakatipu Health Reference Panel (WHRP) as part of this process
- provide a recommendation to the DHB Board by June 2012.

Considerations from Clinical Forum

A clinical forum was held in February to discuss the CT scanner issue. A summary paper from that meeting has previously been included in the Board agenda but it is re-attached for information. Key findings were:

- The consensus view was that better diagnostic tools in Central Otago would have benefits to patients
- Consensus view that a CT scanner would provide greater benefit in short term based on current needs and technology
- General consensus that majority use of a CT would be for non-acute cases and the biggest population cohort to utilise a CT are the +65 years
- General consensus that CT scans for this cohort would predominately be for medical conditions such as Oncology, stroke, complex general medical and managing TIA
- Acknowledgement that a CT scanner would not significantly alter the management of critical/life threatening injuries; in these situations patient transfers would be made to where definitive care can be provided
- The forum identified the need for increased local availability of referral services
- The forum identified that this decision should be in the context of wider district strategic planning and desired to see a focus on this and how the two facilities can work closer together
- Any decision should be on what is best for next five years
- The group desired to see a win-win option proposed

Population Projections

This section provides a series of Stats NZ population projection statistics either by TLA or census unit level (all using medium series projections).

This data table is presented by TLA area. Most of the Southern DHB population growth is projected to be in the Central Otago / Lakes District areas which has implications for the range and quantity of services provided at the Lakes District Hospital and Dunstan Hospital along with community based services, aged residential care and the like.

Over time, the DHB will need to start shifting resources and appropriate services / funding to respond to this growth. Demographic funding streams from PBF allocations will need to be used to support this. As an example the recent mental health & addictions strategic plan recognised this growth and has a number of planned service responses over the next few years.

Territorial Local Authority	Population Projections (at 30 June)					Change	
	2011	2016	2021	2026	2031	Number	%
Waitaki District	20800	20410	19880	19240	18550	-2250	-10.8%
Central Otago District	18880	19580	20150	20580	20940	2060	10.9%
Queenstown-Lakes District	28180	31730	35100	38410	41660	13480	47.8%
Dunedin City	124780	126670	128040	129100	129680	4900	3.9%
Clutha District	17450	17330	17130	16920	16630	-820	-4.7%
Southland District	29540	29660	29610	29400	28980	-560	-1.9%
Gore District	12220	11890	11470	11000	10420	-1800	-14.7%
Invercargill City	52410	52410	51510	50210	48520	-3890	-7.4%
Total	**304260**	**309680**	**312890**	**314860**	**315380**	**11120**	**3.7%**

Tables by TLA area showing growth from 2006 to 2011:

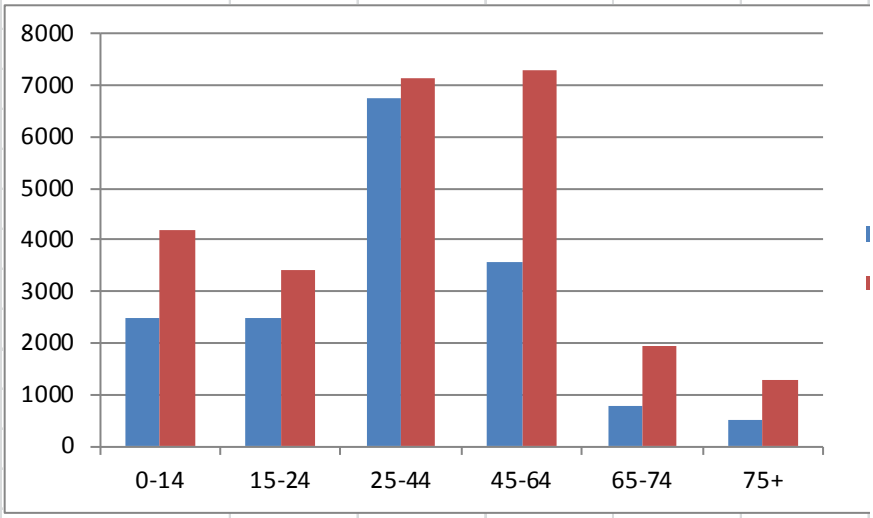
		0-14	15-24	25-44	45-64	65-74	75+	Total
Queenstown-Lakes District	2006	3900	3030	9620	5510	1220	840	24120
	2011	4920	3050	10880	6740	1640	950	28180
	2016	5750	3440	11130	7910	2270	1230	31730
	2021	6370	3720	11110	9540	2710	1650	35100
	2026	6310	4530	10850	11130	3200	2390	38410
	2031	6370	5220	11010	12150	3860	3050	41660

		0-14	15-24	25-44	45-64	65-74	75+	Total
Central Otago District	2006	3130	1750	4070	5130	1710	1280	17070
	2011	3390	1950	4140	5830	2030	1540	18880
	2016	3480	1830	4160	5740	2520	1850	19580
	2021	3440	1840	4160	5630	2910	2170	20150
	2026	3320	1990	4180	5320	3030	2740	20580
	2031	3290	2000	4240	5090	3090	3230	20940

At a census area unit level, residents in Wanaka, Hawea and Matukituki predominately receive services at the Dunstan facility. Data tables have been prepared at the census unit level to show the population splits based on this current (and historically based) service provision.

Wakatipu Area

Age_Group	2006	2026	Change 2006 - 2026	% Change 2006 - 2026
0-14	2490	4177	1687	67.8%
15-24	2483	3403	920	37.1%
25-44	6757	7137	380	5.6%
45-64	3584	7282	3698	103.2%
65-74	757	1954	1197	158.1%
75+	513	1269	756	147.4%
Total	16584	25222	8638	52.1%



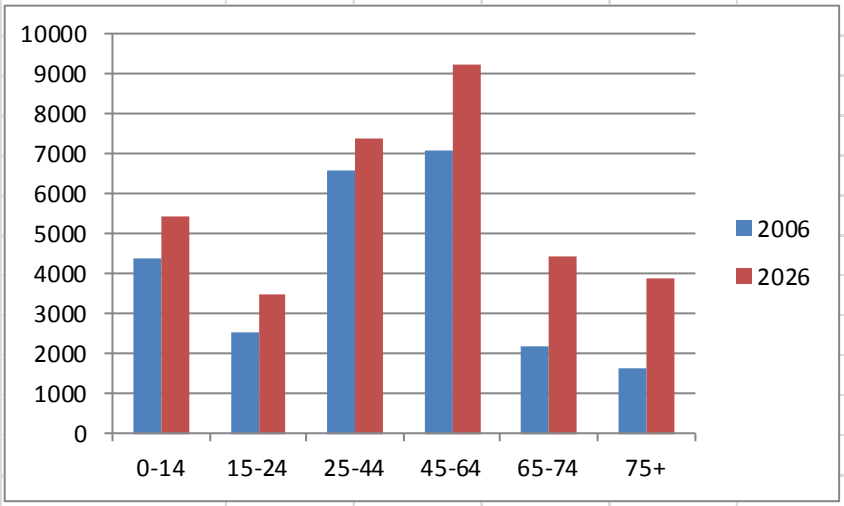
Projected Resident Population by Census Area Unit 2006 to 2026

Wakatipu Area

Census Area Unit	Change 2006 - 2026	% Change 2006 - 2026
Wakatipu	2024	73.9%
Arrowtown	1353	60.2%
Sunshine Bay	1333	57.3%
Queenstown Hill	1226	37.5%
Queenstown Bay	1090	46.3%
Frankton	1005	53.7%
Glenorchy	282	57.8%
Kelvin Heights	241	23.5%
Lake Hayes	83	31.2%
Total	8637	52.1%

Dunstan Area

Age_Group	2006	2026	Change 2006 - 2026	% Change 2006 - 2026
0-14	4385	5445	1060	24.2%
15-24	2530	3505	975	38.5%
25-44	6575	7405	830	12.6%
45-64	7105	9235	2130	30.0%
65-74	2200	4415	2215	100.7%
75+	1615	3860	2245	139.0%
Total	24410	33865	9455	38.7%



Projected Resident Population by Census Area Unit 2006 to 2026

Dunstan Area

Census Area Unit	2006	2026	Change 2006 - 2026	% Change 2006 - 2026
Teviot	1100	1000	-100	-9.1%
Roxburgh	630	590	-40	-6.3%
Ranfurly	720	640	-80	-11.1%
Maniototo	1060	1060	0	0.0%
Naseby	120	120	0	0.0%
Dunstan Area	3860	5780	1920	49.7%
Clyde	940	970	30	3.2%
Alexandra	4940	5140	200	4.0%
Cromwell	3700	5250	1550	41.9%
Hawea	1680	2930	1250	74.4%
Wanaka	5280	9740	4460	84.5%
Matukituki	390	620	230	59.0%
Total	24420	33840	9420	38.6%

The rate of growth for the population group currently serviced by the Lakes District Hospital is higher but the real numbers in the Dunstan facility catchment area are larger and the projected

growth will also be larger in real terms. It should be noted the QLDC projections present higher numbers than the Stats NZ medium series. It is also important to not overly focus on the census unit level population splits and compare these for each facility into the future as this is based on historic service provision.

Closer working arrangements

The key to making the two generalist rural hospital model work into the future is to have the two facilities work closer together focussing on key strengths and reducing unnecessary duplication. Having access to more specialist services would need to ensure no duplication across the sites and this is what requires district wide clinical services. It is important this progresses in a timely fashion, as the Central Otago / Lakes district is where all of the DHB future population growth is projected to occur and it is imperative to configure service provision optimally. This may change the current patterns for patient referrals, but each site will remain an important part of district wide service provision. The DHB has started on this path, but this requires a clinically led approach to service configuration and delivery including how rural hospitals are supported with outreach services.

CT Service Utilisation Data

Based on a two year DHB data set (to June 2011), the total numbers of publicly funded scans for Central Otago / Lakes District residents average to a per annum currently are around 1,300. This is summarised as follows:

Catchment	Outpatient	Emergency	Inpatient	Total
Lakes DH	164	133	154	451
Dunstan	420	153	274	847
Total	584	286	428	1,298

Additionally, the Southland Hospital scans around 25 patients privately, these would be outpatient type / GP referred investigations.

The clinical forum agreed that 90-95% of non-acute scans could be managed locally if a CT scanner was installed. This would pick up the bulk of the outpatient cohort.

A proportion of the inpatient and emergency scans would also be able to be undertaken locally and avoid the need for the patient transfer. Without undertaking detailed analysis of current cases, it is difficult to be precise as to what proportion this would be for each of the two categories; it has been estimated at around 40% of the inpatient/emergency scans. As noted in the clinical forum discussion this would not include critically ill/life threatening situations where the patient would still be transferred to definitive care.

The presence of a local CT scanner would invariably result in utilisation growth from a combination of increased access and increased clinical demand. Therefore it is imperative that appropriate protocols for use be developed and an appropriate funding model is established so that the introduction of CT scanning does not bring with it a requirement to utilise it to justify use or attract funding on a per volume basis.

Some as yet unpublished research data shows that scanning rates per head of population for the Central Otago and Lakes catchment areas have the lowest rates in the Southern district. If scanning rates were brought up to Invercargill and Dunedin levels, the approximate 1,300 scans would equate to around 1,700 scans per annum. This “inequity” of access further supports the installation of local scanning capacity.

It has also been estimated that around 300 scans per annum could be undertaken locally from ACC volumes.

Tourist and visitor numbers are also a relevant consideration for how they impact upon service provision and these numbers are not factored in the data set in this section. The other factor

missing from the data sets; is the amount of privately funded or insurance funded volume from each area. Some feel that a higher proportion of the Queenstown catchment area may elect to have private scans and this is understating the public data set. This is acknowledged, but difficult to quantify the volume due to a lack of data, the DHB does not view the likely numbers as materially distorting the presentation of data.

These volumes indicate significant patient benefit is available from a more localised scanning option being available with the associated reduction in disruption to patient and families from reduced travel to access these services. The DHB would also save money from reduced patient transfer costs. These points were made in the NHB panel report.

Strategic Context

The location of the CT scanner needs to be made in the context of long term strategic planning across the Southern District and in regard to Central Otago / Lakes District and with reference to the population projections. As identified earlier, it is important to configure services using both facilities; building on the strengths of each and avoiding unnecessary duplication. This requires the support of DHB clinical services to plan for district wide services using the single service, multiple sites concepts. This way, historic boundaries can be removed, appropriate pathways and referrals put in place with support for outreach services at the rural facilities. By doing this, residents in the wider Central Otago / Lakes District can maximise access to services that are provided in each of the facilities. The senior doctors at each facility have already started collaborating and working closer together, this needs support from the wider DHB clinical groups.

Diagnostics are a vital step in the pathway to access appropriate treatment. At present, there is limited or no national reporting of the waiting times for most diagnostic tests or procedures even though they can result in significant delays to a patient's episode of care. Improving waiting times for diagnostic services will contribute to Better Sooner More Convenient Healthcare because it will lead to better patient outcomes in a range of areas including cancer pathways, Emergency Department waiting times, and access to elective surgery. The Ministry has begun a three-year programme to improve waiting times for diagnostics. By June 2015; 95% of patients should receive their CT or MRI scan and have it reported on within 42 days unless it is a planned procedure.

Recognising this issue and wishing to ensure capacity is maximised across the district, the DHB is undertaking an assessment of all radiology modalities. This includes CT, however the result from this won't be known for several more months. However it is likely that a CT scanner in Central Otago and ensuring an appropriate level of use for the Oamaru scanner can assist take the current load off the base hospitals and significantly assist in meeting reduced waiting time targets.

Another significant development to provide context for a strategic decision; is the current EOI process for health providers to develop or relocate services to the Lakes District Hospital campus. While this formal process is yet to conclude (15 June closing), interest has been expressed from a private surgical provider to develop day case and other surgical procedures on this site. These services will require a diagnostic suite (likely MRI/CT). This private service could be supported by public service provision creating enhanced access to a range of services for the wider Central Otago / Lakes District population group. However the timing of this requires completion of the formal process in terms of selecting preferred providers to work with, developing a site master plan / service configuration plan, consenting and building facilities along with formal approvals from all parties. This is likely to take a further 2 years from today before facilities and services would be ready but provides an opportunity for the area and wider district from a staff recruitment perspective. It is anticipated a service and site development plan could be finalised around November 2012.

Just as important will be maintaining and enhancing the medical services at both the Dunstan and Frankton sites. This highlights the earlier comments and importance of appropriate planning and service development / site coordination across the district, not only for hospital services, but community based services.

Scanner Placement Options

A number of options for the placement of a CT were reviewed as part of this planning process. A

RFI was issued to assess the feasibility of the mobile unit concept. The RFI drew response relating to mobile units and fixed site units. Options include:

- Mobile CT
- Single site Queenstown
- Single site Dunstan
- Dual Site

Currently the rural facilities receive funding on national pricing units which includes the costs of diagnostics (including CT). Hence the outpatient and inpatient purchase prices (but not ED in some cases) already include this cost. The Rural facilities may hold a differing view of these funding streams. However there are swings and roundabouts with this pricing approach and various diseconomies of scale that are also relevant. Overall, the rural facilities with the current pricing approach run close to break-even and would not be able to absorb the increased costs of a CT into current pricing, despite it containing a component for this. As such, the costs identified in this summary will largely need to be funded by the DHB. Issues such as ACC volumes are likely to attract funding for the provider, but this would result in a transfer away from existing DHB services and not lower the incremental cost to the DHB of installing an additional scanner. If some of this volume transferred from a private provider, then it could result in a lower cost contribution from the DHB.

The following summary provides an indicative cost for each scenario and is from the DHB perspective as a funder of these services. It is not intended to be a detailed business case for the provider of the services, but to indicate the maximum likely DHB cost contribution based on real incremental costs.

Item $'000	Mobile	Single Site Qtown	Single Site Dunstan	Dual Sites
16 Slice CT	495	495	495	900
Workstation / PACS connectivity	50	50	50	100
Trailer Unit	775	-	-	-
Concrete pads @ sites	30			
Building Alterations	-	250	150	400
One off training costs for MRT upskilling				
Capital Investment	1,350	795	695	1,400
Patient Transfer costs avoided	(100)	(50)	(75)	(125)
Depreciation charges CT (7 year life)	78	78	78	143
Depreciation charges trailer (15 years)	52	-	-	-
Depreciation charges buildings (30 years)	-	8	5	13
Trailer maintenance / road user charges	28	-	-	-
Trailer moves (fortnightly)	42	-	-	-
Service Contract	115	115	115	200
MRT costs (40 hour service)	85	45	45	90
Training for MRT's	16	6	10	16
Radiologist readings	98	98	98	98
Administration	8	8	8	16
Services - Power & Radiation protection	10	10	10	20
Consumables - Contrast media, disposables etc	10	10	10	20
Increased data bandwidth	7	5	-	5
Operational Costs	448	333	303	496
Notes				
No Service contract costs in year 1 as covered by warranty,				
May be potential to lower service contract as tube likely to last > 5 years				
Queenstown site assessed as higher building costs due to more limited infrastructure				
MRT assumed @ 0.7 FTE increase for site specific + upskilling of all other MRTs for cross-cover				
MRT assumed @ 1 FTE for mobile option as shared resource				
MRT available for 24/7 call back could increase costs by around $50k per annum				
300 scans via ACC could generate around $150k annual revenue based on RVU's of 11 per scan @ $45				

Recommendation

It is proposed to develop services at both sites.

There is an opportunity to leverage a public / private partnership approach and also to leverage indicative existing community funding support for enhanced services in the area. Without these two aspects, the following proposed approach would not be feasible.

This means the DHB should support installation of a CT scanner in Queenstown under a future private/public partnership (PPP) approach. As noted earlier, this requires completion of the current EOI process and site development between confirmed providers. This proposal has assumed a 70/30% split of the public / private approach for operating costs but a 50/50 split of initial capital for the scanner. The ownership structure for this scanner would need to reflect the community funding support and public service provision. However the final PPP agreements may determine the proportional mix of these factors. Investment would be required in approximately 2 years during the 2014/15 financial year, hence community funding considerations should commence shortly and perhaps as the PPP is finalised.

The DHB should also support an immediate CT scanner installation into the Dunstan facility provided appropriate community funding support can in fact be established. We would work with the Central Otago Health Services Ltd (COHSL) to achieve this and for the ownership and running of this scanner including final detail of funding. COHSL have already indicated they are likely to be able to secure community funding support in the short term. This scanner would support public service provision across the wider Central Otago area until the second scanner is installed at Queenstown.

The reasons for supporting a staged two site approach are that it:

- Supports the current and future population demographics in the wider area
- Provides access to improved diagnostics immediately
- Will assist with district wide demand and help reduce waiting times
- Could support the wider assessment of radiology services and provide an opportunity to look at CT referrals, particularly those from primary care
- Recognises the timeframes required to develop the site plan and public/private partnership at the Lakes District Hospital site
- Supports the continued development of medical services at Dunstan
- Caters to the larger group of patients and patient conditions requiring CT scanning in the current Dunstan catchment
- Provides an opportunity to review models of care for various patient groups (eg stroke) given the presence of scanning capability in the area
- Leverages the opportunity for community funding support
- Provides time for the DHB to align its future demographic funding streams to support two sites as this is not immediately affordable
- Significantly enhances service provision for the Central Otago / Lakes District area

To make overall approach affordable for the DHB; a collective funding arrangement between the DHB, private provider and community support is needed. The amount of community support differs for each installation but this is the reality of the staged approach and likely to simplify community funding based around site specific installations.

The stage 2 site investment approach requires collective investment of $5m across the first 7 years., this total investment would be split by contributors as follows:

- DHB, $2.2m
- Private Investor, $1.4m
- Community funding support, $1.4m

This is shown in the table below.

Financial Summary of Proposal

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
CT Scanners	495		495					990
Connectivity Costs	50		50					100
Building Works	150		250					400
Service Contracts		115	115	230	230	230	230	1,150
Depreciation Charges	83	83	169	169	169	169	169	1,011
Personnel Related	161	161	318	318	318	318	318	1,912
Other Operating Costs	20	20	45	45	45	45	45	265
Patient Transfer Costs avoided	(75)	(75)	(125)	(125)	(125)	(125)	(125)	(775)
Total Investment Outlay	884	304	1,317	637	637	637	637	5,053
Funding of Investment								
DHB	189	189	254	369	369	404	404	2,179
Private	-		665	153	153	233	233	1,437
Community	925							925
Community			513					513
Total Investment funding	1,114	189	1,432	522	522	637	637	5,053

Note - the service costs for the first 3 years for each scanner are assumed to be included and frontloaded into the capital purchase)
Note - the difference in the investment outlay total and investment funding totl relates to the timing of the capitalised service contract for example in year 1, the funding of $1,114k includes $230k of capitalised service contract,

Under the proposal, the DHB will provide operational funding for each scanner that totals $2.2m across the 7 years. To make this affordable and to allow the DHB to stage its investment that increases over time, part of each of the initial scanner purchases will need to include a service contract component upfront. The first year is generally provided under warranty, it is anticipated that the subsequent 2 years are built into the capital purchases of the equipment. The bulk of the service contract relates to the tube replacement which is a capital item.

The DHB procurement team will work to achieve this result in conjunction with the service providers of the scanner (COHSL + future PPP structure). The DHB procurement team will lead the process to source and negotiate the equipment purchase to leverage buying power. A clinical team will be needed to confirm the scanner specifications and connectivity issues.

The DHB funding of operating costs starts at just under $200k per annum moving to $250k in year 3 and to around $400k from year 4 onwards. The funding support provided in the first 7 years includes the depreciation charges which allow for equipment replacement at the end of its lifecycle (approx. 7 years).

The DHB 2012/13 budget has included a new amount of $300k of operational costs for increasing diagnostic capacity for CT (needs to cover Central / Oamaru plus any other impacts from Radiology assessment project). It should be noted however, that the 2012/13 budget has yet to be approved.

Risks and Dependencies

It will be important to ensure the sustainability of the MRT workforce in this proposal. While additional FTE will be required to operate the scanners, additional training is critical so that the entire MRT workforce is up-skilled to provider cross cover. Depending on demand utilisation, call back arrangements may be required which would challenge the financial parameters of this proposal as well as creating additional strain on a relatively small workforce.

Equally, support (and readings support) from Radiologists would need to be established, either with DHB staff or a private provider. Private providers also afford an opportunity for MRT workforce provision. This is viewed as low risk.

Other risks relate to:

- the public / private partnership opportunity being finalised

- acceptability of proposal to potential providers (eg COHSL)
- acceptability / ability to secure community funding support along the lines outlined in this paper
- acceptability / support from community groups including the Wakatipu Health Reference Group

Feedback on Proposal

This proposal has been given to the following groups:

- Clinical forum group (Released Monday 21 May with feedback due end of 24 May)
- Wakatipu Health Reference Group (Released 25 May)
- Central Otago Health Services Limited (Released 25 May)

Of the 17 clinical participants in the February forum, 14 have provided feedback to this paper. Of these 10 support the recommendation, 2 are negative (mainly are the likelihood of any PPP), 1 has reservations still preferring a mobile scanner and 1 neutral response although this person didn't support the mobile option.

The GMFF has met with the Wakatipu Health Reference Group on Tuesday 29 May and with Central Otago Health Services Limited Management and Board members on Wednesday 30 May. Feedback and / or responses from these groups will be provided at the Board meeting.

Summary - Clinical Discussion Forum – CT Scanner for Central Otago / Lakes District

Alexandra, 24 February 2012 (10.30am to 2.30pm)

Attendees

Name	Position
Robert Mackway-Jones	General Manager, Finance & Funding, SDHB
Gerry Wilkins	Clinical Advisor (P&F), Cardiologist, SDHB
Garry Nixon	SMO, Dunstan Hospital
Nigel Thompson	GP, Queenstown
James Reid	SMO, Queenstown Lakes Hospital
Hans Raetz	GP, Queenstown
Tony Travaglia	MRT, Oamaru Hospital
Peter Rodwell	FACEM, SMO, Oamaru Hospital
Jennifer Keys	SMO, Queenstown Lakes Hospital
Elinor Slater	GP, Queenstown
Josie Parker	Radiologist & Clinical Director, Southland Hospital
Joel McReynolds	General Medicine Specialist, Southland Hospital
Roland Meyer	Respiratory Physician Specialist, Southland Hospital
Ben Wilson	Radiologist & Clinical Director, Dunedin Hospital
Glenn Symon	Service Development Manager, P&F, SDHB
Rob Visser	SMO & Clinical Director, Dunstan Hospital & GP, Cromwell
Andrew McLeod	GP, Wanaka
Nic Norman	GP, Alexandra
David Tulloch	Chief Medical Officer, SDHB

The forum commenced with introductions around the table followed by an outline of the terms of reference and the purpose of the meeting.

For the purposes of this document the catchment area of Queenstown, Wakatipu basin, Dunstan, Wanaka, Cromwell, Alexandra; etc. will be referred to as the Central Lakes area.

The following is a summary of the discussions at the forum; they are not minutes reflecting every point made but an attempt to pull together the various threads into a cohesive summary that reflects the day's discussions.

This paper has been endorsed by the attendees as being representative of the day's discussions.

The forum posed some background questions first and then structured the discussion around the 10 items outlined in the terms of reference purpose section.

Background and Introductory Discussion Points

Is a CT scanner the best option?

The initial question posed to the group was to ascertain if the NHB Wakatipu Health Services Expert Panel recommendation for a CT scanner for Central Lakes was the best modality given likely future or current technology developments.

This prompted a wide ranging discussion not only about what the best diagnostic tool, but also the strategic direction for health services in the Central Lakes area. There was agreement that the strategic direction should influence the type and location of services but given the political and community expectations, this is not possible with the CT scanner at this time.

The NHB Expert Panel recommended that a CT scanner is required for the Central Lakes area.

There was a consensus view that better diagnostic tools would have benefits to patients in the area.

It was felt:

- A CT scanner would have a wider range of uses and provide an adequate result in most cases, i.e. more flexible but may not always provide a definitive diagnosis.
- A MRI could provide a more definitive diagnosis in some instances but the scope for use is more limited. It was estimated that the number of procedures where an MRI would be the preferred modality is significantly less than that for CT.
- A CT scanner is quicker and better suited for the type of acute work it would be used for in the area.

Consensus was that a CT scanner would provide greater benefit in the short to medium term based on current needs and the technology available at a reasonable cost.

It was noted, but not discussed in depth, that there are options in the precision of CT scanners. Installing an '8-slice' scanner would be cheaper, but not provide the level of precision of a more expensive '16-slice' scanner (or greater).

The lifespan of a CT scanner is about seven years and technology will have moved on when it comes time to replace. Therefore installing a CT scanner now does not preclude other options being put in place in the medium to long-term. Therefore the any decision should be based on what is best for the next 5 years or so.

Strategic Direction for Health Services in Central Lakes

Strategic direction for hospital services in Central Lakes for the next 5-10-20 years was raised; one base type hospital or two smaller generalist hospitals. The consensus of the forum was that two smaller generalist rural hospitals is the preferred option.

This should be part of a district-wide strategic plan for health services. The rationale for this position was:

- The geography of the area is mountainous and particularly prone to adverse weather in the winter, limiting access in and out numerous times a year.
- The demographics of the area are unique, with four distinct population centres, each with a different population profile.
- A generalist rural hospital is more flexible to the health needs of the population, and has a much closer relationship with primary care and community providers.
- Smaller specialist hospitals are much harder to recruit to, and will always be vulnerable because of the small specialist workforce. The lack of economies of scale makes this a more expensive model. An example given was Grey Hospital.
- The community and political expectations for the status quo are very strong.
- Otago and Southland DHBs had previously canvassed the option of a single larger facility in Cromwell which was not supported.

Key to making the generalist rural hospital model work was the two facilities working closer together, each focussing on their strengths and reducing duplication. It was felt that each have core services that could be reasonably expected to be delivered locally while more specialist services would need to ensure no duplication across the sites.

The group identified that the real gain for services would be in getting the clinical groups working together in the Central region and breaking down any old barriers based on the historic service configuration from the Southland and Otago DHBs. The group desired to see a focus on district wide service planning which addresses these historic issues and made improvements to local services in line with the Governments' expectations and DHB's strategic direction.

It was also felt that the decision around the placement of a CT scanner could have a knock-on effect to service delivery. This however is based on the current referral patterns which are still based on the historic old DHB boundaries.

The group strongly felt that the recommendation on the CT scanner needed a win-win solution so that the bigger opportunity for services and planning in the Central Otago area is not lost.

Terms of Reference Discussion Points

Clinical Indications for CT Scanner

There was general consensus that a CT scanner could be used as a diagnostic tool for both acute and non-acute (elective) patients, but the majority of the usage would be for non-acute cases.

Acute Cases

A CT scanner can be used for acute/urgent cases where the patient is not critical. All critical patients are routinely transported to a base hospital and this wouldn't change with a CT scanner located in the Central Lakes area. These transfers are made to where definitive care can be provided.

A CT scan should not be used as a default diagnostic tool. Clear protocols would need to be developed. Issues such as radiation exposure and over-use were discussed.

A CT scan is generally used for investigation where the clinician hasn't got a definitive answer. The investigation is warranted where it can provide better information that will reduce morbidity and/or influence the treatment options e.g. to rule out a subdural haematoma.

Just as important is what the CT scanner would not be used for. A CT scanner would not be used as a diagnostic tool for:

- acute patients with critical/life threatening injuries
- acute patients where care could not be continued at the local facility
- cases where a CT scan does not provide more definitive answers that other diagnostic tools could provide.

This is important to communicate to the public as the feeling was that the public expectations of the benefits for a CT scanner are incorrect i.e. the erroneous understanding of the public is that a CT is going to save lives in critical cases.

Non-acute (outpatient elective) Cases

Non-acute cases would form the bulk of CT scans done in Central Lakes (the same as elsewhere). The majority of CT scans for outpatient elective cases currently done for Central Lakes patients could be done locally; it is estimated to 90-95% of CT scans for non-acute cases could be done locally.

Usage

Both, Lakes District Hospital and Dunstan Hospital see patients of all ages and presentations with differing distributions during winter and summer months. There are two distinct patient cohorts who will use the CT scanner.

65+ years Cohort

The biggest population cohort to utilise a CT scanner will be people 65 plus years old. CT scans for this cohort will be predominantly for medical conditions such as oncology, stroke, and complex general medicine and managing TIA. Whilst a number will be urgent, the majority of these medical cases will be elective in nature (non-acute) and can be scheduled.

This age cohort is projected to increase by 63% (15,770 increase in people) in the next 20 years and will be a significant driver of future demand. The area currently serviced by the Dunstan facility has twice the number of over 65's than Queenstown Lakes which is serviced by the Lakes District Hospital facility; this is projected to increase to 1.28 times by the year 2026.

Data from a research study by Dr Garry Nixon shows that 44% of current scans are undertaken on the >70 years age band.

15-40 years Cohort

Trauma is the predominant presentation for people in the 15 – 40 year old cohort. A CT scanner may be a useful diagnostic in an estimated 40-50% of cases where it can be used for an increased likelihood for a more definitive diagnosis, improving treatment decisions, minimising morbidity and unnecessary travel to a base hospital.

Queenstown Lakes has a unique population profile with a proportionally large resident population in the 15 – 40 year old cohort and the very large number of visitors, both local and overseas to the area. Adventure and ski tourism contribute the majority of trauma cases for this age cohort and are seasonal in nature. Trauma cases peak during the July to September ski season and the 6-8 weeks holiday break over the summer.

Demand Management

Current CT utilisation rates for the Central Lakes population are significantly lower than for Dunedin and Invercargill. This could be due a number of reasons but access issues will contribute to this. Therefore it is anticipated that demand will increase when a CT scanner is installed locally. This was shown in data for the Oamaru population.

Good protocols will need to be put in place to ensure that CT scans are not used unnecessarily.

Models of Care & Patient Flows

Irrespective of any models of care, everyone was in agreement that there must be radiology oversight of all CT scans. Currently this is challenging due to a number of issues such as disjointed IT systems limiting access to images and reports, differing clinical pathways and administration.

There needs to be universal access to images and reports across the district and good lines of communication are essential.

For acute patients there needs to be a decision tree on where to send patients.

For elective patients, accessing the CT scanner locally will negate the need to travel to either Dunedin or Invercargill. To be really beneficial to patients, the referral services should also increasingly be available locally. Increased outpatient services for the main indications should be explored and encouraged/enabled, e.g. oncology, orthopaedics, general medicine. The group identified there is only limited benefits to have a scan locally only to then later have to travel for the specialist outpatient appointment.

The location of a CT scanner will affect patient flows in a number of ways which have potential significant impacts on services.

1. Access for acute patients – via ambulance, referred from primary care, self-referral.
2. Transfer of patients to base hospital
3. Referral pathways for specialist services.

The group felt that until true district wide services existed, the placement of a CT scanner in one location could pose a risk of patient moving away from definitive care. On existing patterns, it was felt that acute volume from Dunstan to Lakes would be small because of this. The bigger flow could be acute from Lakes to Dunstan but this also has implications for both base facilities if referral patterns change. The winter load at LDH is seen as a significant issue by the LDHB doctors.

Looking at District capacity for scanning, the group felt there is an opportunity for integration between the sites. Capacity could and should be managed across the system on an equitable basis. Services closer to home are best for the patient and should be supported where practicable.

Infrastructure and Operational Considerations of the CT Scanner

Direct CT costs

- capital costs - CT purchase, installation
- operational costs - maintenance, reporting, workforce

Transport costs – ambulance transfer, National Travel Assistance costs, private transport

Increased clinical and support services – new/additional locally outpatient services/clinics,

Patient costs – transport, accommodation, time off work, family and support people.

Operating hours

The consensus was that the majority of CT scans should be performed during normal business hours i.e. 8-5pm Monday to Friday. Extended hours during the ski season would also be beneficial; this could see the service available until 7-8pm including weekends.

It is important to consider the implications for workforce in operating hours. The MECA for MRTs requires adequate breaks; calling someone in at night may mean they are unable to work the next day. This has implications for rosters and adequate cover.

It was probably not feasible to operate a 24/7 CT service, and in reality it probably isn't necessary. Any acute patient who was unable to wait 4-8 hours is usually viewed as critical and should be transferred to a base hospital. It was noted that the Oamaru scanner has 24/7 cover, however this does not operate under DHB MECA rules. Options for operating hours will need to be considered in the business case.

Location Considerations

The medical officers at Lakes District and Dunstan Hospitals have formally established a collaborative working group following the NHB review. This group outlined to the wider forum group what they saw as potential solutions. Following discussion of the options (summarised below) the consensus view from the forum was that these options should be included in the DHB business case. The group again reiterated the importance of finding a win-win scenario.

Option 1 – Mobile CT Scanner

The first option presented was installing a mobile CT scanner that moves between Queenstown Lakes Hospital and Dunstan Hospital. Mobile CT scanners are used in rural areas in the United States, especially where there are large seasonal populations such as ski resorts.

The mobile CT scanner would be sited where the greatest demand is anticipated. This would see the following arrangements:

- based at Queenstown Lakes Hospital during the ski season (July-Sept) and over the summer (Dec-Feb) for the peak in trauma cases.
- Based at Dunstan Hospital Feb-June and Oct-Dec.

It was thought that a mobile CT scanner can operate from the mobile surgical bus pad at each site. The practicalities and costs of shifting a CT scanner were unknown, but weren't seen as an insurmountable issue.

The current MRT workforce is qualified (or can be readily trained) to operate a CT scanner. The increased workload would be minimal and would be in the region of 1 FTE (0.5FTE at each site).

The Oamaru business case from some years back may provide a good reference point.

This "elegant" solution would potentially offer value for money and go a long way to appeasing to communities who both want to host the proposed CT scanner. There are many details to work through to understand if this is a feasible option, but for the majority this concept was the preferred option.

It was acknowledged that this option could be more expensive than a single permanent CT scanner, but that the communities would support this.

It was felt that scheduling for outpatient elective scans would need to be coordinated across the wider district and would simply go to where the scanner was placed at the time.

Option 2 – Two CT Scanners

Given that there are clinical benefits for a CT scanner at both sites, it was thought prudent to investigate what the costs would be for two CT scanners in comparison to the option of a mobile scanner. This option, from a cost perspective, would probably only work from installing the lower precision '8-slice' CT scanner. Cost comparatives to 16 or even 64 slice would be needed and also be dependent on the trained MRT workforce. Workforce requirements would be similar to option one with a small increase in FTE at each site. The current MRTs would operate the CT scanner with the necessary training where required. Again, the Oamaru business case may provide a good reference point.

The group felt the real incremental operating costs may not be as large as some think and this requires a great deal of thought as part of the DHB business case.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**SOUTH ISLAND REGIONAL HEALTH SERVICES PLAN**
Report to:	Board
Date of Meeting:	7 June 2012

Summary:

The issues considered in this paper are:

- Improved access and treatment for cancer patients
- Better mental health and addictions support for consumers and their families
- Quality, timely and accessible treatment for children
- Consistent and restorative care for older people
- Effective support services
- Effective information technology
- Long term support for under 65 year olds with long term conditions
- South Island Regional Training Hub
- Risks and deliverables
- Milestone Dashboard

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	N/A
Workforce:	N/A
Other:	N/A

Document previously submitted to:	Not submitted to another committee	**Date:** 28/05/12
Approved by Chief Executive Officer:	Yes	**Date:** 29/05/12

Prepared by: Jan Barber General Manager South Island Alliance Programme Office **Date:** 2012	**Presented by:** Lexie O'Shea Deputy Chief Executive Officer

RECOMMENDATION:

1. **That the report be received.**

SOUTH ISLAND REGIONAL HEALTH SERVICES PLAN

Progress Report

Subject	South Island Regional Health Services Plan – Q3 Progress Report
Lead Chief Executive	Chris Fleming, Chair, South Island Alliance Leadership Team
Reporting period	January - March 2012

The South Island regional activity aims to provide increasingly integrated and co-ordinated health services through clinically-led service development, and its implementation within a 'best for patient, best for system' framework.

The South Island DHB collaborative activity continues across a large number of clinical and support services. The outcomes from the key activities during the third quarter of 2011-12 are described below.

Key Outcomes achieved in this Reporting Period

Improved access and treatment for cancer patients

The South Island Clinical Cancer Information System project aims to provide key information on outcomes of treatment. METRIQ is the software system used for the South Island Clinical Cancer Information System. METRIQ has been installed and training is ongoing. Imports of the radiation oncology data will occur in June 2012 providing a regional view of radiation oncology data from the two public and one private South Island cancer centres.

A sub-group of the South Island Bowel Working Group has been formed to develop a South Island Rectal Cancer Fast Track Pathway. The data interpretation of the Bowel Patient Mapping Report is being undertaken. This report will now be completed in Q4.

Better mental health and addictions support for consumers and their families

The Mothers and Babies service has begun expanding the scope of education sessions to include wider stakeholders; extra videoconferences have been offered to the DHBs by the Regional Service Coordinator. The next sessions in the teaching programme will focus on assessment tools. Up-skilling staff will enable a better service to be provided.

The South Island Eating Disorder Service (SIEDS) has reviewed the weight recovery programme and made some changes to the service provided. This service continues to experience shorter average lengths of stay as a result of the changes. Guidelines for local pre-admission programmes have been developed; SIEDS is currently working on identified gaps.

The Regional Medical Detoxification Service has started education and support sessions for medical detox to keep DHBs up-to-date on treatment options. There has been a positive response from the sector. Referrers contact the regional provider directly to discuss individual cases for advice in the preparation for a managed withdrawal. Those people utilising the service appear to be better prepared for their detox compared to those not utilising the service. A small increase in referrals for Methadone Stabilisation treatment has been noted.

A Service Provision Framework for regional forensic outpatient services has been drafted for the Forensic Governance Group. The pilot project, *Provision of data and information to inform regional and local planning,* develops a mechanism to capture and report services provided by a DHB to consumers and staff of another DHB in a consistent manner. It is underway at the West Coast and Nelson Marlborough DHBs, and due for

completion May 2012.

Quality, timely and accessible treatment for children

The Child Health Service Level Alliance (SLA) continues to work collaboratively to make collective service improvements for children accessing secondary and tertiary services across the South Island. A documented pathway development procedure has ensured good support and engagement with clinicians across South Island paediatric services. The Hernia Health Pathway has been implemented; two more general surgery pathways for pyloric stenosis and intussusception are in draft. A working group has been established to develop the congenital neonatal pathway. Implementation and support of regional health pathways is facilitated by all South Island DHBs using similar health pathway websites for local pathway development.

The Paediatric Early Warning Observation Charts for children aged 1 to 4 years that were implemented across paediatric services in Q2 have been evaluated and recommended improvements have been made. Observation charts for children aged 5 to 15 years have been developed. The Care Management and Communication Plan project was evaluated to complete the Paediatric Early Warning Score Tool. The Tool is shared across South Island paediatric services. This tool provides a best practice standard and ensures consistency in practice across South Island paediatric services.

Review of the South Island Child and Youth Epidemiology Report by the SLA working group has highlighted areas of variation in service utilisation to elective surgical procedures. Particular areas of focus for further consideration are Ambulatory Sensitive Hospitalisations, gastroenteritis, skin infections, oral health and elective surgeries, including grommets and tonsillectomy. The Child Health Quality Workstream and future shared health pathways work will focus on these areas to drive service improvements and address inequalities.

The Child Health Quality workstream is developing markers of success related to each health pathway and will undertake monitoring, and evaluation, of clinical quality and safety indicators related to service delivery. The Hernia Pathway has three clinical and two quality/safety indicators identified as markers of success. Health pathway will help to ensure patients get access to sub-specialty paediatric services at the right time, in the right place and by the right clinical team.

Further development of travel pathways defining more clearly which infants and children can safely travel on commercial flights will potentially result in more timely transfers between tertiary and secondary paediatric hospitals (shown through tracking travel plans for South Island children) and provide greater convenience for families. As clinicians have precise guidance and tools to assess need, cost savings for DHBs are likely to occur as more expensive transfers can be avoided. Quality indicator development will attempt to document changes as they occur.

Consistent and restorative care for older people

InterRAI continues to be rolled-out across the South Island. The West Coast DHB Needs Assessment Service Coordination (NASC) service is using interRAI. The NASC function is being reconfigured and merged into a wider clinical network as part of the *Better Sooner More Convenient* initiative. Canterbury DHB's roll-out of interRAI is on target, with a focus on transitioning the Contact Assessment for Community Services providers to use in complete needs assessments for older people with non-complex needs. Southern DHB has a significant focus at present on 'bedding in' the system. In large, the information service issues at Southern DHB have been resolved. The use of InterRAI across the South Island will enable a consistent and comprehensive approach to assessments of older people.

The South Island Dementia Initiative continues to be implemented across the region. At the West Coast DHB, a dementia training coordinator has been appointed and is working with the rest home sector. Canterbury DHB has completed the South Island Dementia Initiative (SIDI) business case and decided, in conjunction with the Aged Care Workstream, to focus dementia education programmes on community services providers. At Southern DHB, the business case is being progressed as part of the wider DHB Health of Older People Service Development Plan. SIDI will be encompassed as part of Southern DHB's Day Activity Service planning. Nelson Marlborough DHB has received the proposal from SIDI and is looking at how to embed the 'Walking in Another's Shoes' (WIAS) Programme into Mental Health Services for the Elderly Team. South Canterbury DHB has included SIDI as part of its planning for 2012-13, subject to final Board approval. Older people receiving the service will benefit from the up-skilling of staff through receiving more informed and appropriate care.

The Health of Older People SLA is engaging on the issue of defining the best, most evidence-based

programmes for Restorative Models of Care and developing recommendations on the most appropriate restorative activities for the region. The SLA has also assessed the model of training for WIAS dementia workforce development and highly recommends it to the region as a programme that can supplement other training programmes by concentrating less on knowledge and more on attitude, and culture, change with a focus towards person-centred care. The method through which this will be achieved will be determined.

Effective support services

The savings figure through to the end of February 2012 (8 months) is $12.59m savings from the South Island Alliance (using the HBL reporting methodology). This figure is comprised of Procurement savings ($11.07M) and Other savings ($1.52M).

Food Services and Laundry Services have been established as new workstreams. HBL is actively involved and have commented, *"That's excellent… It's good to build a strong partnership foundation to move things forward".* HBL have been invited to all meetings of the SLA and workstreams, and staff are actively engaged.

Effective information technology

A Programme Director for the Information Services SLA has been appointed. The Information Services SLA has also collaboratively engaged with the National Health Information Technology Board and with the National Institute for Health Innovation to develop a Patient Administration System (PAS) that provides future standards for interoperability.

Long term Support for under 65 year olds with Long term Conditions

Expenditure against devolved funding is managed on a regional basis: Updated funding advice for the LTC service has been provided for 2011-12 that reflects small movements between DHBs. Further information was requested from the Ministry of Health as analysis of current expenditure by the South Island DHBs does not align to the updated funding calculation. Further work is currently underway to try and resolve this difference; as any issues need to be identified prior to the updated 2012-13 funding calculation.

Operationally, all aspects of the LTC service are continuing. The South Island DHBs maintained the same NASC services as contracted by the Ministry of Health for the first 12 months. At this stage it is likely the South Island DHBs will continue to contract with the current NASC services for a further 6 to 12 months to allow further service development work to be undertaken.

South Island Regional Training Hub

The South Island Regional Training Hub Steering Group, with representatives across the four clinical work streams (Medical; Nursing; Midwifery; Allied Health Scientific & Technical) and Maori & Pacific Health has now met for the first time. Key issues identified at that meeting included:

- The approval of the Programme Plan by the SI Alliance Leadership Team.
- An agreement (and process) to finalise the unbundling of the coordination funding as requested by HWNZ.
- Recognition of the discussions currently underway in relation to the General Practice Education Programme Reform.
- Changes to funding of postgraduate medical education by HWNZ and the upcoming road shows regarding this (SIRTH to be advised of South Island dates)
- The need for clarity around the Medical Workstream going forward.
- The breadth of groups included in the Allied Health Scientific & Technical work stream.
- Recruitment for the Regional Programme Director Training position will commence following clarification of HWNZ involvement in funding and appointment process.

Risks to Deliverables	
Risk	**Mitigation**
Incomplete roll-out interRAI across the South Island.	The Health of Older People SLA will meet with the National interRAI Software Service Manager and the Ministry of Health Programme Manager for the roll-out of interRAI in Home-Based Support Services. The Programme Manager will also attend the Health of Older People SLA meeting in May 2012.
Inability to implement the South Island Multi-Disciplinary Meeting (MDM) project to improve the supporting infrastructure and increase access, and utilisation of MDM.	Clarification sought from preferred vendor on aspects of the proposal. Paper re-submitted to South Island Information Services SLA providing further clarification on the decision of the Multi-Disciplinary Meeting Advisory Group. Recommendation required and to be forwarded to the SI Alliance Leadership Team.

Milestones Dashboard

Legend
On Target
Caution
Critical
Complete
Not Started

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
Southern Cancer Network						
1.	Development and implement a SI blood and cancer service plan.	Q4	Q4		On Target	Terms of reference complete and coordination for first meeting underway.
2.	Implementation of the SI Clinical Cancer Information System.	Q3	Q3		Complete	METRIQ purchased and training database in place.
3.	Share cancer control knowledge and information to enable informed decision making.	Q4	Q4		On Target	
4.	Efficiency gains and improvements to the patient journey are identified in the patient mapping reports (lung and bowel tumour streams), implemented and monitored.	Q2	Q4		Caution	Bowel interpretation by external personnel taking extra time. Weekly teleconferences with reviewers. Lung stocktake comparative data cleansed. Data cleansing time required is greater than anticipated. Analysis report being prepared.
5.	Development of an (electronic) integrated referral system, SI medical oncology protocols, e-prescribing and an enhanced system (via SICCIS) for recording the medical oncology prioritisation wait times (pending the outcome of the funding bid for Medical Oncology Prioritisation Wait Time RFP).	Q4	Q4		On Target	Components of the project have been hampered by the continuing delays due to the onetime data import in CDHB for medical oncology, however system functioning in radiation oncology. The Project Advisory Group have agreed to a staggered implementation with the Dunedin Cancer Centre starting first rather than the planned coordinated implementation across both centres.
6.	Develop and support the implementation of a SI 10-year plan for radiation oncology (including linear accelerator review).	Q2	Q2		Complete	South Island Linear Accelerator Demand Modeling Report 2012 -2025 complete.
7.	Implement the SI Multi-Disciplinary Meeting (MDM) project to improve the supporting infrastructure and increase access, and utilisation of MDM.	Q2	Q4		Caution	RFP process complete, recommendation from the MDM Advisory Group made. Delays occurring in process to endorse MDM Advisory Group decision.

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
8.	Ongoing support and monitoring of the utilisation of PET Scans and other diagnostics in the SI.	Q1	Q1	Q1	Complete	
9.	Reducing inequalities projects are supported within the local cancer networks.	Q4	Q4		On Target	
10.	All SCN network groups are provided with ongoing support to progress actions in their respective work plans.	Q4	Q4		On Target	
11.	The advanced symptom management system (ASyMS©) bid (currently with Health Workforce New Zealand) will pilot an integrated cross tertiary and community technology based patient management system that will change current workforce and work flow while supporting a greater number of cancer patients self-manage (with support) while receiving chemotherapy in the community.	Q3	Q4		Caution	HWNZ has approved this pilot proposal. Contract negotiations with the Ministry have pushed out the start date to July 2012. Start date delayed due to contracting issues between the University of Otago Research Office and the international researchers which has now been resolved. Health Workforce has renegotiated the project start date to be the 1 July 2012.
Child Health Service Level Alliance						
1.	Development markers of processes of health care (performance indicators), benchmark and work collaboratively to understand differences and identify opportunities for involvement	Q4	Q4		On Target	
2.	Monitor and evaluate paediatric epidemiology data to assess the health status of the SI child and youth population	Q2	Q2	Q2	Complete	First SI epidemiology report received and informing 2012-13 work plan. Evaluation ongoing.
2a.	Analysis of Epidemiology report	Q4	Q4		On Target	
3.	Develop and implement regional clinical pathways for children from secondary to tertiary care providers and where appropriate from secondary/tertiary to primary care providers	Q4	Q4		On Target	
3a.	Development of travel for unwell children on commercial flights pathway	Q4	Q4		On Target	
4.	Develop a SI regional paediatric workforce development plan in conjunction with national workforce development and planning, including succession planning for regional paediatric multi-disciplinary teams	Q2	Q4		Caution	Linked with SI Regional Training Hub. Shared CME video-conferencing sessions have occurred and are ongoing to support clinicians working in remote/smaller services.

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
5.	Develop and implement regional Paediatric Early Warning Score protocol (PEWS), a quality improvement tool to improve assessment of un-well children and ensure the right care at the right time, by the right service is provided for all SI children	Q4	Q4		On Target	
Health of Older People Service Level Alliance						
1.	Develop a common approach to restorative service delivery of community services	Q1		Q2	Complete	
2.	Roll-out interRAI across each of the SI DHBs	Q4			Caution	Key IT and staff resource and access issues remain to be solved to enable the tool to reach its potential.
3.	Standardise the eligibility criteria and processes for entry to services across the SI	Q1		Q2	Complete	
4.	Implement the SI Dementia Initiative. Each DHB to run a first round of the regional dementia training programme (Walking in Other's Shoes)	Q4			On Target	
5.	Health of Older People Alliance developed workplan focussed on priority areas across the continuum of Older People's Services	Q4			On Target	
Mental Health Service Level Alliance						
Mothers and Babies						
1.	Regional provider expands the scope of regular education sessions beyond secondary care; tailoring specifically for individual districts and the needs of the wider health sector by utilising local/district expertise	Q3			Complete	
2.	Regional service offers case discussion and liaison to DHB service staff	Q3			Complete	
3.	Completing a stocktake of existing peri-natal and post partum screening tools, with a view to developing a suite of tools for SI use	Q4			On Target	
Eating Disorders						

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
4.	The regional provider engages with DHBs to review the length of the weight recovery programme and trial utilisation of short stays	Q3		Q3	Complete	
5.	DHBs and the regional provider develop guidelines for a local "pre-admission programme", including medical stabilisation. The pre-admission programme would provide active treatment at a DHB-level for the consumer while on the waiting list for a tertiary level inpatient bed	Q4			On Target	
Medical Detox						
6.	The regional provider to provide education and support for medical detoxification, keeping DHBs up-to-date on treatment options	Q2		Q3	Complete	Commenced 2 Feb 2012.
7.	Each District improves pre-admission medical detoxification support. DHBs work closely with consumers to reduce the daily intake to an appropriate level for successful medical detoxification, and promote the use of Nicotine Replacement Therapy before entry to the medical detoxification programme	Q4			On Target	
Child and Youth Alcohol and Other Drug Residential						
8.	The regional provider purchase technology (e.g. videoconference equipment or Skype) for enabling distance collaboration (co-working with the DHB service) and ongoing communication	Q2		Q2	Complete	
9.	Odyssey House are supported by DHBs and SIAPO to undertake a facilitated process to clearly define eligibility criteria and define roles and responsibilities of both the regional provider and the DHB services	Q1	Q1	Q1	Complete	
Inpatient Child and Youth Services						
10.	Regional provider improves the routine discharge planning process to facilitate a better transition process	Q2			Complete	
11.	Include DHB staff as early as possible in discharge planning, enabling DHB staff to work with the regional service prior to	Q2			Complete	

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
	discharge if clinically indicated					
Forensic						
12.	Develop business rules for the consistent and standardised collection of data relating to Forensic services across the South Island	Q1	Q4		Caution	6-month pilot in WCDHB and NMDHB for standardised collection of data commenced Nov 2011, due for completion May 2012.
13.	Develop a SI Forensic Outpatient service provision framework	Q3		Q3	Complete	
Canterbury Recovery Actions						
	Yet to be determined					
Information Services Service Level Alliance						
1.	**Clinical information systems which includes Clinical Data Repository (CDR) and clinical workstation.** Initially Labs and Radiology with medicines to follow by Q4 2012/13 All health practitioners across the South Island DHBs will have access to clinical workstations (Concerto™). • All hospital health practitioners will have access (evaluation of GP access currently being undertaken). Future access for ambulance officers currently being scoped using mobile computing. All DHBs will be using e-Pharmacy. • CDHB evaluating new version e-pharmacy then once this is completed roll out to other SI DHBs.	Q4 2011/12 Q4 2011/12			On Target On Target	
2.	**Imaging/picture archive (PACS-Radiology and regional archive)** by Q2 2012/13 Webalogic programme currently being evaluated as a regional solution. Discussions currently underway with radiology group regarding regional radiology image viewing.	Q4 Q4			On Target On Target	
3.	**Clinical Support Systems (E-referrals and electronic ordering of tests) by**	Q3			Complete	

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
	Q2 2012/13 Electronic ordering of tests has been subsequently included in the Clinical Support Systems, intended as a regionally aligned solution using a sysmex product with fax capability in the first instance of the roll out.					
4.	**Patient Administration System (PAS)** For completion by Q4 2012/13	Q4 2012/13			Caution	Caution the completion date of Q4 2012/2013: this project needs to maintain the timeframes as NMDHB has a system that will be supported in a process of good faith for an additional 18 months. Process underway for RFP process.
	Project Initiation Document endorsed by ALT, this is currently being updated to reflect NHITB & National Institute for Health Innovation collaboration	Q3			Complete	
5	**Medicines Management** (Q2 2013/2014) Continue to collaborate with the national initiatives on medicine management and the timelines for every hospital to utilise electronic prescribing by the end of 2014. Initial roll out in Dunedin is on target with discussions are underway regarding a more general rollout across the region with business case in CDHB currently being written	Q4			On Target	
6	**SCN work stream; implementation of the SI Clinical Cancer Information System.** Q4 2012/13				On Target	
	SICCIS Implementation plan has been accepted.	Q3 2011/12			Completed	
	Metriq & Mosaiq-connect are now installed and data imports from training data base have recommenced.	Q3			Completed	
	Advisory group have recommended a staged and iterative implementation. Go live has not occurred yet.	Q4			On Target	

ID	Milestones and Deliverables	Approved Schedule	Current Forecast	Actual	Legend	Reason for deviation and actions to remediate the plans
Support Services Service Level Alliance						
Procurement and Supply Chain Work Stream						
1.	Analysis of SI capex and develop South Island capex plan for 2011/12	Q1	Q1	Aug 2011	Complete	
2.	Develop a single SI savings report	Q1	Q3		Caution	Waiting on finalisation of HBL savings template. SI feedback is currently being incorporated into HBL template. This has been outstanding from HBL since July 2011.
3.	Delivery of agreed 2011/12 procurement projects (commodities and capex)	Q4	Q4		On Target	All projects that were forecast to be in process are progressing.
4.	Processes and Documentation	Q3	Q3	Jan 2012	Complete	Projects and reports consistent using Daptiv project management tool.
5.	Training and Development	Q2	Q4		Caution	PRINCE2 project management training has been offered to staff, however, key procurement staff have resigned at CDHB and NMDHB. Current priority is on keeping staff, rather than training.
6.	Meet the savings expectations	Q4	Q4		On Target	
Other Work Stream Development						
7.	Formalisation of Laundry Services Workstream	Q2	Q4	Mar 2012	Complete	Approved as new workstream.
8.	Formalisation of Food Services Workstream	Q2	Q4	Mar 2012	Complete	Approved as new workstream.
9.	Formalisation of Clinical Engineering Workstream	Q2	Q4		On Hold	Pending development of Business Case for submission to ALT.
10.	Formalisation of Maintenance and Engineering Workstream	Q2	Q4		On Hold	Pending development of Business Case for submission to ALT.
11.	Facilitate initial discussions around workstreams for waste, fleet and support services	Q1	Q2		On Hold	Working with HBL regarding their national plans.

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 2 May 2012, commencing at 5.00 pm, in the Board Room, Southland Hospital Campus, Invercargill

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Present:	Dr Malcolm Macpherson	Chairman
	Mr Neville Cook	
	Ms Sandra Cook	
	Mrs Kaye Crowther	
	Mrs Mary Flannery	
In Attendance:	Mr Joe Butterfield	Board Chairman
	Mr Robert Mackway-Jones	General Manager, Finance & Funding
	Mrs Gemma Griffin-Dzikiewicz	Portfolio Manager – Mental Health (by videoconference)
	Ms Jeanette Kloosterman	Board Secretary (by videoconference)

1.0 WELCOME

The Chairman welcomed everyone to the meeting.

2.0 APOLOGIES

There were no apologies.

3.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Register. None were advised.

The Chairman asked if Committee members were aware of any agenda items with which they may have a potential conflict and reminded them of their responsibility to advise the meeting immediately should any potential conflict, actual or perceived, arise during discussions.

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on 4 April 2012 be approved and adopted as a true and correct record."

Moved: Mrs Crowther
Seconded: Ms Cook

5.0 MENTAL HEALTH AND ADDICTION STRATEGIC PLAN

The General Manager, Finance and Funding presented a report on the feedback received on the draft Mental Health and Addiction Strategic Plan 2012-2015: *Raise Hope: Hapaia te Tumanako,* and recommendations from management on the plan, for the Committees' consideration (agenda item 5).

The Mental Health Portfolio Manager outlined the consultation process undertaken and the key feedback received.

The Committee received a verbal report from Ms Cook summarising the feedback from the Iwi Governance Committee (IGC) meeting that morning. The General Manager, Finance & Funding also advised that there were two IGC representatives on the core planning group and a Māori representative was involved in the submissions analysis.

The General Manager, Finance & Funding and Mental Health Portfolio Manager then took questions from members on the plan and its implementation.

It was resolved:

1. **That the Committees support the eight specific recommendations outlined in the recommendations summary;**

2. **That the Committees note changes made to the Strategic Plan resulting from consultation feedback;**

3. **That the Committees recommend the Board approve the Mental Health and Addiction Plan 2012-2015;**

4. **That the Committees/Board note Planning & Funding will begin implementation of the plan and report on progress to the Disability Support and Community & Public Health Advisory Committees.**

Moved: Mr Cook
Seconded: Mr Macpherson

It was agreed that monitoring of the plan's implementation would become a standing DSAC/CPHAC agenda item and Planning & Funding would submit an implementation plan and regular progress reports to the Committees.

CONFIDENTIAL SESSION

At 5.37 pm it was resolved that the public be excluded for the following agenda items:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda.	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i) and 9(2)(j) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations.

Moved: Dr Macpherson
Seconded: Mr Cook

The meeting closed at 5.38 pm.

Confirmed as a correct record:

Chairman .....

Date .....

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Wednesday, 2 May 2012, commencing at 2.00pm in the Board Room, Community Services Building, Southland Hospital Campus

Present:	Mr Paul Menzies	Chairman
	Mr Neville Cook	
	Dr Malcolm Macpherson	
	Mr Tahu Potiki	
	Dr Branko Sijnja	
	Mr Richard Thomson	
	Mr Tim Ward	
In Attendance:	Mr Joe Butterfield	Board Chairman
	Mrs Kaye Crowther	Board member
	Mrs Lexie O'Shea	Chief Operating Officer, Southland/Deputy CEO
	Mrs Vivian Blake	Chief Operating Officer, Otago (via vc)
	Mrs Leanne Samuel	Chief Nursing and Midwifery Officer
	Mr David Tulloch	Chief Medical Officer
	Ms Bron Anderson	Senior Business Analyst, Southland
	Ms Stacy Belser	Community Relations Officer, Southland
	Mrs Joanne Fannin	Board Secretary Southland
Apologies:	Ms Carole Heatly	Chief Executive Officer

1.0 WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. An apology was noted from HAC member, Mr Tahu Potiki, for lateness and from the CEO, Ms Carole Heatly.

It was resolved:

"That the apologies be accepted."

Moved: Mr Menzies
Seconded: Dr Sijnja
Carried

2.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Register. None were advised.

The Chairman asked if members were aware of any agenda items with which they may have a potential conflict and reminded them of their responsibility to advise the meeting immediately should any potential conflict arise during discussions.

3.0 ACTION SHEET

The Committee reviewed the action sheet and the following highlights were noted:

Action Point 75 – Southern Clinical Services – the report on progress with Southern Clinical Services is still being compiled and the Chief Medical Officer advised that it was unlikely that the target date in June 2012 for the six clinical services would be achieved.
Action Point 76 – HQP Indicators – three new graphs have been included in the HAC agenda. A number of other indicators, particularly relating to quality, are being developed. The process is taking longer than anticipated with challenges around information being recorded in a different way across the two sites. Work continues to get

the indicators for the HAC aligned. Significant work is being done to ensure that the information is being recorded in the same way in the Patient Management System (PMS).

The Board Chairman, Mr Joe Butterfield, joined the meeting at 2.10pm.

The HAC Chair and HAC member, Mr Richard Thomson, agreed to meet following the meeting to discuss Mr Thomson's concerns around the adequacy of the reporting to the HAC.

4.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

"That the minutes of the 4 April 2012 Hospital Advisory Committee meeting be approved and adopted as a true and correct record."

Moved: Mr Ward
Seconded: Dr Sijnja
Carried

5.0 MATTERS ARISING

There were no matters arising from the previous minutes.

6.0 CHIEF OPERATING OFFICERS' REPORT

The Chief Operating Officer, Southland/Deputy CEO, Mrs Lexie O'Shea, provided an update on the Chief Operating Officers' Report and took questions from members and the following highlights were noted:

- Elective caseweights delivered (cwd) and health target elective discharges were above plan for March 2012 and year-to-date (YTD).
- The unfavourable financial result was noted.
- Reporting on the operational performance is included in the Provider Arm Dashboard DAP 2011/12.
- Health targets – progress continues in most of the health target areas.
- The reports on elective caseweights, elective discharges and overall Southern DHB performance against Elective Service Performance Indicators (ESPIs) were noted.
- Mr Thomson noted the increase, with acute cwd being approximately 6% ahead of contracted volumes and queried the degree to which this contributed to the unfavourable financial performance. The budget is built from an historical base and the importance of lining up where the volumes are over was noted.
- An update was provided on the process related to the new Ophthalmologist who is to commence at Southland Hospital.
- In discussion on the steady progress with the health target for shorter stays in Emergency Departments (EDs) in Southland, it was noted that a refreshed team has been appointed to continue the progress. The fluctuations experienced in Dunedin appear to be volume related.
- Management responded to concerns raised over the cost of the increasing numbers presenting at ED, noting a number of areas had been looked at to mitigate the financial risk.
- It was confirmed that the third Linac at Dunedin Hospital to reduce waiting times for radiation oncology is now on track.
- A full report on the Community Oral Health project will be provided for the HAC meeting to be held on 6 June 2012.
- Members expressed concern at the cost of the high rate of 'Did not attends' (DNA) at 10%. The DNA rate is similar to the national rate and the Māori Health Directorate is working hard to reduce the Māori Health DNA rate.
- An update was provided on the delay with the implementation of the InterRAI Project and it is expected that the waiting list should be eliminated within six months.

- An update was provided on the health target to provide better help for smokers to quit. The Chief Nursing and Midwifery Officer (CNMO) advised that clinically there are some patients where it is inappropriate to hold discussions.

7.0 CHIEF OPERATING OFFICER'S REPORT, OTAGO

The Chief Operating Officer, Otago, Mrs Vivian Blake, provided an update on her report and took questions from members, and the following highlights were noted:

- Elective cwd and elective discharges were above plan for March 2012 and (YTD).
- Operational performance was noted with the Elective Theatre utilisation and high ED attendances during March 2012 highlighted.
- An update was provided on the recruitment of a vitreoretinal surgeon at Dunedin Hospital and how the back log of 1500 Ophthalmology patients will be managed.
- In an update on radiology services, the COO Otago advised that work is progressing towards district wide services. Mr Thomson advised the need for members' to have more information on wait times, etc. included in the agenda.
- An update was provided on the Main Operating Theatres and the impact of running two acute theatres every day.
- In response to concerns over the Children's Health Outpatient service, the COO Otago is to provide feedback on completion of the review of the waiting list management.
- The HAC Chairman acknowledged staff on the Dunedin site for their efforts with the elective service cwd 7% above plan. The COO Otago noted that staff had also assisted one of the other DHB's with their additional cardiac procedures.

8.0 CHIEF OPERATING OFFICER'S REPORT, SOUTHLAND

The Chief Operating Officer, Southland/Deputy CEO, Mrs Lexie O'Shea, provided an update on the report for the Southland Hospital site, took questions from members and the following highlights were noted:

- Contract performance for Southland has improved with full staffing within Orthopaedics positively impacting on volume delivery and discharges. An emphasis in Ophthalmology for the current month will also positively impact on the reporting to the HAC for the month of April 2012.
- Operational Performance – noted and taken as read.
- The challenges with the Elective Service Performance Indicators were noted and an improved result is expected in the May 2012 results, due to the activity in the area of Ophthalmology.
- Work progresses to ensure all services achieve within the six month waiting time by the end of June 2012 as required.
- Concern was expressed at the brevity of the Medial Directorate Update report.

9.0 CHIEF MEDICAL OFFICER'S REPORT, SOUTHLAND

- The Chief Medical Officer spoke to his report, noting the results of the Breast Screening Audit had indicated there are some challenges within the service and these are being addressed at the current time. No outstanding outliers were identified. A debrief is planned in the near future.

10.0 CHIEF NURSING AND MIDWIFERY OFFICER'S REPORT

The Chief Nursing and Midwifery Officer (CNMO), Mrs Leanne Samuel, provided an update on the Nursing and Midwifery Dashboard, with the following key points highlighted:

- Southern DHB is moving to an ace match trial for new graduate recruitment for Nursing. This is a national programme and supersedes the South Island new graduate programme for recruitment through Health Workforce NZ. This represents a substantive change and the system is modelled on the first year House Surgeon recruitment programme.
- Following a recent Institute for Healthcare Improvement (IHI) quality meeting held, nursing and medical management have been working together to establish key

performance indicator (KPI) reporting. The challenges to get a common platform across multiple sites due to the data issues identified were noted. There is a willingness to set systems in place and work is progressing. A significant amount of work is going on around patient safety indicators and clinical KPIs.

- The CNMO reported on how Nurse Practitioners achieve registration and why there are so few of them. There are currently five registered Nurse Practitioners across the district and three further candidates currently involved with the process. Training is at a University level. The difficulty with finding clinical placements for the increasing number of students enrolled on the Southern Institute of Technology (SIT) Enrolled Nurse undergraduate Programme was noted.

11.0 FINANCIAL REPORT

The Senior Business Analyst (SBA) Southland, Ms Bron Anderson, provided an update on her financial report and the following areas were highlighted:

- The March 2012 result was unfavourable to budget by $380K and the YTD Provider Arm is $2.524K unfavourable to budget.
- The key issue relates to over-expenditure in the personnel costs area and is due to additional FTE appointments, lump sum collective agreement settlements and leave not being taken as budgeted.
- Revenue is slightly above plan overall by $334K YTD. Personnel costs are unfavourable by $2.707K YTD, with the largest outlier being Medical Personnel costs, offset by a favourable variance in the Nursing Personnel costs. Outsourced expenses are on plan and the need to offset the outsourced expenses against the salary line was noted.
- The unfavourable result for outsourced clinical services of $1.043K YTD was noted. This relates to the outsourcing of radiology services and ESPI compliance.
- Clinical supplies are unfavourable to budget by 1% ($567K) YTD and this relates mainly to acute services.
- Infrastructure and Non Clinical Expenses are unfavourable to budget by 1% ($2.858K) YTD.
- The forecast has been updated to reflect known changes and the impact of the March 2012 result. The forecast reflects an unfavourable variance to budget of $3.644K.

In response to a query around laparoscopic surgery resulting in a saving through shorter stays and less clinical supplies, the CMO advised that any savings are negated by the available beds being utilised for additional patients.

The SBA advised that mitigation strategies were being worked on to minimise the forecast deficit. It was hoped that some of the unfavourable variance attributed to leave would be offset due to leave taken over the Easter and School holiday period. Additional revenue is attached to the target for short waits and if the target is met district wide there will be revenue benefits for Southern DHB.

The SBA responded to queries from Mr Thomson around the methodology used in preparing the forecast position. For budget purposes an assumption is made that all leave will be taken within the year. It was acknowledged that there is a timing issue with budgeting for leave. The COO Southland/Deputy CEO provided an assurance that management across the organisation are aware of and working to address the issue of leave management. There are areas within the organisation where taking leave is difficult due to recruitment challenges.

Mr Tahu Potiki joined the meeting at 2.30pm.

12.0 INFORMATION SYSTEMS (IS) DASHBOARD

Members noted the IS dashboard and the COO Southland/Deputy CEO responded to a query noting that InterRAI was complete from an IS perspective, but work was still progressing with staff training, etc. from an operational perspective.

13.0 HUMAN RESOURCES (HR) DASHBOARD

The HR dashboard was noted and taken as read and the COO Southland/Deputy CEO provided a brief update on the Incubator Programme.

14.0 BUILDING AND PROPERTY SERVICES

The Building and Property Services report was noted and taken as read.

It was resolved:

"That the management and financial reports be noted."

Moved: Mr Menzies
Seconded: Mr Thomson
Carried

15.0 CONFIDENTIAL SESSION

***At 3.22pm, it* was *resolved*:**

"That the public be excluded from the meeting for consideration of the following agenda items:

General subject:	***Reasons for passing this resolution:***	***Grounds for passing the resolution:***
Previous Public Excluded Hospital Advisory Committee Minutes	*As per reasons set out in previous agenda*	*S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.*
Risk Register	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*
Ninth Operating Theatre Dunedin Hospital, Business Case	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*
Chair in Neurosurgery – Invercargill Licensing Trust (ILT) Funding Application	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*

Moved: Mr Menzies
Seconded: Dr Sijnja
Carried

The meeting resumed in open session at 4.20pm.

The Board Chairman queried the process around the recording of resolutions following the confidential session of the meeting.

***It* was *resolved*:**

"That the following business transacted in committee be confirmed:

Ninth Operating Theatre, Dunedin Hospital

That the Hospital Advisory Committee recommends that the Board seeks approval from the South Island Regional Capital Committee and, subject to approval being granted, approve the commissioning of a ninth operating theatre in the Main Operating Theatre Suite at an estimated capital cost of $1.6M.

Chair in Neurosurgery – ILT Funding Application

That the Hospital Advisory Committee recommends that the Board supports an application to the Invercargill Licensing Trust (ILT) for a grant towards the Chair in Neurosurgery at the University of Otago."

The meeting closed at 4.26pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

Minutes of the Iwi Governance Committee Meeting held on Wednesday, 2 May 2012, commencing at 12.15pm in the Committee Room, Murihiku Marae, Tramway Road, Invercargill

Present:	Mrs Eleanor Murphy	Ōtākou Rūnaka - Chair
	Mr Taare Bradshaw	Hokonui Rūnaka
	Ms Ria Brodie	Proxy for Puketeraki Rūnaka
	Ms Sandra Cook	Board Member, Southern DHB
	Mrs Kaye Crowther	Board Member, Southern DHB
	Mr Paul Menzies	Deputy Chairman, Southern DHB
	Mr Tahu Potiki	Board member, Southern DHB
	Ms Odele Stehlin	Waihōpai Rūnaka
	Mrs Ann Wakefield	Ōraka Aparima Rūnaka
In Attendance:	Mr Donovan Clarke	Kaiwhakahaere Hauora Māori
	Ms Pania Coote	District Manager Māori Health
	Mrs Joanne Fannin	Board Secretary Southland
Apologies:	Ms Kingi Dirks	Moeraki Rūnaka
	Mr Peter Ellison	Puketeraki Rūnaka
	Ms Hana Morgan	Awarua Rūnaka – Deputy Chair
	Ms Carole Heatly	CEO, Southern DHB

1.0 WELCOME APOLOGIES AND KARAKIA

The Chair welcomed members to the meeting, noting that karakia had taken place at the launch of the Māori Health Directorate. Ms Ria Brodie attended as proxy for Puketeraki and was welcomed. Apologies were noted from IGC Deputy Chair, Ms Hana Morgan; IGC members, Ms Kingi Dirks and Mr Peter Ellison and the CEO, Ms Carole Heatly.

It was resolved:

"That the apologies as noted be accepted."

2.0 MEMBERS' DECLARATION OF INTEREST

The Chair called for any adjustments or amendments to the Interests Register.

Ms Ria Brodie noted her conflicts of interest as indicated below:

- Runaka member for Puketeraki on Tumai Ora.
- Puketeraki representative on the Manawhenua Health Working Party.
- Puketeraki Runaka Executive member.
- Māori Advisor, Public Health South, Southern DHB.

3.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

"That the minutes of the 3 April 2012 Iwi Governance Committee meeting be approved and adopted as a true and correct record."

Moved: Ms Wakefield
Seconded: Mr Bradshaw
Carried

4.0 MATTERS ARISING

The KHM is to discuss the tobacco control plan further with Public Health South and report back to the next meeting. The smoke free funding is directly through the Ministry of Health (MoH). Board members advised the need for a reporting mechanism that identifies that delivery targets against contract are being met. With statistics showing one in four Māori smoke, the KHM advised the need to get somebody to speak to the IGC on this at a future meeting. The DMMH provided an update for members on the additional funds received for cervical smears across the Southern DHB district. The KHM provided an update on meetings with the CEO and Chair of Southern PHO, noting that Southern PHO recently released its Māori Health Plan (MHP) and Programme of Action. Discussion was held on the alignment between the Southern PHO and Southern DHB MHP.

5.0 MĀORI HEALTH IMPLEMENTATION PLAN (MHIP)

An updated MHIP was tabled for members' information (***appendix 1***) and the DMMH spoke to the changes made. In discussion the following key points were highlighted:

- The changes being made to the Southern DHB MHP for the 2012/13 year. Only minor changes have been made to the local, regional and national targets.
- Work on the local targets was outlined.
- A request was made for more detailed reporting on outcomes against the targets and for the agenda for IGC to be more strategic with more information and analysis to be provided. The priority is the people who require the care and improving the outcomes of the population.
- An update was provided on the Health Workforce funding and a request was made for more targeted reporting on this.
- It is important that a reporting mechanism is in place for the Directorates to feed back to the MHD on the Māori Health targets in their respective areas.
- A request was made that reporting be provided for all services delivering outcomes to Māori, including one provider that is now capturing 19% of Māori youth.

6.0 ACTION SHEET

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

- **Action No. 75 – Southern PHO Board** – Mr Paul Menzies advised on the initiatives being looked at to ensure closer alignment between Southern PHO and Southern DHB governance and management meetings and formal notification regarding these will be forwarded by Southern PHO.

- **Action No. 92 – Southern PHO MHP** – it was agreed that an invitation should be extended to the CEO, Southern PHO to attend the next meeting of the IGC to provide an update on the next steps with the Southern PHO MHP.
- **Action No. 97 – Raise Hope – Hapaia te Tumanako** – discussion was held and members noted they were happy to support the document provided the recommendations made by the MAGMH were captured following the consultation. The Chair highlighted the reference under C11 noting the need for Māori to be more visible in the document. Members requested that for future documents requiring feedback, management provide a summary position highlighting the areas of concern and how they are being addressed. It was agreed that Mrs Kaye Crowther would speak to IGC's position at the joint meeting of the Disability Support Advisory Committee (DSAC)/ Community and Public Health Advisory Committee (CPHAC).

Mr Paul Menzies left the meeting at 1.20pm.

The BSS left the meeting at 1.35pm.

7.0 UPDATE BY THE KAIWHAKAHAERE HAUORA MĀORI (KHM)

The report by the KHM, Mr Donovan Clarke, was received and noted.

The KHM advised on the proposed structural change announced by the CEO on 19 April 2012. It was noted that the KHM role actively participates within Southern PHO.

8.0 MĀORI REPRESENTATION ON STEERING/ADVISORY GROUPS

Smokefree Steering Group – agreed that the DMMH continue her role on the steering group. The Chair recommended that Mr Josh Clarke be appointed as Māori representative on the steering group and this was supported subject to the appointment being in line with the Terms of Reference for the group.

Health of the Older Person (HOP) Advisory Committee – the IGC supported the recommendation that Ms Janeece Cournane be the Māori representative on the HOP Advisory Committee.

Gateway Assessment Steering Group – appointments to Gateway have not been confirmed. The Terms of Reference (ToR) for the group are to go out for wider consultation and this is to be included in the agenda for the meeting to be held on 6 June 2012.

9.0 EXPRESSIONS OF INTEREST - MAGMH

Ms Ria Brodie left the room for the discussion due to her conflict of interest. IGC members supported the following appointments to the MAGMH:

- Ria Brodie
- Joanne Hayes
- Carol Padgett

10.0 GENERAL

Public Health South (PHS) – in discussion, members requested that a representative/s from PHS be invited to present to the IGC meeting in July 2012.

Māori Health Targets and Outcomes – a request was made for more information on the targets and accountability for Māori Health services for all services provided by Southern DHB, Southern PHO and Māori Health Providers. In particular there is a concern around the alleged high number of Māori not enrolled with a GP.

Te Waipounamu Māori Health Summit, Christchurch – brief discussion was held on the summit to be held on 11 May 2012.

11.0 CONCLUSION

The meeting concluded with a closing karakia.

The meeting closed at 2.50pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

SOUTHERN DISTRICT HEALTH BOARD

The Audit & Risk Committee is scheduled to review its terms of reference at its meeting on 7 June 2012 and will make a recommendation to the Board.

Title:	**TERMS OF REFERENCE**
Report to:	Audit & Risk Committee
Date of Meeting:	7 June 2012

Summary:

The issues considered in this paper are:

- If ToR are still appropriate / current
- No changes to the current ToR are proposed by management

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	None
Workforce:	None
Other:	None

Document previously submitted to:	N/A	**Date:** N/A
Approved by Chief Executive Officer:	Pending	**Date:** dd/mm/yy

Prepared by: Robert Mackway-Jones, Gm Finance & Funding **Date:** 21/05/12	**Presented by:** Robert Mackway-Jones, GM Finance & Funding

RECOMMENDATIONS:

1. **That the Committee recommends the current Terms of Reference be approved by the Board for a further one year term**

Southern District Health Board

AUDIT & RISK MANAGEMENT COMMITTEE'S TERMS OF REFERENCE

ACCOUNTABILITY

The Audit and Risk Management (A&R) Committee is constituted by the Board under clause 38 of schedule 3 to the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).

The procedures of the Committee shall also comply with Schedule 3 of the Act.

Any recommendations made by the A&R Committee must be ratified by the Board prior to any release of recommendations or decisions to other parties. Any decisions that are sub-delegated and made by the A&R Committee must be ratified by the Board.

The Internal Auditor is responsible to the Board through the Chair of the A&R Committee. The Internal Auditor reports to the Committee against an agreed programme as determined by the A&R Committee.

OBJECTIVES

The objective of the A&R Committee is to assist the Board in fulfilling its responsibilities relating across all financial management controls and risk based operational areas namely Governance, Funder and Provider-arm. These responsibilities include but are not limited to those set out in sections 41-42 of the NZPHD Act and section 51 and part 4 Crown Entities Act 2004 (CE Act) and related regulations.

SCOPE

To give advice and recommendations to the Board members of the DHB on audit and risk management matters including:

1. Assurance that control mechanisms are in place to ensure compliance with legislation, regulations, and Ministry of Health strategies relating to the services provided or funded by the DHB.

2. Assurance that the DHB has appropriate service agreements, monitoring and auditing processes in place to optimise financial and operational outcomes.

3. Assurance that appropriate internal and external audits are carried out to ensure high standards of patient care, service delivery, resource management and internal control mechanisms.

4. Assurance that internal and external systems are in place to identify and manage financial, clinical and other operational risks through robust contingency planning.

5. Assurance that the level of clinical planning, policy, patient care and quality improvement activity aligns with national standards and Ministry of Health guidelines.

RESPONSIBILITIES

Audit

- Overseeing the development of the audit function, policies and procedures for the Board and recommending to the Board an appropriate annual audit strategy that is based on the DHB's key risk areas.
- Assist the external auditor to identify risks and issues relevant to the external audit planning process.
- Liaise with the internal auditor, review the internal audit scope, planning and resourcing.
- Recommend to the Board the appointment of the internal auditor and periodically review the performance and effectiveness of the internal auditor.
- Receive the reports of the internal and external auditors and review their findings.
- Meet with both the internal and external auditors at least once per annum with management excluded.
- Monitor the progress made by management in implementing recommendations arising from audit.

Financial Controls & Reporting

- Review all significant or statutory accounting policy changes and recommend acceptance by the Board.
- Review the annual report with the Chief Executive Officer, Chief Financial Officer and the external auditors and recommend acceptance by the Board.
- Review and advise the Board regarding finance-related policies and procedures requiring Board approval, including an annual review of its delegation policy.

Risk and Quality Management Oversight

- Ensuring that the DHB complies with its obligations under key legislation and keeps other legislative compliance arrangements under review.
- Review the development of risk management strategy for the DHB and monitor its implementation and risk reporting.

- Review and monitor options for annual insurance cover within the DHB national collective approach to insurance. Any shortfall or risk identified by the Committee shall be reported to the Board.

- Oversee as appropriate the ongoing development of a quality improvement framework and effective operational system that assures safe quality patient focused care.

- Annual presentation of the quality and risk framework by the Quality & Risk Manager.

- Fraud Hotline reporting in line with the Fraud Policy.

- Review organisation wide risk assessment and management processes to ensure appropriate and timely action and contingency planning to manage risks, including internal control.

- Review the approach to maintaining an effective internal control framework, including external parties such as contractors is sound and effective.

- Review the risk associated with capital expenditure prioritisation and any potential impacts on quality and safety standards

- Oversee the development of a Fraud Prevention Strategy, policies and procedures for the Board and recommending to the Board an appropriate Fraud Policy and Fraud Prevention Framework.

- Receive and investigate disclosures under the DHB's Protected Disclosures / Whistle-Blowing policy where it is not appropriate for these to be received and investigated by the Chief Executive.

MEMBERSHIP

All members of the Committee are to be appointed by the Board. The Board will appoint the chairperson.

The Committee is to comprise of Board members, supplemented with external appointees as required.

Where a person, who is not a Board member, is appointed to the Committee, the person must give the Board a statement that discloses any present or future conflict of interest, or a statement that no such conflicts exist or are likely to exist in the future.

In the absence of the appointed Chairperson, the Committee shall elect a member to act as Chairperson for the purposes of any properly constituted meeting.

The following Executive staff while not members of the A&R Committees will be in attendance when appropriate and when requested by the Committees:

- Chief Executive Officer
- General Manager Finance & Funding
- Executive Management staff when appropriate

- Risk and Quality Manager when appropriate
- Internal Auditor & External Auditor by invitation

Committee Members shall be appointed for the term of the Board.

CONFLICT OF INTEREST

To be declared by members and staff when a potential conflict exists with an agenda item. A register of interests shall form part of each Committee meeting agenda.

MEETING

Four Committee meetings are to be held per annum with additional meetings as required, in particular to meet financial reporting requirements.

QUORUM

The quorum of members of a committee is,—

(a) if the total number of members of the committee is an even number, half that number; but

(b) if the total number of members of the committee is an odd number, a majority of the members.

REVIEW

These Terms of Reference shall be reviewed annually by the Board.

ACCESS AND REPORTING

The A&R Committee has confidential access to the internal and external auditors (and vice versa) as required to fulfil its objectives, roles and responsibilities. It also has access to the DHB's Chief Executive Officer and to any other staff through the Chief Executive Officer. The A&R Committee is authorised by the Board to obtain outside legal or other independent professional advice if necessary to fulfil its role. The A&R Committee shall report its activities via its minutes to the Board.

INFORMATION

The following information will be supplied to the A&R Committee:

Audit

- Draft and final internal and external audit plans and strategies
- External audit engagement letter
- Internal and external audit reports/letters (draft and final)
- Schedule of action points and management reporting of progress made.

Financial Controls and Reporting

- Draft and final financial statements of the DHB for the Annual Report
- Details of any proposals to change accounting policies and their impact
- Finance related policies and procedures of the DHB and details of any planned amendments
- Asset Management Plan.

Risk Management Oversight

- Risk management policies, procedures and regular reports.

CHFA Debt Renewal

The Audit & Risk Committee will be considering the following request at its meeting on 7 June 2012 and will make a recommendation to the Board.

RECOMMENDATION:
That the Committee recommends the Board approve the $10.0m loans maturing on 16th July 2012 be renewed to 15th May 2021 at an indicative rate of 3.73%

Briefing to:	Audit & Risk Committee		
Subject:	CHFA Debt renewal		
Author:	David Dickson / Robert Mackway-Jones Finance Manager / GMFF	Date	14 May 2012

Purpose of Report : **For Information Only** √ **Decision Required**

Background

Current debt with the CHFA is $97,400m with two loans totalling $10.0m maturing on the 16th of July 2012.
The current debt amounts and terms are as follows;

Loan Name	Total Principal	Maturity Date	Interest Rate
CHFA SL007 70811/71051	**5,000**	**16/07/2012**	**4.90%**
CHFA Sthn DHB 77101/77341	**5,000**	**16/07/2012**	**3.88%**
CHFA SL008 46895/47135	12,000	15/04/2013	6.11%
CHFA OT DHB 54632	5,000	15/04/2013	6.96%
CHFA Sthn DHB 76495/76735	10,000	15/04/2014	4.28%
CHFA OT DHB 54633	6,250	15/04/2015	6.55%
CHFA SL007 70812/71052	6,000	15/04/2016	5.75%
CHFA Sthn DHB 77102/77342	10,000	15/04/2016	4.75%
CHFA OT DHB 54634	10,000	15/12/2017	6.42%
CHFA Sthn DHB 76496/76736	10,000	15/12/2018	5.06%
CHFA Sthn DHB 77045/77285	4,500	15/03/2019	4.34%
CHFA Sthn DHB 77103/77343	7,000	15/12/2019	5.22%
CHFA Sthn DHB 82851/83091	1,250	15/05/2021	4.40%
CHFA Sthn DHB 82846/83086	5,400	15/05/2021	4.40%
	97,400		

Proposal

The recommendation fit compared to the guidelines provided by the Treasury policy is as follows:

Value	Maturity	Term	% of loan portfolio*	Range in Policy
$17m	April 2013	Less than one Year	17.45%	0-20%
$10.0m	April 2014	1-2 Years	10.27%	0-20%
$22.25m	$6m April 2015 $16m April 2016	2-5 Years	22.84%	20-35%
$24.5m	$10m Dec 2017 $10m Dec 2018 $4.5m March 2019	5-7 Years	**25.15%**	10-25%
$23.65m	$7.0m Dec 2019 $6.65m May 2021 $10m May 2021	> 7 Years	24.28%	0-25%

*As at 31st July 2012

For the interest expense budget in 2012-2013 the interest rate estimated for these loans was 4.5%. With the rate indicated now of 3.73% reduced interest costs from budget will be $73.6k

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) - MAY 2012

PROVIDER NAME	DESCRIPTION OF SERVICES	SIGNED BY	CONTRACT/VARIATION END DATE
Montecillo Veterans Home & Hospital Ltd t.a Montecillo Veterans Home & Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Leanne Illingworth	27.06.12
Nga Kete Matauranga Pounamu Charitable Trust Variation to Agreement	Antenatal Breastfeeding Classes.	Thelma Brown	31.03.12
Otago Mental Health Support Trust Variation to Agreement	Consumer Advocacy & Peer Support & Development Network	Peter Hay	31.03.13
Southern Primary Health Organisation Service Schedule	Workforce Development.	Peter Hay	31.10.12
Ryman Healthcare Limited t.a Rowena Jackson Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	04.07.12
Corpac Trust Variation to Agreement	Budget Advisory Service for People Living with Mental Illness.	Gemma Griffin-Dzikiewicz	30.06.13
Roayl New Zealand Plunket Society Southland Variation to Agreement	Tamariki Ora/Well Child Services.	Thelma Brown	30.06.12
Royal New Zealand Plunket Society Incorporated Variation to Agreement	Pregnancy & Parenting Education.	Peter Hay	31.03.13
Oceania Care Company Limited t.a Cargill Home Variation to Agreement	Individual Agreement for a Named Individual.	Peter Hay	30.09.12
Ryman Healthcare Limited t.a Rowena Jackson Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	10.07.12
Little Sisters of the Poor Aged Care New Zealand Ltd t.a Sacred Heart Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	01.07.12
Marne Street Hospital Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	15.07.12

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) - MAY 2012

Southern PHO Variation to Agreement	After Hours Primary Care Initiatives.	Carole Heatly	30.06.12
Caring Communities Incorporated Variation to Agreement	Family / Whanau Advocacy & Peer Support.	Gemma Griffin-Dzikiewicz	30.09.12
Oamaru Mental Health Support Charitable Trust Variation to Agreement	Adult Activity Based Rehabilitation	Gemma Griffin-Dzikiewicz	31.10.12
The Carroll Street Trust Variation to Agreement	Community Residential	Peter Hay	31.03.13
Central Southland Hospital Charitable Trust Board Agreement	Winton Maternity Services.	Peter Hay	31.03.15
Queenstown Medical Centre Partnership Agreement	Pregnancy and Parenting Education	Peter Hay	31.03.13
Teviot Valley Rest Home Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	09.07.12

TOTAL AMOUNT FOR THE MONTH: $2,438,291.09