Southern DHB Board Meeting

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

04/05/2021 09:30 AM - 12:30 PM

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	9.1	Strategic Refresh (verbal update)	11.15 am PACEO	
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APOLOGIES

An apology has been received from Prof Peter Crampton, Deputy Board Chair.

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Board, 4 May 2021

Recommendation

That the Board receive and note the Interests Registers.

Purpose

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

Changes to Interests Registers over the last month:

- Peter Crampton, Deputy Board Chair, added
- Lisa Gestro, former Executive Director Strategy, Primary and Community, removed

Background

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

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

Appendices

- Board and Executive Leadership Team Interests Registers

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Pete Hodgson (Board Chair)	22.12.2020	Trustee, Koputai Lodge Trust (unpaid)	Mental Health Provider	
	22.12.2020	Chair, Callaghan Innovation Board (paid)		
	22.12.2020	Chair, Local Advisory Group, New Dunedin Hospital		
	22.12.2020	Member, Steering Group, New Dunedin Hospital		
	22.12.2020	Board Member, Otago Innovation Ltd (paid)		
	25.02.2021	Board Member, Quitta Ltd (unpaid)	Nicotine replacement therapy under development.	
Peter Crampton (Deputy Board Chair)	16.04.2021	Employment: Professor, Kōhatu Centre for Hauora Māori, University of Otago (appointed July 2018)		
	16.04.2021	Member, Health Quality and Safety Commission Board (appointed April 2020)		
	16.04.2021	Chair, Executive of Medical Deans Australia and New Zealand Social Accountability Committee		
	16.04.2021	Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)		
	16.04.2021	Member, Board of the National Science Challenge - A Better Start (appointed 2015)		
	16.04.2021	Honorary Fellow, Royal New Zealand College of General Practitioners		
	16.04.2021	Fellow, New Zealand College of Public Health Medicine		
	16.04.2021	Wife, Alison Douglass, is a member of the Health Practitioners Disciplinary Tribunal		
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	~~Secretary~~, Member, Spokes Dunedin (cycling advocacy group)		Updated 22.10.2020
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company).	
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	09.12.2019	Employee, Findex NZ		
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
	12.01.2021	Nga Kete Matauranga Pounamu Trust Board Member		
Jean O'Callaghan	~~13.05.2019~~	~~Employee of Geneva Health~~	~~Provides care in the community; supports one long term client but has no financial or management input.~~	Resigned, effective August 2020
	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	~~Taking six months' leave.~~ Recommencing 22.08.2020.
Tuari Potiki	09.12.2019	Employee, University of Otago		
	09.12.2019	~~Chair, NZ Drug Foundation~~	(Chair role ended 04.12.2020)	
	09.12.2019	Chair, Te Rūnaka Otākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	~~08.09.2020~~	~~Member, District Licensing Committee, Dunedin City Council (1 September 2020 to 31 May 2023)~~		Resigned 06.11.2020
	09.12.2019	*Shareholder in Te Kaika		
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.01.2020	Deputy Commissioner, Waikato DHB		
	21.01.2020	~~Southern Partnership Group~~	(Role ended December 2020)	
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	~~CFO,~~ Advisor to Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020 (Updated 28.01.2021)	~~Member~~, Chair, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Management of staff conflicts of interest is covered by SDHB's Conflict of Interest Policy and Guidelines.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Hamish BROWN	22.09.2020	Nil	
Kaye CHEETHAM	~~08.07.2019~~	~~Ministry of Health Appointed Member of the Occupational Therapy Board~~	(05/08/2020 - Stood down from the Occupational Therapy Board)
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
	21.05.2020	Director, New Zealand Institute of Skills and Technology	
	20.11.2020	Chair, South Island CIOs	
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	Director Otākou Healther Services Ltd	
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	~~25.09.2016~~	~~Deputy Chair, InterRAI NZ~~	Removed 23.09.2020
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	~~17.11.2017~~	~~Wife works for key technology supplier CCL~~	~~Nil~~

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	~~18.12.2017~~	~~Daughter, medical student at Auckland University.~~	
	27.01.2021	Daughter, is a junior doctor in Auckland and is involved in orthopaedic and general surgery research and occasionally publishes papers	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
	04.08.2020	Shareholder and Director, Inversionne Limited	Nil, clothing wholesaler.
		Specified contractor for JER Limited in respect of:	
	31.10.2017	H G Leach Company Limited to termination	Nil, Quarry and Contracting.
	21.10.2019	Member, Chartered Accountants Advisory Group	
	28.01.2021	Member, National FPIM Governance Board	
	28.01.2021	South Island representative on Banking and Insurance Special Project Group	
Gilbert TAURUA	05.12.2018	Prostate Cancer Outcomes Registry (New Zealand) - Steering Committee	Nil
	05.04.2019	South Island HepC Steering Group	Nil
	03.05.2019	Member of WellSouth's Senior Management Team	Reports to Chief Executives of SDHB and WellSouth.
	21.12.2020	Te Whare Tukutuku	Te Whare Tukutuku is sponsored by the NZ Drug Foundation and Te Rau Ora. Programme is designed to increase education and awareness on Maori illicit drug use to primary care and in Maori communities funded by MoH Workforce NZ.
Gail THOMSON	19.10.2018	Member Chartered Management Institute UK	Nil
	22.11.2019	Deputy Chair Otago Civil Defence Emergency Management Group, Coordinating Executive Group	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

Minutes of the Southern District Health Board Meeting

Thursday, 8 April 2021, 9.40 am
Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Pete Hodgson	Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	
	Miss Lesley Soper	
	Dr Moana Theodore	
In Attendance:	Mr Andrew Connolly	Advisor
	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Mr Mike Collins	Executive Director People, Culture and Technology
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Ms Greer Harper	Principal Advisor to the Chief Executive
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement and Facilities
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 KARAKIA AND WELCOME

The Chair welcomed everyone, and the meeting was opened with a karakia.

2.0 APOLOGIES

Apologies for an early departure were received from the Chief Māori Health Strategy and Improvement Officer and Executive Director Strategy, Primary and Community.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the Board meeting held on 2 March 2021 be approved and adopted as a true and correct record."

I Beekhuis/J Chambers

5.0 MATTERS ARISING

Dialysis Chairs, Southland

The CEO reported that the GM Medicine, Women's and Children's Health was waiting on a building report for the dialysis room in the Community Services Building to finalise the business case.

6.0 ACTION SHEET

The Board received the Action Sheet (tab 5) and management provided the following updates.

Quantitative Performance Dashboard

The Principal Advisor to the CEO reported that work was under way on the quantitative performance dashboard, with 28 tiles being prepared.

The CEO advised that the measures to be reported on had been agreed with Mrs O'Callaghan and Mr Jarrold, and it was hoped to have these all completed by August 2021.

Population Based Funding Formula (PBFF)

It was agreed that another presentation on PBFF was not required and noted that the Ministry of Health was offering financial tutorials to Board Members.

Master Site Planning

The CEO advised that it would take up to a year to complete a robust long term master site plan, which needed to be informed by the Health Needs Analysis. This should not be confused with shorter term capacity issues that could be addressed in the interim.

Radiology Services

It was noted that a report on MRI access was being prepared for consideration at the May 2021 Hospital Advisory Committee meeting.

7.0 ADVISORY COMMITTEE REPORTS

<u>Finance, Audit and Risk Committee</u>

Email, Internet and Information Security Policy

In presenting the revised Email, Internet and Information Security Policy, Mr Jarrold, Finance, Audit and Risk Committee Chair, recommended that staff be

reminded that, to ensure security, this policy included the right of SDHB to monitor all traffic on its systems and that material stored on the system belongs to SDHB.

It was noted that the policy clause numbering needed to be corrected.

Treasury Policy

Mr Jarrold reported that the key changes to the Treasury Policy were:

- A tightening up to prevent foreign exchange risk;
- Prohibiting the linking or swiping of electronic signatures onto banking documents, to prevent access to the banking system should the SDHB system be compromised;
- The Finance, Audit and Risk Committee would receive quarterly updates on all current signatories on bank accounts to provide reassurance that they were updated as staff left the organisation.

It was resolved:

"That the Board approve the following policies:

1. **Email, Internet and Information Security**
2. **Treasury."**

Community and Public Health Advisory Committee

The Board received a verbal report from Mr Tuari Potiki, Community and Public Health Advisory Committee (CPHAC) Chair, on the meeting held on 7 April 2021, during which he reported that the Committee received updates on several issues that would be further considered by the Board, such as COVID-19 management.

Disability Support Advisory Committee

The Board received a verbal report from Dr Moana Theodore, Disability Support Advisory Committee Chair, on the meeting held on 7 April 2021 to launch the Disability Strategy. Dr Theodore thanked Board members and staff for their support and attendance at the launch.

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee (HAC) meeting held on 1 March 2021 were taken as read and Mrs O'Callaghan, HAC Chair, took questions.

The Board Chair confirmed that letters of thanks had been sent to the Urology team.

The Executive Director Specialist Services (EDSS) apologised for not providing an update on the risk of incurring outpatient costs but not earning planned care recovery funding. A discussion had been held with the Ministry of Health to gain an understanding of how the revenue would be paid and a formal proposal would now be constructed and sent to the Ministry.

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 7) was taken as read and the following items were brought to the Board's attention.

- *Financial Result* – The CEO commented that, in the context of a $1.167 billion annual budget, the core adverse operating result of $1.7 million was close to plan, however the organisation still needed to do better.
- *Volumes* – The Crown Monitor confirmed that other DHBs were experiencing the same phenomenon of staff being under pressure but throughput statistics had flatlined.
- *Risk* – It was suggested that time be set aside to consider the top strategic risks at the Strategic Risk Workshop when it is rescheduled.
- *Code Black, 24 March 2021* – The CEO noted that the implementation of an escalation policy had been successful and would ensure that hospital status codes would not leap from green to black again unless there was a major disaster.
- *Recruitment to Executive Leadership Team* – The CEO reported that Nigel Trainor had been appointed to the Executive Director Finance, Procurement and Facilities role, commencing in May 2021, and interviews for the Executive Director Strategy, Primary and Community would take place the following week.
- *Gastroenterology* – Correction: It was noted reference in the report to "junior consultant" should read "Registered Medical Officer (RMO)".

  Mr Connolly presented colonoscopy performance data, which showed improvement, particularly in the Southland non-urgent waiting times. He advised that to sustain this performance, some staffing changes may be required.

  Mr Connolly also informed the Board that over the past three months no examples had been found of patients being declined a referral who had later presented acutely.

  The Board expressed its gratitude to Mr Connolly for his attention to this issue and his ethical approach to it.

Ms Karen Browne, Chair, Community Health Council, joined the meeting.

9.0 FINANCE AND PERFORMANCE

The financial and performance reports for February 2021 (tab 8) were taken as read and the Principal Advisor to the CEO responded to questions on the strategic progress reports.

Mike Collins, Executive Director People, Culture and Technology joined the meeting for the following agenda item, and was supported by Karl Rivett, Change Delivery Manager, IT, Damon Thompson, Clinical Leader, Early Works Team, IT, Gary Blick, Sapere, and Shayne Hunter, Deputy Director-General Data and Digital, Ministry of Health (via Zoom).

10.0 DIGITAL INDICATIVE BUSINESS CASE

A report seeking approval to progress the Digital Indicative Business Case (IBC) to the Ministry of Health in order to initiate the next phase of approvals was taken as read (tab 9), and the Board received a presentation from the Executive Director People, Culture and Technology (EDPC&T) summarising the Strategic, Economic, Financial, Commercial, and Management Cases, and explaining the external review process and findings (tab 14).

During its deliberations the Board received advice:

- That the $4.2m investment required in 2021/22 was not included in the draft budget submitted to the Ministry of Health but would be included in the next iteration;
- That, overall, the Deputy Director-General (DDG) Data and Digital, Ministry of Health, was comfortable with the draft Indicative Business Case. He confirmed it was not inconsistent with what was happening elsewhere in New Zealand and there was alignment across the South Island.

  The DDG advised that the programme was ambitious, but it needed to be; leadership would be critical during delivery.

The Board requested that:

- The assumptions made regarding costs and affordability on page x of the IBC and the table on page 15 be checked;
- Requested that affirmative action be used to ensure equity in staff recruitment.

The Board also requested that the Detailed Business Case (DBC) explicitly state and/or clearly demonstrate:

- The scope of the investment, ie the extent it will cover parts of the health system other than Dunedin Hospital;
- The expenditure on each component, eg infrastructure, software, etc,
- The assurance received from benchmarking the cost with similar projects undertaken elsewhere;
- That software as a service (SAS) is supported nationally;
- Benefits realisation and the cost drivers that will be addressed, eg FTEs and better health outcomes;
- The split of the $215 million expenditure between the Ministry of Health and Southern DHB.

It was resolved:

"That the Board:

- **Receive the findings of the Gateway Review and urge management to make progress on recommendation 5, as a matter of urgency;**
- **Endorse the Digital Indicative Business Case (IBC) to the next phase of approvals;**
- **Acknowledge the efforts of all those involved in developing the IBC;**
- **Note that the Chief Executive and Chairman need to be mindful that the funding to progress the project during 2021/22 is not yet to hand and subject to negotiation yet to be held with the Ministry of Health."**

Dr Tim Mackay, Chair of the Clinical Council, and Ms Gail Thomson, Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) joined the meeting for the following agenda item.

11.0 CLINICAL COUNCIL

An update from the Clinical Council (tab 10.1) was taken as read and the Clinical Council Chair and EDQ&CGS responded to Members' questions.

During discussion, the Board outlined its expectations of the Clinical Council, which included bringing clinical safety and service deficit risks to its attention and forewarning it of clinical issues that may arise in future.

It was agreed that the Board would receive an update from the Clinical Council in two months' time.

12.0 PATIENT FLOW TASKFORCE

An update on the progress of the Patient Flow Taskforce was circulated with the agenda (tab 10.2) and the Board received a presentation (tab 15.2) from the Chief Medical Officer (CMO), Chief Allied Health, Scientific and Technical Officer, and Chief Nursing and Midwifery Officer recapping the purpose, vision and mission of the initiative and summarising:

- The strategy and approach – what the Taskforce said they would do;
- Action – what the Taskforce had done since their last update;
- Progress and outcomes – what had been achieved so far;
- The opportunities and challenges.

In summary, the CMO advised that:

- More operational challenges than expected had been encountered;
- There had been good clinical engagement;
- Processes were being rebuilt, eg rapid rounds;
- There had been no change in the metrics yet;
- There were significant opportunities to realise improvements.

Management then responded to questions from members.

The Principal Advisor to the Chief Executive left the meeting at 12.52 pm.

Mr Hamish Brown, Southern COVID-19 Vaccine Rollout Incident Controller, and Mr Karl Metzler, Chief Executive of Gore Health Ltd (by Zoom), joined the meeting for the following agenda item.

13.0 COVID-19 VACCINATION UPDATE

A report on the implementation of the COVID-19 vaccine programme (tab 11) was taken as read and Mr Brown provided the following updates.

- Numerous people had worked long hours to get the vaccination programme under way, in particular Rory Dowding's team in the Primary, Strategy and Community directorate, especially Victoria Bryant and the public nursing team, and the DHB's PHO colleagues.
- From an equity perspective, there had been excellent engagement from Māori Health providers.

- Sourcing and recruitment of an independent workforce was occurring but remained the greatest challenge.
- The booking system was also a challenge, as it was manual and time consuming. An interim solution with greater functionality would be in place the following week, until the implementation of the national booking system.
- Managing the logistics of vaccine supply was another challenge and the Ministry of Health was working with DHBs to streamline the process going forward.
- Successes included the establishment of the vaccination centre in the Meridian Mall in Dunedin and a centre would be opened in Invercargill on 12 April 2021. Queenstown clinics, targeting border workers and frontline health workers, would commence in the weekend.
- Rural practices would come on-stream in the coming weeks and planning was about to commence for aged residential care, and the mental health and disability sector.

Despite the challenges, which were being experienced nationally, Mr Brown reported the programme was going well.

Messrs Brown and Metzler then responded to Members' questions on the booking system, workforce issues, and communication strategy.

14.0 CORRESPONDENCE

Public Service Commissioner – Code of Conduct for Crown Entity Board Members

A notice from the Public Service Commissioner applying a code of conduct for Board Members under section 17(3) of the Public Service Act 2020 was circulated with the agenda (tab 12) and noted.

PUBLIC EXCLUDED SESSION

***At 1.25 pm it* was *resolved*:**

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

General subject:	***Reason for passing this resolution:***	***Grounds for passing the resolution:***
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 25 February 2021 Minutes ▪ 25 March 2021 Minutes b) Community & Public Health Advisory Committee ▪ 7 April 2021 Verbal Report	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
CEO's Report - Public Excluded Business	To allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Presentation – Staff Survey Results	Feedback is provided in confidence.	Section 9(2)(ba) of the Official Information Act.
Contract Approvals ▪ Strategy, Primary and Community ▪ Regional Intellectual Disability Secure Services ▪ MoH Variation for the Provision of Funding for Post Grad Clinical Training (Med)	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
New Dunedin Hospital	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Southern Health Alliance	To allow activities to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.

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

> **"That the Board resume in open meeting and the business transacted in committee be confirmed."**

The meeting closed with a karakia at 4.05 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 23 April 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020 Updated Nov 2020	**Quantitative Performance Dashboard** (Minute item 6.0)	Draft quantitative dashboard to be presented to the Board.	CEO	Work in progress, 28 tiles. Progress of what has been developed so far to be shown (time permitting).	August 2021
June 2020	**Population Based Funding Formula** (Minute item 4.0)	Management to provide an update and discussion document in preparation for the 2021 PBFF review.	EDSP&C	MoH PBFF review is on hold pending further work to be completed by Health and Disability System Review Transition Unit.	~~December 2020~~ June 2021
Feb 2021	**Radiology Services** (Minute item 8.0)	Report on MRI access to be submitted to May HAC meeting and update on other radiology initiatives to improve access to be submitted to the March HAC meeting.	EDSS		3 May 2021
Feb 2021 April 2021	**Master Site Planning** (Minute item 9.0) (Minute item 6.0)	Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed. Update to be provided in July 2021.	CEO CEO	Terms of Reference being developed currently.	To be determined July 2021
April 2021	**Email, Internet and Information Security Policy** (Minute item 7.0)	▪ Numbering to be corrected (3.4 listed twice). ▪ Staff to be reminded that, to ensure security, this policy includes the right of SDHB to monitor all traffic on its systems and material stored on the system belongs to SDHB.	EDPC&T	Completed	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
April 2021	**Digital Indicative Business Case** (Minute item 9.0)	▪ Assumptions made regarding costs and affordability on page x of the IBC and the table on page 15 be checked; ▪ Affirmative action to be used to ensure equity in staff recruitment. ▪ Recommendation 5 of the Gateway Review to be progressed as a matter of urgency. ▪ DBC to explicitly state and/or clearly demonstrate the items listed in the Board minutes.	EDPC&T	Paper for noting being developed for Board meeting in June, which will address actions and feedback raised regarding IBC.	
April 2021	**Clinical Council** (Minute item 10.0)	To provide an update in two months' time.	EDQCGS Deputy CMO		June 2021
April 2021	**Risk** (Minute item 8.0)	Time to be set aside to consider the top strategic risks at the Strategic Risk Workshop.	EDQCGS		June 2021

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Wednesday, 7 April 2021, commencing at 2.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tuari Potiki	Chair
	Ms Ilka Beekhuis	Deputy Chair
	Dr Doug Hill	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Mr Kiringāua Cassidy	DSAC Member
	Dr John Chambers	Board Member
	Mrs Kaye Crowther	Board Member
	Mr Roger Jarrold	Crown Monitor
	Dr Moana Theodore	Board Member
	Mrs Jean O'Callaghan	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality and Clinical Governance Solutions
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone to the meeting and extended a special welcome to Dr Doug Hill, recent appointee to the Committee.

2.0 APOLOGIES

Apologies were received from Ms Odele Stehlin, Committee Member, and Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 1 February 2021 be approved and adopted as a correct record."

5.0 REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 7) and received the following updates from the Executive Director Strategy, Primary and Community (EDSP&C).

- *Invercargill Primary Care Access* – The CEO of WellSouth had offered to give a more detailed presentation to the next meeting on primary care activity in Invercargill.
- *B4 School Checks* – There was a risk that performance against targets could slip again due to staff involvement in the COVID-19 vaccination programme.
- *Fluoridation and Public Health* – These actions had been deferred to the next meeting, as Public Health were preoccupied with COVID-19 vaccination.

6.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 8) was taken as read. The EDSP&C provided the following updates, then took questions.

- *COVID-19 Vaccination Programme* – The team had once again risen to the challenge of a large logistical undertaking and worked long hours to set up a vaccination clinic in the Meridian Mall, Dunedin.

  The focus now was on trying to onboard a significant number of new staff to work on the programme over the next 12-18 months, so seconded staff could transition back to their substantive roles.

  The Invercargill clinic was being stood up and there was intense planning for coverage of rural areas. Vaccination would commence in Queenstown on 10 April 2021.
- *Aged Residential Care (ARC)* – There were some pinch points in access to aged residential care, particularly psychogeriatric beds.

Management responded to questions on the COVID-19 vaccination programme and booking system, projected health care demand with an ageing population, psychogeriatric care, Mental Health, Addiction and Intellectual Disability (MHAID) bed capacity and transition plans, specialist addiction services, and cervical screening.

The EDSP&C advised that she would clarify the meaning of "open referrals" mentioned in the MHAID Transition Plans report.

Kaupapa Māori Primary Mental Health and Addiction Services

Mr King's interest in this matter was noted.

In response to concerns about the process followed by the Ministry of Health, particularly around cultural issues, for the Access and Choice Request for Proposal (RfP), the CEO suggested that this matter be referred to the Iwi Governance Committee to take up with the Ministry.

7.0 FINANCE REPORT

A report on Strategy, Primary and Community financial performance to 28 February 2021 (tab 9) was taken as read and the EDSP&C took questions.

The EDSP&C and her team were congratulated for their performance against savings targets.

8.0 REPORTING

The Board Chair asked the Committee to consider whether the current reporting format meets its needs.

9.0 INFORMATION UPDATES

Updates and information on the following issues (tab 10) were taken as read:

1. Māori primary care enrolment
2. Primary care in Invercargill
3. Waikouaiti/Karitane/Hawksbury Village – lead in water supply
4. Mental Health Review
5. Continuation and expansion of Integrated Primary Mental Health and Addiction Services

It was agreed that items 1 and 2 would be carried over to the next meeting.

Mental Health Review

The EDSP&C reported that the Mental Health Review had reached its mid-point and the review panel were writing a preliminary report. The second phase of the review would look at co-designed solutions.

The EDSP&C and Chief Māori Health Strategy and Improvement Officer (CMHS&IO) responded to questions on how the Review was progressing and Māori engagement.

PUBLIC EXCLUDED SESSION

***At 2.53 pm it* was *resolved*:**

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

General subject:	***Reason for passing this resolution:***	***Grounds for passing the resolution:***
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Health Hub Request for Proposal (RfP)	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
2020-21 PHO Performance Summary	To allow activities to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.

T Potiki/T King

The meeting closed at 3.00 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 7 April 2021, commencing at 3.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr Moana Theodore	Chair
	Mrs Kaye Crowther	Deputy Chair
	Mr Kiringāua Cassidy	
	Dr John Chambers	
	Ms Paula Waby	
In Attendance:	Mr Pete Hodgson	Board Chair
	Ms I Beekhuis	Board Member
	Mrs Jean O'Callaghan	Board member
	Mr Tuari Potiki	Board Member
	Mr Terry King	Board Member
	Dr Lyndell Kelly	Board Member
	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Gail Thomson	Executive Director Quality & Clinical Governance Solutions
	Ms Charlotte Adank	Community Health and Clinical Council Facilitator
	Mr Andy Crossman	Technology and Services Manager
	Mr Chris Ford	Senior Kaituitui, Disabled Persons Assembly (DPA) NZ Inc
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Ms Greer Harper	Principal Advisor to the Chief Executive
	Mr John Marrable	Working Group Chair
	Dr Nicola Mutch	Executive Director Communications
	Mr Paul Pugh	General Manager Facilities and Property
	Ms Natasha Robinson	PA to the Executive Director Quality and Clinical Governance Solutions
	Mr William Robertson	Consumer Experience Manager *(by Zoom)*
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Louise Travers	General Manager Mental Health
	Ms Carolyn Weston	*(by Zoom)*
	Ms Dot Wilson	*(by Zoom)*
	Ms Jeanette Kloosterman	Board Secretary

A number of people were also present in the public gallery and on Zoom from Invercargill.

1.0 WELCOME

The Chair welcomed everyone to the special meeting of the Disability Support Advisory Committee (DSAC) to launch the Disability Strategy, then introduced members of the Committee and executive staff.

2.0 APOLOGIES

An apology was received from Ms Odele Stehlin, Disability Support Advisory Committee member.

3.0 DISABILITY STRATEGY LAUNCH

Mr Tuari Potiki, Board Member, officially opened the launch, during which he acknowledged members of the disabled community who had put their "heart and soul" into the development of the Strategy and thanked them for their time, energy, guidance, and wisdom.

Mr Pete Hodgson, Board Chair, then addressed the meeting, noting that a quarter of the population were affected by disabilities and for the Māori population it was closer to a third. Mr Hodgson outlined some of the political history leading up to the implementation of the New Zealand Disability Strategy and the promulgation of the United Nations' Convention on the Rights of Persons with Disabilities, then acknowledged those who had contributed to the Southern DHB Disability Strategy.

Dr Moana Theodore, DSAC Chair, advised that the Southern DHB Disability Strategy was the first strategy of its type in the Southern region, with the vision that, "*Within the Southern district all disabled people, tāngata whaikaha, and deaf people will have an equal opportunity to achieve their best possible health outcomes, enabling their participation within their community. Health and disability support services will recognise the agency of disabled people, tāngata whaikaha, and deaf people and their family or whānau through responding to their diverse requirements and removing disabling barriers".* The three goals of the Strategy are:

1. Bold and purposeful
2. Inclusive of individual, whānau or family and community
3. Equitable, responsive and accessible

Dr Theodore advised that the Strategy was the work of many people over the years, who had strived towards a human rights based approach and social model of disability, with the mantra *"nothing about us without us".* Dr Theodore acknowledged the contributions made by Dot Wilson, former DSAC Chair, and the work of the Donald Beasley Institute and the Disability Strategy Steering Group.

Mr Chris Fleming, CEO, briefly outlined the process that had been followed, and the consultation that had taken place, in developing the Strategy. He advised that the value of the Strategy would be how it was made tangible in action, noting that, "*It's not an optional extra to understand someone entering the health system has a condition or impairment. I think acknowledging vulnerability needs to start from management down. It needs to be shown in how management speak to it, the language we use and the language we don't use"* (quote taken from consultation submission).

Mr Chris Ford, Senior Kaituitui, Disabled Persons Assembly (DPA) NZ Inc, and Kaituitui, DPA Dunedin and Districts, then addressed the meeting on what the experience of developing the Strategy meant to him and the DPA. He advised that the Strategy represented a significant milestone and hoped that it would serve as one of the key cornerstone documents of the Southern DHB that would determine the quality and level of disability and health services delivered to disabled people in the Southern region, reflecting the principles of co-design.

Mr Ford recorded DPA's thanks to the Donald Beasley Institute, the Disability Support Advisory Committee, Community Health Council member and former DPA President, Paula Waby, and the SDHB Board. Mr Ford noted that it was only the beginning of the journey, as disabled people encountered many barriers and experienced poorer health outcomes than the general population. There was much work to do and many challenges ahead in bringing the Strategy to life.

Ms Gail Thomson, Executive Director Quality and Clinical Governance Solutions, informed the meeting that the Strategy would be taken forward and turned into an action plan. A Working Group, chaired by Mr John Marrable, had been formed to address that and would be supported by staff from Building and Property, ICT, and Human Resources. The working group would report to the Disability Support Advisory Committee (DSAC) and have links to the Community Health Council and Iwi Governance Committee.

Mr Marrable, Chair of the Working Group, advised that he looked forward to bringing the Strategy to life.

Ms Thomson acknowledged her SDHB colleagues and staff who had worked on getting the Strategy printed and available in various formats including Te Reo, braille, and easy read, and launching the Disability Strategy page on SDHB's website.

Ms Thomson reported that a library of patient stories had been collected, the primary purpose of which was to raise staff awareness, learning and improvement. An example of a patient story by Paula Waby was played to the meeting.

Dr Theodore, DSAC Chair, thanked everyone who had contributed to the Strategy and attended the launch, and closed with the following quote from the Strategy:

"We are committed to achieving all goals and leading the Southern District into a future where disabled people, whānau and families are living well within our community, barriers are eliminated, and individuals have the ability to access appropriate services."

Mr Kiringāua Cassidy, DSAC Member, formally blessed the Strategy.

The meeting closed at 4.00 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Hospital Advisory Committee Meeting
3 May 2021

- Verbal report from Jean O'Callaghan, Chair, Hospital Advisory Committee

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 4 May 2021

Recommendation

That the Board:

- **notes the attached report and**
- **discusses and notes any issues which they require further information or follow-up on.**

Purpose

This report is provided to update the Board on key issues and activities for the District Health Board (DHB). The intention is to raise key issues, but it is also to inform the Board on wider issues which are occurring within the Southern Health System.

As this is a Hospital Advisory Committee (HAC) meeting month the Chief Executive report assumes Board members would have reviewed the HAC papers and as such many issues raised in these papers are not repeated here, but the Board are welcome to refer to any issue for further discussion at the Board meeting.

1. Organisational Performance

There are three papers on the agenda under finance and performance:

- Finance report
- High Level Volumes
- Performance Dashboard.

Financial performance for the month of March is a deficit of $9.346 million compared to a planned surplus of $4.545 million, and hence an adverse result against plan for the month of $4.801 million. Year to date (YTD) financial performance is a $17.532 million deficit against a planned deficit of $3.814 million, resulting in a year to date deficit against plan of $13.718 million. However, the budget for the year explicitly excluded three known factors which were to be reported separately:

- Impact of COVID
- Holidays Act
- Accelerated Depreciation of Dunedin Hospital once the detailed business case (DBC) was endorsed.

These three items are all impacting on the result as noted in the financial reports, however refining these results to core activities (which exclude the three items above), the core operating results, which reflects our operating business as usual results, are a deficit of $9.101 million compared to a planned deficit of $3.814 million so an adverse result of $5.287 million. The result for the month was extremely disappointing and impacted materially by two factors:

- The Government had previously committed an additional $74 million to Pharmac to cover the increased cost of medications associated with the pandemic. This month they informed DHBs that this funding was going to be reduced by $24 million. Southern DHB's share of this is $1.6 million. It is impossible to determine the correct amount as there is no delineation of utilisation provided. We have recognised a year to date impact of $1.2 million this month.
- Planned care was significantly impacted by resourced bed shortages this month. While we were marginally behind the target last month year to date the margin was so close that we had not recognised any revenue impact. Year to date the impact is now a net $2 million and this has had to be booked. The service is addressing recovery presently, however resourced bed availability remains the critical rate limiting factor.

From a volumes perspective, comparison to previous year is now no longer relevant due to the fact that we started to wind down activity in mid March leading up to the Alert Level 4 lockdown for COVID-19 which occurred at midnight on 25 March 2020. We have therefore moved to comparing to plan:

- Total case weighted discharges were down 380 or 7.4% for the month compared to the plan, but up 875 or 2.06% year to date. On a year to date basis medical is 909 or 5.86% ahead of plan, maternity 281 or 7.08%, but surgery was 314 or 1.37% behind plan. There was a significant deterioration in surgical activity in the month largely attributable to nursing staff shortages in the surgical wards which is improving but still having significant bed closure challenges. This was discussed in the HAC reporting but we were 378 caseweights down (13.4%) which meant overall caseweights were around the same level as last March and yet last March had the COVID-19 lockdown impact particularly planned surgery significantly for the month. See commentary further down.
- Raw discharges are up 89 or 1.69% for the month against plan, and up 1,755 or 3.98% year to date. It should be noted the disparity between raw discharges being up and caseweights being down is largely attributable to the mix of planned care with Orthopaedics impacted more significantly than other services, and Orthopaedics have a much higher caseweight per discharge due to the complexity of the major joint work.
- Mental Health bed days are 728 or 22.15% below planned levels for the month and 5,998 or 20.65% below plan year to date.

2. Health System Reforms

As the Board will be aware, the Minister of Health announced decisions that Cabinet has made in terms of the Health and Disability System Review. Prior to the announcement there was a lot of speculation about the direction of travel however the extent of the changes are far more significant than anticipated. There are two documents attached as appendices to this report:

- Appendix 1 – Transformation of the New Zealand health and disability system
- Appendix 2 – Our health and disability system – Building a stronger health and disability system that delivers for all New Zealanders.

The first identifies the five key system shifts:

- The health system will reinforce Te Tiriti principles and obligations
- All people will be able to access a comprehensive range of support in their local communities to help them stay well
- Everyone will have access to high quality emergency or specialist care when they need it
- Digital services will provide more people the care they need in their homes and communities
- Health and care workers will be valued and well-trained for the future health system.

The concepts in the Government's decisions must be lauded. I have been involved in the health system for almost 30 years and this is the most significant reform of the health system over that time period. The concept of having a Māori Health Authority with real teeth to lead policy and the system response commissioning Kaupapa Māori services and co-commissioning all other services provides a real opportunity to ensure that services evolve and are configured in a manner which will give real meaning to Te Tiriti principles and obligations. It provides the opportunity to make tangible gains in addressing the inequities in health outcomes that have pervaded the system for far too long. One of the interesting things will be the extent to which the Māori Health Authority will be able to leverage changes in the broader public service to influence the determinants of health which sit on the edge of the health system but have direct consequences to health outcomes.

The configuration of Health NZ also brings some real opportunities to enhance the integration of our system planning. Health NZ will have the two arms of a National Hospital Network and a more coordinated Commissioning function at a national, regional, district, and locality level. Over the past few years there has been much more work occurring at a regional level where in the South Island we have made real gains, some of these are in infrastructure (particularly the work in data and digital) and others have been the strengthening of regional clinical networks. However, the current structures support working together when the DHBs are aligned however where competing priorities and challenges appear the DHB structure allows the retrenchment back to respective districts and a divergence of focus.

There is a lot of detail that will be required to be worked through, and there are a lot of questions which remain unanswered, and will only be able to be answered as we all move into the more detailed planning. Questions that have been asked to date include:

- What are the regions? There is nothing in the documentation that specifies what the regions are, however it seems logical that there has been four DHB regions historically (which date back to the Regional Health Authority days) with Northern, Midland, Central and Southern. It would appear that the entire South Island will be a region.
- What happens to Southern? The cabinet paper states "I would expect regional commissioning to operate in a "hub and spoke" model, with each region establishing several district offices that are located closer to communities…". The paper then states "…each region may have 4/5 district offices depending on their circumstances, which in many cases will initially cover a geographic area similar to existing DHBs". There is also reference to mapping to the 15 government service regions. In government service regions Southern is actually two regions of Otago and Southland, however the government lead for both the Otago and Southland regions is the same person.
- What about the hospitals / provider arms of DHBs? The cabinet paper states "…this approach to hospital and specialist services – 'nationally planned, regionally managed' – would allow for decisions on the precise configuration of services within a network to be made closer to communities and in the context of their local needs and circumstances. Moreover given the complexity and size of these services, each hospital or service in a network would require its local management, reporting to the regional network and in turn to the national leadership of Health NZ". This means that there will be much more coordination of service planning across the South Island and will not have disjointed planning and development of services. This sounds good in principle, but the devil will be in the detail, Southern has had 10 years of integrating services across Otago and Southland and there is still much to do, bringing this together for the entire South Island will be extremely challenging, but it makes sense as we have differing levels of access to services across the South Island.
- What about Primary Health Organisations? Questions have been asked as to why the Government made overt decisions about DHBs but did not do the same thing with regard to Primary Health Organisations. In the document it states "There will also be structural changes to primary and community-based care – mainly that GP services will no longer need to be funded through a Primary Health Organisation. This opens new, flexible options for how communities want to coordinate and manage care for their needs."

This is a fundamental change as presently all DHBs (with the exception of South Canterbury) are required to commission General Practice services through a Primary Health Organisation (PHO). The changes being implemented mean that it will be more up to Commissioning functions of Health NZ at a national, regional and district level to determine the best means of commissioning effective tier 1 services. Where a PHO can add value to this process it may well be that a PHO may be retained with a potentially broader remit, alternatively the Commissioning function of Health NZ may wish to commission services in a different manner. Only time will tell on this one.

- Localities – where are they going to be, how many will be in our region? The intention for locality networks is that they will have between 50 to 100,000 population within them. Given that the person leading the Transition Unit was also the lead partner for EY when we developed our Primary and Community Strategy, the guidance in that document which suggests six localities in our district should be a good starting point.

There are many staff who have been challenged by the announcements and are naturally concerned about their futures. The challenge that we face as an organisation over the next 14 months is to continue to lead the Southern Health System, drive improvements forward in a manner which is consistent with the future direction of travel and progress improvements for our region. The Minister has issued a revised letter of expectations which also sets out expectations for this transition period. However, there are a few key issues which we need to reaffirm our commitment:

- Strategic Refresh – when deciding to embark on the Strategic Refresh as an organisation we knew that the decisions about the Health and Disability System Review may impact us as an organisation. A very deliberate decision was made that indicated we should develop the Southern DHB's Strategic Plan for the Southern Health System. The idea endorsed was that this would then be the Strategic Plan for how we as an organisation led the system for the next decade, or alternatively it would be a document that we would hand to the organisation responsible for the Southern Health System moving forward. The latter is now clearly the direction of travel, but it is suggested that it is even more important that we pursue this pathway.
- Mental Health Review – the challenges facing Mental Health are huge. Given that any major reorganisations take a long time to settle and move forward, we cannot allow two years or more to pass while we wait for the reforms to be implemented and settle. We must double down on our resolve of this review and initiate early actions to ensure we improve Mental Health and Addiction services across the Southern Health System.
- New Dunedin Hospital and Associated Change Programme – this programme will continue unabated, and in particular we must strengthen the change programme associated with the New Dunedin Hospital to ensure our models of care a contemporary and aligned with the direction of travel contained within the recently approved Detailed Business Case (DBC).
- Data and Digital Programme – like the previous topic there is too much criticality associated with this programme to allow any delays in taking the next steps. The DBC must be completed and submitted as schedule in September 2021, and we must identify the funding pathway to allow progress to continue across 2021/22.
- Patient Flow – continuing the work of the Patient Flow Task Force must proceed at pace, the blockages in the system as evidence in the Code Black situation are unacceptable, is placing stress on our workforce and increased clinical risk.

Over the coming 12 months it is essential that these, along with other priorities committed to in our Annual Plan for 2021/22 are delivered and our focus not distracted too much in terms of the reforms. There will be challenge as significant reforms like this will see many people looking at where they fit within the future plans, and may see some choose to leave for further opportunities elsewhere (both within the health system and beyond). The coming period of time will be destabilising, but as Executive and Governors we must double down on our resolve to ensure that the Southern Health System benefits from the changes approaching.

3. Top Five Risks (will be updated post the Board Risk Workshop)

Risk	Management of Risk Avenue	Effectiveness
Adverse clinical event causing death, permanent disability, or long term harm to patient	SAC system in place with all SAC 1 and 2 events being reviewed and reported to the Clinical Council, Executive Leadership Team and Finance, Audit and Risk Committee	Need to improve feedback loop and extend to near miss events
Adverse health and safety event causing death, permanent disability or long term harm to staff, volunteer or contractor	Health and Safety Governance Group with agreed charter and work programme reporting regularly to the Finance, Audit and Risk Committee	Need to improve feedback loop and extend to near miss events
Critical failure of facilities, IT or equipment resulting in Susdisruption to service	Interim works programme being implemented to maintain facilities, asset management plan developed, IT digital transformation business case in development, disaster recovery plans in place to address critical failures	Moderate effectiveness, state of facilities in Dunedin well documented, Mental Health business case needed. Capacity issues in Southland.
Critical shortage of appropriately skilled staff, or loss of significant key skills	Workforce strategy developed however more robust action planning required	Further focus must be applied.
Misappropriation of financial resources provided by the Crown for optimising the health and well being of our community.	Delegations of authority policy, internal audit work programme, external audit. All reporting through the Finance, Audit and Risk Committee	Improvement through upgrading financial system will assist in more effective management of risk

4. DHB Comparative Financial Performance

The Ministry of Health has released DHB financial performance to the end of January 2021. Overall, the sector is running a $327 million deficit compared to a planned deficit of $201 million year to date. There is a $151 million of exceptional costs which includes Holidays Act, unfunded COVID costs and minor other items. This in essence suggests the sector is running favourable by circa $25 million on a 'business as usual basis'. The Ministry note however that the sector is running at an FTE level higher than expected with 3,112 more FTE than the same time period last year, which is 276 higher than plan. Given the intensity of COVID responses on the workforce requirements the FTEs being only 276 higher than plan is surprising.

From a Southern DHB perspective, our planned deficit of $3.672 million year to date represents 1.8% of the planned national deficit, and the actual result of $10.945 million represents 3.3% of the national deficit. Both of these numbers are well below our population

based share, however it is reasonable to point out that Canterbury deficit is dramatically higher than any other DHB and as such influences this perspective.

The full reports can be found on the following link:

https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports/dhb-sector-financial-reports-2020-21

5. Recruitment to Key Vacancies in the Executive Leadership Team

Nigel Trainor, the new Executive Director Finance, Procurement and Facilities will start on 3 May 2021. Julie Rickman's last day is 30 April, so there will not be a gap once Julie finishes.

Interviews for the Executive Director Strategy, Primary and Community role were undertaken in mid-April following Lisa Gestro's departure (15 April), Rory Dowding is Acting Executive Director Strategy, Primary and Community with the exception of Mental Health, Addictions and Intellectual Disability Directorate which is reporting to Gilbert Taurua, Executive Director Māori Health Strategy and Improvement Officer. We are making a decision between two final candidates, both of them are aware of the Health System Reform changes and are still interested in pursuing the opportunity to contribute to the Southern Health System over the coming year and then see what opportunities the reforms bring up.

6. Inpatient Workload Comparison

There has been considerable disquiet debate in terms of what has been occurring in terms of volumes and workload pressures. The tables in the report in the HAC agenda show occupancy and discharges for both Dunedin Hospital and Southland Hospital for the periods September through to mid April for the 2019/20 and 2020/21 years.

The table below shows a comparison between the two financial years for the period September through to 20 March for 2019/20 (which was the day in which workload began to be directly affected by the wind down for COVID Alert Level 4. The 2020/21 is to the end of March. The nursing FTE is for Specialist Services to the end of February as they are only reported at month end and March 2020 was directly affected by COVID.

Care needs to be taken in interpreting the data and it should only be used for comparative purposes as clearly nursing FTE of course includes many activities not directly associated with inpatient care. This said it shows that on average there are five less occupied beds in 2020/21 compared to 2019/20, six lower in Dunedin and one higher in Southland. There are three fewer discharges per day. In terms of FTE there are 43 more nursing FTE year to date in 2020/21 compared to 2019/20. This increase in FTE includes the uplift in Intensive Care Unit (ICU) resourcing as a consequence of stage one ICU opening, however overall this indicates an increase in resourcing with a reduction in both occupancy and discharges.

	Dunedin		**Southland**	
	2019/20	**2020/21**	**2019/20**	**2020/21**
Average Occupancy	201	195	72	73
Minimum Occupancy	131	126	45	54
Maximum Occupancy	230	221	81	84
Average Discharges	44	43	20	18
Minimum Discharges	12	11	3	4
Maximum Discharges	73	71	35	36
Specialist Services Nursing FTE	811	845	327	336

These results are counter intuitive to the pressures found in the workplace where stress and morale are both really challenged. However, on investigating there has been significant focus on safe staffing, which has seen a clear change in process and practice whereby beds have been more regularly closed because of roster gaps, and acuity of patients, there has also been an increase in the use of specials and watches which will in part be due to the awareness of areas where negative variances exist and ensuring safety of vulnerable patients. Unfortunately, bed closures have not been recorded in an easily retrievable manner, however steps have been taken to capture this data moving forward.

A reduction of three discharges per day on average does not sound like much but if this averaged across the entire year given our average caseweighted discharge per patient is circa 0.9 this equates to circa 985 case weights per annum. In the order to eliminate this problem it is vital that we fully address the care capacity and demand management (CCDM) FTE calculations in the 2020/21 budget process as we are committed to ensuring that safe staffing is front and centre and as such bed closures will have to occur where staffing fails to meet the clinically required levels.

The impact of this issue manifests in an apparent reduction in productivity, however CCDM / Safe Staffing has been driven due to the concerns that historically the nursing pressure has created environments in which nursing workforce was pushed beyond acceptable levels.

7. Gastroenterology Performance

This subject would have been discussed at the HAC meeting, however performance is reported again to Board in line with Board expectations of close monitoring. Progress continues to be much improved. The challenge will be around prioritisation decisions the Board will need to make re investments in 2021/22, clearly physical capacity exists to access to this service, however it will require and operational investment which will need to be prioritised against other critical needs.

Colonoscopy performance for March 2021

Performance on Ministry Targets - Region combined

End of Month	Diag Urgent 14 days(90%)	Var Urgent	Non Urgent 42 days (70%)	Var Non Urgent	NBSP 45 Days (95%)	NBSP Var
31 July 2020	91.23%	1.23%	69.18%	-0.82%	97.78%	2.78%
31 August 2020	85.71%	-4.29%	74.52%	4.52%	97.25%	2.25%
30 September 2020	89.80%	-0.20%	82.79%	12.79%	97.25%	2.25%
31 October 2020	92.59%	2.59%	84.87%	14.87%	96.63%	1.63%
30 November 2020	100.00%	10.00%	79.60%	9.60%	100.00%	5.00%
31 December 2020	92.86%	2.86%	91.27%	21.27%	98.68%	3.68%
31 January 2021	78.95%	-11.05%	75.25%	5.25%	98.46%	3.46%
28 February 2021	88.89%	-1.11%	78.95%	8.95%	100.00%	5.00%
31 March 2021	93.10%	3.10%	69.51%	-0.49%	97.78%	2.78%

Colonoscopy waiting times as of 29 March 2021

Real time waitlist - combined

Priority new	No of Waiting Patients	Average waiting time	Median Wait time	Longest Wait
Diag Urgent	6	6.83	5.00	14
Diag Non-Urgent	150	23.87	20.00	117
Diag Planned and Staged	62	32.08	29.50	117
NBSP	49	18.90	14.00	123
SURV	501	108.28	91.00	404

Real time waitlist - by region

Hospital	No of Waiting Patients	Average waiting time	Median Wait time	Longest Wait
Dunedin				
Diag Urgent	4	7.75	7.00	14
Diag Non-Urgent	95	24.36	20.00	117
Diag Planned and Staged	39	30.03	25.00	96
NBSP	36	19.72	14.00	123
SURV	164	53.94	44.50	404
Southland				
Diag Urgent	2	5.00	5.00	6
Diag Non-Urgent	55	23.04	20.00	53
Diag Planned and Staged	23	35.57	31.00	117
NBSP	13	16.62	14.00	47
SURV	337	134.73	134.00	376

Maximum Wait time Breach

Hospital	Urg >30	Non urg >90	SURV >120	NBSP > 45
Dunedin		1	7	4
Southland			186	1
Total		**1**	**193**	**5**

Of concern remains the overdue surveillance with 193 over the 'maximum' waiting time, however this is a significant improvement since January and the trajectory is heading in the correct direction. Dunedin Hospital has almost recovered completely and attention is now turning to Southland, ensuring that all lists are filled, Saturday lists undertaken and offering all patients appointments in Dunedin, where appropriate.

Work continuing on implementing recommendations of the Bissett report. Significant progress has been made on developing reporting and referral practices with refinements now being made to improve the quality of reporting.

ESPI-2 breaches are expected to be recovered in gastroenterology early in 2021.

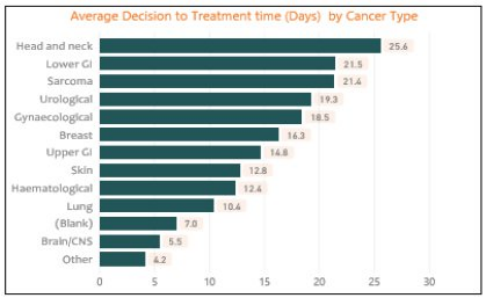
February Colonoscopy Waiting Time Target Commentary (last full month)

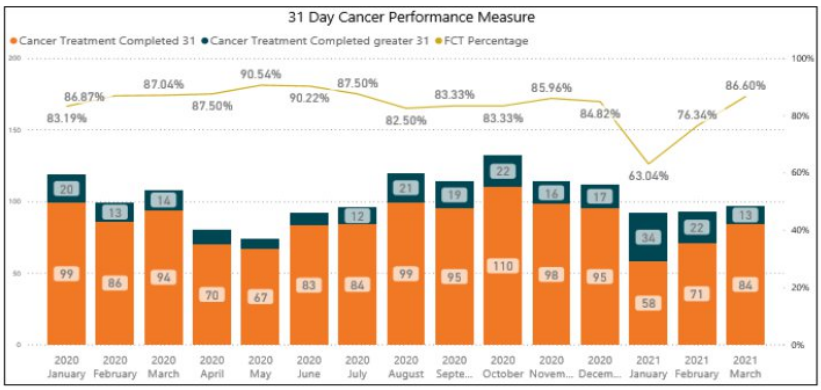
Target	Commentary
Urgent 88.9%	Only represents one patient
Non-urgent 79%	Meets target
Surveillance 44%	Performance improved but way below 70% target. Patients least at risk of delay in this group however will be next focus of recovery.

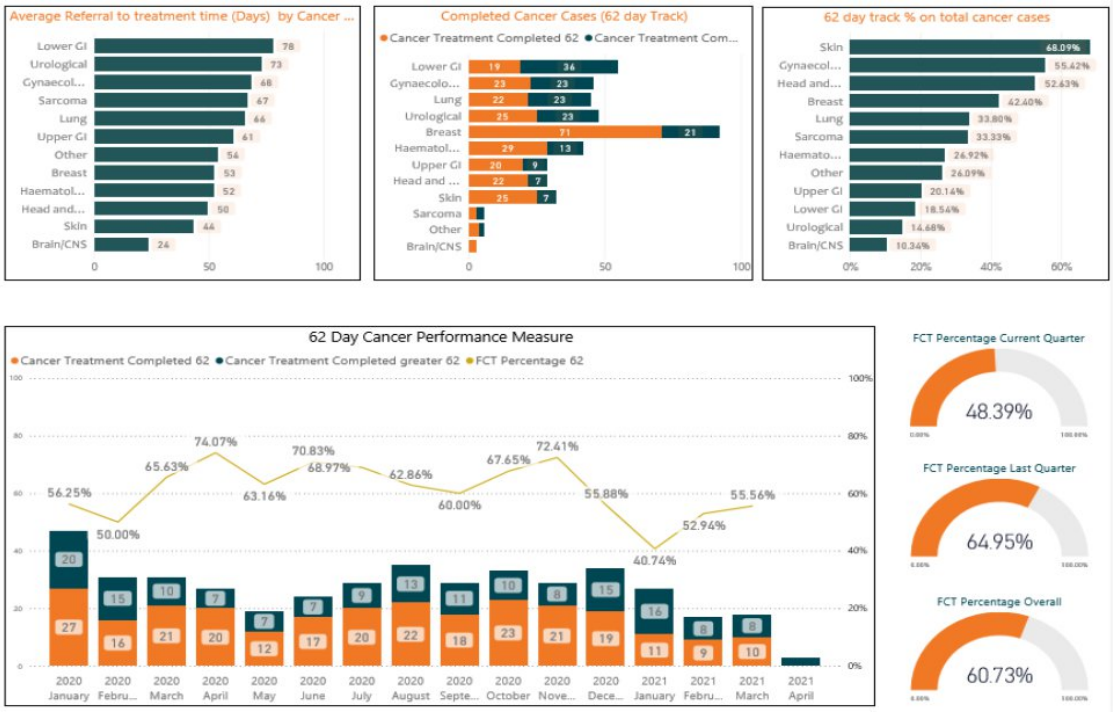
	Only 7 patients in Dunedin exceeding 120 day maximum wait but over 100 in Southland. Focus on Southland recovery with appointments being offered in Dunedin. High-risk (1-year) surveillance patients prioritised.
NBSP 100%	Meets target.

8. Oncology

Oncology Services will be discussed in more detail at the HAC meeting. The current results are shown below. Performance continues to be concerning and the actions being taken will be discussed at the HAC meeting. A more substantive presentation will be undertaken at the next Board meeting and key Clinical Directors will be present to discuss progress, concerns and priorities.







The following table provides a brief summary of the wait lists for the oncology services – haematology, oncology and radiation oncology.

Combined Monthly View

Year	Speciality desc / Month	Haematology FSA Authorised (Demand)	Haematology FSA SEEN	Haematology Waitlist	Oncology FSA Authorised (Demand)	Oncology FSA SEEN	Oncology Waitlist	Radiation Oncology FSA Authorised (Demand)	Radiation Oncology FSA SEEN	Radiation Oncology Waitlist
2020	July	39	27	56	72	48	57	93	65	90
	August	37	34	57	59	64	62	113	94	117
	September	40	27	80	76	63	52	133	113	92
	October	31	34	68	60	39	76	93	90	116
	November	30	33	61	83	61	80	126	103	129
	December	28	17	80	67	52	96	117	101	147
2021	January	21	29	77	38	36	77	81	69	118
	February	41	17	96	50	43	43	95	80	122
	March	29	27	108	55	53	29	113	99	127
	April	6	7	103	9	13	45	14	19	134

Capacity Average/ Month

Haematology	Oncology	Radiation Oncology
27.60	57.00	95.30

This shows that the haematology wait list is growing (although noting that a large proportion of the haematology first specialist appointments are for non-cancerous conditions). The radiation oncology wait list is of most concern. It is currently at 134 whereas the ideal numbers on the waiting list would be in the region of 70 (which is less than one month of forward load).

We have developed a quantitative plan to understand what will be required to recover the radiation oncology wait list from circa 134 to circa 70. The plan has been tested with the service and will now have to be adapted. The adapted plan will then be re-tested with the service. It is very challenging to supply the required capacity to manage our volumes and catch up on our backlogs and in the meantime, we need to redouble our recruitment focus as the capacity created by the employment of a sixth radiation oncologist is key to the overall sustainability of the service.

In the meantime, we have recruited a speciality nurse and we have recruited a second registered medical officer (RMO) trainee (we previously only had one trainee in the service). The speciality nurse is seeing follow up appointments and is allowing us to schedule first specialist appointments (FSAs) for one of our senior medical officer (SMO) team who has recently only had the capacity to see follow ups. The RMO trainee increases our chances of growing the future workforce of the service and will also be able to assist in follow up and FSA activity once they are at a suitable point in the training programme.

In the meantime, we are in the very challenging situation of having to try to expand the capacity of the service to address the FSA backlog and maintain FSA capacity without overloading our existing SMO colleagues.

We completed some outsourcing (10 cases) earlier in the year. It is not a preferred option as it is very expensive. Each FSA and treatment course averages approximately $15k plus travel costs. It is also not preferred by our patients, a number of whom have previously preferred to face treatment delays and wait for treatment locally.

We have also commenced an initiative (in partnership with the medical oncology clinical leader and associate director of nursing) to implement an electronic whiteboard for oncology to make the status of oncology cases more visible. Once this is implemented and the delays are made more obvious, we then hope to continue to with a process improvement initiative to systematically work on improving the process where the delays are most evident.

9. COVID-19 Vaccine Programme

COVID Vaccination Centres

The Meridian COVID-19 vaccination centre opened on 29 March. This clinic is initially operating six vaccinators in a pod of six rooms, the target volume per day is 360, however, with 'Did Not Arrive' (DNAs) the daily volumes will be slightly lower. The Meridian has residual capacity to scale this operation to 18 vaccinators operating on site.

The Invercargill site in the Victoria Room in the Invercargill Municipal Chambers opened on 12 April. This site will also have six vaccinators onsite.

Aged Residential Care (ARC)

ARC facilities continue to prepare for both the Influenza and COVID vaccine roll-outs for staff and residents.

Māori Health Providers

The Associate Māori Health Strategy & Improvement Officer – Secondary/Tertiary has been working with the four Māori Health Providers (Awarua Whānau Services, Nga Kite Matauranga Pounamu, Arai Te Uru Whare Hauora and Ōtakou Health Ltd) and is taking the lead in the COVID-19 vaccination programme rollout. This is a co-design process with WellSouth, Southern DHB and the four lead providers consulting with rūnaka. To date, we are very pleased with the whānau ora approach being used and will be finalising the model of delivery and workforce requirements early next week. Southern DHB and WellSouth will assist with resources and workforce as identified. Other Māori health providers will be working in partnership with the lead providers to offer whānau support to access the vaccination programme, provide health promotion and education opportunities, health and wellbeing checks, a focus on general practice enrolment and support services. The Māori health rollout will offer venues within the localities of Central Otago, Clutha, Dunedin, Gore, Invercargill, Queenstown, Southland and Waitaki. The Māori health delivery plan, workforce and locality venues will form the Covid-19 Vaccination Programme – Māori Health plan. We are meeting anticipated timelines for a rollout commencing at the end of May 2021.

Pacific Island COVID-19 Consultation – Oamaru

On 15 April a Pacific Island community hui was held to discuss the COVID-19 vaccination programme. This is led by the Oamaru Pacific Island Community Group and discussions with the Pacific community on how, where and when the community will receive the vaccine. There is a further discussion with Southern DHB, WellSouth general practices and Waitaki District Health Services Ltd to better understand what is happening in the Waitaki area. The Associate Māori Health Strategy and Improvement Officer – Secondary/Tertiary will respond to any questions on behalf of the COVID-19 taskforce group and provide a feedback loop to the taskforce group.

10. Ongoing Coronavirus Management Response

There is currently no transmission of Covid-19 in the community in Southern DHB area. A significant amount of work continues in this area, which is outlined in the following sections.

Border Work

The maritime border continues to take up a large portion of Health Protection work, particularly while staff are on-call. Shipping agents continue to request shore leave and other requirements for disembarkation under the border order. There is work towards this becoming a permanent role and removing it from the on-call function. Training on the Border Register on National Contact Tracing Solution (NCTS) has been organised with the Ministry of Health for all Health Protection Officers on 24 March.

The team have been working to prepare for the opening of travel between Australia and New Zealand on 19 April 2021. Flights will be travelling out of Queenstown airport in our district. Planning was undertaken with airport stakeholders, the Ministry of Health and other agencies. The team were asked to prepare for a flight capacity of 80% pre-COVID which for Queenstown is approximately 1,000 passenger arrivals per day. Our planning involves an estimated 20 staff per day (two shifts a day) are required for exit and entry screening at Queenstown airport. The issue that Queenstown does not have a Managed Isolation/Quarantine Facility is being worked through.

Ongoing COVID-19 Response Work

The COVID-19 Response Manager went to Auckland for ten days to assist Auckland Regional Public Health Service with their COVID-19 response. The manager provided assistance to their COVID-19 response unit in an operations management role. This experience provided an excellent learning opportunity for ideas and knowledge that could be utilised in our service response. This included how they operate overall as well as their workforce and surge responses. Further discussion is being held with our team as to how these ideas could be implemented in our response.

Work is underway to revise our surge workforce, to be worked out on the number of contacts rather than the number of cases. The number of contacts that are attached to a case are what increases workloads for teams exponentially and can do so very rapidly. Once reviewed it will advise what our staffing capacity looks like and how much additional workforce would be required to be able to maintain a sustainable workforce.

Aged Residential Care (ARC)

The ARC infection prevention and control nurses have initiated virtual monthly education sessions, with 36 facilities attending the first session. They continue to work one-on one with facilities reviewing their COVID-readiness. High ARC staff turnover makes this work essential.

Psychosocial Recovery

The group continues to meet. Lisa Gear commenced her role as Central Lakes Mental Wellbeing Navigator on 23 March. This a full time role with governance provided by the

Central lakes Wellbeing Recovery Group – a partnership between Southern DHB, WellSouth, Central Lakes Family Services, Queenstown Lakes District Council and Mana Tahuna Charitable Trust. A meeting was held with Mayor Jim Boult to explain the activities of our group with agreement to meet every six weeks, a meeting was held with the leader of marketing for 1737 which led to geotargeting key events in the district as well as on the ground promotion (Queenstown Lakes District Council are planning an event for the Mayor and Councillors to wear the 1737 t-shirts). We met with Getting Through Together campaign leaders from Christchurch which has led to shared resources. A group met face to face this work to set key priorities and a work plan for the next 100 days and a further meeting was held to consider communication strategies.

11. Community Renal Unit at Southland Hospital

A location for the community renal unit in Southland has been confirmed in the community services building at Southland Hospital. The room is currently utilised as a staff kitchen and a consultation process has been undertaken with the staff involved to inform them of the intent to repurpose the room and to identify an alternate area for them. In parallel, the biomedical technicians have visited the site and identified the actions that need to be completed in order for the dialysis machines to be installed. These are primarily minor, however there is the need to install a new sink, two pumps to ensure that the water pressure is at the appropriate level for the machines to operate and the appropriate electricity supply. Our facilities team have worked through the specifications of the requirements and a capital expenditure application for the necessary fixtures, fittings, equipment and the decanting of the space ($46,290) has been submitted and approved. It is anticipated that work will commence on converting the kitchen in May 2021 with the room being operational by July 2021.

12. Mental Health Addiction and Intellectual Disability (MHAID)

Specialist and Adult Services

March has been a busy period for the MHAID Specialist Services, both clinically and with regard to developments. Generally, acuity has reduced in inpatient areas although individual patients present challenges in all wards. Service demand remains high across the District, particularly for Specialist Addiction Service (SAS) and the rural Child and Youth (C&Y) services, the latter exacerbated by vacancies in the Central-Lakes District. Developments and planning to response to service demand is occurring in areas, particularly the rural C&Y service (telehealth) and SAS (OST caseload management). A visit to Southland by key Mental Health Services of Older Persons staff is planned for 30 April to develop the relationship with local services and establish clearer pathways of care. Teams are discussing the independent review of mental health services and engaging with the review team.

Demand for inpatient beds in the Adult (Otago) services has been steady with the service able to meet this in a timely way. Average occupancy has been around the 80% mark which is the services ideal. Ward 9b has six long term chronic patients with challenging behaviours that require significant input by nursing and allied health staff. This situation in effect reduces the inpatient capacity by 40%.

Workloads continue to be busy and high acuity with a number of patients being seen on a more than weekly basis. The Gore Community Mental Health Team (CMHT) are trailing a format to give visibility to caseloads and workflow.

Zero Seclusion

The average hours of seclusion episodes continues to trend downwards but the total unique individual episodes and total number of events is on the increase. This group continues to assertively work towards reducing and eliminating the use of seclusion.

Kaupapa Māori Primary Mental Health and Addiction Services ROI

Nga Kete Matauranga Pounamu Charitable Trust has been successful in attracting funding from the Access and Choice request for proposal (RFP) for Māori. The new service, called Mahana, is based in Dunedin and was officially opened on Tuesday 23 March 2021. The agreement for the service is directly between the Ministry of Health and Nga Kete Matauranga Pounamu. The service is essentially an extension of the existing service based in Invercargill and provides for a Kaupapa Māori community alcohol and drug service with 3.5 FTE. The contract has a three year term and the service will run from Monday to Friday between the hours of 8:30am-4:30pm. The service will provide counselling and peer support and a range of cultural activities to assist with rehabilitation. The service will also provide outreach to rural areas.

Mental Health Advanced Preferences

Southern DHB's work to make better use of advanced directives to support clinicians to work with tangata Mātau ā-wheako preferences to the maximum extent possible, including those who are subject to compulsory treatment, was positively mentioned in the Mental Health and Wellbeing Commission's recent report.

Integrated Mental Health and Addiction Primary Mental Health and Addiction System

WellSouth has provided their monthly report to the Ministry of Health which indicates that all funded positions for Health Improvement Practitioners, Health Coaches and Support Workers have all been recruited to. The service is currently provided through 16 general practices across the Southern DHB area.

As highlighted in last month's report, we have had an initial indication that the Ministry of Health would like Southern DHB to be one of the early leaders for the next tranche of funding for this service (extending the service out to more General Practices). We have received correspondence on 25 March indicating the Ministry's formal offer in this respect. The correspondence is offering an extension of the programme for the next two financial years (2021/22 and 2022/23) which would see the FTE increased as follows:

Workforce Role	Current FTE	Additional FTE 2021/22	Additional FTE 2022/23	Total FTE at end of 2022/23
Health Improvement Practitioner	10.1	5.1	4.0	19.2
Health Coach/Support worker	15.2	7.7	6.0	28.9

In addition to the FTE described in the table above, the Ministry will continue to fund implementation funding and FTE for clinical leadership for the programme over these two years. Clinical leadership funding is provided for 0.3 FTE in 2021/22 and 0.15 FTE in 2022/23.

The Ministry are indicating an expectation that the extended programme will commence in May 2021 programme. We will need to engage with WellSouth to determine whether this is realistic in terms of their capacity and also the capacity of the training programme run separately by Te Pou to train practitioners in time for this.

Open Forum in Invercargill

On 26 March 2021, Future Directions, the local Network Regional Group, convened an open forum with a focus on Child and Youth. Presentations were from local providers. Henck Van Bilsen, Clinical Psychologist, completed a Cognitive Behavioural Therapy workshop for the general public which saw 55 people attending from the Southland community.

13. Mental Health and Addiction Māori Consultation Hui

The Māori Health Leadership Team has supported the coordination of three Māori consultation hui as part of the Mental Health and Addiction review. The hui were supported by Matire Harwood as part of Synergia team. Matire is of Ngāpuhi descent, a general practitioner operating out of South Auckland and an Associated Professor with the University of Auckland. The hui participants were a diverse group of individuals and collectives with representation from service user and whānau. The hui were held across three localities and included 89 participants inclusive of the facilitators.

- Dunedin, Te Rau Ora - 12 April 2021 (29 participants)
- Invercargill, Ascot Park Hotel - 13 April 2012 (44 participants)
- Queenstown, Mercure Resort - 13 April 2021 (16 participants)

The Māori Health Leadership Team will now look to coordinate meetings via Zoom for Synergia with our kaupapa Māori health providers and those contractors that hold kaupapa Māori mental health contracts. An additional meeting will be coordinated for our Māori Mental Health, Addiction and Intellectual Disability staff employed by the Southern DHB. Synergia has offered one on one interviews with potential respondents as required and a survey tool has been developed to seek additional feedback.

14. Amendable Mortality

The Chief Māori Health Strategy and Improvement Officer (CMHSIO) has met with Dr George Gray, a Māori public health physician, to support the Southern DHB in developing a report on amendable mortality data.

Amenable mortality is defined as premature deaths that could potentially be avoided, given effective and timely healthcare. The last review of this data was undertaken by the Eru Pomare Centre back in 2015 based on 2013 data.

The initial observations are that the gap in Māori and non-Māori amenable mortality rates has increased. The Māori amendable mortality rate was over twice that of non-Māori rates, compared to being one-and-a-half times as high in 2012 (or 86% higher averaged over the whole period). Average rates over the five years were 159 per 100,000 for Māori and 86 per 100,000 for non-Māori.

The highest amendable mortality rates for Māori include firstly heart disease (including coronary, valvular, hypertensive and stroke) and these were the leading cause over the period 2012-16. Second was identified as suicide, respiratory third (COPD and asthma), Cancers fourth (prostate, breast, with some stomach, rectal and melanoma) and diabetes fifth.

We are looking to engage George Gray to support us in developing a report and presentation for the Board based on Māori versus non-Māori amendable mortality data for the Southern DHB region.

15. Review of Māori Health Provider Contracts

The Māori Health Leadership Team has engaged Janice Donaldson from the South Island Alliance Programme Office to undertake this review. Janice has extensive Māori health experience and current contract knowledge responsible for the Canterbury DHB Māori health contracts. Janice will firstly undertake a desktop review of all provider contracts. She will consider links between contracts under Personal Health, Mental Health, Child Health, etc. She will consider our Southern DHB Māori Health Plan, Profile and Annual Plan including Whānau Ora interface. She will meet with the Iwi Governance Committee to consider their aspirations and expectations. She plans to meet with the providers to understand from a

providers perspective with qualitative input. Janice is also looking to understand our Southern DHB strategic directions, aspirations and budget considerations.

16. Minister Hon Pene Henare Visit – 8 and 9 April 2021

Southern DHB received a positive response from Minister Henare for the COVID-19 vaccination programme rollout for Māori and in particular the Equity Response Plan. This plan and key contacts have been shared with other DHBs for advice if required. Southern DHB assisted in the coordination of the Ministry of Health Māori COVID-19 Vaccination Roadshow. The Minister and his team meet with whānau at Murihiku Marae, Invercargill, Te Kaika in Dunedin and at Wakari Hospital, Dunedin. Both health services and whānau were able to discuss the programme rollout and the COVID-19 vaccine. Following on from the roadshow and in response to the Minister's roadshow outcomes, the Māori Health Directorate will undertake community hui with question and answer sessions for Māori communities and others about the COVID-19 vaccination programme.

17. Southern DHB Cultural Education Programme

The Pou Taki Education Team has provided the Te Tiriti o Waitangi workshop to General Practices and WellSouth employees as part of the education schedule for primary care. To date, 239 (221 general practice and 18 WellSouth Invercargill staff) participants have received education. The education programme meets clinical competencies and continuing medical education (CME) points. Feedback has been positive, and the team has enjoyed working with the primary care population.

18. Aukaha Kia Kaha – Wellbeing at Southern DHB

We have launched a wellbeing programme *Aukaha Kia Kaha* – meaning: 'the strength of the bindings' – for Southern DHB staff. The name of the programme is a reference to use of a particular knot used in lashing the washtrake/top board to the hull of a waka, seeking to ensure they are tightly bound and watertight because if they weren't securely lashed together then all would come undone and calamity would befall them. This is an analogy to working diligently, working carefully together to ensure safety and success.

Southern DHB recognises that a comprehensive framework is the best way to bring wellbeing initiatives together in a sustainable way that leads to long-term outcomes for health and wellbeing and has committed to improving the wellbeing of all employees through signing up with WorkWell. All senior managers have signed the pledge, demonstrating their support. WorkWell is a Ministry of Health supported wellbeing initiative, and more information on the ins and outs of the programme can be found on their website.

An Aukaha Kia Kaha Committee has been formed who meet each month to progress the programme. Information is available to staff on a dedicated SharePoint site and Aukaha Kia Kaha Representatives are available across the Southern DHB. The representatives can act as a liaison for feedback, will be the champions in departments, and they will be involved in promoting the programme and assisting in the planning stages.

19. Improvement Movement

The Improvement Movement is now in its third year and has gone from strength to strength.

274 people are enrolled in the programme this year, 259 are staff; medical, nursing, allied health, management and admin, plus 15 free educational licences allocated to students. Primary care (15 places) and rural hospitals are also included this year's membership for the first time.

Chris Fleming
Chief Executive Officer

27 April 2021

Appendices

1. Transformation of the NZ Health and Disability System
2. Our Health and Disability System

Transformation of the New Zealand health & disability system

21 April

The five key system shifts

1 The health system will reinforce Te Tiriti principles and obligations

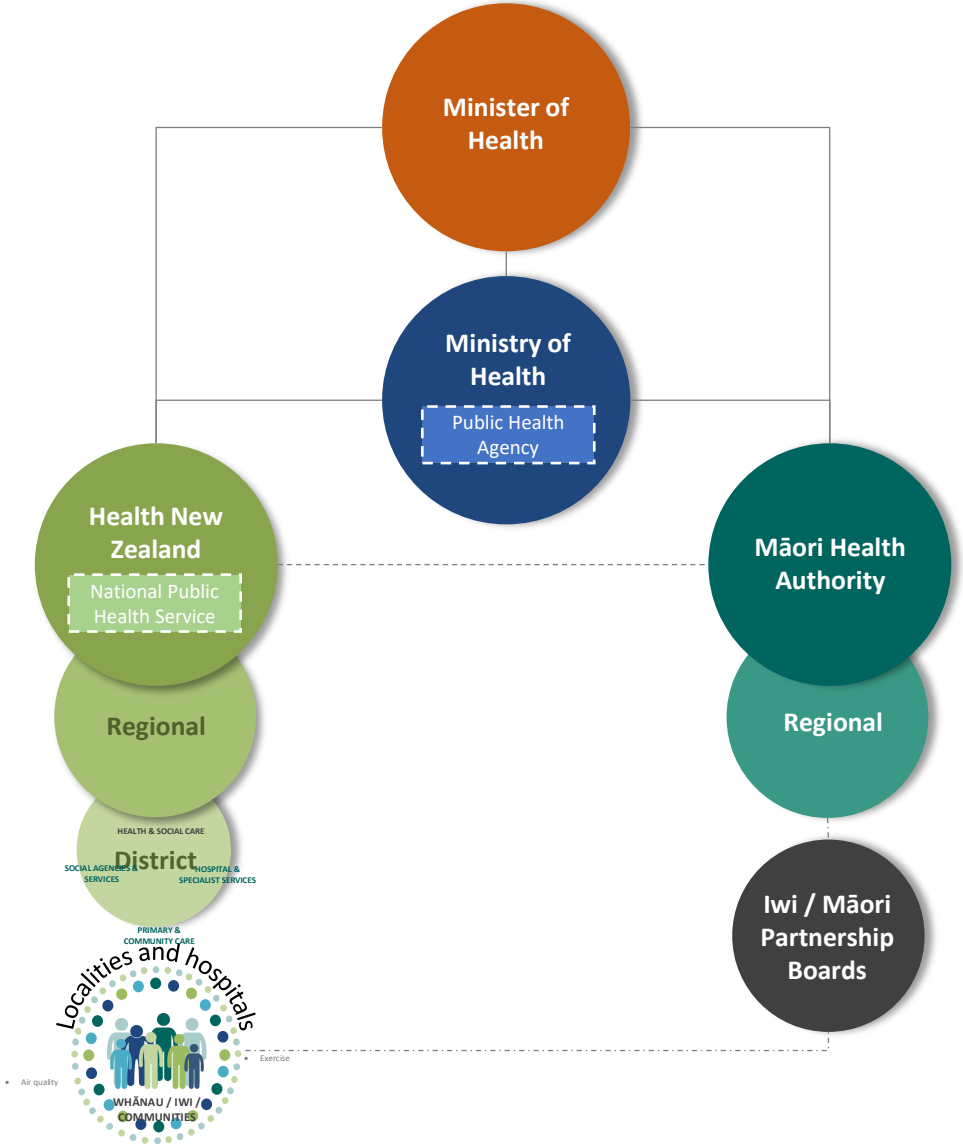
2 All people will be able to access a comprehensive range of support in their local communities to help them stay well

3 Everyone will have access to high quality emergency or specialist care when they need it

4 Digital services will provide more people the care they need in their homes and communities

5 Health and care workers will be valued and well-trained for the future health system

Our future health & disability system



1 Cohesive

A single, cohesive New Zealand health service providing consistent, high-quality health services for all people

2 Equitable

Working in true partnership with Māori to improve services and achieve equitable health outcomes

3 People-centred

A system based on the voice of Pacific, disabled, and all other users of health services to design and deliver services that work for them

4 Accessible

Simpler and better access to services, with innovation and digital options bringing services closer to home than ever before

Our future health & disability system

Cohesive

A single, cohesive New Zealand health service providing consistent, high-quality health services for all people

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Working in true partnership with Māori to improve services and achieve equitable health outcomes

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Simpler and better access to services, with innovation and digital options bringing services closer to home than ever before

People-centred

A system based on the voice of Pacific, disabled, and all other users of health services to design and deliver services that work for them

Our health and disability system

Building a stronger health and disability system that delivers for all New Zealanders

April 2021

Our health system is supported by a dedicated workforce – but has become overly complex and fragmented, and could provide more equitable and better care.

In 2018, the Government commissioned the Health and Disability System Review to identify how we could reform our health system to deliver on that promise. This paper summarises the Government's initial response to that Review, and explains how we plan to strengthen our health system to ensure every New Zealander can access the right care at the right time.

Why reform our health system?

The case for reform of the New Zealand health system is clear. While the public health and disability system performs well overall by some measures, it has significant and persistent issues in delivering equity and consistency for all.

An ageing population, advances in care and a growing burden from chronic disease mean that demand for health services will only grow over decades to come. There are indications that our health system is struggling to keep up with current demand, and that our workforce needs greater support to keep New Zealanders well for longer. These reforms aim to tackle these challenges, and better equip our health system to thrive into the future.

What will reform look like?

Our aim is to strengthen our health system into a **single nationwide health service** which provides consistent, high-quality health services for everyone, particularly groups who have been traditionally underserved.

In our future health system, instead of a 'postcode lottery' which determines the care people can access, we will have a better balance of national consistency for hospital and specialist services and local tailoring of primary and community care. This will improve care quality and equity, while ensuring the services you receive close to home reflect the needs of your community.

To make this future possible, we need structures which ensure government is both closer to communities, and more nationally connected. To achieve that, we will:

- **refocus the role of the Ministry of Health** as the chief steward of the health system and the lead advisor to Government on matters relating to health
- **create a new organisation, Health NZ,** to take responsibility for day-to-day running of our health system – into which **all District Health Boards will be consolidated**
- **create a new Māori Health Authority** to ensure our health system delivers improved outcomes for Māori, and to directly commission tailored health services for Māori
- **establish a new Public Health Agency** within the Ministry of Health and a strengthened, **national public health service within Health NZ**, to make sure we are always ready to respond to threats to public health, like pandemics.

Contents

Vision for our future

Our public health system is one of New Zealand's greatest assets, driving health, wellbeing and economic growth. We have a significant opportunity to make sure it performs at its best, and does better by New Zealanders who have been underserved in the past.

Our vision is to build a system which achieves pae ora | healthy futures for all New Zealanders.

A health system which achieves pae ora must focus on delivering:

- **Equity**, tackling the gap in access and outcomes between New Zealanders, particularly for Māori, Pacific peoples, disabled people, and vulnerable groups.
- **Partnership** with Māori in how healthcare is designed and delivered, and empowering everyone to help design systems which work for them.
- **Sustainability**, preventing and reducing health need instead of just addressing illness, and promoting efficient, high quality care.
- **Person and whānau-centred care** which empowers everyone to manage their own health and wellbeing, giving people, their carers and whānau meaningful control**.**
- **Excellence**, ensuring consistent, high-quality care everywhere, supported by clinical leadership, innovation and new technologies to continuously improve services.

In practice, this looks like a system where:

- our health system reinforces Te Tiriti o Waitangi principles and obligations, with rangatiratanga shaping care design for Māori, so Māori models of care flourish
- everyone can access a wider range of support to stay well in the community, with more services designed around people's needs and which better support self-care
- emergency and specialist care is accessible and consistently outstanding, with a national network ensuring excellent care doesn't depend on where you live
- digital services are far more accessible, with care close to home far more common
- health and care workers are valued, supported and well-trained, supported by shared values, better long-term planning, and collaboration between health organisations.

This future is within reach – but requires major changes in how our health system operates.

The approach to reform

The people working in our hospitals, general practices, pharmacies, outpatient units, Māori and Pacific providers, care homes and offices are exceptionally hard working and dedicated – but aren't well enough supported by the settings and infrastructure of our health system. There are many examples of innovation and great practice, but often these are not recognised or struggle to spread across the system.

For that reason, the Government is starting reform with the organisations which support delivery of our health system – including the Ministry of Health and District Health Boards.

If our goal is to improve the quality, consistency and equity of care our system delivers, we have to start with strengthening the functions, structures and organisations which make care possible.

Our health system has become too complex and difficult to manage. It is far too complicated for a small nation with limits on people, funding and resources. As a result, it makes it harder than it needs to be to deliver the best care for all.

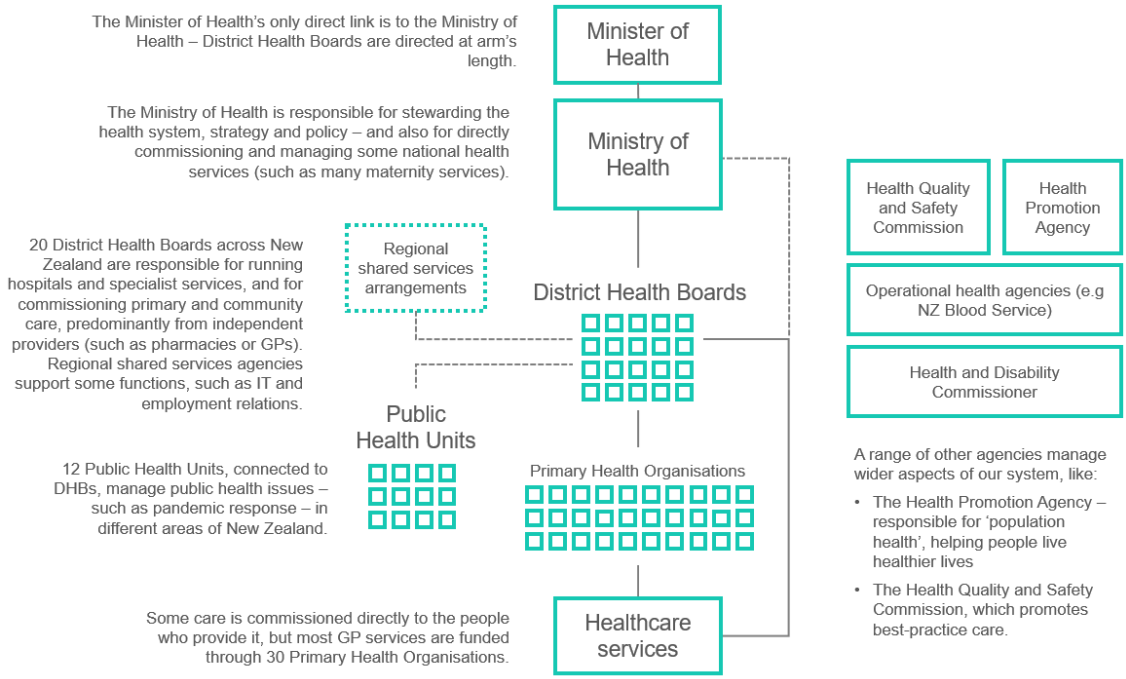
Over time, we want to better support care providers to take advantage of our strengthened health system to improve the quality and consistency of care, and better involve people as partners in their own care. This means things like working together to make care seamless and more convenient to access; redesigning services to better meet the needs of our diverse communities; and giving our health professionals the support they need to work at the top of their scopes of practice.

It also means making sure the 'enablers' which surround the health system – like having enough new health and hauora professionals, digital infrastructure, quality data and fit-for-purpose facilities and equipment – are fit for the health system of the future.

These changes will all come in time, and we will continue talking with both communities and health professionals about them over the coming months. But before that change in care can be effective, we need the infrastructure of our health system to better support our front lines.

Structural change

Our health system is relatively complex; it involves many organisations, each with their own roles and relationships. But at the highest level, our health system broadly works like this:

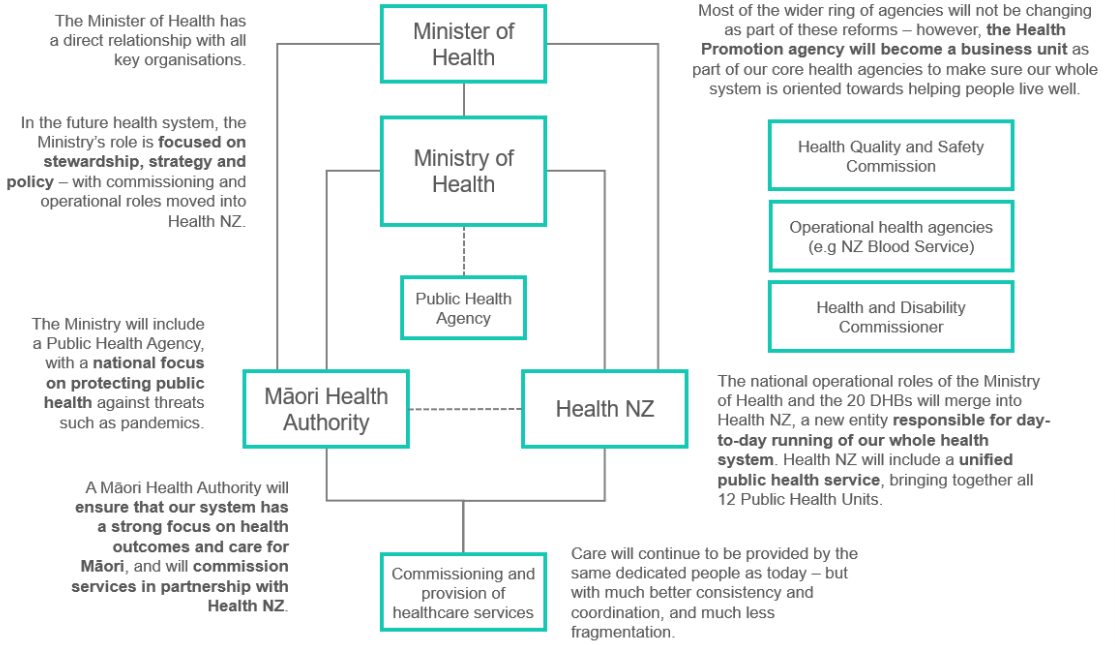


This system is characterised by:

- inequitable outcomes for Māori, Pacific communities, disabled people and others
- limited national planning, so that decisions which could be made once for the whole population are repeated multiple times
- insufficient focus on and investment in primary and community care which helps keep people well and out of hospital
- a 'postcode lottery' which means the care you receive depends on where you live, and which DHB and Primary Health Organisation covers you.

The new structures and organisations being created by these reforms are intended to remedy these problems – and create a consistent, equitable system to provide care to everyone.

Instead of that complex system, the health system of the future will look more like:



This system will be simpler and more coordinated, allowing for better and more consistent care. It will tackle the challenges of our current system through several key changes:

- Creating a new organisation, Health NZ, to manage our health system day-to-day. Instead of 20 DHBs, around 30 PHOs and a complex web of contracts, a single Health NZ will be able to ensure simplicity, consistency and quality of care.

- Health NZ will plan and commission health services for the whole population. It will set up four regional divisions and a range of district offices (Population Health and Wellbeing Networks in DHB localities) so decisions are made close to the ground.

- A new Māori Health Authority will have dual responsibilities: it will support the Ministry in shaping system policy and strategy to ensure performance for Māori, and will work in partnership with Health NZ to commission care across New Zealand, ensuring that the needs and expectations of Māori communities are also centred in design and delivery.

- The Ministry of Health will be able to refocus on stewarding the health system and providing advice to Ministers on health strategy and policy – meaning it will be better able to maintain visibility of the health system and New Zealanders' holistic wellbeing.

- The Ministry will host a new Public Health Agency to provide national leadership on public health policy, strategy and intelligence; while Public Health Units will be brought together into a national public health service within Health NZ. This will ensure our Public Health Units are well equipped to respond as one to threats like COVID-19.

- To ensure a focus on keeping people well for longer is embedded in the heart of our health system, the Health Promotion Agency will be merged into Health NZ.

Hauora Māori

Over past decades, our health system has failed to perform for Māori. Māori suffer from more avoidable deaths than most New Zealanders, have lower life expectancy, and do not always receive the same quality care. These inequities cannot continue. To ensure they do not persist, and in recognition of the government's obligations to Māori under Te Tiriti o Waitangi, our health system needs to support hauora Māori in a very different way.

These reforms aim to strengthen rangatiratanga Māori over hauora Māori, empower Māori to shape care provision, and give real effect to Te Tiriti o Waitangi.

Initiatives such as Māori-led adult influenza vaccination campaigns in 2020 have shown the massive impact Māori leadership can have on achieving equity. These reforms will build on, and learn from, these successes.

To champion the voice of Māori in the health system, the future health system will have:

- a **Māori Health Authority with significant authority** to work alongside the Ministry of Health on strategy and policy, and to partner with Health NZ to craft care which better meets the needs of both Māori and other New Zealanders – as well as directly funding and commissioning more kaupapa Māori and te ao Māori-grounded services
- **strengthened Iwi-Māori Partnership Boards** to act as an influencing and decision-making voice for iwi and Māori in each locality, so that Te Tiriti partnership operates at every level of our health system
- much stronger expectations on all health agencies and care providers to deliver better care for Māori and other vulnerable groups who have not historically received equitable care or outcomes.

This means that our future health system will have more deliberate investment in equity of access and outcomes for Māori, increased accountability, and a much greater role for iwi and Māori in shaping service design and provision for Māori communities.

In addition, targeted support for Māori care providers will allow us to grow the range of kaupapa Māori and Māori-centred services offered in our health system – which will improve reach into Māori communities, the diversity of service options available, and will improve health outcomes for Māori and non-Māori alike. It will also offer new arrangements to make sure that all networks of service providers are catering to the diversity of our communities, not only those who traditionally find it easy to access healthcare.

Primary and community care

Most New Zealanders interact mainly with the health system through primary and community care. That includes your local general practice, community pharmacies, Māori and Pacific community providers, aged care services, pharmacists, midwives, community mental health services, physiotherapists, dentists and others who help treat you and keep you well at home or in the community.

Lessening the burden on our health system requires that we keep people well for longer, with care provided close to home.

At the moment, it is too easy for funding and focus to be drawn away from community-based care towards hospitals and specialist services – even though we know that quality, accessible primary care is vital to keep people well for longer, and avoid more serious illness.

In the future health system, your area will have one or more **locality networks** of healthcare providers in the community. This will still include people like your local GP, maternity carers, district nurses and optometrists; but the care they provide will be more seamless and accessible. That might look like:

- tightening the connections between care providers, so that records and care pathways follow patients between all those contributing to their care
- better, greater use of digital technology to enable care closer to home, and more self-management of healthcare
- better tailoring of local services to meet community needs, like ensuring kaupapa Māori services are more available, or that funding makes whānau GP consultations or affordable after-hours appointments sustainable for providers.

These services will be shaped by both Health NZ and the Māori Health Authority, to make sure they are fit for purpose for the diversity of New Zealanders in our communities.

There will also be structural changes to primary and community-based care – mainly that GP services will no longer need to be funded through a Primary Health Organisation. This opens new, flexible options for how communities want to coordinate and manage care for their needs.

Hospital and specialist care

Hospital and specialist services tend to be accessed in specialist medical facilities – such as a hospital or outpatient clinic – and deal with more serious, complex or rare medical conditions. They include most of what doesn't fall into primary and community-based care, including hospitals and all the services attached to them, and outpatient specialist services.

Quality hospital and specialist care, when it counts, makes a tremendous difference to New Zealanders' health – but requires greater coordination and consistency than what we have now.

We know that hospital and specialist services in many parts of New Zealand are under significant pressure. A major cause of this pressure is that our hospital and specialist care is not managed as a coherent network – instead, services are managed in relative isolation from one another. This makes it harder than it should be to:

- ensure consistency of care across New Zealand, so the care you receive doesn't depend on where you live
- offer care where it is accessible and practical
- manage costs over time, which tends to reduce how much we have available to fund care in the community.

In the future health system, this will be improved by planning our hospital and specialist services nationally and managing them through wider **regional networks**. Instead of decisions about care being made in isolation from other surrounding regions, hospital and specialist services should be funded where they will make the biggest difference to New Zealanders' care. This will look like:

- more consistency in care across New Zealand – meaning that rural and small urban communities will have better access to care which is needed regularly close to home (such as well-equipped emergency departments and acute maternity care), and greater certainty where more specialist or complex care is needed
- reduced administration and complexity caused by the fragmentation of services across the country, reducing staff workload and making patients' experiences more seamless
- less competition between districts for staff and resources, so funding and staffing follows need.

Public health

Public health is where many of our opportunities to prevent illness begin, with activities like:

- population health – targeting the things which tend to make us sick (like smoking)
- disease prevention, such as through vaccinations
- responding to epidemics and pandemics.

COVID-19 has proven that we can lead the world in tackling public health threats – but only when we break down barriers and work together as a national team.

The past twelve months have shown that our public health system is proactive, innovative and closely connected to our communities. Initiatives led in partnership with Māori and diverse communities have kept us safer than almost any other country in the world.

But our experiences with COVID-19 have also highlighted weaknesses – particularly that our 12 dispersed Public Health Units need better national coordination and leadership when responding to nationwide threats to ensure best practice and improvements can scale.

Our future health system will have a stronger focus on public health, with particular focus on addressing the range of factors which contribute to health and wellbeing, from housing to employment to social care. Two major changes will reshape how we ensure public health:

- The Ministry of Health will host a new **Public Health Agency** which will be responsible for public health policy, strategy and intelligence. It will help us better understand and respond to threats to public health, and put scientific expertise at the heart of policymaking.
- Health NZ will include a **national public health service**, bringing together our Public Health Units under a national banner. This means we'll be better able to coordinate public health services, responding to threats like COVID-19, measles outbreaks, and smoking.

As part of this shift, it is also important that population health – which includes how factors like personal habits, housing and social care influence our health and wellbeing – is at the heart of our core health agencies. To ensure that occurs, the Health Promotion Agency will move into Health NZ to ensure we retain capability and expertise in population health. This capability will be available to both Health NZ and the Māori Health Authority, to ensure all New Zealanders are supported to stay healthy and live well.

The change programme

These announcements represent only the start of strengthening our health system. Changes to the structures of that system won't have an immediate impact on how, where and when you receive care; or where and how you work, if you're a member of the health workforce.

In the medium term, the ways that we support our frontline health professionals to provide care will need to improve so we can offer New Zealanders better care, and a more sustainable, empowering environment for our health workforce. In the future health system, you will still have a GP and a local hospital; but the care you receive will better reflect what you need, the values and expectations of your community, and what's convenient and practical for both you and healthcare professionals.

There are three major parts of the change programme to come:

- further policy work and reform
- detailed, collaborative design
- implementation and change.

These initial reforms are the start of an enduring, long-term project to improve care quality, consistency and equity – and to ensure our workforce feel valued and supported.

There will still be policy change and announcements to come in areas such as funding, workforce and digital health. These changes will take us further down the line towards meaningful change to care.

At the same time, health agencies will be working with you – whether you work in the health system or are a member of the wider community – on the details of how our future health system will work. There will be opportunities across all of the areas discussed above to influence how our future system can deliver better, more consistent and more equitable care.

Finally, there are major changes which need to start happening now, including establishing the new Health NZ and Māori Health Authority, and supporting DHBs and the Ministry of Health to get ready to transition responsibilities and employees into Health NZ.

Our commitment to you is that we will stay in touch, communicating openly, as we move towards a strengthened health system. If you have any questions, you can reach out to the Transition Unit managing the reforms:

Website: www.dpmc.govt.nz/our-business-units/transition-unit
Email: enquiries.tu@dpmc.govt.nz

FOR APPROVAL

Item: Financial Report for the period ended 31 March 2021.

Proposed by: Julie Rickman, Executive Director Finance, Procurement & Facilities

Meeting of: Board, 4 May 2021

Recommendation

That the Board approves the Financial Report for the period ended 31 March 2021.

Purpose

1. To provide the Board and Finance, Audit & Risk Committee with the financial performance of the DHB for the month and year to date ended 31 March 2021.

Specific Implications for Consideration

2. **Financial**

   The historical financial performance impacts on the options for future investment by the organisation as unfavourable results reduce the resources available.

Next Steps & Action

3. Executive Leadership Team to advise actions to recover under-delivery of elective services and implications on expenditure for remainder of financial year.

Appendices

Appendix 1 Financial Report for the Board

Appendix 1: Financial Report for the Board

Southern DHB Financial Report

Financial Report for:	31 March 2021
Report Prepared by:	Finance
Date:	4 May 2021

Report to Board

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the period ending 31 March 2021.

The net deficit for the month of 31 March 2021 was $9.3m, being $4.8m unfavourable to budget. The result includes a $2.1m reduction in revenue related to under-delivery of Planned Care procedures and $1.2m of Combined Pharmaceutical funding which the Ministry of Health has withdrawn at the instruction of Treasury. The expenditure includes COVID-19, Holidays Act 2003, New Dunedin Hospital Accelerated Depreciation and Digital Hospital Project Costs, totalling $2.2m.

Revenue was $0.3m unfavourable to budget.

Government Funding included unbudgeted revenue of $0.7m for COVID-19 funding Surveillance & Testing, $0.2m for Mental Health funding and $0.5m for IDF funding.

There was an additional amount of funding approved to increase the Combined Pharmaceutical Budget in the 2020/21 financial year of $74 million. Our PBFF share of this funding was included within our monthly funding payments from October 2020. The funding was approved to cover the increased costs of medicines through the COVID-19 pandemic. PHARMAC have informed the Ministry of Health that their latest assessment of the increased costs being driven by global supply issues through the COVID-19 pandemic has been revised down. At this stage, their revised assessment is that no more than $50 million of the additional $74 million allocated will be required in this financial year. Therefore, at the request of the Treasury, this additional funding is to be returned to the Crown. In order to do that, the funding will be deducted from the monthly allocations made to each DHB. The impact on us is to reduce the funding by $1.65m of which $1.2m has been recognised in March 2021.

The revenue for COVID-19 Surveillance & Testing has been recognised to match expenditure. The recognition of $1,607k as accrued revenue is based on the understanding from Ministry of Health guidance of the intention to "wash up" the impact of the additional spend on Surveillance and Testing incurred by the DHBs.

Expenses were $4.5m unfavourable to budget.

The Workforce costs were $1.5m unfavourable inclusive of $0.6m additional Holidays Act 2003 provision and $0.5m additional Continuing Medical Education to recognise the agreement for extending the CME expiry date from three to five years for Senior Medical Officers.

The Clinical Supplies were $1.8m unfavourable, reflecting higher treatment disposables, instruments & equipment and pharmaceuticals expenditure which was partially offset by lower implants & prostheses costs.

Depreciation was $0.1m unfavourable due to accelerated depreciation on the Dunedin Public Hospital. Provider Payments were $1.1m unfavourable, reflecting COVID-19 Surveillance and Testing expenses and higher Residential Care payments. Capital Charge Expense was $0.4m favourable.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 March 2021

Month Actual $000	Month Budget $000	Variance $000			YTD Actual $000	YTD Budget $000	Variance $000		LY Full Year Actual $000	Full Year Budget $000
				REVENUE						
95,994	96,290	(296)	U	Government & Crown Agency	883,903	866,834	17,069	F	1,089,019	1,155,951
892	877	15	F	Non-Government & Crown Agency	10,121	7,896	2,225	F	11,047	10,528
96,886	97,167	(281)	U	*Total Revenue*	894,024	874,730	19,294	F	1,100,066	1,166,479
				EXPENSES						
43,230	41,697	(1,533)	U	Workforce Costs	354,054	342,966	(11,088)	U	484,392	462,125
3,855	3,794	(61)	U	Outsourced Services	34,499	32,884	(1,615)	U	41,837	43,556
10,014	8,191	(1,823)	U	Clinical Supplies	83,389	72,995	(10,394)	U	99,345	96,871
5,355	5,040	(315)	U	Infrastructure & Non-Clinical Supplies	45,160	44,994	(166)	U	63,258	60,354
40,590	39,471	(1,119)	U	Provider Payments	367,058	354,966	(12,092)	U	466,737	474,021
3,188	3,519	331	F	Non-Operating Expenses	27,396	29,739	2,343	F	34,951	40,469
106,232	101,712	(4,520)	U	*Total Expenses*	911,556	878,544	(33,012)	U	1,190,520	1,177,396
(9,346)	(4,545)	(4,801)	U	**NET SURPLUS / (DEFICIT)**	(17,532)	(3,814)	(13,718)	U	(90,454)	(10,917)

Revenue (Year to Date)

Overall, Revenue is $19.3m favourable to budget year to date.

Government and Crown Agency revenue is $17.1m favourable, including additional funding for COVID-19 $7.7m, Primary Mental Health & Addiction $2.8m and Community Pharmaceuticals $2.1m. These revenue streams have a direct connection to expenditure. The Community Pharmaceutical revenue has been revised down based on Pharmac advice to the MoH. The limitation on bed capacity had a significant impact on the achievement of Planned Care delivery resulting in a revision down of revenue by $2.1m this month. The Capital Charge funding has been reduced by $1.5m to align with the change in the Treasury rate from 6% to 5%.

Non-Government & Crown Agency revenue is $2.2m favourable to budget. The recognition of the donated clinical equipment and PPE from the Ministry of Health of $3.2m has offset for the most part the reduced Non Resident revenue of $0.7m.

Expenditure (Year to Date)

Total Expenses year to date are $911.6m, which is $33.0m unfavourable to budget.

The Workforce costs are $11.1m unfavourable year to date. This includes $5.7m of Holidays Act 2003 liability which was not budgeted.

Outsourced Clinical Services are $1.6m unfavourable year to date reflecting additional costs incurred for delivery of the Improvement Action Plans.

Clinical Supplies are $10.4m unfavourable year to date for hospital clinical activity to deliver Business as Usual and the Improvement Action Plan. The major contributors include Treatment Disposables, Instruments & Equipment and Pharmaceuticals.

Provider Payments are $12.1m unfavourable year to date; comprising payments to NGOs supporting COVID-19 activity, including $7.1m COVID-19 testing in the community, $2.1m for Mental Health & Addiction and $0.4m for Community Pharmaceuticals. The Disability Support payments for Residential Care are $2.4m unfavourable as there has been a higher than expected volume of hospital level care for patients.

Year to Date Results – By Key Drivers

The Financial Performance includes unbudgeted expenditure outside the normal Business as Usual (BAU). The year to date Financial Performance table below indicates the split of financial performance across unbudgeted activities and Business as Usual (BAU).

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 31 March 2021

	YTD Actual Total $000	YTD COVID-19 $000	YTD Holidays Act $000	YTD ODPH Accelerated Depreciation $000	YTD NDPH $000	YTD BAU $000	YTD Budget Total $000	YTD BAU Variance $000	
REVENUE									
Government & Crown Agency	883,903	7,719	-	-	-	876,184	866,834	9,350	F
Non-Government & Crown Agency	10,121	3,156	-	-	-	6,965	7,896	(931)	U
Total Revenue	894,024	10,875	-	-	-	883,149	874,730	8,419	F
EXPENSES									
Workforce Costs	354,054	1,552	5,663	-	943	345,896	342,966	(2,930)	U
Outsourced Services	34,499	(3)	-	-	-	34,502	32,884	(1,618)	U
Clinical Supplies	83,389	570	-	-	-	82,819	72,995	(9,824)	U
Infrastructure & Non-Clinical Supplies	45,160	153	-	1,388	262	43,357	44,994	1,637	F
Provider Payments	367,058	8,778	-	-	-	358,280	354,966	(3,314)	U
Non-Operating Expenses	27,396	-	-	-	-	27,396	29,739	2,343	F
Total Expenses	911,556	11,050	5,663	1,388	1,205	892,250	878,544	(13,706)	U
NET SURPLUS / (DEFICIT)	(17,532)	(175)	(5,663)	(1,388)	(1,205)	(9,101)	(3,814)	(5,287)	U

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 31 March 2021

Actual 30 Jun 2020 $000		Actual 31 Mar 2021 $000	Budget 31 Mar 2021 $000	Actual 28 Feb 2021 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	14,546	7	27,472	7
49,819	Trade & Other Receivables	54,648	50,011	57,037	48,830
6,095	Inventories	6,146	5,148	6,301	5,235
86,925	*Total Current Assets*	75,340	55,166	90,810	54,072
	NON-CURRENT ASSETS				
326,463	Property, Plant & Equipment	325,861	349,673	327,788	355,122
3,307	Intangible Assets	6,486	18,682	4,145	20,149
329,770	*Total Non-Current Assets*	332,347	368,355	331,933	375,271
416,695	**TOTAL ASSETS**	407,687	423,521	422,743	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	4,655	-	16,259
64,666	Payables & Deferred Revenue	66,700	67,771	73,278	64,494
962	Short Term Borrowings	461	1,021	460	955
88,645	Employee Entitlements	89,411	83,394	88,787	85,533
154,273	*Total Current Liabilities*	156,572	156,841	162,525	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	883	1,039	891	1,018
75,528	Holidays Act 2003	80,816	18,925	80,562	-
19,810	Employee Entitlements	19,810	19,810	19,810	19,810
96,429	*Total Non-Current Liabilities*	101,509	39,774	101,263	20,828
250,702	**TOTAL LIABILITIES**	258,081	196,615	263,788	188,069
165,993	**NET ASSETS**	149,606	226,907	158,955	241,274
	EQUITY				
485,955	Contributed Capital	487,100	510,281	487,104	531,750
108,500	Property Revaluation Reserves	108,500	108,502	108,500	108,502
(428,462)	Accumulated Surplus/(Deficit)	(445,994)	(391,876)	(436,649)	(398,978)
165,993	*Total Equity*	149,606	226,907	158,955	241,274
	Statement of Changes in Equity				
172,410	Opening Balance	165,993	206,398	165,993	206,398
(90,454)	Operating Surplus/(Deficit)	(17,532)	(3,814)	(8,185)	(10,917)
84,744	Crown Capital Contributions	1,145	24,323	1,147	46,500
(707)	Return of Capital	-	-	-	(707)
165,993	Closing Balance	149,606	226,907	158,955	241,274

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 March 2021

	YTD Actual $000	YTD Budget $000	Variance $000	Full Year Budget $000	LY YTD Actual $000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash was provided from Operating Activities:					
Government & Crown Agency Revenue	884,967	871,130	13,837	1,156,983	833,616
Non-Government & Crown Agency Revenue	8,024	7,722	302	10,296	8,422
Interest Received	270	174	96	232	223
Cash was applied to:					
Payments to Suppliers	(545,258)	(514,973)	(30,285)	(675,364)	(500,687)
Payments to Employees	(339,234)	(361,236)	22,002	(499,568)	(318,454)
Capital Charge	(4,124)	(6,263)	2,139	(12,605)	(5,138)
Goods & Services Tax (net)	751	1,498	(747)	(486)	4,239
Net Cash Inflow / (Outflow) from Operations	5,396	(1,948)	7,344	(20,512)	22,221
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	3	-	3	-	4
Cash was applied to:					
Capital Expenditure	(22,291)	(57,444)	35,153	(72,294)	(25,932)
Net Cash Inflow / (Outflow) from Investing Activity	(22,288)	(57,444)	35,156	(72,294)	(25,928)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	1,145	24,324	(23,179)	45,763	4,306
Cash was applied to:					
Repayment of Borrowings	(718)	(593)	(125)	(220)	(523)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	427	23,731	(23,304)	45,543	3,783
Total Increase / (Decrease) in Cash	(16,465)	(35,661)	19,196	(47,263)	76
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	14,546	(4,649)	19,195	(16,252)	(9,812)

Cash flow from Operating Activities is favourable to budget by $7.3 million. Revenue received and Payments to Suppliers are in line with the Statement of Financial Performance, however Payments to Employees is favourable as the budget included payments for the Holidays Act 2003 and the Capital Charge payment is lower than budgeted with the reduction in rate from 6% to 5%.
Cash flow from Investing Activities is favourable to budget by $35.2m. The Capital Expenditure cash spend reflects the timelines for scoping, procurement, approval and supply chain delivery for capital expenditure.

Cash flow from Financing Activities is unfavourable to budget by $23.3m. The 2021 Annual Plan budgeted for equity funding to pay for settlement of the Holidays Act 2003 liability. However, while the review phase has been completed, the rectification phase remains in progress.

Overall, Cash flow is favourable to budget by $19.2m.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure - Cash Flow
For the period ending 31 March 2021

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	5,195	20,616	15,421	U	10,322
Clinical Equipment	11,281	12,063	782	U	9,952
Other Equipment	521	781	260	U	370
Information Technology	2,671	8,305	5,634	U	2,426
Motor Vehicles	14	-	(14)	O	3
Software	2,609	15,679	13,070	U	2,859
Total Expenditure	22,291	57,444	35,153	U	25,932

At 31 March 2021, our Financial Position on page 5 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $332.3m, which is $36.1m less than the budget of $368.4m.

Land, Buildings & Plant variance of $15.4m YTD reflects changes to the timing of the following projects Critical Infrastructure Works, the new Sterile Services Facility, the Tenth Operating Theatre/PACU and Southland Chillers for general air-conditioning.

Information Technology and Software variance combined at $18.7m reflects delays to date in the Vocera Hands Free Clinical Communications and South Island Patient Information Care System (SIPICS) projects. In addition, the Patientrack project has been cancelled.

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

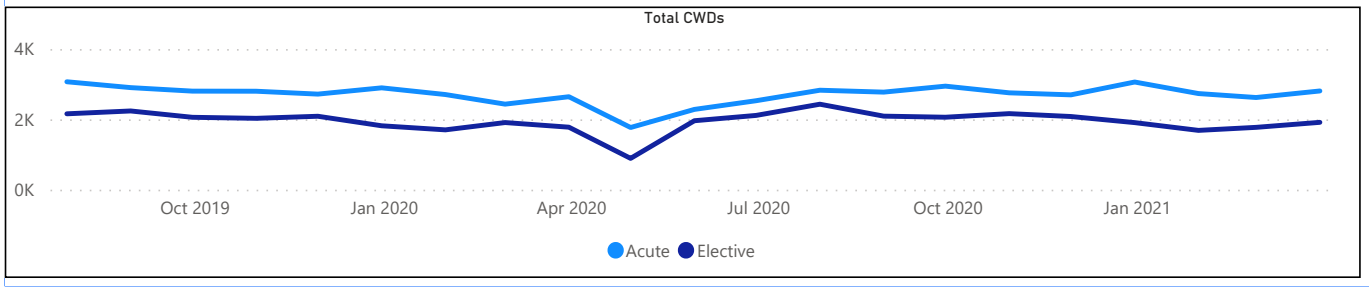
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year On Year YTD Variance
Maternity Caseweights												
Maternity Acute	102	95	8	8	113	-11	884	803	82	10	914	-30
Maternity Elective	404	368	36	10	341	63	3,365	3,166	199	6	3,074	291
Total	**506**	**463**	**43**	**9**	**455**	**52**	**4,250**	**3,969**	**281**	**7**	**3,988**	**262**
Medical Caseweights												
Medical Acute	1,459	1,506	-47	-3	1,238	221	13,365	12,904	462	4	13,346	20
Medical Elective	321	319	2	1	298	23	3,042	2,595	447	17	2,954	87
Total	**1,780**	**1,825**	**-45**	**-2**	**1,536**	**244**	**16,407**	**15,499**	**909**	**6**	**16,300**	**107**
Surgical Caseweights												
Surgical Acute	1,246	1,296	-50	-4	1,292	-46	10,975	10,936	39	0	10,713	262
Surgical Elective	1,190	1,518	-328	-22	1,138	52	11,702	12,055	-353	-3	11,751	-48
Total	**2,436**	**2,814**	**-378**	**-13**	**2,430**	**6**	**22,677**	**22,991**	**-314**	**-1**	**22,464**	**214**
Total	**4,723**	**5,103**	**-380**	**-7**	**4,421**	**302**	**43,334**	**42,459**	**875**	**2**	**42,752**	**582**

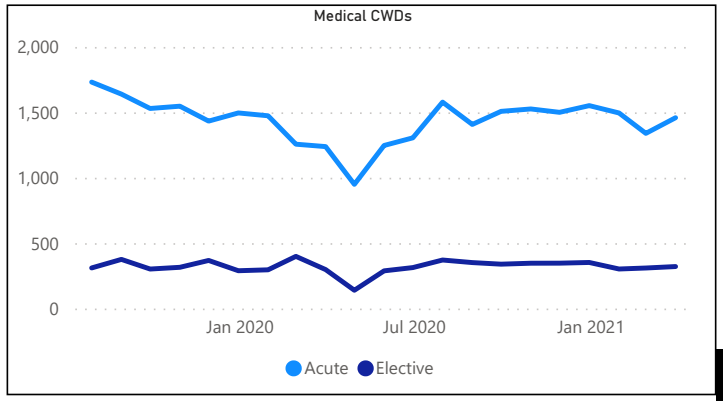
TOTALS

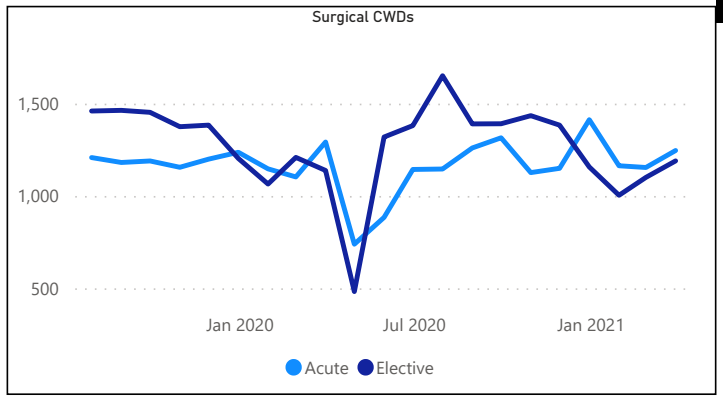
Acute	2,808	2,897	-90	-3	2,644	164	25,225	24,642	582	2	24,973	252
Elective	1,915	2,205	-290	-13	1,777	138	18,110	17,817	293	2	17,779	331
Total	**4,723**	**5,103**	**-380**	**-7**	**4,421**	**302**	**43,334**	**42,459**	**875**	**2**	**42,752**	**582**

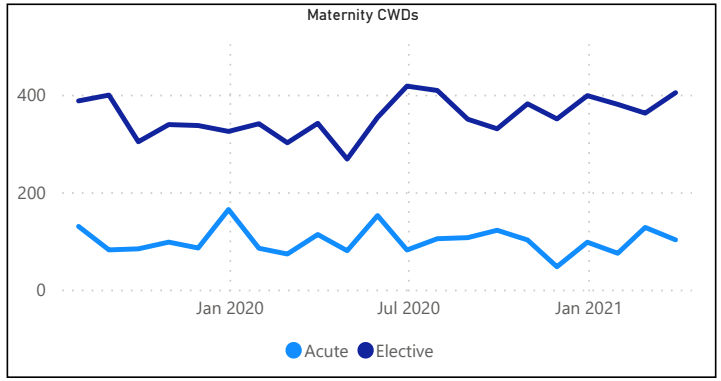
TOTALS excluding Maternity

Acute	2,705	2,803	-97	-3	2,530	175	24,340	23,840	500	2	24,058	282
Elective	1,511	1,837	-326	-18	1,436	75	14,744	14,650	94	1	14,705	39
Total	**4,216**	**4,640**	**-423**	**-9**	**3,967**	**250**	**39,084**	**38,490**	**594**	**2**	**38,763**	**321**









8.2

SERVICE PROVIDER RAW DISCHARGES

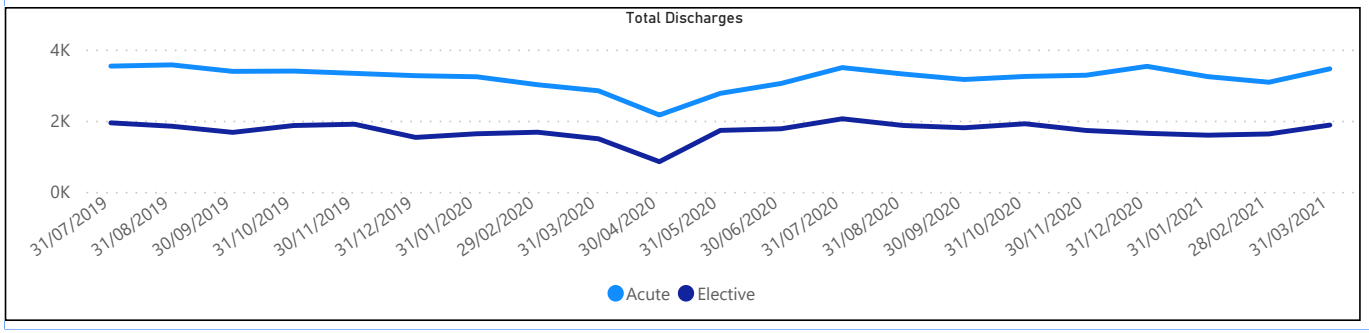
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Maternity Discharges												
Maternity Acute	77	84	-7	-9	93	-16	784	716	68	10	774	10
Maternity Elective	568	491	77	16	465	103	4,448	4,235	213	5	4,330	118
Total	**645**	**576**	**69**	**12**	**558**	**87**	**5,232**	**4,951**	**281**	**6**	**5,104**	**128**
Medical Discharges												
Medical Acute	2,503	2,401	102	4	1,947	556	21,619	20,628	991	5	21,757	-138
Medical Elective	426	365	61	17	326	100	3,511	3,011	500	17	3,181	330
Total	**2,929**	**2,765**	**164**	**6**	**2,273**	**656**	**25,130**	**23,639**	**1,491**	**6**	**24,938**	**192**
Surgical Discharges												
Surgical Acute	877	840	37	4	800	77	7,377	7,085	292	4	7,026	351
Surgical Elective	883	1,064	-181	-17	700	183	8,138	8,448	-310	-4	8,036	102
Total	**1,760**	**1,904**	**-144**	**-8**	**1,500**	**260**	**15,515**	**15,532**	**-17**	**0**	**15,062**	**453**
Total	**5,334**	**5,245**	**89**	**2**	**4,331**	**1,003**	**45,877**	**44,122**	**1,755**	**4**	**45,104**	**773**

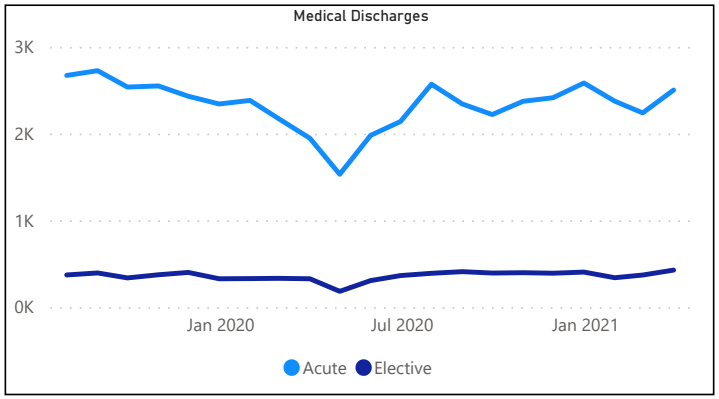
TOTALS

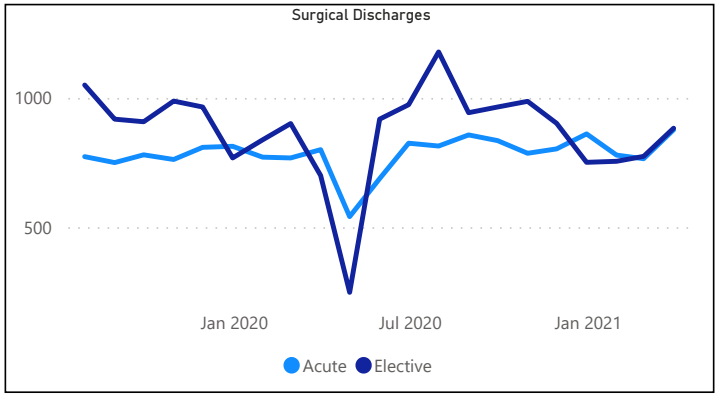
Acute	3,457	3,325	132	4	2,840	617	29,780	28,428	1,352	5	29,557	223
Elective	1,877	1,920	-43	-2	1,491	386	16,097	15,694	403	3	15,547	550
Total	**5,334**	**5,245**	**89**	**2**	**4,331**	**1,003**	**45,877**	**44,122**	**1,755**	**4**	**45,104**	**773**

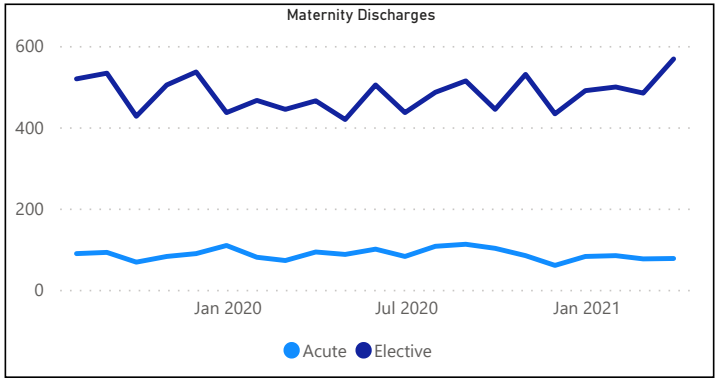
TOTALS excluding Maternity

Acute	3,380	3,241	139	4	2,747	633	28,996	27,712	1,284	5	28,783	213
Elective	1,309	1,429	-120	-8	1,026	283	11,649	11,459	190	2	11,217	432
Total	**4,689**	**4,670**	**19**	**0**	**3,773**	**916**	**40,645**	**39,171**	**1,474**	**4**	**40,000**	**645**



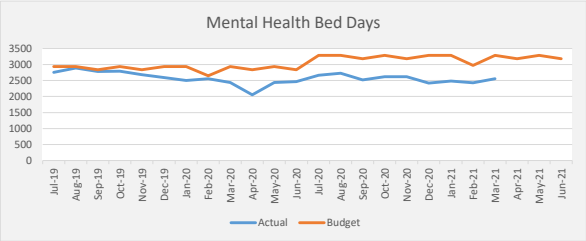




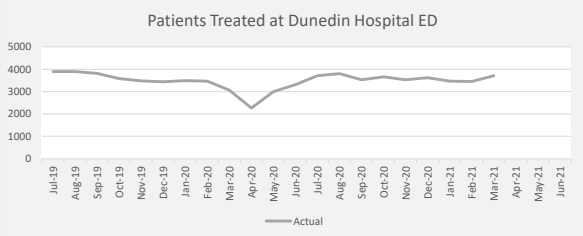


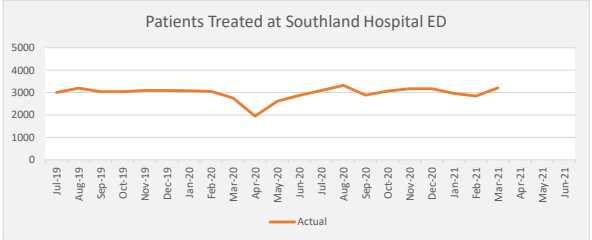
OTHER ACTIVITY

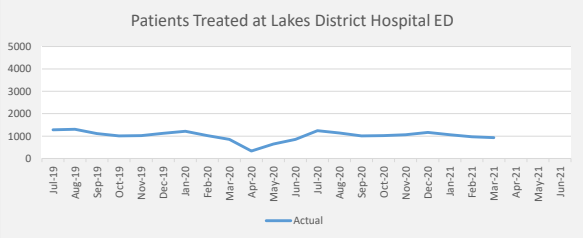
Mar-21				Mar-20	YEAR ON YEAR		YTD 2020/2021				YTD Mar 20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,558	3,286	(728)	-22%	2,434	124	**Mental Health bed days**	23,046	29,044	(5,998)	-21%	23,979	(933)

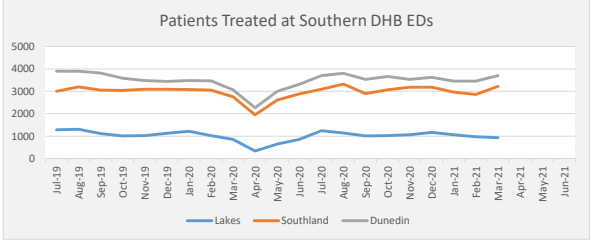


Mar-21	Mar-20	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Mar 20	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,705	3,063	642	Dunedin	32,473	32,123	350
931	847	84	Lakes	9,593	9,919	(326)
3,217	2,752	465	Southland	27,761	27,364	397
7,853	6,662	1,191	**Total ED presentations**	69,827	69,406	421









FOR INFORMATION

Item:	Quality Dashboard – March 2021
Prepared by:	Gail Thomson, Executive Director Quality & Clinical Governance
	Patrick O'Connor, Quality Improvement Manager
Meeting of:	Board – May 2021

Recommendation

That the Board **notes** the attached quality dashboards

Purpose

The Executive Quality Dashboard presents key metrics for the Southern region across the dimensions of effectiveness, patient experience, efficiency and timeliness. It is intended to highlight clinical quality risks, issues and performance at a system wide level.

Specific Implications for Consideration

1. Financial

    - The cost of harm to patients is substantial and derived from additional diagnostics, interventions, treatments and additional length of stay.

2. Workforce

    - Sickness and absence reporting is currently being rolled out. We expect that to be available by the end of the first quarter.

3. Equity

    - No obvious issues with equity have been identified during March from the quality dashboard, but further analysis would be required to fully understand this.

4. Other

    - Please note comments in the discussion section

Background

5. The Executive Quality Dashboard was created in 2019. It presents key metrics for the Southern region across the dimensions of effectiveness, patient experience, efficiency, and timeliness. It is intended to highlight clinical quality risks, issues and performance at a system wide level.

6. The dashboard elements have recently been transitioned into Power BI and is widely available to staff via the PowerBi reporting platform. There are still some design features that require fine tuning and consistency such as axis naming conventions, easy to read axis and some other individual features. The IT reporting team are working on this and expect improvements to be noted each month.

7. Changes to dashboards and/or creation of new indicators or charts take one full time IT/reporting analyst two weeks to complete. To help the IT/reporting team prioritise the most important work requests, the ED Quality and Clinical Governance Solutions has established a weekly prioritisation meeting. The team are finding this very helpful to date.

8. Please note: Southern includes hospitals in the Southern Region. Dunedin relates to Dunedin Public Hospital. Wakari is included in the Southern Region reporting. Unless otherwise stated any definitions in the commentary for Southern apply to Dunedin and Invercargill

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Discussion

9. In line with last month, rising volumes of complaints over the last few months are increasing workloads in the Consumer Feedback team. The reasons for this rise are not clear yet but may be linked to the hospital performance issues in the last few months. The newly appointed Consumer Experience Manager and Feedback Facilitator are looking at the team's workload and consumer complaints to understand what is driving the rise in complaints and any possible solutions

10. Cleaning time for theatres has now been added to the dashboard in the Average Theatre Utilisation graph

11. The imaging graph showing the % completed within 42 days has been excluded for this month. Data has now been extracted from the new Karisma system but still needs to be checked and verified. We expect this graph to be included next month

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Next Steps & Actions

Investigate drivers of complaints and impact of workload on turnaround times for Consumer Experience Team

Verify imaging data and include graph in next month's report

Appendices

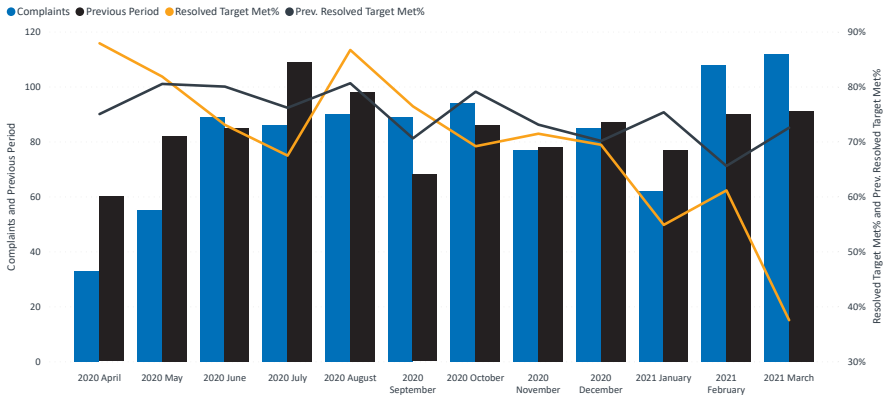
Appendix 1	Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital

Executive Dashboard - Patient Experience

(Southern)

Southern - Complaints, Previous Period, Resolved Target Met%, Prev. Resolved Target Met%

BY YEAR, MONTH



Safety 1st data.

Complaints

The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

Resolutions

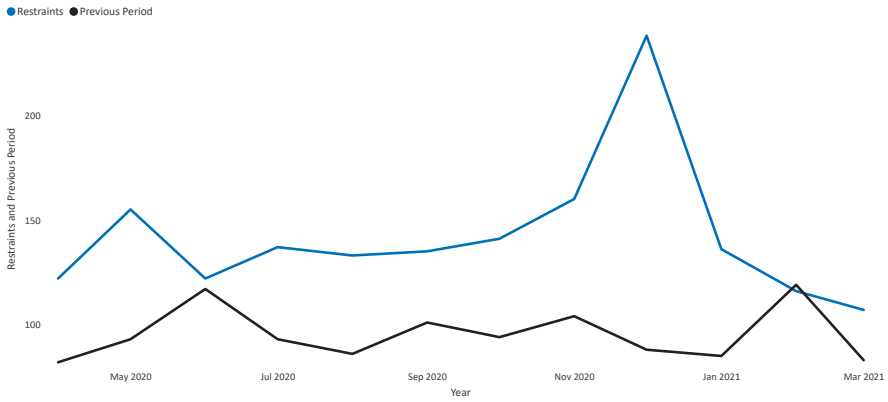
There is a one month (20 working days) time period for complaints to be resolved, or to communicate additional time required to the patient. For that reason the current reporting month will always appear as a lag.

Rising volumes of complaints over the last few months are increasing workloads in the Consumer Feedback team.

The reasons for this rise are not clear yet but may be linked to the hospital performance issues in the last few months. The newly appointed Consumer Experience Manager and Feedback Facilitator are looking at the team's workload and consumer complaints to understand what is driving the rise in complaints and any possible solutions

Southern - Restraints, Previous Period

BY YEAR, MONTH



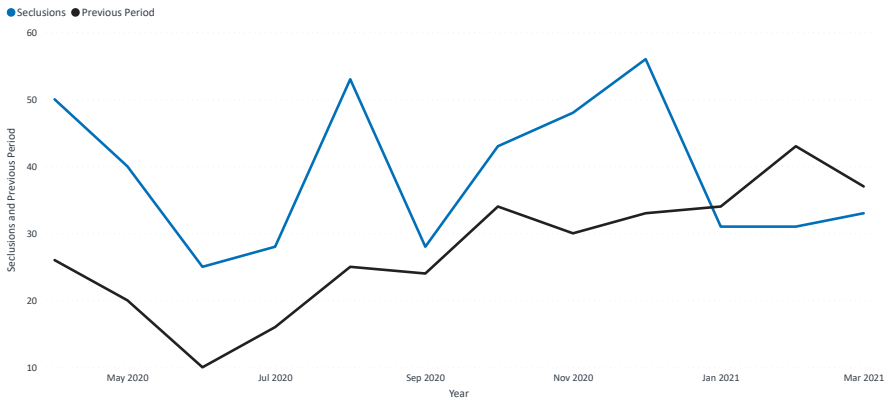
Restraints

Safety 1st data. The number of restraint events per month.

Restraints data includes Dunedin, Invercargill, Wakari & Lakes.

Southern - Seclusions, Previous Period

BY YEAR, MONTH



Seclusions

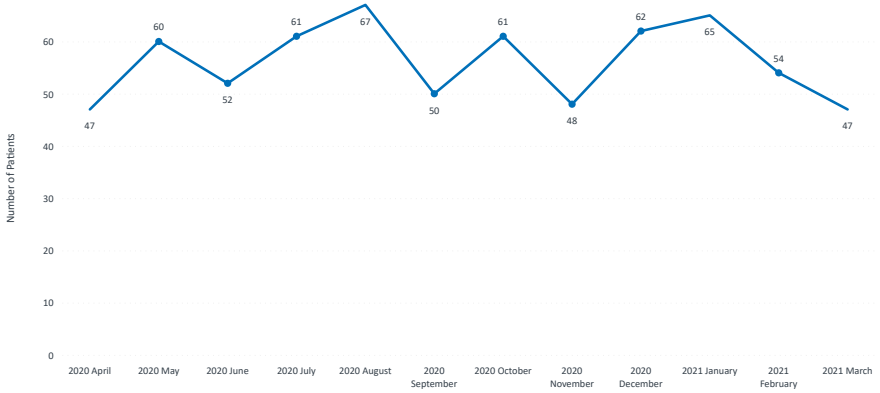
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Southern)

Southern - Deaths

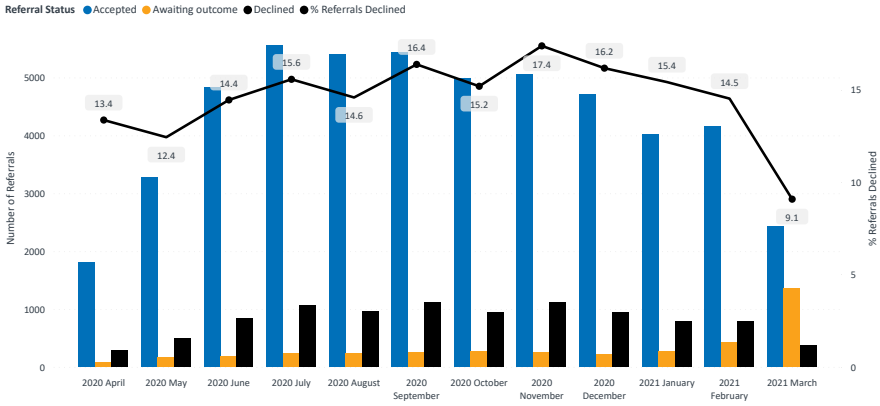
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths

Number of patients deceased by discharge month.

Southern - Referrals Accepted / Awaiting Outcome and Declined

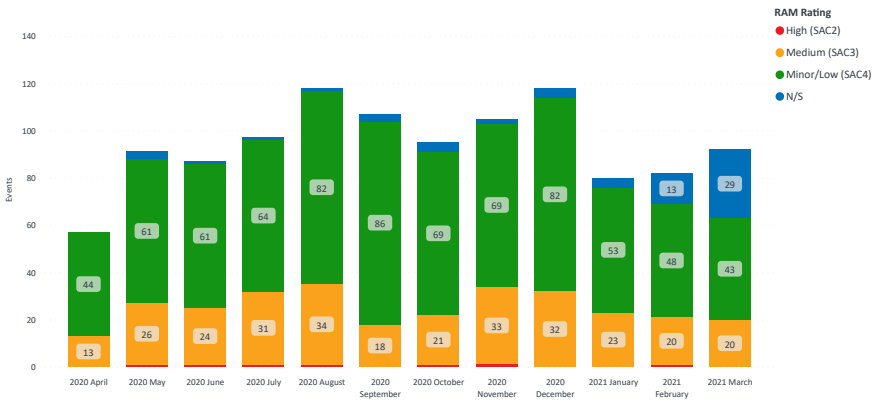


Referrals accepted (authorised), awaiting outcome or declined by month.

% referrals declined

Southern - Staff Events

BY RAM RATING, YEAR, MONTH



Safety 1st data.

The monthly number of reported staff adverse events

Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

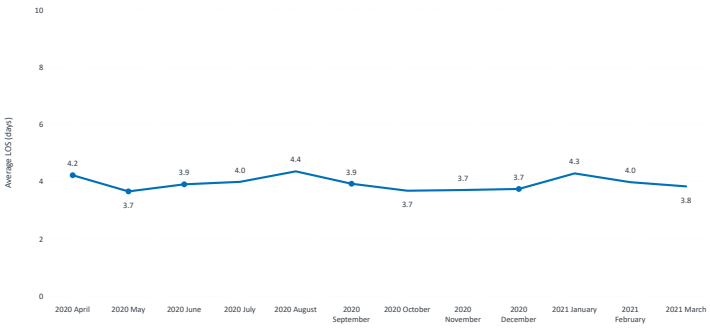
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls forms (visitor falls) which are not associated with clinical practice. These events are not assessed in the same way as clinical events and do not receive a risk assessment score and thus have appeared as "not scored".

Executive Dashboard - Efficiency

(Southern)

Southern - Average LOS

BY DAYS

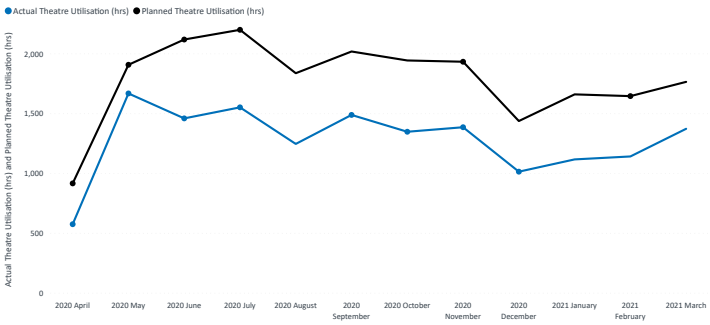


Average Length of stay

Average Length of stay by specialty of all patients present in the hospital at any point of time

Southern - Planned vs Actual Theatre Utilisation (hrs)

BY HRS



Actual Theatre Utilisation

Actual theatre utilisation given by CaseLength Time = Anaesthetic Time + Procedure Time

Anaesthetic Time = Time duration between "Anaesthetic Start Time" and "Patient Ready for Procedure Time"

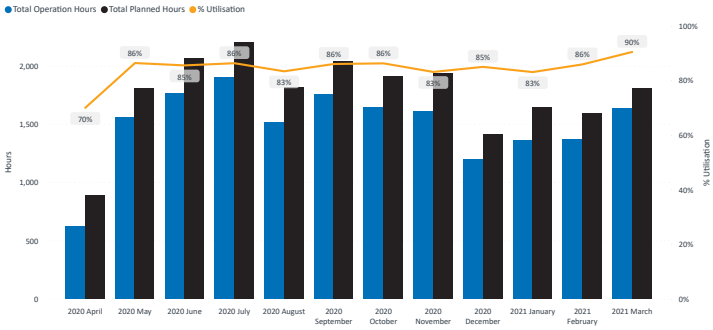
Procedure Time = Time duration between "Procedure Start Time" and "Procedure Complete Vs the scheduled / planned theatre time given by the scheduled session time

Southern - Monthly 6 Hour %

Monthly 6 Hour %

Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This excludes the time spent in ED observation

Southern - Average Theatre Utilisation (%)



Average Theatre Utilisation (%)

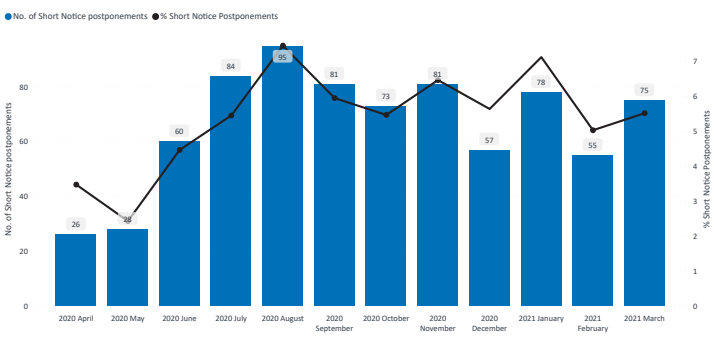
Numerator: Planned and acute operations from when the patient is brought into operating theatre to the patient leaves

"Theatre cleaning time included - Cleaning time of 12 mins per operation"

Denominator: Planned session time

Excluded: overruns (where an operation runs over the planned session time); out of theatre anesthetic

Southern - Short Notice Postponements



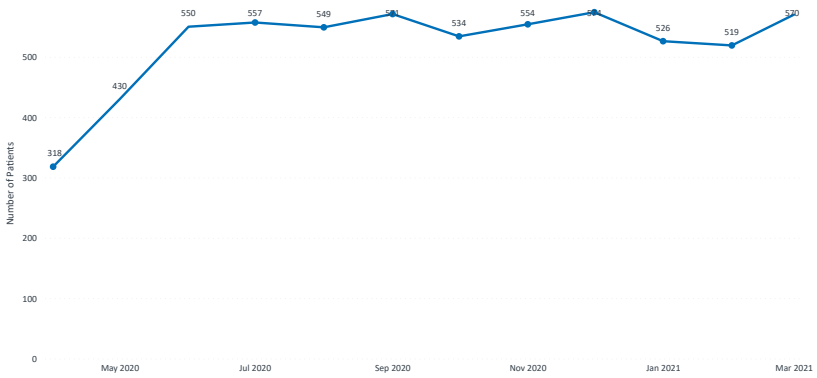
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Southern)

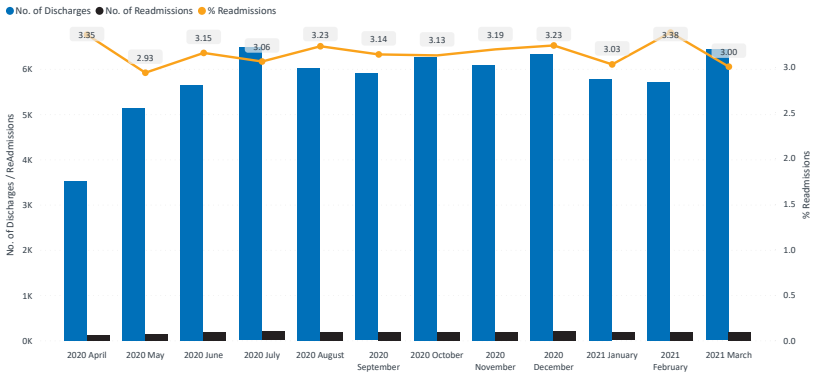
Southern - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

Number of patients in hospital at any point of time when they have exceeded 7 days since admission

Southern DHB - Unplanned Hospital Readmissions within 7 days

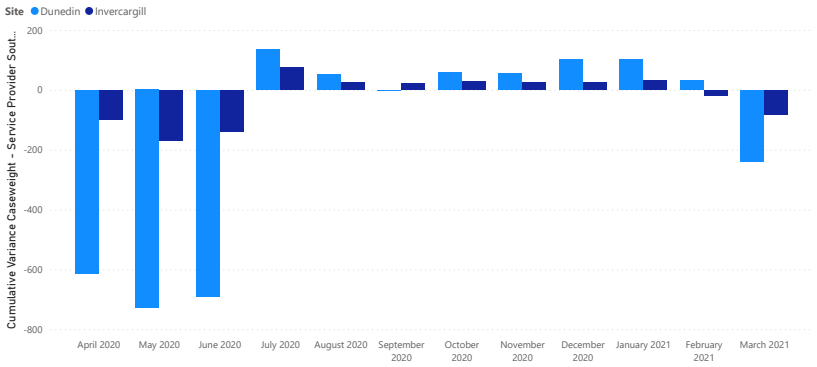


Unplanned Hospital Readmissions within 7 Days

Acute / Unplanned readmissions within 7 days of the initial discharge from hospital organised on the basis of the month of discharge

Cumulative Variance Caseweight - Service Provider Southern

BY CALENDARMONTHYEAR, SITE



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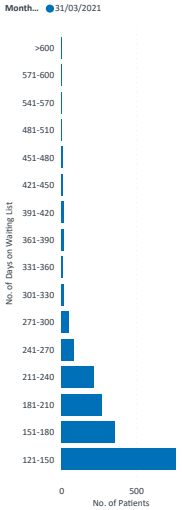
The graph shows how ahead or behind the actuals for Dunedin and Invercargill with 33 purchase units within the elective initiative in the last 12 months.

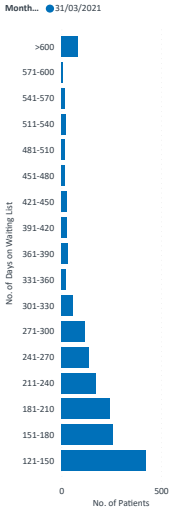
Southern - ESPI 2 Breaches

FOR THE LAST COMPLETED MONTH



Southern - ESPI 5 Breaches

FOR THE LAST COMPLETED MONTH



ESPI 2 and ESPI 5

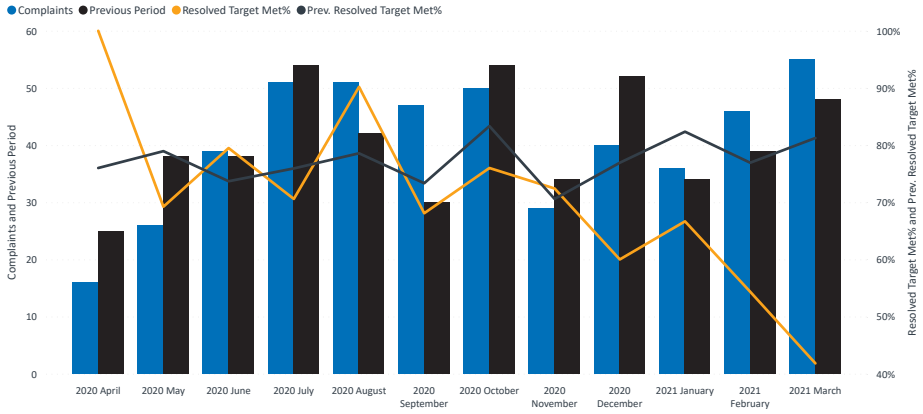
ESPI 2 and ESPI 5 waitlists organised into the given time buckets

Executive Dashboard - Patient Experience

(Dunedin)

Dunedin - Complaints and Previous Period

BY YEAR AND MONTH



Safety 1st data.

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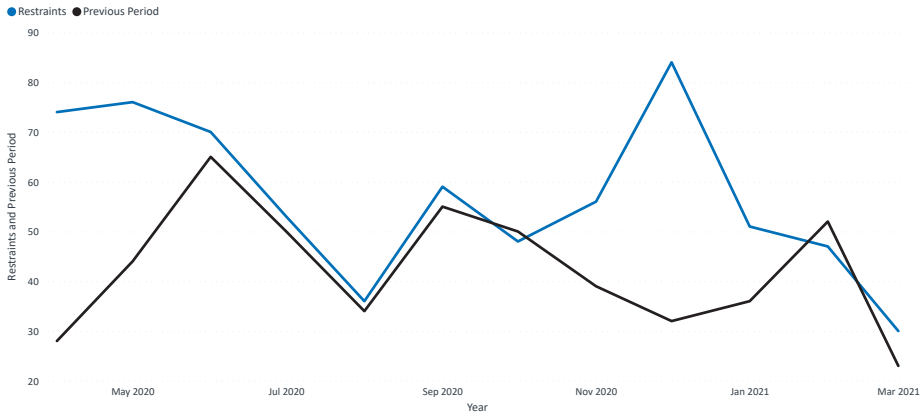
Dunedin - Restraints and Previous Period

BY YEAR AND MONTH



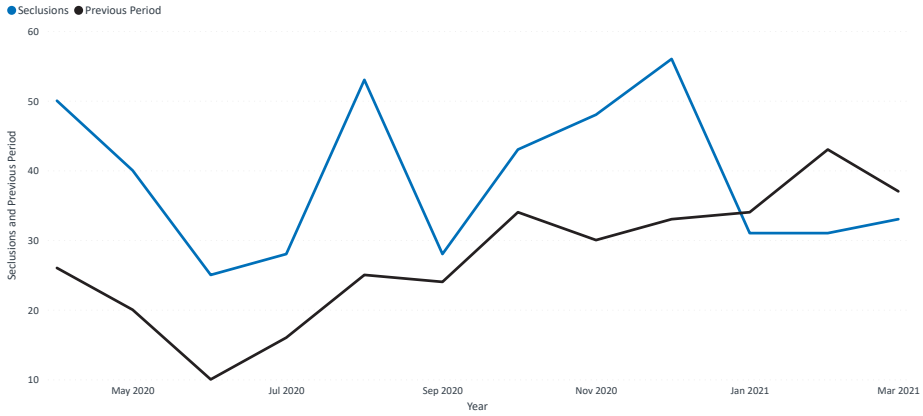
Restraints

Safety 1st data. The number of restraint events per month.

Restraints data for Dunedin only.

Dunedin - Seclusions and Previous Period

BY YEAR AND MONTH

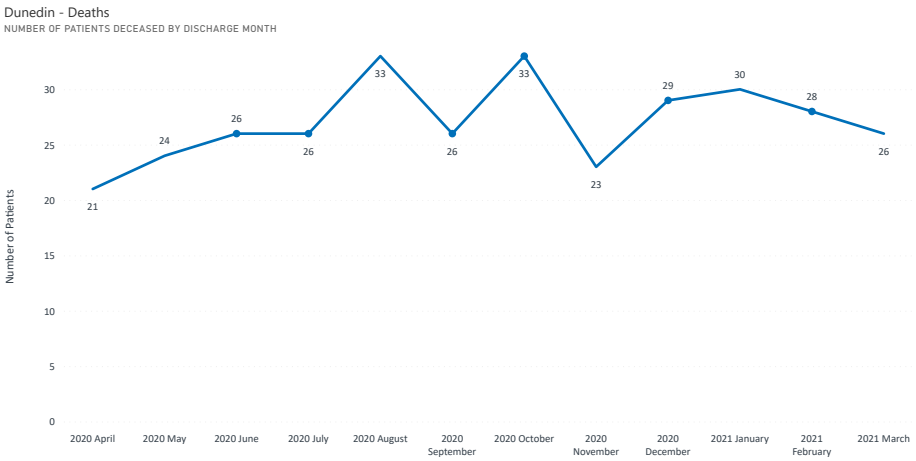


Seclusions

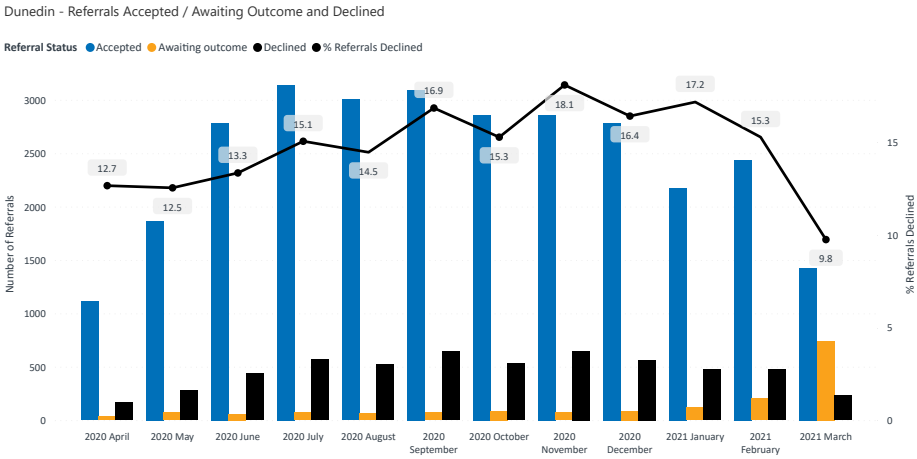
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

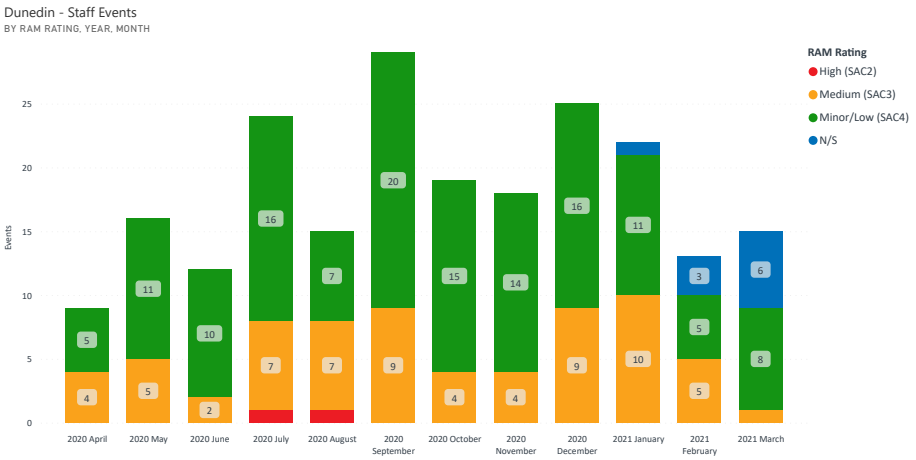
(Dunedin)



Deaths
Number of patients deceased by discharge month.



Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



Safety 1st data.
The monthly number of reported staff adverse events
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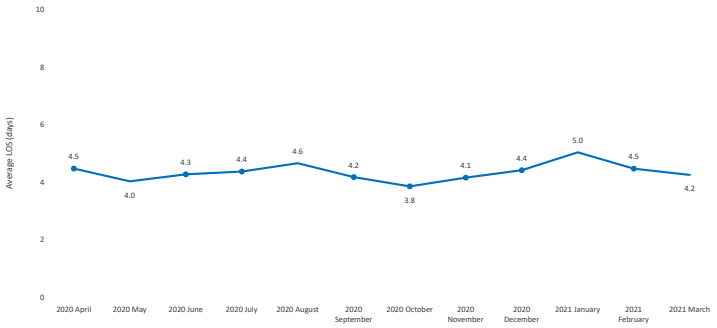
Executive Dashboard - Efficiency

(Dunedin)

Dunedin - Average LOS

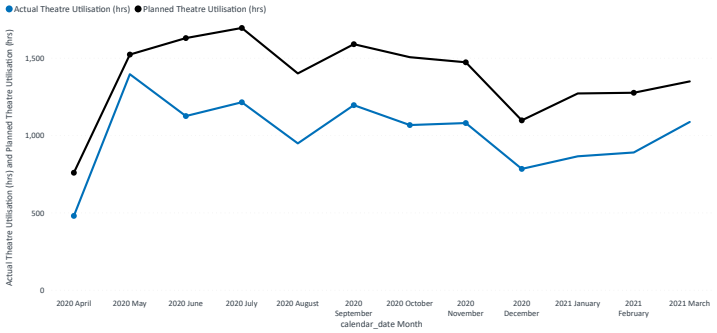
BY DAYS



Average Length of stay

Average Length of stay by specialty of all patients present in the hospital at any point of time

Dunedin - Planned vs Actual Theatre Utilisation (hrs)



Actual Theatre Utilisation

Actual theatre utilisation given by
CaseLength Time = Anaesthetic Time + Procedure Time
Anaesthetic Time = Time duration between "Anaesthetic Start Time" and "Patient Ready for Procedure Time"
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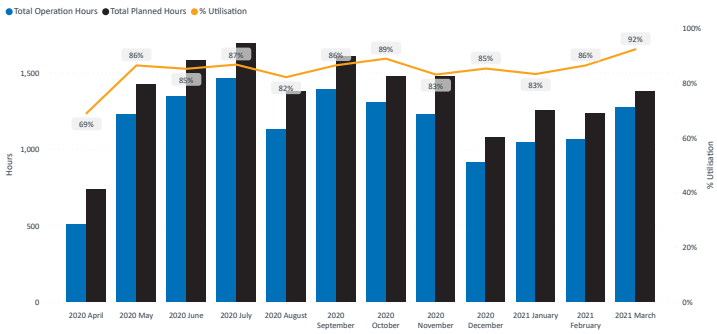
Dunedin - Monthly 6 Hour %

Monthly 6 Hour %

Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This excludes the time spent in ED observation

Dunedin - Average Theatre Utilisation (%)



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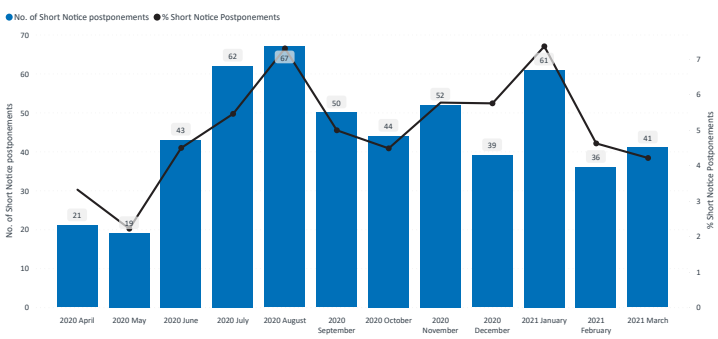
Dunedin - Short Notice Postponements



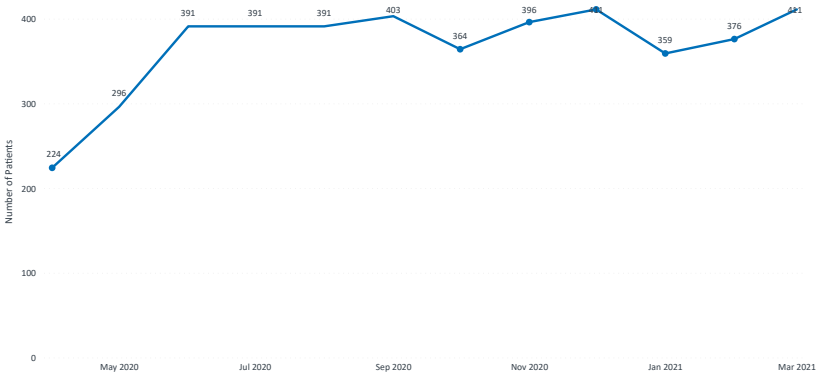
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Dunedin)

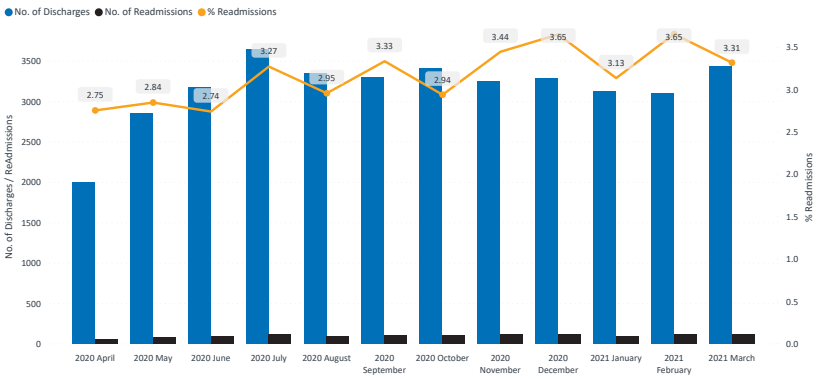
Dunedin - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

Number of patients per month who have a LOS > 7 days

Dunedin - Unplanned Hospital Readmissions within 7 days



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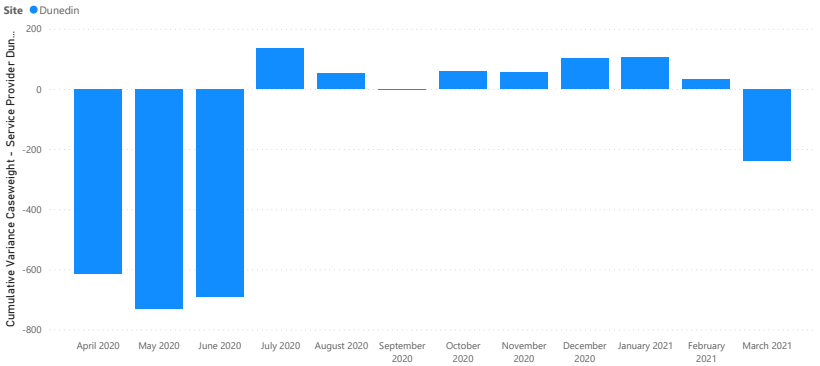
Cumulative Variance Caseweight - Service Provider Dunedin

BY CALENDAR, MONTH, YEAR AND SITE



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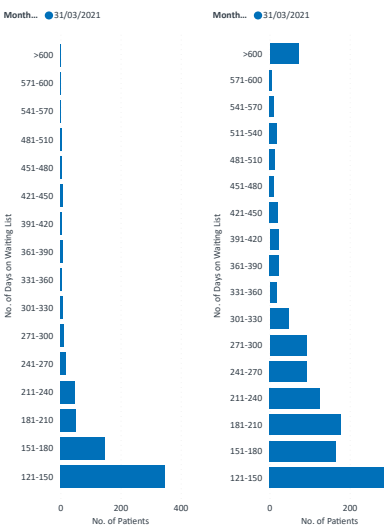
Dunedin - ESPI 2 Breaches f...

Dunedin - ESPI 5 Breaches f...



ESPI 2 and ESPI 5

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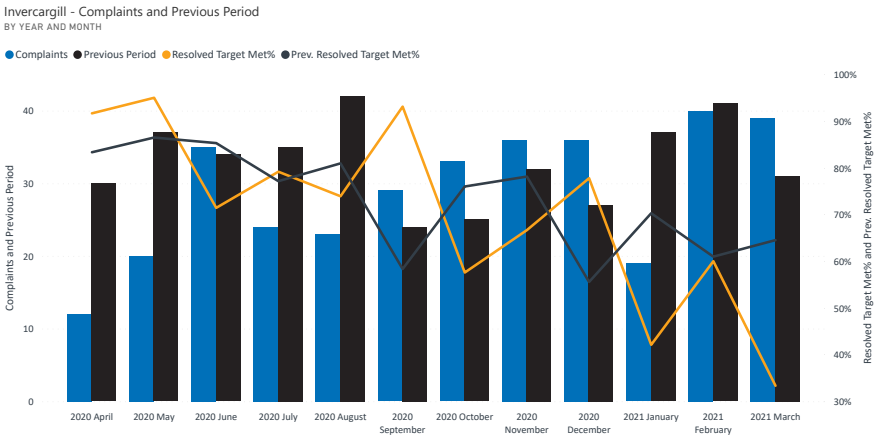
Executive Dashboard - Patient Experience

(Invercargill)



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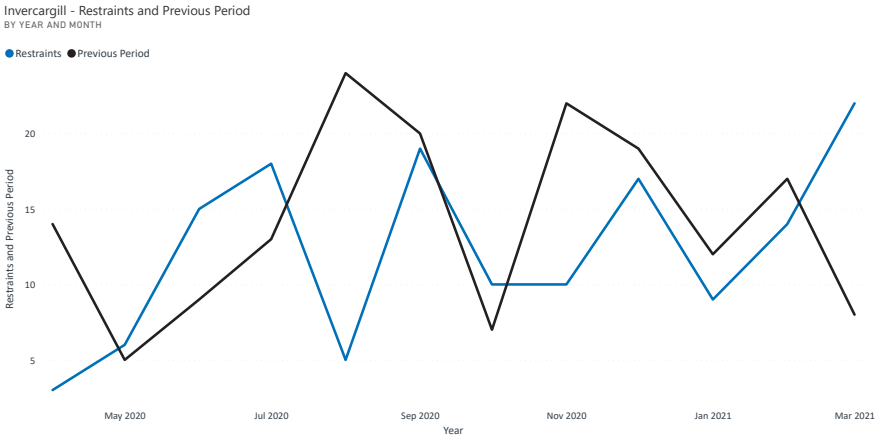

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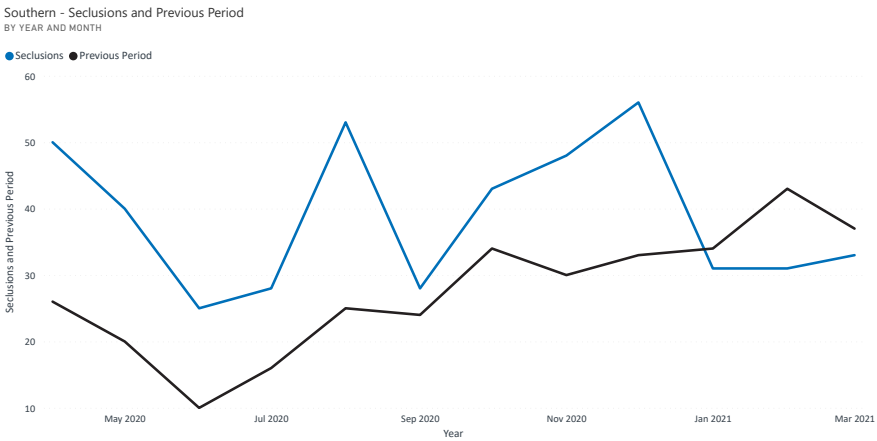

Seclusions

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Executive Dashboard - Effectiveness

(Invercargill)

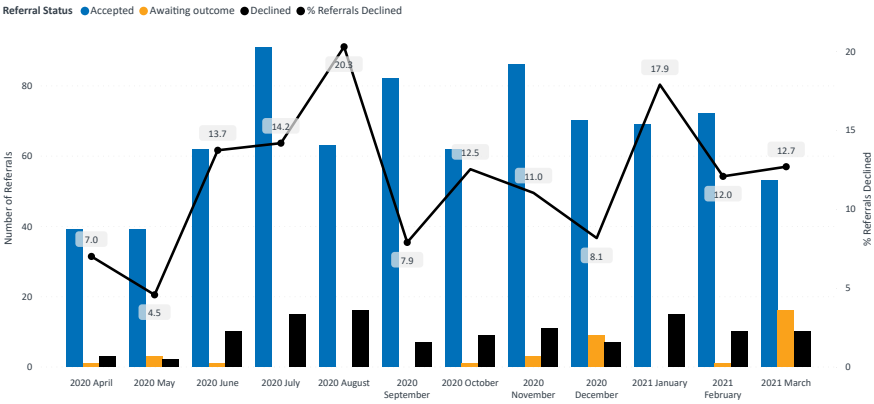
Invercargill - Deaths

NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH

Deaths

Number of patients deceased by discharge month.

Invercargill - Referrals Accepted / Awaiting Outcome and Declined

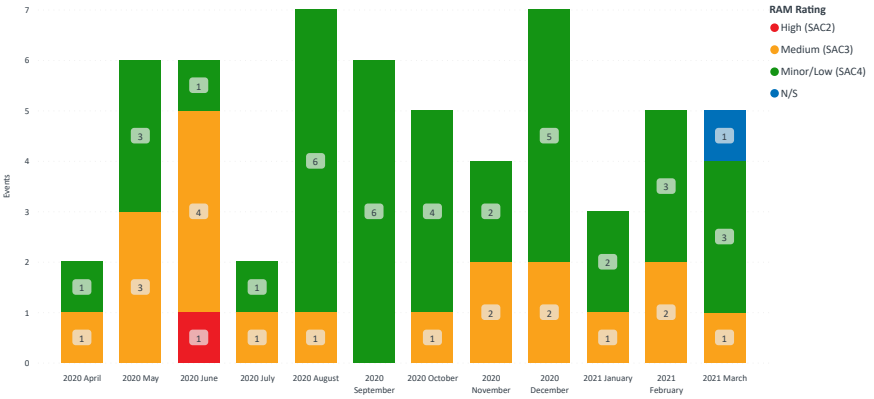


Referrals accepted (authorised), awaiting outcome or declined by month.

% referrals declined

Invercargill - Staff Events

BY RAM RATING, YEAR, MONTH



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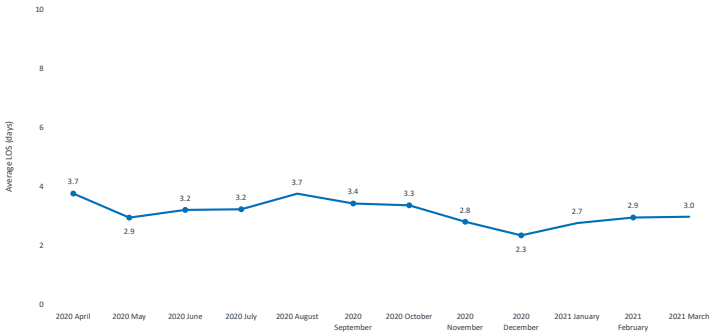
Executive Dashboard - Efficiency

(Invercargill)

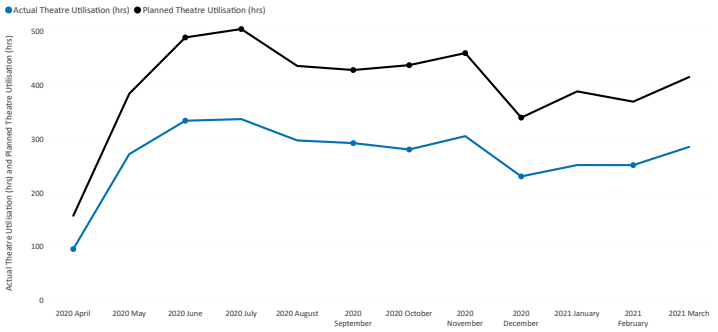
Invercargill - Average LOS (days)



Average Length of stay

From Triage Time in ED(if admitted from ED) or admission to ward to discharge from ward for each episode of care. No specialities are excluded. Only patients discharged in that month are included in each months data

Invercargill - Planned vs Actual Theatre Utilisation (hrs)



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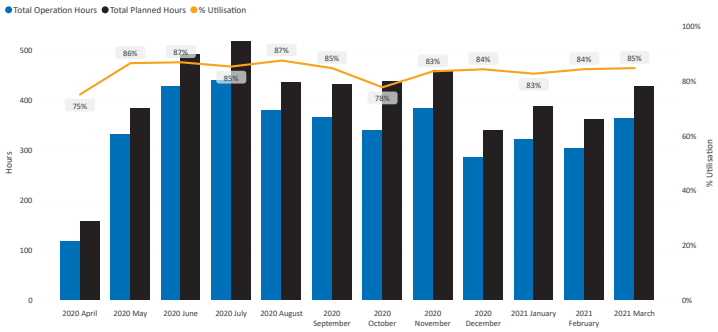

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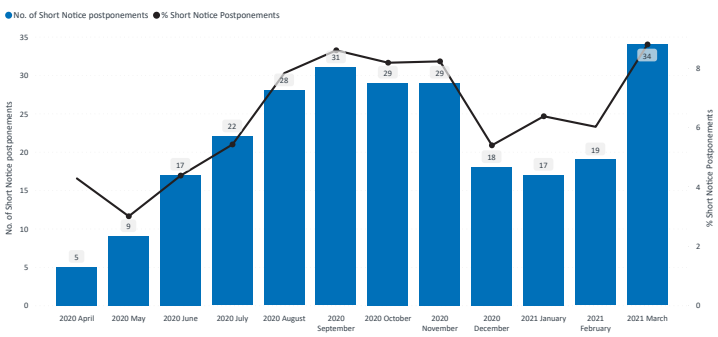

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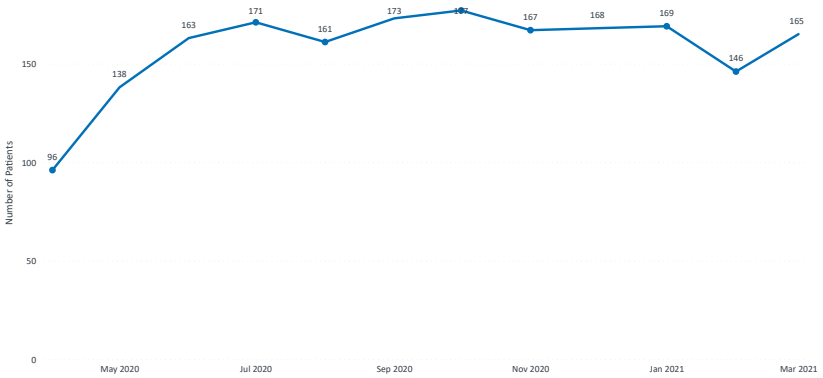
Executive Dashboard - Timely

(Invercargill)

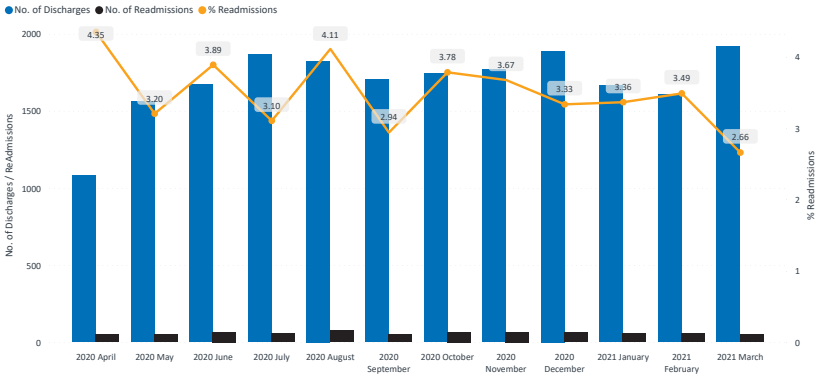
Invercargill - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

Number of patients per month who have a LOS > 7 days

Invercargill - Unplanned Hospital Readmissions within 7 days



Unplanned Hospital Readmissions within 7 Days

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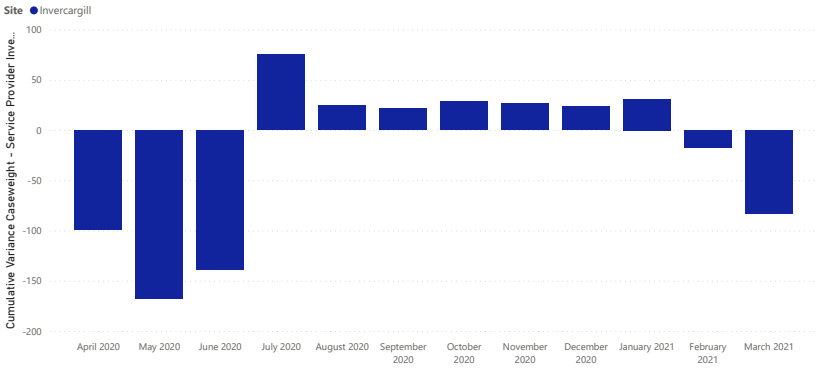
Cumulative Variance Caseweight - Service Provider Invercargill

BY CALENDARMONTHYEAR, SITE



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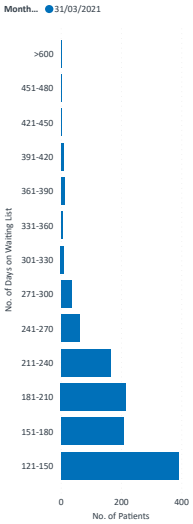

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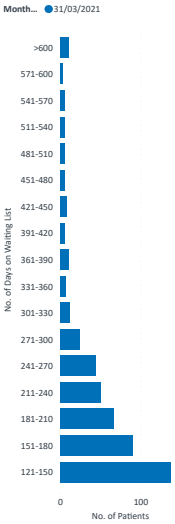

ESPI 2 and ESPI 5

ESPI 2 and ESPI 5 waitlists organised into the given time buckets

Specialist Services monthly report for Mar 2021

Lead Executive: Patrick Ng

Southern District Health Board

EXECUTIVE SUMMARY

Nurse roster gaps improved in March as the graduate recruits from late January completed their training and were added to the roster. We continue to have some vacancies, particularly in Southland, We are also lean on perioperative staffing in Southland with Anesthetic Technician roles in particular continuing to be difficult to recruit into.

Performance area	Previous month	Current month	Commentary
Case weights surgery			Team working on recovery focusing on acute capacity in Dunedin and on what ousourcing volumes can be achieved.
Discharges			Less adverse than CWD as substitution of daycase actvity occured when bed block issues were encountered.
ED six-hour target			Modelling suggests fit for purpose spaces in ED Southland B/C will meaningfully improve SSED performance.
Cancer target <31 days			31 day target slightly adverse to target but 62 day performance is key area of concern. Investigation is underway to compare how we measure our FCT with others. Wait for diagnostic a key area of constraint.
FSA (ESPI 2)			Orthopaedic Dunedin and ENT Southland key focus. Dunedin had reduced orthopaedic outpatient capacity and has been asked to ammend this.
Elective treatment< 4 months			Orthopaedics has been most impacted by inpatient bed issues over the last few months. Lists are systematically being booked back at capacity again and work is underway re: how much acute capacity is required.
Medical imaging CT			CT shift in place and performance has improved in February and March compared to January. Another machine outage in March, unfortunately.
Medical imaging MRI			Performance improved from earlier in year. MRI capacity in Dunedin remains challenging. Strategy proposes making a case for more Dunedin based capacity.
Colonoscopy 14 days			Remains on target.
Colonoscopy 42 days			Southland was below target for the latest report but we believe it will be back on target by the next report.
Colonoscopy 84 days			Surveillance forecast to achieve compliance by September. New guidelines to be implemented in Southland will accelerate this.

Current Issues	Update/Achievements	Upcoming key deliverables
Elective surgical delivery	Adverse to plan as under delivered in both population (out of district) and in hospital delivered year to date.	Recovery plan focused on lifting outsourcing volumes and using Timaru capacity + returning inpatient lists to normal..
Financial performance	Product catalogue work ongoing. RMO run review project initiated.	Month end checklist work contining to be refined.
ICU air handling issues (for stage 2) slow to be addressed	Mechanical engineers have submitted first designs for 15 of 18 air handling systems to peer review mechanical engineers and are in peer review process on these.	Legal obligations of respective parties being worked through with Anderson Llyod support.

8.4

• Planned Care Recovery

- We have clarified with the Minsitry that we are forecast to earn circa $1.3m of our outpatient recovery funding based on the volumes delivered year to date.
- We have written to the Ministry requesting an extension of time that would enable us to get to the baseline volumes for opthalmology outpatients and then achieve the additional volumes required to earn planned care recovery funding. This would enable us to get on top of opthalmology follow ups that have waited more than 1.5 their indicated wait time. This was at zero pre-COVID but there are now several thousand that need to be caught up (these are high volume appointments).

• Oncology

- We have developed a quantified plan to recover the radiation oncology first specialist appointment wait list and tested it with the Radiation Oncologists. Unfortunately, the regular volumes to stay on top of total FSA until we are successful with recruitment for a 6th radiation oncologist are not achievable and we are re-drafting the plan, which we are also discussing with the Ministry.
- The re-drafted plan will still utilise the specialty nurse but will now add a relatively significant outsourcing component if we can't find a fixed term locum. We are proposing putting an RFP tender together as our RO colleagues tell us that there is outsourcing capacity around the country we coudl try and attract.
- We will also approach our CDHB colleagues and other centres to see whether some treatment could occur via inter district flow to other centres but we believe CDHB have a similar capacity shortfall to us.

• Gastroenterology

- New internal digital referral has gone live and is being used consistently.
- New codes introduced which should enable us to track reasons for colonoscopy decline after they have been through the second review process and report on this.
- Working on surveillance backlog, particulalry for Southland. Clinical Leader driving an initiative that will see each long wait surveillance patient contacted to check that their status is up to date and offered a survellinace scope in Dunedin to get one done quicker.

SP&C Services monthly report for Mar 2021

Lead Executive: Lisa Gestro

EXECUTIVE SUMMARY

Positioning Public Health services for the future	Previous month	Current month	Commentary
COVID-19 Response			▪ Covid-10 Swabbing – 5124 swabs undertaken over the past month including 445 at the maritime ports. ▪ Virtual monthly education facilities have been initiated with ARC facilities, with 36 facilities attending the first session. ▪ The Ministry of Health has advised the team to be prepared for a Quarantine Free Zone for New Zealand with flights coming in at the ports of Auckland, Wellington, Christchurch and Queenstown. Planning is underway with the airport stakeholders, Ministry of Health and the Public Health Unit. We have been advised to be prepared for 80% flight capacity pre-COVID, which has been estimated at approximately 1,000 passenger arrivals per day. ▪ The Meridian COVID-19 vaccination centre opened on 29 March. This clinic is initially operating six vaccinator's in a pod of six rooms, the target volume per day is 360, however, with 'Did Not Arrive' (DNAs) the daily volumes will be slightly lower. The Meridian has residual capacity to scale this operation to 18 vaccinators operating on site. ▪ The Invercargill site has been confirmed as the Victoria Room in the Municipal Chambers. This centre will be opening on 12 April. This site will support a six vaccinator operation.
Psychosocial Response planning			▪ The Mental Health Wellbeing Navigator role has been appointed with governance provided by the Central Lakes Wellbeing Recovery Group. The Group has met to set key priorities and a work plan for the 100 days, as well as communication strategies.
Immunisation			▪ Further work is underway on overarching COVID/measles programme immunisation response plan. ▪ Demands on this service remain high. Work in some areas has ceased temporarily due to workforce issues related to COVID-19 vaccination.
Maternity			▪ Four workshops were run by an independent facilitator, resulting in improved financial estimates that will be included in a paper to the Board next month seeking approval to progress with the two unit solution.

Current Issues	Summary of risk	Mitigation strategies
COVID-19 vaccination programme	Public Health nurse work force has been deployed for vaccination of priority groups in Southern. This will mean some Business as Usual (BAU) and programme work will need to stop.	Urgent development of an independent vaccinator workforce is underway. Prioritisation of what work is stopped to ensure further inequities do not occur.
WellSouth PHO - Invercargill After Hours Primary Care	Clinical safety compromised if no overnight primary care is available to the population of the Invercargill	Engage with key stakeholders: WellSouth and Local General Practices (GPs). Hold contract holders to account.

Strategy and Planning

- Annual Plan 21/22 - The first draft of the Annual Plan, incorporating the SLM, was submitted to the Ministry of Health on 5 March. The first draft was incomplete and does not include budget related content, although the majority of the content has been created/updated.
- Financial tables (and narrative) are being prepared separately to the Annual Plan word document
- A combined IGC/CPHAC workshop is scheduled for 7 April and the draft will be submitted to the Board on 8 April. MoH will commence feedback on 9 April.

Aged Residential Care

- The DHB continues to experience elevated levels of occupancy in Aged Related Residential Care (ARRC), primarily at Hospital and Psychogeriatric levels of care.
- Timely admission to ARC continues to be a challenge in some areas. While it appears there are sufficient ARC bed capacity to allow for good patient flow, in several facilities those empty beds are not available for new admissions due to staff shortages. ARC facilities are being significantly impacted by the continually loss of RNs, especially to DHB recruitment. This is compounded by the flow of new internationally qualified nurses being almost non-existent at present, resulting in few opportunities for replacing staff.
- Psychogeriatric Residential Care Beds continue at full capacity, with older people requiring that care waiting in hospital or at the wrong level of care in aged residential care.

Refugee Quota Programme

- There will be limited intakes this year with anticipated increases in the next financial year. Arrivals into Dunedin are expected in April. There will be limited re-settlers in 2020-21 and anticipated efforts to meet the minimum 1,500 refugees per annum resettling across aligned cities in 2021-22. For context, this is a 50% increase in refugee cohort volumes compared with previous years.

SP&C Services monthly report for Mar 2021

Lead Executive: Lisa Gestro

Southern District Health Board
Piki Te Ora

8.4

EXECUTIVE SUMMARY

Mental health and addiction system transformation

- Synergia have continued to progress the first stage of the review, engaging with many individuals and groups across the district. Surveys are in progress for the mental health and addiction system workforce and people with lived experience. A series of Māori focussed hui will be held in Dunedin, Invercargill and Queenstown in April. The co-design phase will occur in mid April with forums in Waitaki, Dunedin, Invercargill and Central Lakes.
- The priority objectives proposed following the Ministry visit earlier this year have continued to be progressed:
  - Purple Consulting have commenced a health and safety review of the Wakari site.
  - Executive Director Strategy, Primary and Community is in discussion with the Learning Lab in Christchurch.
  - The NGO SPOE group have continued to explore what is required to establish appropriate services to enable the transition of long-stay patients from inpatient wards at Wakari. In addition a review to establish the needs of this patient group is in the early planning stages

Mental health updates

- Service demand remains high across the District, particularly for Specialist Addiction Service (SAS) and the rural Child and Youth (C&Y) services, the latter exacerbated by vacancies in the Central-Lakes District. Developments and planning to response to service demand is occurring in areas, particularly the rural C&Y service (telehealth) and SAS (OST caseload management). A visit to Southland by key Mental Health Services of Older Persons staff is planned for 30 April to develop the relationship with local services and establish clearer pathways of care.
- Challenges remain about accommodation for patients in the Invercargill Mental Health Unit and community.
- The average hours of seclusion episodes continues to trend downwards but the total unique individual episodes and total number of events is on the increase. This group continues to assertively work towards reducing and eliminating the use of seclusion.
- Nga Kete Matauranga Pounamu Charitable Trust, has been successful in attracting funding from the Access and Choice RFP for Māori. The new service, called Mahana, is based in Dunedin and was officially opened on Tuesday 23 March 2021. The agreement for the service is directly between the Ministry of Health and Nga Kete Matauranga Pounamu. The service is essentially an extension of the existing service based in Invercargill and provides for a Kaupapa Maori community alcohol and drug service with 3.5 FTE.
- WellSouth's monthly report to the Ministry of Health indicates that all funded positions for Health Improvement Practitioners, Health Coaches and Support Workers have been recruited to. The service is currently provided through 16 General Practices across the Southern DHB area. The Ministry of Health has invited Southern DHB to be one of the early leaders for the next tranche of funding for this service (extending the service out to more General Practices). MoH is offering an extension of the programme for the next two financial years (2021/22 and 2022/23) which would see an increase in FTE to 19.2 FTE Health Improvement Practitioner and 28.9 FTE Health Coach/Support work by the end of 22/23. The extended programme would commence in May 2021 programme. We will need to engage with WellSouth to determine whether this is realistic in terms of their capacity and also the capacity of the training programme run separately by Te Pou to train practitioners in time for this.

Public Health Service

COVID-19 impacts

- The COVID Vaccination programme has impacted significantly on the population health team. Staff have been released from Public nursing and immunisation coordination/outreach programmes and administration to support the COVID vaccination clinics. This has meant work in these areas has ceased for the next few weeks including Public Health Nursing, MMR catch up campaign, School Based Human Papillomavirus Vaccination Programme (HPV) Otago, School Based Services Contract and Immunisation Outreach and Vaccine Preventable Disease (VPD

Drinking water

- The Waikouaiti lead issue continues to involve our staff, including work done by Health Protection Officers around the environmental investigations for the households with residents that had elevated blood lead levels. There were a number of environmental investigations around people's homes that were able to be linked to possible causes of these elevated levels (for example, renovations involving lead-based paint). A public meeting was held with the community on 10 March to provide information from the blood testing investigations and from investigations undertaken by the Dunedin City Council

Community Oral Health Service

- Spatial Equity Project: Will proceed with a pilot project on service distribution regarding population, access to service, distribution, and equity. This pilot is being completed in partnership with the Strategy and Planning Team

Rural health

- The Project Manager for Rural Hospitals has been seconded to assist with the planning of COVID-19 vaccine roll out to rural areas. The Chief Executive (CE) of Gore Health is co-lead of the Emergency Operations Centre (EOC) overseeing the planning of Covid-19 vaccine roll out.
- Radiology solutions for Rural Trust Hospitals are yet to be agreed. Work continues to ascertain if there is merit in working with a single provider of radiology services and one contract with all Rural Trust Hospitals, or if there is another solution that will enable cost effective access to radiology services across the District on a sustainable basis.
- Price increases for St John's ambulance Patient Transfer Service (PTS) have been issued. This will create financial pressure for Rural Trust Hospitals who cannot predict the volume of demand they will experience throughout the year.

Primary Health Care

Pharmacy

- A review of the Client Led Integrated Care – Long Term Conditions (CLIC_LTC) pilot is progressing well in Gore. General Practices (GP) and local community pharmacies in Gore have been engaged in this project and are now able to implement the new model of care. This work is supported by a small team of Southern DHB and WellSouth staff. The main objectives are to ensure that Medicines support for our LTC patients is provided through Community pharmacy integrated into the wider Multi-Disciplinary Team (MDT).

Tobacco control

- Implementation of the Vape to Quit pilot has been delayed due to COVID. The IT platform has been built and will be beta tested through April and then rolled out in May 2021. The aim is to support smokers over 18 years to quit using a vape device, supplied through community pharmacies.

Systems for success monthly report for March 2021 *Lead Executive: Gail Thomson*

Executive Summary

The Improvement Movement is now in its third year and has gone from strength to strength. 274 people are enrolled in the programme this year, 259 are staff; medical, nursing, allied health, management and admin, plus 15 free educational licences allocated to students. Primary care (WellSouth-15 places) and Rurals hospitals are included this year's membership for the first time.

Quality Improvement Activities	
Safe	Reporting on events, feedback and risks from the rural hospitals, starting with Lakes District Hospital, is under development. The Service manager rural health is engaged in understanding and validating the data before wider sharing occurs.
Effective	34 Consumer advisors were engaged in 23 projects across the Southern Health system in March. Engagement remains high which is positive.
Patient Centred	A review of the patient handbook is under way to make it more relevant, readable and accessible. Consumers will be involved in this work.
Equitable	The Consumer Experience Manager is working in partnership with WellSouth to understand why some people come to ED. This will provide a current state for improvement across the system.
Efficient	Access to CDHB hospital pathways has been free since COVID 19 lockdown in 2020. Many RMO's have been accessing these. We are seeking understand the benefit of their access before fully committing to hospital pathways at Southern.
Timely	Feedback from last year's improvement movement cohort was very positive, such as "Well structured. Well organised. Excellent content. Very useful."

Service Updates	Previous month	Current month	Commentary
Infection Prevention & Control			An IPC representatives day was held in March with engagement from across the District. Themes included COVID preparedness, PPE, fit testing and vaccination amongst other topics.

Gail Thomson

Current Issues	Update/Achievements	Upcoming key deliverables
Service risks	Currently reported in monthly operational reports not visible to the risk advisor or EDQ&CGS	A mechanism for ensuring risks go to the risk advisor has been established.

Disability Strategy

The Disability Strategy was successfully launched at the DSAC meeting early April. The Disability working group, that will be governed by DSAC, plan to have their first meeting in April to commence development of an action plan. There have been multiple people with lived Disability put their hand up to be involved in this work which is encouraging.

Risk Management Programme

There has been significant discussion in the past month about where the next 'ology' might come from, how can we get ahead of it and nip things in the bud early. Good risk identification and management is key to early intervention.

The Risk Advisor, appointed 2020, has recently developed a good mechanism for engagement with Specialist Services which will go a long way to achieving this. Supported by a planned go-live of an online risk management system in July 2021, risks should be identified and managed much earlier. The online system will enable staff to directly raise risks which will be reviewed by their local management teams plus be visible to the Quality & Risk teams for further engagement and escalation if needed.

Clinical Governance

The Risk Advisor is working with services on early identification of risk. Clinical risks are overseen by the Clinical Council where robust discussions are now taking place about the escalation and de-escalation of risks. This could be further strengthened across the organisation with a stronger emphasis on planning, not only for tomorrow but for the next 1 – 3 years.

People and data & digital monthly report for Mar 2021

Lead Executive: Mike Collins

Southern District Health Board
Piki Te Ora

EXECUTIVE SUMMARY

- Focus is on embedding the HR proposal for change, still challenges in terms of meeting BAU requests from an HR perspective due to excess demand for HR services. Workforce planning underway in some areas of the organisation.
- People forum established and will assist in strengthen our culture
- Staff Engagement survey closed and analysis being collated and presented to the Exec
- Focus on developing an HR dashboard underway, draft ready for FARC in March meeting
- Continual focus on AL liability continues to be monitored and reported

	Previous month	Current month	
Workforce & HS/W			
HR Dashboard Development			Draft report now produced for FARC feedback, report will be generated monthly and feedback included. More narrative to be added of the progress against actions from previous month reporting.
Workforce Strategy and Action Plan			Tanya to provide an update WIP (Due to workload demands still action required in preperation for June board meeting)
HS/W			Reporting to FARC and HS Governance group progress already.

Implementation of Workforce Strategy

Progressing Q2 & 3 actions within the strategy document (focus on the new recruitment system, workforce planning. Management of BAU tasks within HR remains constant. Draft proposal for change out for review during November.

Culture and change initiatives

People Forum established and work plan to be formalised by Exec in April

Current Issues	Update/Achievements	Upcoming key deliverables
Management of BAU within HR	Staff Engagement Survey presented to exec and wider communications.	Actions and communication plan being developed week 19th April
New Electronic Tools	New recruitment system progressing well launch in Feb 2021	Now Live
Workforce Planning	Jo recruited to NDH team	Status report to come from Jo via NDH team reporting
HR Implementation of Proposal for change	Embedding new roles and responsibilities and processes	Recruitment and Implementation of recommendations (Jan/Feb/Mar/April)
Volume of BAU workloads and Resource to support	Benchmarking complete	Budget rounds only opportunity plus top slice from CAPEX resource appropriately to provide support

- **Green Healthcare Strategy** Q2 and Q3 actions within the strategy have been updated
  - Carbon footprint
  - Energy Supply and Efficiency
  - Waste
  - Travel
  - Procurement
  - Built Environment
  - Staff engagement and culture

- **Regional collaboration** Assisting with review of SIAPO
- New role "Chair South Island CIO/CDO monthly forum**) - complete Mike now Chair**
- **Next Steps another workshop re implementation and resourcing of the roadmap**
- **Mike attendance at CE and Chairs meeting re Data and Digital (April)**

People and data & digital monthly report for Mar 2021

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

- Digital programme of work for the NDH progressing well, just need confirmation from the MOH refunding to progress. Currently reviewing structure and roles/responsibilities of the Digital team to ensure we are aligned for the uplift of work moving forward. Running scenario planning session with the Digital team re Covid 19 readiness

Digital & Tech Performance Indicators	Previous month	Current month	
My Lab (Physical space developed to assist with Change in technology and behaviours)			Site location now not confirmed was Feb now no date confirmed. Asbuilt RFP closed and are preferred supplier. Funding required for Asbuilt contract from NDH project costs for change.
Digital programme of work			
New Dunedin Hospital (Digital)	 	 	Programme Business approved at April board meeting. Now with MoH for DG & CIC approval. Funding approved for T1.1. Paper going to board in June for T2.1 funding. External gateway, technical and independent reviews all now complete, advice taken forward to the detailed business case (DBC). Start-up clinic with Treasury for the DBC scheduled April 29th.
Digital Strategy Update			SI PIC's project initiated. Currently reviewing Digital team structure to ensure its able to meet the demands of BAU, Projects and NDH development.
New Dunedin Hospital (Workforce)			On track Jo working on project plan and rollout re workforce planning and requirements for MOC's. Areas of concern are service level planning re workforce and lack of proactive models of care being developed.
South Island PICS			Team currently being recruited, steering group established and project milestones being confirmed.

Current Issues	Update/Achievements	Upcoming key deliverables
Funding for Digital Work plan	Paper being presented to the board in June for T1.2	Board approval
HR Team Volumes of work Project/BAU	Concerns raised and additional resources have been provided. EOC work as well causing extreme stress for staff.	
Regional Collaboration Review	HR proposal for change developed for consultation	Rafted for CE/s re next steps

Digital Strategy

- Emergency Department Information System Update has been rescheduled due to FPIM go-live & resource constraint (now Sep 2021)
- Network and Desktop replacement pool progressing 2020.21
- HealthOne access across ARC and Māori Health Providers – Good progress
- Cyber security role appointment made as per Audit NZ request and activity underway
- E-pharmacy go live complete
- SI PIC's approval of SIPICS business case now with Joint Ministers for approval
- Wireless improvements on track progressing well. On track to complete 05/05/21
- FPIM dates changed go live Q4 FY20/21 on track
- Tap to go, complete & project closed
- Scanning Solution to digitize records business case to Exec in May 2021
- Recruitment Upgrade complete & post implementation review underway
- RIS Replacement complete & project closed
- Exec review of Human Capital System Upgrade
- iMedX (digital transcription) rollout phase 2 complete. Phase 3 planning with Mental health underway
- Windows 10 rollout on track for BAU handover May 2021
- Allied Health information system, RFP complete & vendor selected, draft business case for Exec in May 2021

Finance monthly report for March 2021

Lead Executive: Julie Rickman

Southern District Health Board
Piki Te Ora

EXECUTIVE SUMMARY

The net deficit for the month ending 31 March 2021 was $9.3m. During March 2021, Revenue was $0.3m favourable to budget, whereas Expenses were $4.5m unfavourable to budget.

The Revenue was revised in March to reflect the under-delivery of elective services by $2.1m as a result of bed capacity limiting the elective activity and return of Combined Pharmaceutical funding of $1.2m (for the year $1.7m) to MoH because Pharmac revised down the costs of pharmaceuticals and Treasury requested the funding be returned to the Crown.

The overrun in Expenses primarily attributable to Workforce $1.5m which includes the unbudgeted increase in liability for Holidays Act 2003 and Clinical Supplies $1.8m which includes Pharmaceutical overspend of $1.0m.

Key Projects	Previous month	Current month	Commentary
Financial sustainability			The delivery of savings plans for the last months of the year continue to be challenging to achieve. The unbudgeted expenditure for Holidays Act 2003, COVID-19, new Dunedin Hospital team and accelerated depreciation for Dunedin Hospital continue to flow through the results.
Holidays Act 2003			The Holidays Act project remains in the 'Rectification phase.' The unbudgeted impact on the 2021 year is $7.5m. We continue to work closely with the unions and other DHBs to understand how the issues can be resolved.
FPIM: Finance Procurement & Information Systems			The user acceptance testing was completed in March 2021. The development of training and communications documentation is being finalised for distribution to the wider teams throughout April.
New Dunedin Hospital Business Case			The Detailed Business Case has been revised and is scheduled for submission to Cabinet for approval.

Current Issues	Update/Achievements	Upcoming key deliverables
Savings plans	The delivery continues to be "at risk".	There continue to be supply chain impacts on manufacturing supply and freight & distribution as a result of the flow on from COVID-19.
FPIM go live date	Date set at 1 June 2021	The communications and training programme are being prepared.
Holidays Act 2003	The project is gaining momentum.	There is work underway to modify the payroll system to resolve the issues. In addition, development of training for employees on the changes is also being prepared.

Systems for Success

- The existing processes are being further refined as part of the preparation for FPIM go live and we are seeking to improve the way in which data is managed.

Facilities

- The project plan for delivery of Radiology CT machine within the 20 week timeframe is progressing as expected with orders of construction material placed so the area is ready for installation of the CT when it arrives.

8.4

Reporting RAG (Red Amber Green) Guidelines		
OVERALL STATUS	GREEN	On track
	AMBER	Planned delivery at risk / concern with action underway to resolve
	RED	Significant concern with delivery / intervention required to prevent failure
FINANCE	GREEN	Tracking to budget 5% (or $100k).
	AMBER	Moderate variance to approved budget 10% (or $100-$500k)
	RED	Significant variance to approved budget 25% (or $50k+)
RESOURCES	GREEN	Adequately resourced
	AMBER	Constrained resources which will impact delivery
	RED	Resource shortfall, preventing tasks from being completed
FORECAST		Status expected to improve
		No change expected in status
		Status expected to decline

FOR INFORMATION

Item: Patient Flow Update Report April 19th, 2021

Proposed by: Patient Flow Taskforce

Meeting of: 4 May 2021

Recommendation

That the Board notes the content of this update, supports the course of action to date, and moving forward.

Purpose

To summarise progress of actions of the Patient Flow Taskforce.

Specific Implications for Consideration

1. Financial: none
2. Operational Efficiency
    - **The Patient Flow activities identified are believed to have a significant long-term impact on increasing patient flow and in turn providing operational efficiencies.**
3. Workforce
4. Equity

Background

The Patient Flow Taskforce was established in response to urgent focus needed addressing our hospital's bed block issues and staff stress and burnout. The 'SAFER' Bundle framework was introduced as an evolution of the 'Valuing Patient Time' and is being used as a vehicle to embed the necessary system changes to alleviate pressure, increase patient and staff wellbeing.

Discussion

Progress to date has involved further planning, targeted engagement, developing resources/education, gathering feedback, communications and surfacing of metrics and facilitating enhanced processes where possible.

Next Steps & Actions

Further comms to support the efforts and further focus and embedding of best practise for the components of SAFER. Metrics & Run charts out to Clinical Teams.

Appendices

1. Patient Flow Taskforce Progress Update
2. SAFER Framework programme

PATIENT FLOW IMPROVEMENT PROGRAMME

Month #3 Progress Update

Summary of Patient Flow Taskforce activity to date:

- Identification of 6 key workstreams: Senior Review, Rapid Rounds, Discharge Summaries, Clinical criteria for discharge, transitions, staff wellbeing, and stranded patients. These workstreams are aligned with the 'SAFER' bundle which is the international framework that we are working too & an evolution of the Valuing Patient Time work. See appendix #2 to this report.

- Rapid Rounds have been markedly better – teams have really stepped up and we are seeing increased involvement from all professional groups. There is increased focus on ensuring estimated discharge dates and care plans are in place and the right questions are being asked to ensure patient flow is optimised where possible. There is still more improvement to make though and further embedding of this more standardised practise in all areas. Some of the problems for our patients still being identified include complex social issues, coordination of support plans with ACC, staffing issues for social workers and nursing and waits whilst investigations are needed.

- Clinical Criteria for Discharge has been the focus for the past week to two weeks. Refreshed educational resources have been developed and circulated and training sessions have been delivered to teams.

- A dedicated intense focus has been given to overall planning before weekends since the Code Black event. This was first used pre-Easter and since then the operational management team have committed to making this a prelude to every weekend. Key clinicians and responsible managers on-call for the weekend will meet at the end of the week to plan for expected operational challenges for that weekend.

- Comms/Engagement: Ongoing – weekly newsletters to staff outlining feedback, activity and the wins we are seeing in teams. A spot on the upcoming webinar is planned and the fortnightly standup open to any Executive and Directorate leaders and others to join is ongoing. A plan to reinvigorate the e-TXT service has happened so that we can send pre-planned texts out to our relevant groups (SMO's etc.). Code black identified the need for a fast efficient communication method. This will be managed by Ops, per weekly roster.

- Wellbeing initiatives have begun – a free yoga offer to staff has gone out. This is accessible district wide as although it is held in a studio it is zoomed live and videoed.

- Metrics: Work to refine the content of these dashboards so they are more easily digestible to clinical teams is ongoing. The security group for the three clinical groups to have access is still a work in progress. Feedback suggests we need to make the data easier for teams to decipher.

Latest metrics snapshots (as @ 19 April):

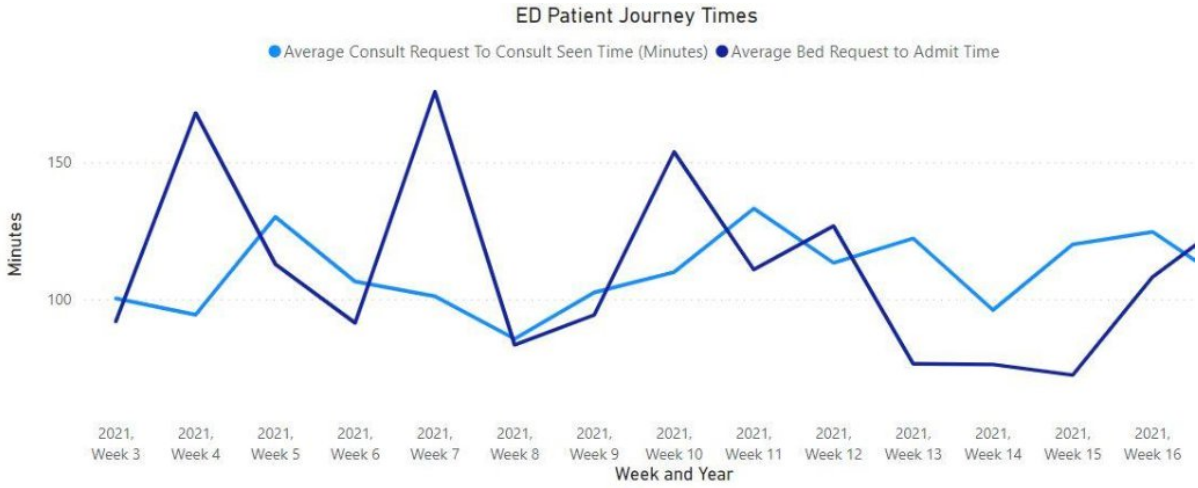

Fig 1. Southland: Weekly consult to bed request average times

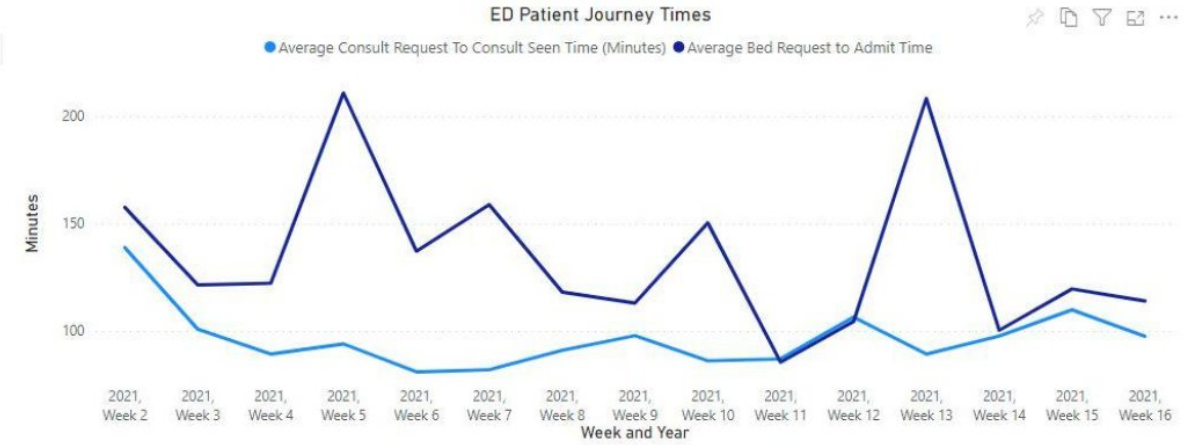

Fig. 2 Dunedin: Weekly consult to bed request average times

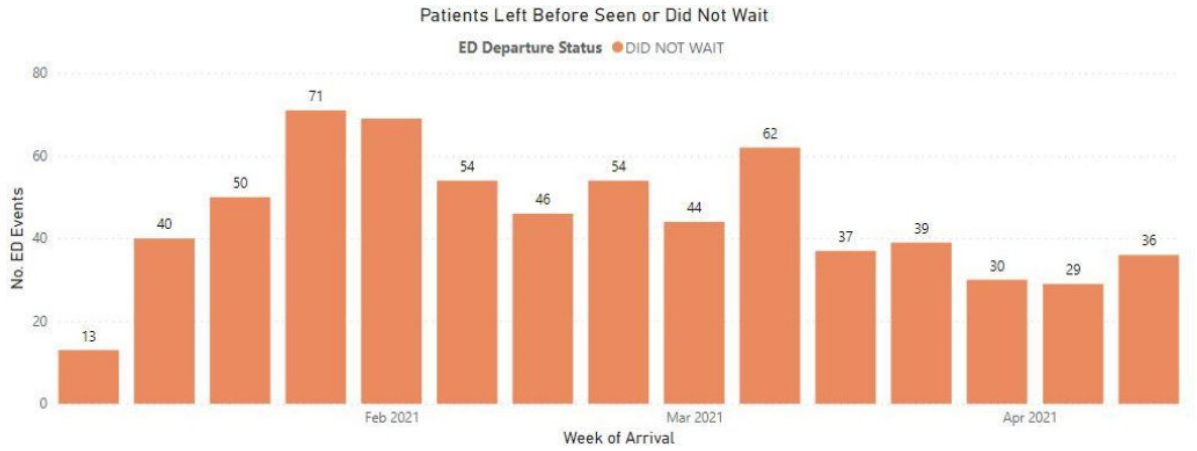

Fig. 3 Southland: Did not Wait's

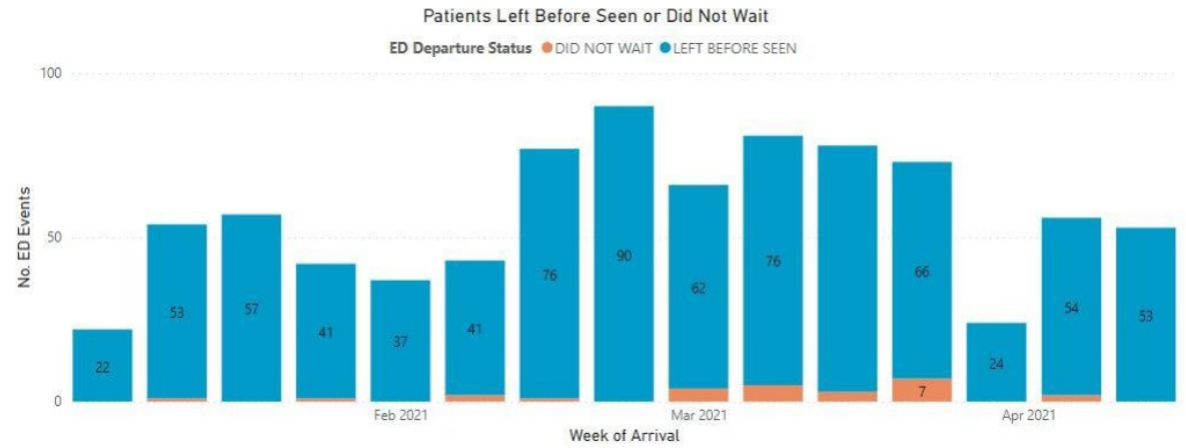

Fig. 4 Dunedin: Did not wait/Left before Seen

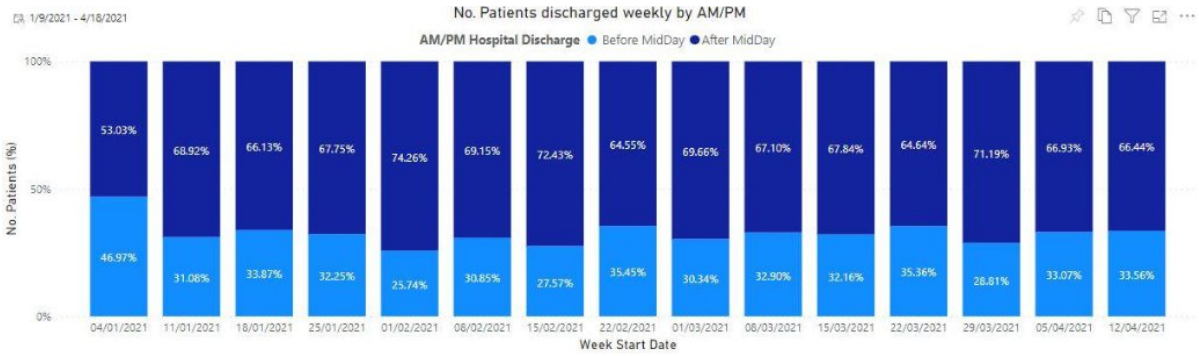

Fig. 5 Southland: Before Midday Discharges weekly average

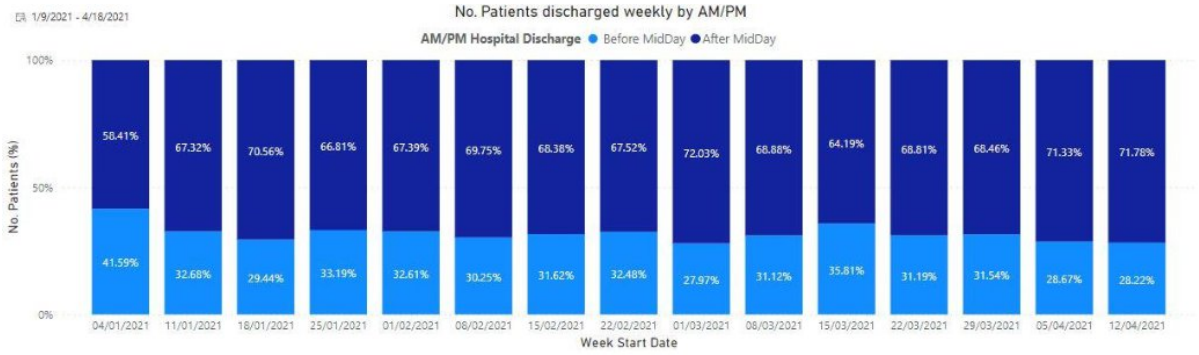

Fig 6. Dunedin: Before Midday Discharges weekly average

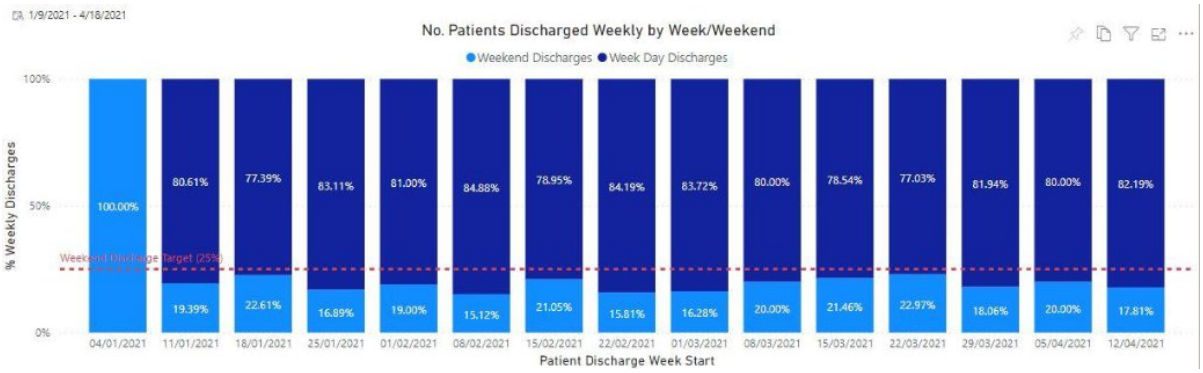

Fig. 7 Southland: Weekend Discharges weekly average

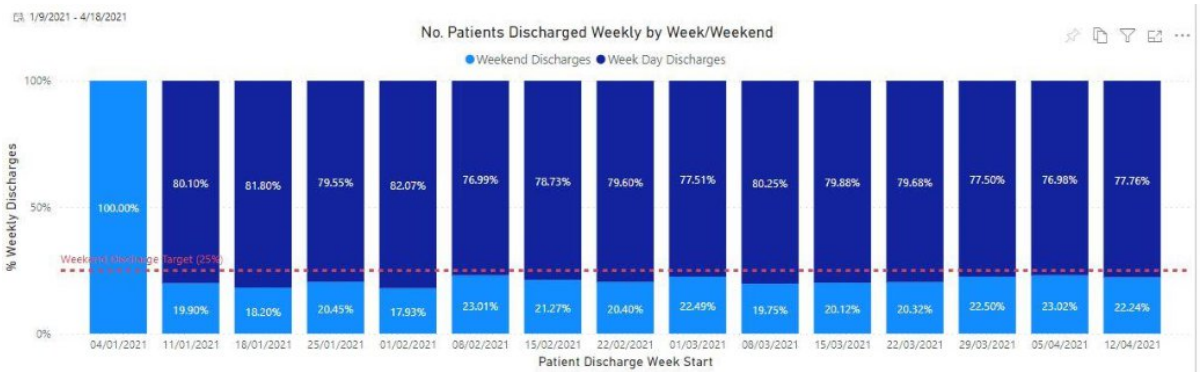

Fig. 8 Dunedin: Weekend Discharges weekly average

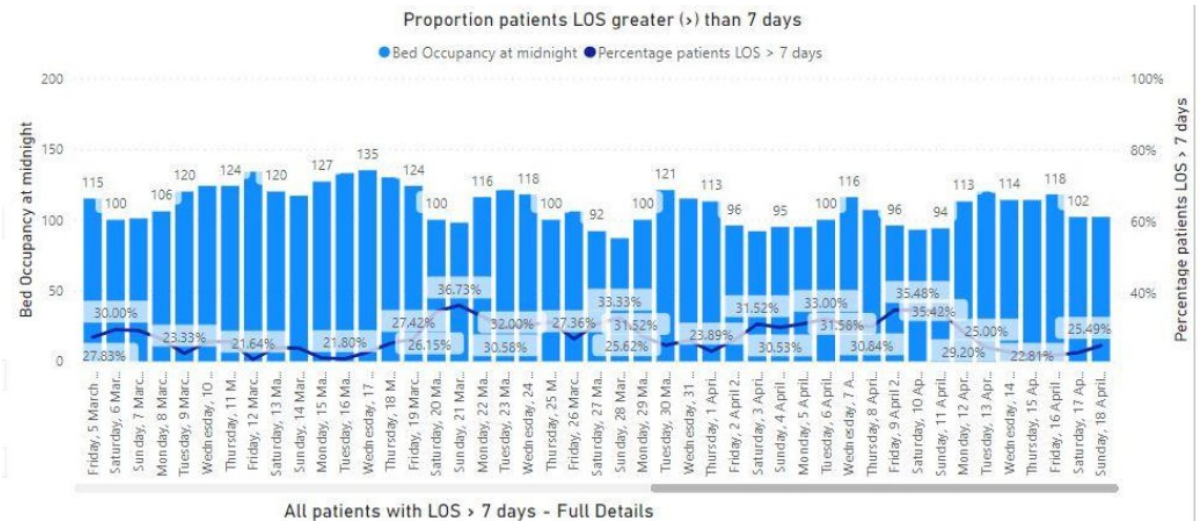

Fig 9. Southland: LOS > than 7 days daily

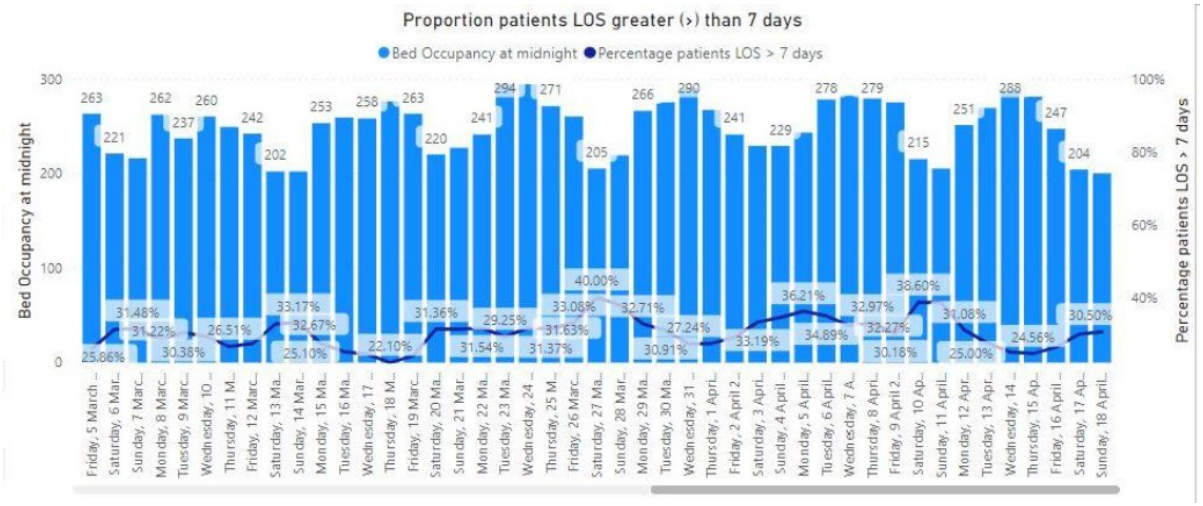

Fig. 10 Dunedin: LOS > 7 days daily

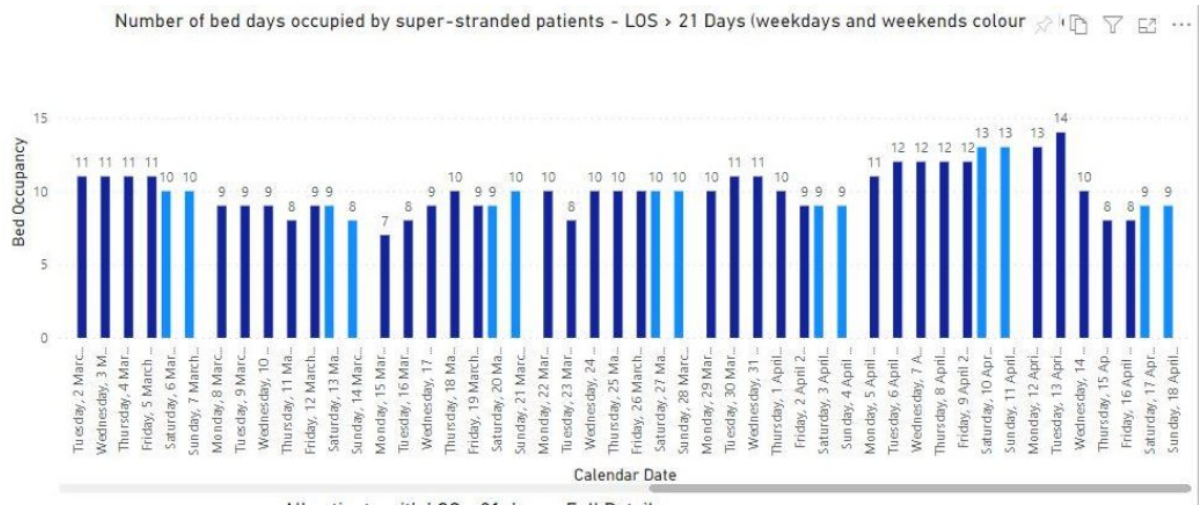

Fig. 11 Southland: LOS > 21 days daily

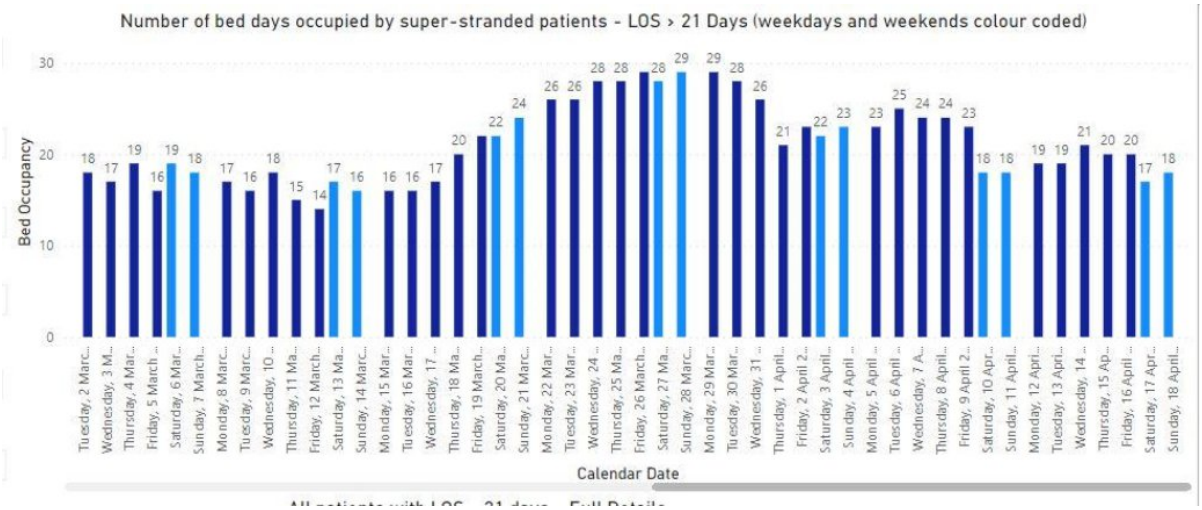

Fig. 12 Dunedin: LOS > 21 days daily

- **Next Steps:**

Some further work addressing 'transitions' in particular is planned. External transitions and internal transitions are a key theme that decreases flow. Some work is planned wrapping support, education and training around the PPPR process which can be problematic and slow a patient's flow into external care by 5 days or more.

The discharge summaries piece of work is a significant project stream that is planned for in the next stages as well. Considerable time is spent by House Surgeons compiling, writing and editing discharge summaries. This is problematic at weekends when staffing is less and is not best use of their expert time. A larger piece of work will be required to change this involving the whole health system and our IT partners.

Provision of timely acute surgical interventions has been identified as a significant contributor to delays for patients, interruptions to elective surgery provision and fluctuations in theatre demand. Work has been initiated in the Surgical Service to analyse in more detail the drivers and opportunities available to smooth the provision of acute surgery to match demand.

- **Risks/dependencies/constraints: these remain the same as last month & are still relevant.**

a) This work will continue beyond 100 days and that expectation should be set now. This is a cycle of continuous improvement, process change, and behaviour change that will be ongoing.

b) Engagement from clinical teams (access to the messaging and willingness to do some things differently) still an ongoing risk, especially senior clinical availability/active participation. There is a risk that this work will be perceived as an alternative to restoring appropriate nurse staffing on the wards rather than it being alongside.

c) Also have identified we need strengthened support wrapped around our charge nurse cohort, so they feel empowered to lead and make decisions associated with rapid rounds.

d) There is a significant amount of feedback received via the patient flow email that represents quite a large amount of operational change & process improvement that could be done in multiple areas. Whilst this is positive in many regards, executing these changes will take resource beyond the current team – largely it also depends on changing the cultural narrative and ensuring staff see patient flow as everyone's responsibility, therefore they are empowered to take ownership of these issues and try different things which will take time to embed.

Closed 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 (NZPHDA) 2000* for the passing of this resolution are as follows.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 3 May 2021 Verbal Report b) Community & Public Health Advisory Committee ▪ 7 April 2021 Minutes	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
CEO's Report - Public Excluded Business	To allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Presentation – Mental Health Review	To allow activities to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Contract Approvals ▪ Strategy, Primary and Community ▪ IV Pump Replacement ▪ Oncology Patient Management System	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.
New Dunedin Hospital	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

*S 32(a), Schedule 3, of the NZ Public Health and Disability Act 2000, allows the Board to exclude the public if 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.

The Board may also exclude the public if disclosure of information is contrary to a specified enactment or constitutes contempt of court or the House of Representatives, is to consider a recommendation from an Ombudsman, communication from the Privacy Commissioner, or to enable the Board to deliberate in private on whether any of the above grounds are established.