Southern DHB Board Meeting

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

02/06/2021 09:30 AM - 12:30 PM

APOLOGIES

No apologies had been received at the time of going to print.

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Board, 2 June 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:

- Kaye Crowther – Findex NZ removed
- Julie Rickman, former Executive Director Finance, Procurement and Facilities, removed
- Nigel Trainor, Executive Director Finance, Procurement and Facilities, added

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.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	09.12.2019	~~Employee, Findex NZ~~	Removed 21/05/21 (retired).	
	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	
	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 Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	~~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		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings Ltd	Corporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	~~Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)~~	Removed 07/09/2020	
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	17.08.2020	Health Research Council Fellow		
Andrew Connolly (Advisor)	21.01.2020	Employee, Counties Manukau DHB		
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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	
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	
Nigel TRAINOR	17.05.2021	Daughter, Sonographer (works part-time for Dunstan Hospital)	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

Minutes of the Southern District Health Board Meeting

Tuesday, 4 May 2021, 9.30 am
Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Pete Hodgson	Chair
	Prof Peter Crampton	Deputy Chair *(until 12.20 pm)*
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly *(by Zoom)*	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	*(from 10.00 am to 2.35 pm)*
	Miss Lesley Soper	
	Dr Moana Theodore	
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Mr Rory Dowding	Acting 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
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mr Nigel Trainor	Executive Director Finance, Procurement and Facilities
	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 by the Chief Māori Health Strategy and Improvement Officer.

The passing of Dave Cull, previous Board Chair, and the work he did for the community and Southern DHB was acknowledged.

A special welcome was extended to the new Deputy Board Chair, Prof Peter Crampton, and recently appointed Executive Director Finance, Procurement and Facilities, Nigel Trainor.

2.0 APOLOGIES

An apology for lateness was received from Mr Potiki.

Apologies for an early departure were received from Prof Crampton and Mr Potiki.

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 8 April 2021 be approved and adopted as a true and correct record."

I Beekhuis/L Soper

5.0 ACTION SHEET

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

Master Site Planning

The CEO advised that he intended bringing in an external resource to undertake master site planning for the Southland campus but had not yet gone to market.

It was agreed that the draft terms of reference for the Southland site would be shared with Southland Board Members.

Population Based Funding Formula

It was agreed that this item could be removed from the action sheet.

Strategic Risk Workshop

The Strategic Risk Workshop had been confirmed for Thursday, 3 June 2021.

Amenable Mortality Rates for Māori and Māori Workforce

It was noted that these items were to be moved to the public meeting action sheet.

Community Dialysis Chairs, Southland

The CEO reported that capital expenditure to install community dialysis chairs in the Community Services Building on the Southland Hospital site had been approved and the room should be opened in July 2021. He advised that the facility would be for people who could not dialyse in their own home; it would not be a renal unit.

6.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The unconfirmed minutes of the Community and Public Health Advisory Committee (CPHAC) meeting held on 7 April 2021 (tab 6.1) were taken as read and Ms Ilka

Beekhuis, Deputy CPHAC Chair, highlighted the key items considered by the Committee.

Disability Support Advisory Committee

The unconfirmed minutes of the Disability Support Advisory Committee (DSAC) meeting held on 7 April 2021 were taken as read.

Dr Moana Theodore, DSAC Chair, thanked everyone for their attendance at the Disability Strategy launch and responded to a question about disabled workforce strategy.

Hospital Advisory Committee

The Board received a verbal report from Mrs Jean O'Callaghan, Hospital Advisory Committee (HAC) Chair, on the HAC meeting held on 3 May 2021, during which she reported that:

- The meeting commenced with a mihi whakatau by Matapura Ellison, Kaumātua, for Nigel Trainor, who had taken up the role of Executive Director Finance, Procurement and Facilities.
- A presentation on improving the letters sent to patients was received. The Committee wished to see further liaison and consistency throughout the South Island, based on the implementation of the Patient Information and Care System (PICS) and the work undertaken by Canterbury DHB.
- Standardised intervention rates and aligning service delivery with health needs were discussed.
- A draft radiology strategy was presented. Further work was required on data, particularly in relation to MRI.
- A report was received on Enhanced Generalism. The Committee was pleased to see three General Medicine Consultants would be commencing in July/August 2021 and requested that the decanting process for the Medical Assessment Unit (MAU) take place with urgency.
- The inclusion of equity data as business as usual was noted and that would continue to improve.
- The Committee was concerned about bed closures and staffing shortages impacting on service delivery.
- Deterioration in Oncology performance over the last quarter was a concern and would be a major focus for the Committee and Board.

7.0 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* – Financial performance for March was significantly impacted by reduction in revenue due to under-delivery of planned care procedures and the withdrawal of pharmaceutical funding for COVID-19 costs.

  The CEO reported that since writing his report, advice had been received that if 95% of planned care was delivered full funding would be received.

The Executive Director Quality and Clinical Governance Solutions joined the meeting at 9.55 am.

- *Health System Reforms* - The Chair and CEO emphasised that the recently announced health system reforms did not affect the Board's commitment to strategically important initiatives including: the Strategic Refresh, Mental Health Review, new Dunedin Hospital and associated change programme, Data and Digital Programme, and the work of the Patient Flow Taskforce.
- *Executive Leadership Team (ELT) Vacancies* – The recruitment process for the Executive Director Strategy, Primary and Community was continuing.
- *Inpatient Workload Comparison* - Further work would be done to analyse the impact of opening and closing beds.

Mr Potiki joined the meeting at 10.00 am.

- *Colonoscopy and Oncology* – The Executive Director Specialist Services (EDSS) reported that colonoscopy and oncology performance was discussed in detail at the previous day's Hospital Advisory Committee meeting. Improving the oncology waitlist was being worked on as a priority.
- *COVID-19 Vaccination Programme* – Vaccination rates were above the planned target.
- *Mental Health Addiction and Intellectual Disability (MHAID)* – The Ministry of Health had made funding available for the continuation and expansion of the successfully implemented Integrated Primary Mental Health and Addiction Services by WellSouth Primary Health Network.

Management responded to questions on the Data and Digital Programme work, Care Capacity Demand Management (CCDM) and colonoscopy staffing.

Transformation of the New Zealand Health and Disability System

During discussion on the changes to the Health and Disability System announced by the Minister of Health, the observation was made that the transformation provided a raft of opportunities and the reinforcement of Te Tiriti principles and obligations was welcomed. The Board would be playing an active stewardship role over the next fourteen months to prepare the organisation for the transition to Health New Zealand and ensuring the local voice was fed into the planning process.

8.0 FINANCE AND PERFORMANCE

Financial Report

In presenting the Financial Report for the period ended 31 March 2021 (tab 8.1) the Executive Director Finance, Procurement and Facilities (EDFP&F) commented that:

- Revenue had been affected by planned care under-delivery but if 95% of volumes were delivered that could be reversed.
- Personnel costs were $11.1m unfavourable year to date. $8.1m of that was Holidays Act liability and COVID-19 activity, and $1m for the new Dunedin Hospital.
- The biggest concern was Clinical Supplies, as activity appeared to be similar to last year.
- There was an adverse financial trend in aged residential care throughout the country due to a lower death rate.

Quality Dashboard

The Executive Quality Dashboard for March 2021 (tab 8.3) was taken as read and the Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) took questions.

The Board provided feedback on the reporting of key metrics and requested that calibration points (expected norms or standards) and an equity lens (Māori, Pacifika, etc) be added to the quality graphs, along with management or Clinical Council comment.

Annual Plan Strategic Progress Report

The CEO advised that reporting on strategic priorities would be improved for the new financial year.

Management responded to questions on plans to catch up on population health work, the community oral health equity project, fluoridation, and the COVID-19 immunisation workforce. The Acting Executive Director Strategy, Primary and Community (EDSP&C) advised that updates on these issues would be submitted to the next Community and Public Health Advisory Committee (CPHAC) meeting.

The Board also requested that CPHAC be provided with updates on Mental Health and Addiction Services waiting lists.

Advisory Committees

The Board confirmed the following Advisory Committee appointments:

- Pete Hodgson – Finance, Audit and Risk Committee; Hospital Advisory Committee
- Peter Crampton – Disability Support Advisory Committee; Community and Public Health Advisory Committee
- Kaye Crowther – Community and Public Health Advisory Committee.

The Executive Director Quality and Clinical Governance Solutions left the meeting at 11.15 am.

9.0 STRATEGIC REFRESH

The Board received a verbal update on the Strategic Refresh work from the Principal Advisor to the CEO, during which she advised that a more detailed project plan and communication and engagement plan were expected from Synergia later that week, and a working group was being formed.

Mr Karl Metzler joined the meeting at 11.25 am.

10.0 COVID-19 VACCINATION PROGRAMME

The Board received a verbal update on the COVID-19 vaccination programme from Mr Metzler, during which he reported that:

- 20,000 vaccinations had been given to date. Vaccination rates had slowed a little due to statutory holidays but, overall, were still on target;

- The tier 3 rollout had commenced on 1 May 2021;
- Workforce planning was challenging, as the process was manual, however 90 FTE had been recruited;
- Vaccination in aged residential care facilities had commenced;
- The new booking system had gone live;
- Plans were in place for Māori providers to commence vaccination from early June, bringing together tiers 3 and 4 of the Māori and Pacific populations, including 70 years and older;
- Research indicated that vaccination needed to become part of business as usual in primary care and community pharmacy but that needed to be balanced against retaining capacity to continue other critical business.

Mr Metzler then responded to questions on the COVID-19 vaccination programme.

At 11.45 am Mr Metzler left the meeting and Mrs Karen Browne, Chair of the Community Health Council, joined the meeting by Zoom.

11.0 PATIENT FLOW TASKFORCE

A progress report from the Patient Flow Taskforce was circulated with the agenda (tab 9.3) and the Board received a presentation (tab 11) from the Chief Medical Officer (CMO), Chief Allied Health, Scientific and Technical Officer (CAHSTO) and Chief Nursing and Midwifery Officer (CNMO) summarising their approach and priorities, achievements, what was currently being worked on, and key graphical information. In summary they advised that:

- There were still operational challenges being uncovered;
- Clinical engagement was being strengthened;
- Processes were being rebuilt;
- The bigger constraints were now being tackled;
- There were early measurable change in some metrics; and
- There were still significant opportunities to realise improvements.

Management then responded to questions from members.

The Patient Management Flow Taskforce were thanked for their presentation and it was agreed that they would be allocated 30 minutes to present to the next meeting.

Mrs Browne left the meeting.

PUBLIC EXCLUDED SESSION

***At 12.20 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) 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 and Addiction Services 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.

Professor Crampton left the meeting.

***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 25 May 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020 Updated Nov 2020	**Quantitative Performance Dashboard** (Minute 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
Feb 2021	**Master Site Planning** (Minute 9.0)	Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed.	CEO/ EDFPF		Sept 2021
April 2021	(Minute 6.0)	Update to be provided in July 2021.	CEO		July 2021
May 2021	(Minute 5.0)	Draft terms of reference to be shared with Southland Board Members.	CEO		Mid-June 2021
April 2021	**Digital Indicative Business Case** (Minute 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	Report included in agenda.	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
April 2021	**Clinical Council** (Minute 10.0)	To provide an update in two months' time.	EDQCGS Deputy CMO		July 2021
April 2021	**Risk** (Minute 8.0)	Time to be set aside to consider the top strategic risks at the Strategic Risk Workshop.	EDQCGS		June 2021
Nov 2020	**Amenable Mortality Rates for Māori** (Public excl minute 13.0)	Addressing the disparity in life expectancy for Māori to be a continued focus, with a view to linking it to the equity work being undertaken by Specialist Services.	EDSP&C CMHSIO	The CMHSIO has met with Dr George Gray, a Māori public health physician to support the Southern DHB in developing a report and presentation for the Board based on Māori versus non-Māori amendable mortality data for the Southern DHB region.	~~May 2021~~ ~~June 2021~~
Dec 2020	**Māori Workforce** (Public excl minute 16.0)	Strategy to be developed to grow the SDHB Māori workforce, esp. nursing and allied health, scientific and technical professions.	CN&MO CAHSTO CMHSIO	Proequity recruitment strategy and guidance for recruiting managers is under development. This will be trialled with the AHS&T workforce commencing mid-June 2021. Training programmes will be implemented for managers and interview questions will be reviewed. Process and document will be trialled for three months, modified as required and then widened to include all workforces - nursing and medical and administration. Delivery of the Māori Workforce Strategy delayed due to Exec Director stepping into Mental Health role.	Proposed to defer to August 2021
March 2021	(Public excluded minute 15.0)	Board to be provided with staff ethnicity data, if possible by profession, directorate, and recruitment rate.	EDPC&T	Data by service included in HR dashboard. Recruitment data will not be available until the new recruitments system is embedded.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
May 2021	**Quality Dashboard** (Minute 8.0)	Calibration points (expected norms or standards) and an equity lens (Māori, Pacifika, etc) to be added to the quality graphs, along with management or Clinical Council comment.	EDQCGS	Management comments now included where there is a noticeable change in trend or a significant spike or fall in numbers. Calibration points and an equity lens are currently being prioritised as require IT resource to complete.	
May 2021	**Population Health** (Minute item 8.0)	Update on plans to catch up population health programmes to be submitted to June CPHAC meeting.	EDSP&C	Included in CPHAC agenda.	Complete
May 2021	**Mental Health** (Minute item 8.0)	CPHAC to be provided with updates on Mental Health and Addiction Services waiting lists.	CMHSIO		

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING 1 JUNE 2021

- Verbal report from Mr Tuari Potiki, Chair, Community and Public Health Advisory Committee

DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
1 JUNE 2021

- Verbal report from Dr Moana Theodore, Chair, Disability Support Advisory Committee

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 3 May 2021, commencing at 9.00 am in the Board Room, Level 2, Main Block, Wakari Hospital Campus, Dunedin

Present:	Mrs Jean O'Callaghan	Chair
	Dr John Chambers	Committee Member
	Hon Pete Hodgson	Board Chair and Committee Member
	Dr Lyndell Kelly	Committee Member *by zoom*
	Miss Lesley Soper	Committee Member
	Dr Moana Theodore	Committee Member
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mrs Kaye Crowther	Board Member *by phone zoom*
	Mr Terry King	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Nigel Trainor	Chief Finance, Procurement & Facilities Officer
	Mr Gilbert Taurua	Chief Māori Health Strategy & Improvement Officer and Interim Executive Director Mental Health
	Mr Patrick Ng	Executive Director Specialist Services
	Dr Nigel Millar	Chief Medical Officer
	Ms Kaye Cheetham	Chief Allied Health Scientific and Technical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mr Rory Dowding	Interim Executive Director Strategy, Primary and Community
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

A mihi Whakatau led by Mr Matapura Ellison was held for the newly appointed Execuitve Director Finance, Procurement and Facilities, Mr Nigel Trainor, followed by Whanaungatanga. Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from HAC Member, Ms Justine Camp and Board Members, Mr Tuari Potiki and Ms Ilka Beekhuis.

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

***It was resolved**:*

"That the minutes of the meeting held on 1 March 2021 be approved and adopted as a true and correct record with a change to the final sentence on page seven of the minutes to read "The EDSS advised that the rate at which the number of Tavis being done is not budgeted for."

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

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

- Management is to provide the number of resourced and physical bed numbers for Dunedin Hospital.
- Members noted that all other actions had been completed and the CEO confirmed that a letter had gone to the Sole Urologist as indicated on page three of the minutes.

Ms Gail Thomson, Executive Director, Quality and Clinical Governance Solutions and Mr Partrick O'Connor, Quality and Performance Improvement Manager joined the meeting.

6.0 LETTER IMPROVEMENT PRESENTATION

The Committee considered the presentation (included with the agenda as tab 4) by Ms Thomson and Mr O'Connor and in discussion the following was highlighted:

- The complexity and challenges of the system with the volume (350,000 letters forward in the last year, approximately 1,000 letter templates and 12 different systems producing letters).
- The areas of concern and the proposed steps to improve the letters process.
- The lessons learned from the Canterbury DHB, who moved to 20 templates only after undertaking a similar exercise. The CMO clarified that the process was part of the South Island Patient Information Care System (SI PICS).
- Following discussion the HAC Chair advised that this was a key issue for the Committee and the Board and requested that:
  - The letter improvement work be fast tracked, using the learnings from the SI PICS work implemented by Canterbury DHB and ensuring there is an equity lens across the process.
  - Text and e-mail correspondence is to be a part of the solution and the work is to be carried out with i-medics in mind.
  - A clear action plan with a timeline and benchmarks is to be provided for the July 2021 HAC meeting.
  - The confusion currently caused by the use of different letterheads is to be addressed more quickly through a communications strategy.

Ms Gail Thomson and Mr Partrick O'Connor left the meeting.

7.0 REVIEW OF ACTION SHEET – INFORMATION PAPERS

The Committee considered the information papers attached to the Action Sheet.

Standardised Intervention Rates (tab 5.1)

The report was taken as read and a verbal update was provided by the Executive Director of Specialist Services (EDSS), Patrick Ng.

- A summary of the next actions was provided:
  - Initiatives are to continue to lift Ophthalmology rates.
  - Work is to be done to prioritise knee replacements over other large Orthopaedic procedures.
  - Review opportunities to lift plastic surgery intervention rates, including allocating more bed capacity for this.

In response to concerns raised by the Committee concerning historical under and over supply in specialty areas, management advised:

- On the challenges with recruitment in some areas, e.g. Ophthalmology and the recent success in recruiting in to positions.
- The Board's prioritisation process should be influenced by the information on actions taken by management, using the information as a catalyst to improve, e.g. increased number of cataracts done.
- The information provided shows public intervention rates only and does not include what is being provided privately. Consideration is being given at a national level as to whether the private rates should be published.

The Committee acknowledged the impact of the inability to recruit to long term vacancies and requested:

- An update on recruitment to long term vacancies, including information on how early we start the recruitment process and whether we recruit to what has been there historically or what is needed now.
- Clarification on how available theatre lists are allocated to the specialties. This will be supplied for a future HAC meeting.
- A funder plan with recommendations on adjustments required.
- An update on hospital referral arrangements with South Canterbury and possible arrangements with any other DHB to meet the needs of the Southern DHB population.

Radiology Strategy (tab 5.2)

The Committee considered the draft strategy included in the agenda and the verbal update from the EDSS, who acknowledged that the document was very secondary care focussed. He advised that there was an error with the calculations for the MRI Modelling. Key points within the draft strategy were highlighted, including staffing challenges and the short term, medium term and long term initiatives. Robust discussion was held on the placement of the MRI machine in Dunedin and access to CT and MRI scanning. The Committee noted the error in the calculations on page 10 of the draft strategy document and requested that the figures be recalculated and resubmitted for consideration by members. The Committee requested more urgency be given to progress on the strategy, particularly concerning the second MRI for Dunedin, noting it was not acceptable to wait until December 2021 for a business case for a second MRI machine. The EDSS is to provide the updated figures for discussion at the Board meeting on 4 May 2021. The Committee and Board are to consider the priority of the MRI as part of a wider prioritisation process. The Committee advised the need to have the right diagnostics in place to meet population based need and to progress this with urgency. The discussion was deferred until the Board meeting on 4 May 2021.

Enhanced Generalism Dunedin Hospital (tab 5.3)

The Committee considered the enhanced generalism/Medical Assessment Unit (MAU) Dunedin Hospital quarterly update and the EDSS advised on:

- Progress made with recruitment since the business case was approved in December 2020.
- The General Medicine Team acceptance of sub-specialty referrals.
- The Project Plan and pro-forma Benefits Realisation Plan and Risk Register.
- The full benefits of enhanced generalism in the MAU will not be realised until the MAU is built.
- Progress with the build being led by the Building and Property team. Decanting is required to enable the demolition to progress.
- The CEO advised the need to seek Board approval for funding for the decanting to enable the design work to get underway.
- The Committee acknowledged the progress made as outlined in the report and requested a greater sense of urgency to progress the decanting work to enable the MAU build and requested that update reports be provided for every HAC meeting.

8.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director of Specialist Services Report

The EDSS monthly report (tab 6.1) was taken as read and the EDSS, Mr Patrick Ng, drew the Committee's attention to the following items:

Equity

An update was provided on the work being done to improve reporting on equity issues. The Chief Māori Health Strategy and Improvement Officer has made contact with a colleague in Auckland and a meeting is to be held to assist with progressing the work. Committee member, Moana Theodore, commended management on the progress being made to improve equity reporting.

Surgical Performance – Case Weights Discharges

An update was provided on the deterioration against the year-to-date plan for case weight discharge elective surgery and the initiatives underway to improve performance. Orthopaedics is the specialty most impacted and arrangements have been made to utilise spare capacity at Timaru Hospital to provide operations for Southern's population. Work is being done to determine the amount of acute surgical capacity needed. The report is due back to the EDSS prior to 7 May 2021 and it is expected that the surgery will pay for itsef from the revenue generated by the Elective case weight surgery. Work is progressing to determine what can be done from an outsourced surgical point of view. Management are hopeful that the Ministry of Health (MoH) may flex the funding rules this year as there are a number of DHBs struggling to meet their elective targets. The EDSS is working with the Executive Director of Finance, Procurement and Facilities (EDFPF) to establish a high level forecast for the year-end position for Specialist Services. It is expected that this will be discussed at the Finance Audit and Risk Committee (FARC) meeting to be held on 5 May 2021.

The Crown Monitor expressed concern around the Code Black decision made in March 2021 that impacted patients and the budget and discussion was held on who has the authority to close beds. An update was provided by the Chief Nursing and

Midwifery Officer and the Committee was advised that the reporting is being enhanced and future reporting will show the reasons for bed closures. This matter will be discussed at the FARC meeting on 5 May 2021.

Oncology

An update was provided on the deterioration in the 31-day and 62-day target for Faster Cancer Treatment for the last quarter and actions required as part of the recovery plan. The EDSS advised on the actions required, i.e. recruiting a sixth Radiation Oncologist or a Locum Radiation Oncologist. Outsourcing is also underway to St Georges and a tender process is underway to achieve the best outsourcing solution at the lowest cost possible. HAC Committee member, Lyndell Kelly, commented on the challenges with recruitment and the waiting times. Options for a collaborative approach are being explored with Canterbury DHB. Accuracy is required when labelling graphs, e.g. the graph on page 12 of the report showed "completed cancer cases" it should be "cancer cases commenced". More urgency is required when addressing issues, in particular referencing the advertising for a locum in Australia. An update was provided on scanning requirements for cancer patients and a request was made for the Interim Executive Director of Strategy, Primary and Community (EDSPC) to obtain the PET scanning volumes from Canterbury DHB. A request was made for further information to be provided for the recent increase in the waiting list for haematology.

Endoscopy

An update was provided on Endoscopy with colonoscopy performance and the requirement for surveillance scopes at Southland Hospital highlighted as a key area of focus. Southland patients are being offered treatment at Dunedin Hospital. Enhancements have been made to reporting with the use of additional codes within the Inpatient Management (IPM) Administration System, which allows information to be captured on why a procedure has been declined.

Emergency Department (ED)

Management responded to queries around the ED in Southland and advised the importance of benchmarking and working with primary care to reduce the primary care presentations. A recent snapshot of presentations to the Southland Hospital ED identified that 35% of the presentations were from outside of the Invercargill area.

Financial Performance Summary

The EDSS presented the Specialist Services financial results (tab 6.2) for the month of March 2021, outlined the contributing factors to the adverse $3.2M variance for the month and responded to members' queries.

The Interim EDSPC advised on the adverse pharmaceuticals result, noting the impact of high cost drugs. The change to the Pharmac Schedule advising of the change was received after the budget had been set.

***It was resolved**:*

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

CONFIDENTIAL SESSION

At 11.28am it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Executive Director of Specialist Services Report: **1. Planned Care Outpatient Recovery Targets** **2. Faster Cancer Treatment**	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage. Feedback is provided in confidence.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act. Section 9(2)(ba) protect information which is subject to an obligation of confidence and making available of the information would be likely to prejudice the supply of similar information.

Confirmed as a true and correct record:

Chair: _____

Date: _____

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 2 June 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 Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC) meeting month the Chief Executive report assumes Board members would have reviewed the CPHAC and DSAC 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 April is a deficit of $2.179 million compared to a planned deficit of $2.822 million, and hence a favourable result against plan for the month of $0.643 million. Year to date (YTD) financial performance is a $19.711 million deficit against a planned deficit of $6.637 million, resulting in a year to date deficit against plan of $13.074 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 $12.385 million compared to a planned deficit of $6.637 million, so an adverse result of $5.748 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 $1.333 million on a year to.
- Planned care continues to be significantly impacted by resourced bed shortages this month. On a year to date basis this is now $2.3 million adverse.

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 up 215 or 4.9% for the month compared to the plan, and up 1,210 or 2.59% year to date. On a year to date basis medical is 1,080 or 6.32% ahead of plan, maternity 443 or 10.13%, but surgery was 312 or 1.23% behind plan. There was a continued deterioration in surgical activity in the month.
- Raw discharges are up 434 or 9.63% for the month against plan, and up 2,179 or 4.49% year to date. It should be noted the disparity between raw discharges being up and case weights 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 case weight per discharge due to the complexity of the major joint work.
- Mental Health bed days are 830 or 26.10% below planned levels for the month and 6,828 or 21.12% below plan year to date.

2. Top Five Risks (will be updated post the Board Risk Workshop on 3 June 2021)

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 disruption 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

3. New Zealand Nurses Organisation (NZNO) Industrial Action

Notice of strike action by NZNO members has been received from Wednesday 9 June 2021 11:00am to 7:00pm. Contingency planning is underway and a request for life preserving services has been submitted to the NZNO and is currently being negotiated.

4. COVID-19 Vaccination Programme Update

As off 20 May, 34,000 vaccinations (12,000 completed courses) have been delivered to the southern community. Delivery has been via the two large mass vaccination centres in Dunedin and Invercargill and 24 additional sites based out of or delivered by general practice across the region. A further twelve sites have been approved for vaccine delivery. Southern DHB is running slightly ahead of the plan agreed with the Ministry of Health in April. The Ministry of Health is holding DHBs to plan to ensure continued uninterrupted vaccine supply across the country.

The COVID Vaccination Immunisation Programme (CVIP) team has been working collaboratively across the southern region with WellSouth, rural hospitals, general practice, pharmacies and Māori Health providers which has allowed the programme to progress at pace and with strength.

Rural Sites

The last of the rural sites (Gore) is now live and all rural sites are planning on a transition into Tier 3 as part of business as usual operations. Tier 3 has been live in some of the smaller rural areas since late April and a formal transition into Tier 3 is planned for early to mid-June. Tier 4 is planned for early to mid-July to coincide with the large vaccine deliveries expected by the Ministry of Health.

Aged Residential Care

Planning and delivery into Aged Residential Care is underway with 45% delivered and a final completion date of 30 June targeted.

General Practice and Pharmacy Sites

Planning for urban general practice sites and pharmacy sites is currently underway to align with the greater volumes within Tier 3 and the move into Tier 4. Engagement with pharmacy providers in rural areas is also commencing. The initial move into Tier 3 will target high needs populations.

Māori and Pasifika Populations

Southern DHB and WellSouth have partnered with four lead Māori providers to undertake the rollout for Māori and Pasifika populations. These four lead providers are Nga Kite Matauranga Pounamu and Awarua Whanau Services in Invercargill and Arai Te Uru Whare Hauora and Otakou Health Ltd in Dunedin. Other Māori and Pasifika health providers will be working in partnership with the lead providers to offer whānau support to access the

vaccination programme (e.g. help with making bookings and organising transport), provide health promotion and education opportunities, health and wellbeing checks, a focus on general practitioner (GP) enrolment and support services.

This is a co-design process that has provided strong engagement and willingness to participate to improve Māori and Pasifika health outcomes and commences on 8 June. The model is a combination of clinics and outreach services across rural and urban sites. Vaccination sites will also include GP enrolments, health checks, childhood vaccinations, Work and Income and housing support for whānau.

Booking Systems

Booking errors and concerns have reduced and we have had a significant reduction in did not attends (DNAs) and churn within clinics has resulted from the transition to the online booking platform. A further transition to the national booking system (once out of its test phase) will be required in late June which should see further functionality and greater connection with the COVID Immunisation Register. Our approach to bookings is via an invitation strategy which is consistent with Ministry of Health advice.

Workforce

An independent workforce has been recruited for the mass vaccination sites and these sites will scale up in mid to late June as vaccine supply becomes assured and we move towards vaccinating the general population. Workforce remains a pressure point across the region and challenging in rural areas. Work is underway nationally regarding a vaccinator assistant workforce which would see an unregulated workforce vaccinating under supervision which would reduce some of this pressure. Access to vaccinator training via the Immunisation Advisory Centre (IMAC) has improved.

5. Emergency Departments and Long Weekend Planning

Work continues to progress on the Southland Emergency Department (ED) business case. The case has been constructed on the same basis as a Treasury Better Business Case, with headers for strategic case, economic case, financial case, commercial case and management case.

The strategic case is focused on the reasons we need to develop the ED, which are in turn tied to a lack of fit for purpose ED spaces. The key reason for developing the ED is to enable patients to be seen in fit for purpose treatment spaces, including a clinic room for sensitive female consultations and an appropriate facility for mentally unwell consultations. The proposed ED development will also result in a net gain of two additional ED beds (we lose two beds to open up the fracture clinic space to become the fit for purpose treatment space and we gain four beds in the new space). Although this is a minor expansion, a benchmarking exercise is required to demonstrate that the total treatment spaces under the proposed building development would not result in more treatment spaces than is appropriate for the presentations which should be coming to our Southland ED. A benchmarking exercise will be undertaken in the coming weeks with the assistance of the Ministry of Health to seek to establish an appropriate size for the ED, when compared to other hospitals and relative to the presentations which should be seen.

The economic case focuses on options analysis and three options are considered – do nothing, just address the fitness for purpose issues, and address the fitness for purpose issues inclusive of adding a net two additional beds. A modelling exercise was done which shows the impact of the fit for purpose spaces plus beds and this led to a material improvement to the numbers of patients able to be seen within the six hour target timeframe. The financial case is focused on what the capital requirements are for the building work and we are seeking quantity surveyor input working off our high level concept plans to determine this. The financial case will also outline any operating cost implications, for example whether there are any operating costs associated with the new development such as staffing or staffing mix. The commercial case outlines how we will tender detailed design

work and the intended approach for construction and council consents. Finally, the management case outlines how we will manage the disruption associated with building fit for purpose spaces next door to a live ED environment and the need to relocate the fracture clinic and the medical records areas to facilitate the additional space. Once the benchmarking work has been satisfactorily completed we will be able to conclude the case and start to move it through the appropriate sign-offs for a final Board consideration.

Since Easter we have implemented a special meeting ahead of a long weekend where we meet to confirm what house officer cover we will have over the long weekend and plan additional cover as appropriate. We also confirm what the allied health support will be and communicate this and we plan for additional acute theatre where appropriate. We have engaged a member of the quality and clinical governance team to now formulate a set of standard operating procedures, working in some cases with documentation which already exists, so that we can standardise our approach ahead of each long weekend. We will then consider how this is used ahead of regular weekends as well. The hospital escalation pathway has now been implemented at Dunedin hospital and part of the daily 8:40am hospital meeting is used to score the status of the hospital using criteria which includes how much acute operating time has accumulated, how many are waiting for beds in our ED, our current status with resourced bed occupancy and our current status in terms of staffing. The score then determines what our status is and the status is updated on the hospital 'capacity at a glance' (CAAG) tool which is our key tool that tells us what the status of our beds is. An e-texting service has been established in Dunedin and the e-text service sends a message out to the relevant team/s when the status changes. The General Manager in Southland is in the process of implementing a modified version of the Dunedin checklist in Southland and we are also looking to establish the same e-texting solution there as well. As the status of the hospital changes this then allows us to communicate this to the relevant teams who are being engaged by the Chief Medical Officer, Director of Nursing and Director of Allied Health in terms of how they should respond to the change in status.

6. Oncology Services

There is considerable concern with regards the Oncology Services both Radiation and Medical Oncology. Initiatives have been put in place to attempt to mitigate the concerns, however the waiting times continue to exceed the standards that we expect and the community ought to receive. Discussion with the Oncologists as well as the Cancer Control Agency are ongoing and we will support any practical solutions that are identified to make further improvements. We have also determined that we will appoint a dedicated operational management position for a fixed period of time to ensure there is a clear focus on resolving the bottlenecks and blockages.

Specific actions that have been taken as below:

Radiation Oncology

The radiation oncology waiting list is our most significant area of concern with regard to oncology. As noted previously, the most sustainable solutions for Radiation Oncology are to confirm a permanent sixth radiation oncologist (and we are actively recruiting for this) and in the meantime to confirm a fixed term locum (6 or 12 months) who would see first specialist appointments (FSAs) and also management the consequent treatment courses.

We have engaged with the Cancer Control Agency who will provide us with any support they can in terms of how we can approach recruitment, and we have refreshed our recruitment strategy. Successfully attracting either a locum or the permanent position is key to a sustainable way forward. Our average FSAs per week have been in the region of 22-23 for the last few years. We have 4.8 senior medical officers (SMOs) whom we have concluded can reasonably see five FSAs per SMO per week, but who can only be expected to be available 42 weeks per annum (standard for SMOs). This means that 4.8 SMOs is insufficient to see our accepted volumes, but 5.8 SMOs would be sufficient to stay on top of volume.

Whilst we are awaiting the success of recruitment, we are also outsourcing cases off the back of our wait list so that those who are waiting the longest and who elect to take up the offer can receive their treatment in Christchurch with an outsourced provider who is based there. This is an expensive option but is necessary until we are successful with either locum or permanent recruitment as there are no other options which we have identified to lift the capacity in the service other than the specialty nurse which has enabled us to stay on top of follow up volumes and to get the FSA rate to five per 1.0 FTE SMO. As outsourcing is likely to be required in the short to medium term we have gone to the market with an Request for Proposal (RFP) requesting responses from parties interested in providing an outsourcing service. We have already been approached by one party (whom we have invited to respond to the RFP), and we are making direct approaches to a number of other parties recommended by our clinical leader (as they may have spare linear accelerator (LINAC) capacity). It is our hope that the RFP will lead to a more cost effective and sustainable outsourcing solution and we will utilise this to top up our capacity until we are successful with recruitment.

Medical Oncology

In a similar manner to Radiation Oncology, medical oncology is a small service and the SMOs have had to work hard to stay on top of volumes. We have combined a 0.5 maternity leave and recovery money to form a 1.0 FTE locum in the short term so that the SMO team can take leave and undertake professional development and so on. We believe that we have been successful with locum recruitment and that we will be able to confirm the locum shortly. However, we need to increase the SMO in the service to stay on top of growing demand. We are actively recruiting for an additional locum and we have put an investment request in asking for an additional SMO this year and a further SMO in the following year.

We are also seeing some delays getting initial treatment after having been seen by an SMO and are recruiting for a fixed term speciality nurse in Dunedin and another in Southland. We have made an investment request asking for these resources permanently, also. And a further issue that has been identified is that there is a backlog in medical typing. A fixed term resource has been approved and is being recruited into to get on top of this backlog.

As well as staffing, a small team is working on process improvement within this service. We have identified that a visual whiteboard showing active cases and their current status would be a good initial win and this is the initial focus that we have set for this working group.

7. Planned Care and Radiology

A combination of nursing roster gaps earlier in the year and subsequent acute demand has left us behind case weight delivery (our elective surgery target) on a year to date basis. We are presently a net 259.4 case weights (CWDs) behind target year to date and are forecasting that we will be circa 500 adverse at the end of the financial year. We are now working as hard as we can to reduce this shortfall. A key service that has been impacted by the challenges earlier in the year and now has a large backlog (unrecovered COVID plus reduced throughput earlier this year) is orthopaedic surgery.

A number of initiatives have been identified for orthopaedic surgery. The first is that we have successfully completed the first week of cases at Timaru Hospital and we are now ironing out teething issues to allow a weekly case load to proceed each week. The second initiative is that we have discovered that there is now additional capacity at Southern Cross Hospital in Christchurch, because the Canterbury have opened their acute hospital and have taken back in house a reasonable proportion of their case load. The added benefit of this solution is that Southern Cross in Christchurch are able to take our 'ASA3' cases, which are relatively complex. This is what we need for an outsourcing solution, as the more straight forward cases are thinning out and not long waiting. We are now working up a caseload for Southern Cross in Canterbury as quickly as we can, which will allow us to achieve better outsourcing rates than we have been able to achieve locally (there is very limited capacity at both Mercy Hospital in Dunedin and Southern Cross in Invercargill).

The build work for the second computed tomography (CT) machine in Dunedin appears to be progressing well. Key materials such as lead-lined plywood have been ordered and the teams are working hard to align the completion of building work to the arrival of the second CT machine for the radiology department. In the meantime, we have identified the additional medical imaging technologist (MIT) staffing that is required (per the radiology strategy) and have asked the team to commence initial work on recruitment whilst we await investment prioritisation and confirmation that we can proceed with this recruitment.

In anticipation that the Board will ask us to formulate a rapid proposal for a second MRI machine for Dunedin we have also commenced an RFP process to select a machine. As part of the RFP process we will ask potential suppliers to review the space in the Dunedin Radiology service we would like the machine to go into and confirm that this is possible.

The Allied Health team has worked with the General Manager Surgery and Radiology to formulate a training proposal for ultrasonography. We have asked that three trainees in Dunedin and a further trainee in Southland be recruited into and the teams are currently testing how this could be made to work as it will stretch the teams (each trainee needs an ultra-sonographer to work with). Once confirmed as workable a quick proposal will be developed internally and will be given the go ahead. Training at this rate would allow the vacancies we have to be recruited into and a reasonable level of attrition to be managed. We can then dial down this level of training in the future if we find ourselves with sufficient ultrasonography numbers.

8. Care Capacity and Demand Management (CCDM)

Southern DHB requested that the Safe Staffing, Healthy Workplaces Unit (SSHWU) complete a moderation of our FTE calculations (2020) in six selected wards (8 Medical, Surgical, Medical Southland, ATR Southland, 4C Dunedin and 7A Dunedin). The purpose of moderation was to assess compliance with the FTE calculation methodology and identify any corrective actions and/or recommendations where required.

The SSHWU has completed the moderation process and have made five recommendations. The FTE calculations only require minor adjustment with no material change in FTE overall. The Executive Director Specialist Services, Chief Nursing and Midwifery Officer and Executive Director Finance, Procurement and Facilities are finalising and agreeing the FTE investment recommendation as requested by the Chief Executive.

Considerable concerns exist in being able to fill current registered nurse (RN) vacancies let alone any additionally CCDM approved FTE with regulated staff going forward. This is now presenting as a national workforce crisis and is going to require some radical and urgent adjustment to different ways of working with non-regulated staff where that is appropriate and to a level that allows for safe direction and delegation. There will still be the requirement for a significant proportion of RNs and enrolled nurses (ENs) to be employed and even usual replacement is a challenge. This may mean that there will be delays in recruitment until new graduates are available. The other real concern on our doorstep is the potential for a lot of nurses to move across to Australia (from now) or elsewhere once the borders are more relaxed.

9. Aged Residential Care Registered Nurse (RN) Workforce Issues

There is significant concern regarding RN staffing in aged residential care. Patient flow continues to be negatively impacted by a lack of staffing in many aged care facilities, with beds not always available in a timely manner, or at all.

RN staffing shortages (increasingly due to aged residential care nurses moving to employment at the DHB) in facilities has resulted in vacant beds not available and admissions being delayed as the remaining workforce quite rightly prioritise existing residents' needs over admissions of new residents. This is particularly an issue in Southland.

Our Chief Nursing and Midwifery Officer (CNMO) is balancing the requirement to meet the safe staffing needs of patients and staff at the DHB (e.g. implementation of CCDM), with the resulting needs of residents and staff in aged residential care. With the current global pandemic, and resulting border issues, the pool of RN staff is limited, and increased staffing in any one area results in decreased staffing in another part of the system, in this case, aged residential care. This is not peculiar to Southern DHB and is an issue across the country.

A meeting was held with a number of aged care sector managers in Southland on 14 May with the Southern DHB CNMO, Health or Older People Portfolio Manager and senior nurse leaders to hear the issues first hand. It was agreed that it is really important that we are all working together and taking a whole of system approach to the recruitment and retention challenges. We are all committed to ensuring that our most vulnerable older people are being cared for safely and compassionately.

While pay parity is not the only issue impacting the availability of this workforce, there is a remuneration gap between DHB employed nursing and Aged Residential Care. This is also an issue for other parts of the health sector including Primary Care, Maori Health Providers, Mental Health NGOs, Rural Hospital Trusts and others. The challenge is that when the last NZNO negotiations resulted in a notable increase for DHB Nursing funded by the Crown however while the flow on impacts were noted there has been no notable movement on this front. This is an issue being considered by the Public Services Commission however there are very real impacts showing up with many workers moving from other parts of the health system to DHB employment where there are better terms and conditions.

10. Primary Maternity Facilities

In recent months, further consultation with midwives across the district has occurred, and further analysis on possible models of care for the district has been undertaken.

A paper was initially intended to be presented at the April Board meeting, however the timeframe has been extended to enable more detailed analysis to be included. Once the paper has been endorsed by the Board, the next steps to developing the agreed primary birthing services in the area can begin. The delay of the paper is unfortunate, however we needed to ensure the themes that arose from our consultation process were well considered so the Board has the detail they need to inform their decisions.

A business case for the associated capital expenditure and the next steps in the Request for Proposal provider process cannot be progressed until there is confirmation of a two unit or single unit plan.

The managers of Charlotte Jean Maternity Hospital in Alexandra have given notice of their intention to exit their contract to provide primary birthing services in Central Otago. They have agreed that from July 2021 the Southern DHB will be leasing the Charlotte Jean premises in Alexandra. The service will continue as normal but will be managed by the Southern DHB from July 2021.

Both parties believe it is in the interests of the community to begin a seamless transition process now, prior to the commissioning of the new maternity facility or facilities. This will provide certainty for the community that there will be no disruption to maternity services in the interim. There will be no discernible change to the care provided at the Charlotte Jean Maternity Hospital.

A new Maternal and Child Hub is to open in Wanaka at the end of April. It is centrally located and will provide a welcome facility for Lead Maternity Carers (LMCs) to work from. Other health services may be able to be accommodated in the future.

11. Blessing of the Whānau Room at Lakes District Hospital

Our Kaumatua Matapura Ellison supported the opening of the new whānau room in the Queenstown Lake Hospital on 7 May. The opening was supported by the local community and key stakeholders with approximately 32 in attendance. This facility now allows family/ whānau to stay on site at the hospital and to provide support for patients, in particular those that come from outside the Queenstown locality. The new facility was supported by the Lakes Hospital Foundation and Central Lakes Trust.

12. Te Tiriti and Māori Health Equity Governance and Leadership Workshop

The Te Wai Pounamu Wānanga Hauora 2021 was held in the Dunedin Centre on 29 and 30 April. The leadership workshop targeted Iwi/Māori Partnership and DHB boards with attendance from around the motu. Key themes included the health sector reforms, building relationships and developing shared ownership and accountability for Māori health equity as governors and leaders.

13. Harti Hauora

The Harti Hauora Programme is now underway at Southland Hospital with the first assessments completed for Māori and Pacific respiratory admissions aged 0-4 years. During April seven referrals were made to the Harti Hauora programme with four assessments by 28 April 2021. While there have been some delays getting underway, the programme is ready for an increasing number of referrals over the coming months. The partnership between the Southland Hospital staff and Awarua Whānau Services is now working well.

14. Amendable Mortality

The Chief Māori Health Strategy and Improvement Officer has meet with Dr George Gray, a Māori public health physician, to support the 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.

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 over the period 2012-16 include:

1. heart disease (including coronary, valvular, hypertensive and stroke)
2. suicide
3. respiratory (COPD and asthma)
4. cancers (prostate, breast, with some stomach, rectal and melanoma)
5. diabetes.

We are looking to engage Dr 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. Mental Health, Addictions and Intellectual Disability (MHAID) Directorate

Psychosocial Recovery

The Central Lakes psychosocial mental wellbeing recovery plan continues to be a focus with active engagement with community leaders, health professionals, the business community, Māori and Pasifika, migrants and others to listen to their concerns and ideas. Adell Cox, Director of Allied Health for the MHAID Directorate, is the DHB MHAID lead for this initative and this month has strengthened links with local Mayors, the Wanaka Chamber of Commerce, the Wanaka Community hub, Ministry of Social Development Regional Manager and Regional Commissioner, Education, Police, Oranga Tamariki, non-government organisations, Citizens Advice, Mana Tahuna, Age Concern. The Mental Wellbeing Navigator role has been appointed to and orientation to community networks has been a focus this month.

We sponsored MH101 workshop in Central which were well received and fully subscribed with at least 47 on a waiting list. A diverse group of people attended ranging from large companies to community volunteers. Very well received.

Adell Cox attended a collaboration frameworks workshop hosted by the Leadership Lab (Christchurch). This was organised by Queenstown Lakes District Council (QLDC) this brought together a wide range of community leaders to workshop collaborative ways of working together and breaking down silos. Mental wellbeing was highlighted as a key concern.

MHAID Patients with challenging behaviours

There are a number of patients in the Adult (Otago) services that continue to be challenging due to their complex presentations. The pattern of assaultive episodes continues both on staff and fellow patients. Discussions continue between the directorate and executive about additional FTE required to enhance the safety for all concerned particularly at Ward 9b the Intensive Care/Acute inpatient unit.

Independent review of the Southern Mental Health and Addiction System Continuum of Care

The review has continued at pace following on from the first phase of listening and understanding to solutions and the future, with four well attended co-design workshops, four lived experience workshops and three Māori Hui held across the District in Waitaki, Dunedin, Invercargill and Cromwell. The workshops had four focus areas; Create an operating model of the proposed Mental Health and Addiction System on one page; design some community crisis response options; map current community resources so that they are better aligned and able to support mental health and wellbeing; identify some possible community-based mental health and addiction solutions for children, youth and their families/whanau. Each workshop identified 'wild cards' for their area. Synergia commented positively on the engagement with the review that has occurred with over 600 people engaged, 470 workforce provider survey responses and 200 plus lived experience survey responses received.

Workshops in Invercargill

Future Directions, Southland Mental Health and Addiction Network hosted a half day informative education session for agencies and the community about what services were available in Invercargill for young people. This saw presentations from Mirror Counselling, Thrive, number 10 and the MHAID Child Adolescent and Family services. Approximately 65 people attended this workshop.

16. Frailty Workshop

A Frailty workshop was held in April in order to bring a number of stakeholders together on the topic of reducing harm to frail and elderly people. Chairs of key groups such as Falls and

Fractures, Delirium and Pressure Injury joined the newly formed frailty group to share work programmes and establish ways of supporting and working together to improve patient outcomes and reduce harm. Quarterly meetings will continue.

17. Disability Strategy

The Disability Working Group meets for the first time in June ahead of the next DSAC committee meeting to commence work on an action plan.

A process for regular engagement and communication with the wider community via key groups such as the Disabled Persons Assembly will be one of the first tasks the group will undertake.

18. Finance, Procurement and Information Management (FPIM) System 'Go Live'

The decision to defer the 'go live' on FPIM to 1 July 2021 was made by the Executive Director Finance, Procurement and Facilities after discussing this with the leads for each module. There are two main concerns, which are:

- Readiness of the supply chain – good progress was made on loading items into the system, however as of Monday there were circa 649 OneLink stock items and 300 other consumable items to be loaded into the system. This in turn leads to delays in printing bar codes and applying theses to the shelves throughout the hospitals.

- The other area of concern is the transfer of data to the reporting systems, this would lead to no reporting available as at 30 June 2021.

The above are, in our view, areas that must be completed and tested to ensure the continued smooth operation of the hospitals, supply is critical.

There will be a three week effort across a team of five individuals in our Business Intelligence (BI) area to test and validate the data to ensure the reporting is accurate, at the same time the supply team and New Zealand Health Partnerships (NZHP) will complete the master data work to ensure a smooth transition on 1 July 2021 for supply.

Chris Fleming
Chief Executive Officer

25 May 2021

FOR APPROVAL

Item: Financial Report for the period ended 30 April 2021.

Proposed by: Nigel Trainor, Executive Director Finance, Procurement & Facilities

Meeting of: 2 June 2021

Recommendation

That the Board approves the Financial Report for the period ended 30 April 2021.

Purpose

1. To provide the Board with the financial performance of the DHB for the month and year to date ended 30 April 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:	30 April 2021
Report Prepared by:	Finance
Date:	2 June 2021

Report to Board

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the period ending 30 April 2021.

The net deficit for the month of 30 April 2021 was $2.2m, being $0.6m favourable to budget. The result includes $2.1m revenue related to previously unfunded COVID-19 incremental expenditure. The expenditure includes COVID-19, Holidays Act 2003, New Dunedin Hospital Accelerated Depreciation and Digital Hospital Project Costs, totalling $2.7m.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 30 April 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						
100,953	96,335	4,618	F	Government & Crown Agency	984,855	963,169	21,686	F	1,089,019	1,155,951
489	877	(388)	U	Non-Government & Crown Agency	10,610	8,773	1,837	F	11,047	10,528
101,442	97,212	4,230	F	*Total Revenue*	995,465	971,942	23,523	F	1,100,066	1,166,479
				EXPENSES						
43,443	41,003	(2,440)	U	Workforce Costs	397,496	383,969	(13,527)	U	484,392	462,125
3,820	3,684	(136)	U	Outsourced Services	38,319	36,571	(1,748)	U	41,837	43,556
8,576	7,709	(867)	U	Clinical Supplies	91,965	80,704	(11,261)	U	99,345	96,871
5,367	5,019	(348)	U	Infrastructure & Non-Clinical Supplies	50,527	50,013	(514)	U	63,258	60,354
39,206	39,087	(119)	U	Provider Payments	406,264	394,052	(12,212)	U	466,737	474,021
3,209	3,532	323	F	Non-Operating Expenses	30,605	33,270	2,665	F	34,951	40,469
103,621	100,034	(3,587)	U	*Total Expenses*	1,015,176	978,579	(36,597)	U	1,190,520	1,177,396
(2,179)	(2,822)	643	F	**NET SURPLUS / (DEFICIT)**	(19,711)	(6,637)	(13,074)	U	(90,454)	(10,917)

Revenue was $4.2m favourable to budget.

Government Funding included unbudgeted COVID-19 funding of $2.1m to cover Incremental Costs and $0.4m Surveillance & Testing, $0.3m for Mental Health funding and $0.2m for IDF funding.

The Ministry of Health advised on 28 April 2021 funding has been made available for COVID-19 Incremental expenditure incurred that was not covered by any existing COVID-19 funding streams. This equates to $2.1m revenue, of which $1.5m is Community Pharmaceuticals and $0.6m of other costs. There has also been $0.5m of revenue to cover the PSA pay equity payments.

The revenue for COVID-19 Surveillance & Testing has been recognised to match expenditure. The recognition of $0.4m 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 $3.6m unfavourable to budget.

The Workforce costs were $2.4m unfavourable inclusive of $0.6m additional Holidays Act 2003 provision, $0.5m Clerical Admin Pay Equity (offset by equivalent revenue) and continued overtime/penal costs in Medical and Nursing staffing.

Clinical Supplies were $0.9m unfavourable, reflecting higher treatment disposables and pharmaceuticals expenditure which was partially offset by lower Air Ambulance costs.

Revenue (Year to Date)

Overall, Revenue is $23.5m favourable to budget year to date.

Government and Crown Agency revenue is $21.7m favourable, including additional funding for COVID-19 $10.9m, Primary Mental Health & Addiction $3.0m and Community Pharmaceuticals $2.3m. 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 has had a significant impact on the achievement of Planned Care delivery resulting in a revenue reduction of $2.3m. The Capital Charge funding has been reduced by $1.7m to align with the change in the Treasury rate from 6% to 5%.

Non-Government & Crown Agency revenue is $1.8m favourable to budget. The recognition of the donated clinical equipment and PPE from the Ministry of Health of $3.2m has offset the reduced Non Resident revenue of $1.0m.

Expenditure (Year to Date)

Total Expenses year to date are $1m, which is $36.6m unfavourable to budget.

The Workforce costs are $13.5m unfavourable year to date. This includes $6.3m of Holidays Act 2003 liability and $1.4m for Covid and NDH which was not budgeted. There is $0.5m for pay equity and the remainder is costs of cover, one on one patient watch.

Outsourced Clinical Services are $1.7m unfavourable year to date reflecting additional costs incurred for delivery of the delivery of elective services.

Clinical Supplies are $11.3m unfavourable year to date for hospital clinical activity to deliver Business as Usual. The major contributors remain Treatment Disposables, Instruments & Equipment and Pharmaceuticals, particularly blood and Pharms, the Pharms are offset by $2.3m of additional revenue.

Provider Payments are $12.2m unfavourable year to date; comprising payments to NGOs supporting COVID-19 activity of $9.3m which includes $7.7m COVID-19 testing in the community, $2.5m for Mental Health & Addiction and $0.2m for Community Pharmaceuticals. The Disability Support payments for Residential Care are $2.3m 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 30 April 2021

	YTD Actual Total $000	YTD COVID-19 Incremental $000	YTD COVID-19 Vaccination $000	YTD Holidays Act $000	YTD ODPH Accelerated Depreciation $000	YTD NDPH $000	YTD Digital Programme $000	YTD BAU $000	YTD Budget Total $000	YTD BAU Variance $000	
REVENUE											
Government & Crown Agency	984,855	10,232	666	-	-	-	-	973,957	963,169	10,788	F
Non-Government & Crown Agency	10,610	3,156	-	-	-	-	-	7,454	8,773	(1,319)	U
Total Revenue	995,465	13,388	666	-	-	-	-	981,411	971,942	9,469	F
EXPENSES											
Workforce Costs	397,496	1,535	408	6,292	-	912	84	388,265	383,969	(4,296)	U
Outsourced Services	38,319	(3)	3	-	-	-	-	38,319	36,571	(1,748)	U
Clinical Supplies	91,965	467	106	-	-	-	-	91,392	80,704	(10,688)	U
Infrastructure & Non-Clinical Supplies	50,527	236	-	-	1,620	262	100	48,309	50,013	1,704	F
Provider Payments	406,264	9,209	149	-	-	-	-	396,906	394,052	(2,854)	U
Non-Operating Expenses	30,605	-	-	-	-	-	-	30,605	33,270	2,665	F
Total Expenses	1,015,176	11,444	666	6,292	1,620	1,174	184	993,796	978,579	(15,217)	U
NET SURPLUS / (DEFICIT)	(19,711)	1,944	-	(6,292)	(1,620)	(1,174)	(184)	(12,385)	(6,637)	(5,748)	U

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 30 April 2021

Actual 30 Jun 2020 $000		Actual 30 Apr 2021 $000	Budget 30 Apr 2021 $000	Actual 31 Mar 2021 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	26,092	7	14,546	7
49,819	Trade & Other Receivables	53,238	50,556	54,648	48,830
6,095	Inventories	6,277	5,150	6,146	5,235
86,925	*Total Current Assets*	85,607	55,713	75,340	54,072
	NON-CURRENT ASSETS				
326,463	Property, Plant & Equipment	320,653	351,757	325,861	355,122
3,307	Intangible Assets	11,204	19,272	6,486	20,149
329,770	*Total Non-Current Assets*	331,857	371,029	332,347	375,271
416,695	**TOTAL ASSETS**	417,464	426,742	407,687	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	2,468	-	16,259
64,666	Payables & Deferred Revenue	72,052	71,685	66,699	64,494
962	Short Term Borrowings	397	955	461	955
88,645	Employee Entitlements	95,338	87,781	89,411	85,533
154,273	*Total Current Liabilities*	167,787	162,889	156,571	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	874	1,032	883	1,018
75,528	Holidays Act 2003	81,403	12,617	80,816	-
19,810	Employee Entitlements	19,810	19,810	19,810	19,810
96,429	*Total Non-Current Liabilities*	102,087	33,459	101,509	20,828
250,702	**TOTAL LIABILITIES**	269,874	196,348	258,080	188,069
165,993	**NET ASSETS**	147,590	230,394	149,607	241,274
	EQUITY				
485,955	Contributed Capital	487,263	516,590	487,102	531,750
108,500	Property Revaluation Reserves	108,500	108,502	108,500	108,502
(428,462)	Accumulated Surplus/(Deficit)	(448,173)	(394,698)	(445,995)	(398,978)
165,993	*Total Equity*	147,590	230,394	149,607	241,274
	Statement of Changes in Equity				
172,410	Opening Balance	165,993	206,398	165,993	206,398
(90,454)	Operating Surplus/(Deficit)	(19,711)	(6,637)	(17,532)	(10,917)
84,744	Crown Capital Contributions	1,308	30,633	1,146	46,500
(707)	Return of Capital	-	-	-	(707)
165,993	Closing Balance	147,590	230,394	149,607	241,274

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 30 April 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	987,740	965,732	22,008	1,156,983	918,448
Non-Government & Crown Agency Revenue	8,498	8,580	(82)	10,296	9,013
Interest Received	285	193	92	232	238
Cash was applied to:					
Payments to Suppliers	(597,887)	(569,480)	(28,407)	(675,364)	(564,990)
Payments to Employees	(377,001)	(405,369)	28,368	(499,568)	(358,485)
Capital Charge	(4,124)	(6,263)	2,139	(12,605)	(5,138)
Goods & Services Tax (net)	1,677	5,194	(3,517)	(486)	8,515
Net Cash Inflow / (Outflow) from Operations	19,188	(1,413)	20,601	(20,512)	7,601
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	4	-	4	-	4
Cash was applied to:					
Capital Expenditure	(24,626)	(62,014)	37,388	(72,294)	(28,004)
Net Cash Inflow / (Outflow) from Investing Activity	(24,622)	(62,014)	37,392	(72,294)	(28,000)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	1,308	30,632	(29,324)	45,763	4,306
Cash was applied to:					
Repayment of Borrowings	(792)	(680)	(112)	(220)	(601)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	516	29,952	(29,436)	45,543	3,705
Total Increase / (Decrease) in Cash	(4,918)	(33,475)	28,557	(47,263)	(16,694)
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	26,093	(2,463)	28,556	(16,252)	(26,582)

Cash flow from Operating Activities is favourable to budget by $20.6 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 $37.4m. 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 $29.4m. 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 $28.9m.
Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure - Cash Flow
For the period ending 30 April 2021

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	6,570	22,833	16,263	U	10,852
Clinical Equipment	12,083	13,035	952	U	10,867
Other Equipment	635	825	190	U	372
Information Technology	2,643	8,753	6,110	U	2,837
Motor Vehicles	14	-	(14)	O	3
Software	2,680	16,568	13,888	U	3,073
Total Expenditure	24,625	62,014	37,389	U	28,004

At 30 April 2021, our Financial Position on page 5 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $331.9m, which is $39.2m less than the budget of $371.0m.

The majority of Clinical and other equipment has been purchased year to date.

Land, Buildings & Plant variance of $16.3m 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 $20.0m 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.

Forecast:

SOUTHERN DISTRICT HEALTH BOARD
Forecast Statement of Financial Performance
As at 30 April 2021

	BAU Forecast $000	Full Year 2021 Budget $000	BAU Variance		Forecast Holidays Act 2003 $000	Actual YTD COVID-19 $000	Actual YTD COVID-19 Vaccination Programme	Forecast NDPH Rebuild $000	Forecast DPH Accelerated Depreciation $000	Full Year 2021 Forecast $000
REVENUE										
Government & Crown Agency	1,169,640	1,155,951	13,689	F		10,232	666			1,180,538
Non-Government & Crown Agency	9,087	10,528	(1,441)	U		3,256				12,343
Total Revenue	1,178,727	1,166,479	12,248	F	-	13,488	666	-	-	1,192,881
EXPENSES										
Workforce Costs	465,837	462,125	(3,712)	U	7,550	1,535	408	1,649		476,979
Outsourced Services	46,359	43,556	(2,803)	U		(3)	3			46,359
Clinical Supplies	109,438	96,871	(12,567)	U		467	106			110,011
Infrastructure & Non-Clinical Supplies	60,911	60,354	(557)	U		236		628	2,035	63,810
Provider Payments	476,640	474,021	(2,619)	U		9,209	149			485,998
Non-Operating Expenses	35,233	40,469	5,236	F						35,233
Total Expenses	1,194,418	1,177,396	(17,022)	U	7,550	11,444	666	2,277	2,035	1,218,390
NET SURPLUS / (DEFICIT)	(15,691)	(10,917)	(4,774)	U	(7,550)	2,044	-	(2,277)	(2,035)	(25,509)

The Business as Usual forecast is a deficit of $15.7m against a budget of $10.9m which is $4.8m adverse to budget.

As reported during the year, there has been additional revenue received from the MOH which generally has additional costs attached to deliver the requirements of the new revenue. Included is the lost revenue of $2.3m for the Elective delivery. The Improvement funding for outpatients has been recognised, however the impatient work has not.

The Workforce variance reduces due to some accrual made for additional costs being reversed, this is $0.9m.

Outsourced services have been increased to cover the potential costs of additional electives $1.1m and Oncology radiation of $0.45m.

Clinical supplies is following the current trend of costs.

Provider payments included the unbudgeted additional revenue for services.

Non Operating revenue reflects the reduction in capital charge.

Risks:
Revenue: The main risk is the delivery of electives, however if capacity cannot be found then there will be an offset with outsource costs.

Workforce costs: The risk here is two fold, employing sufficient staff to deliver the required volumes, this manifests itself in additional over time and allowances partly offset by reduced ordinary time.

Outsourced services: The risk is not finding the capacity to provide the volumes required, this would see the variance reduce.

Clinical supplies: Large or unforecast usage of blood products.

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

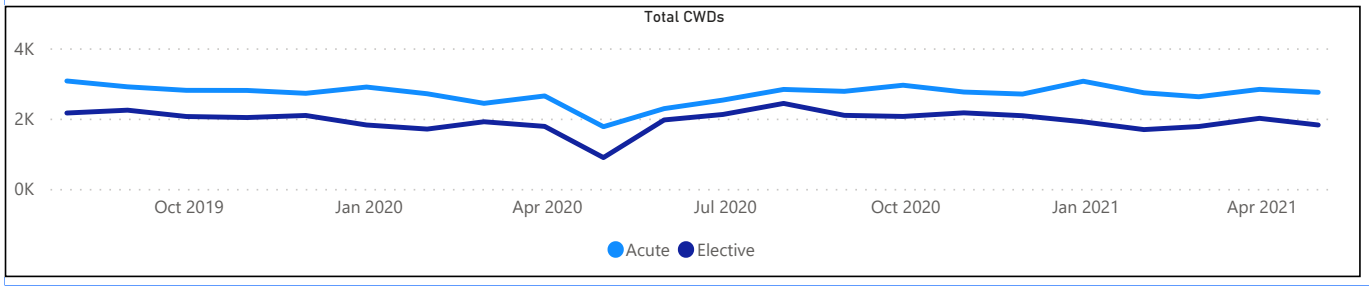
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year On Year YTD Variance
Surgical Caseweights												
Surgical Elective	1,100	1,207	-107	-9	482	618	12,833	13,262	-430	-3	12,233	600
Surgical Acute	1,236	1,169	68	6	739	498	12,222	12,105	117	1	11,452	770
Total	**2,336**	**2,376**	**-39**	**-2**	**1,221**	**1,115**	**25,055**	**25,367**	**-312**	**-1**	**23,685**	**1370**
Medical Caseweights												
Medical Elective	330	255	75	29	140	190	3,402	2,850	553	19	3,094	308
Medical Acute	1,349	1,315	34	3	950	400	14,746	14,219	527	4	14,295	450
Total	**1,679**	**1,570**	**109**	**7**	**1,090**	**589**	**18,148**	**17,068**	**1,080**	**6**	**17,389**	**759**
Maternity Caseweights												
Maternity Elective	387	322	65	20	268	119	3,785	3,489	296	8	3,342	443
Maternity Acute	161	80	81	101	80	81	1,029	883	147	17	994	35
Total	**548**	**402**	**146**	**36**	**348**	**200**	**4,814**	**4,371**	**443**	**10**	**4,336**	**478**
Total	**4,564**	**4,348**	**215**	**5**	**2,659**	**1,905**	**48,017**	**46,807**	**1,210**	**3**	**45,410**	**2607**

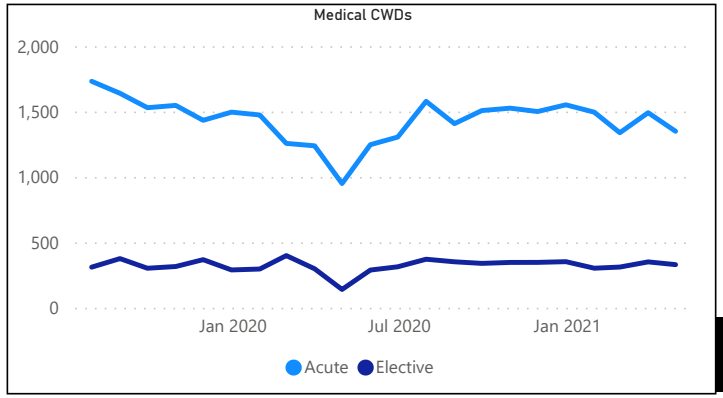
TOTALS

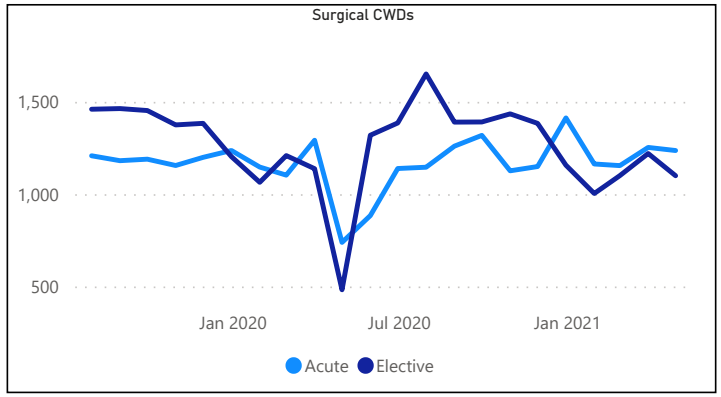
Acute	2,746	2,564	182	7	1,769	978	27,997	27,206	791	3	26,741	1256
Elective	1,817	1,784	33	2	890	927	20,020	19,601	419	2	18,669	1351
Total	**4,564**	**4,348**	**215**	**5**	**2,659**	**1,905**	**48,017**	**46,807**	**1,210**	**3**	**45,410**	**2607**

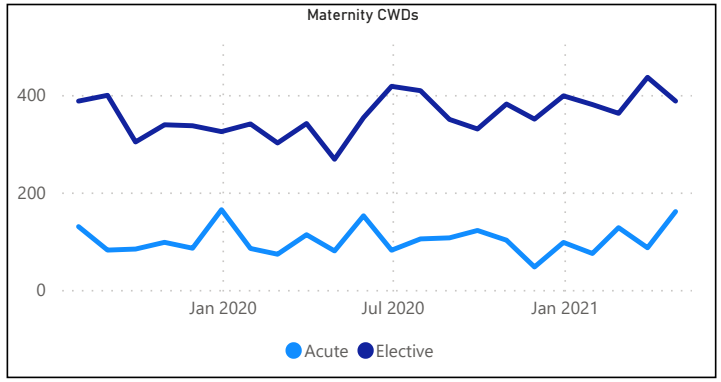
TOTALS excluding Maternity

Acute	2,586	2,484	102	4	1,689	897	26,968	26,324	644	2	25,747	1221
Elective	1,430	1,462	-32	-2	622	807	16,235	16,112	123	1	15,327	908
Total	**4,015**	**3,946**	**70**	**2**	**2,311**	**1,704**	**43,203**	**42,436**	**767**	**2**	**41,074**	**2129**









8.2

SERVICE PROVIDER RAW DISCHARGES

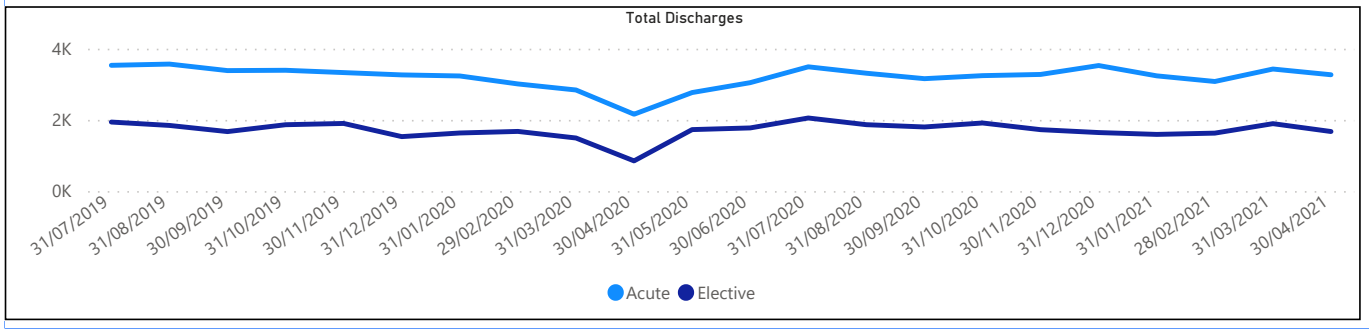
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Surgical Discharges												
Surgical Elective	759	847	-88	-10	248	511	8,909	9,295	-386	-4	8,284	625
Surgical Acute	848	756	92	12	541	307	8,203	7,840	363	5	7,567	636
Total	**1,607**	**1,602**	**5**	**0**	**789**	**818**	**17,112**	**17,135**	**-23**	**0**	**15,851**	**1261**
Medical Discharges												
Medical Elective	387	297	90	30	181	206	3,903	3,308	595	18	3,362	541
Medical Acute	2,306	2,104	202	10	1,531	775	23,920	22,732	1,188	5	23,288	632
Total	**2,693**	**2,401**	**292**	**12**	**1,712**	**981**	**27,823**	**26,040**	**1,783**	**7**	**26,650**	**1173**
Maternity Discharges												
Maternity Elective	527	433	94	22	419	108	4,976	4,668	308	7	4,749	227
Maternity Acute	114	72	42	59	87	27	897	787	110	14	861	36
Total	**641**	**504**	**137**	**27**	**506**	**135**	**5,873**	**5,455**	**418**	**8**	**5,610**	**263**
Total	**4,941**	**4,507**	**434**	**10**	**3,007**	**1,934**	**50,808**	**48,629**	**2,179**	**4**	**48,111**	**2697**

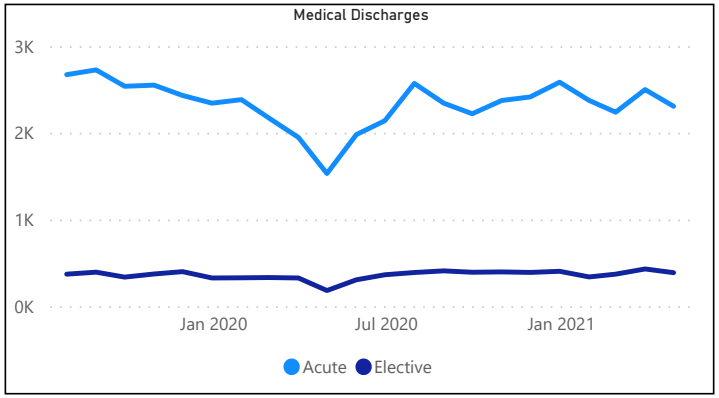
TOTALS

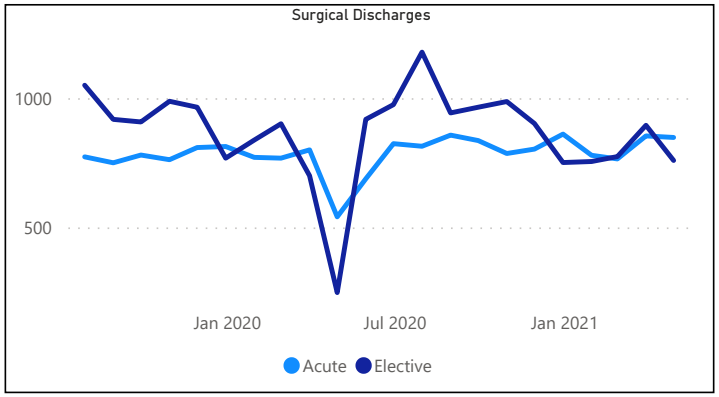
Acute	3,268	2,931	337	12	2,159	1,109	33,020	31,359	1,661	5	31,716	1304
Elective	1,673	1,576	97	6	848	825	17,788	17,270	518	3	16,395	1393
Total	**4,941**	**4,507**	**434**	**10**	**3,007**	**1,934**	**50,808**	**48,629**	**2,179**	**4**	**48,111**	**2697**

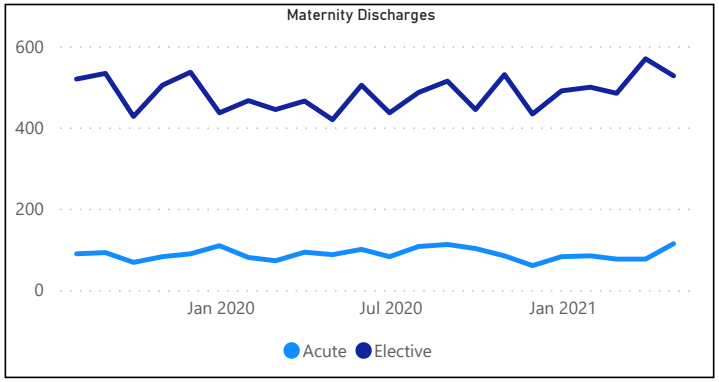
TOTALS excluding Maternity

Acute	3,154	2,859	295	10	2,072	1,082	32,123	30,572	1,551	5	30,855	1268
Elective	1,146	1,144	2	0	429	717	12,812	12,603	209	2	11,646	1166
Total	**4,300**	**4,003**	**297**	**7**	**2,501**	**1,799**	**44,935**	**43,174**	**1,761**	**4**	**42,501**	**2434**



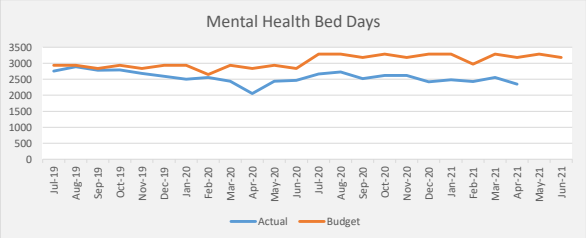




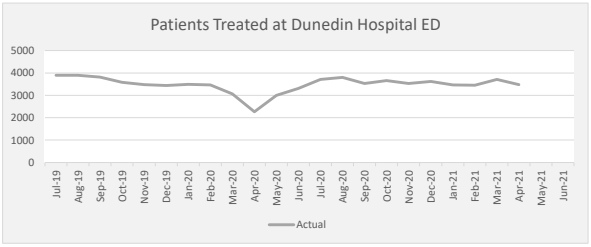


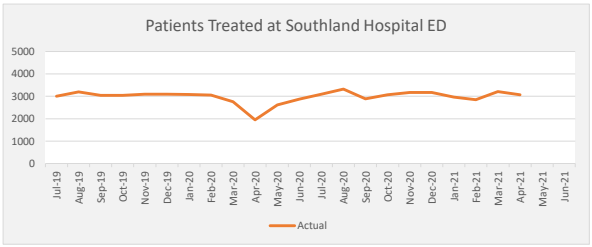
OTHER ACTIVITY

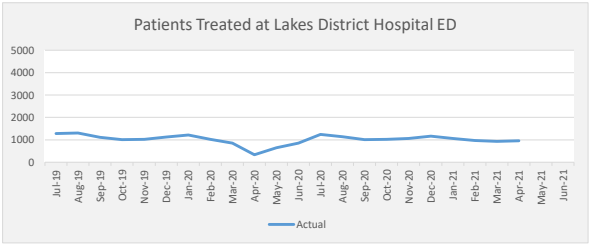
Apr-21				Apr-20	YEAR ON YEAR		YTD 2020/2021				YTD Apr-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,350	3,180	(830)	-26%	2,053	297	Mental Health bed days	25,396	32,224	(6,828)	-21%	26,032	(636)

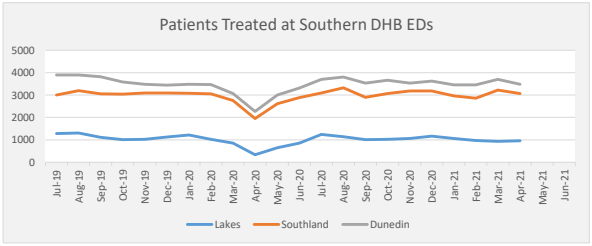


Apr-21	Apr-20	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Apr-20	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,474	2,266	1,208	Dunedin	35,947	34,389	1,558
950	333	617	Lakes	10,543	10,252	291
3,068	1,949	1,119	Southland	30,829	29,313	1,516
7,492	4,548	2,944	**Total ED presentations**	77,319	73,954	3,365









FOR INFORMATION

Item: Quality Dashboard – May 2021

Prepared by: Gail Thomson, Executive Director Quality & Clinical Governance

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – June 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 April 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 is working to understand what is driving the rise in complaints and any possible solutions. However the underlying reasons are not clear and require additional investigation

10. The imaging graph showing the % completed within 42 days has been excluded for this month. IT have run into issues with extracting the data and require assistance from the vendor. This is being worked on as a high priority but it is currently difficult to give a timeframe for the fix. We expect to be able to give a clearer picture next month

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Next Steps & Actions

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

Give a clearer picture as to when the imaging graph will be corrected. We expect this next month

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Appendices

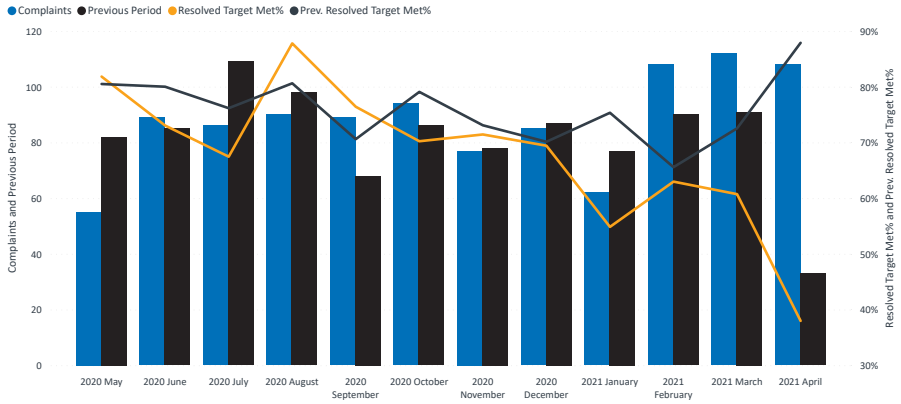
Appendix 1	Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital

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.

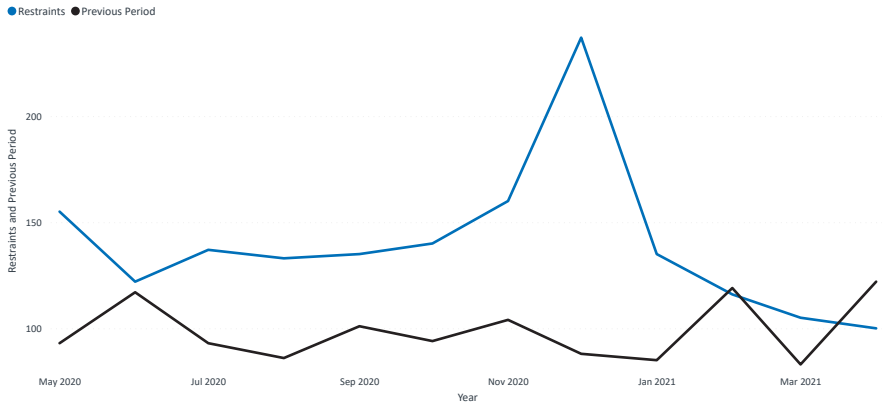
Rising volumes of complaints over the last few months are increasing workloads in the Consumer Feedback team.

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

This has proved to be more complicated than first thought with the underlying reasons still not clear and requiring further investigation

Southern - Restraints, Previous Period

BY YEAR, MONTH



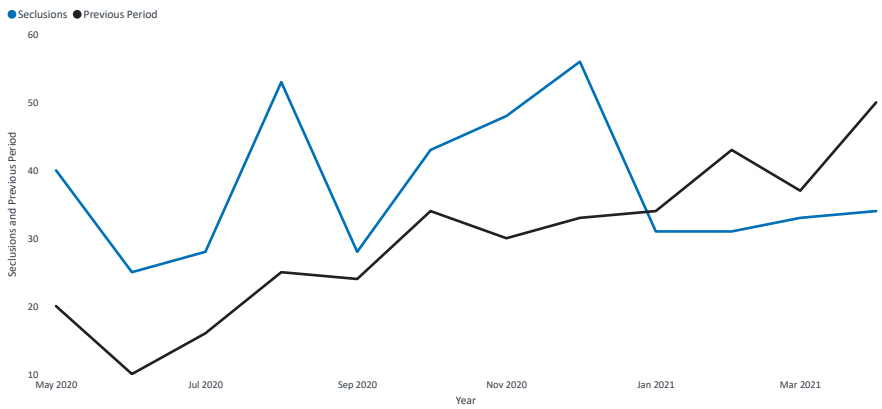
Restraints

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

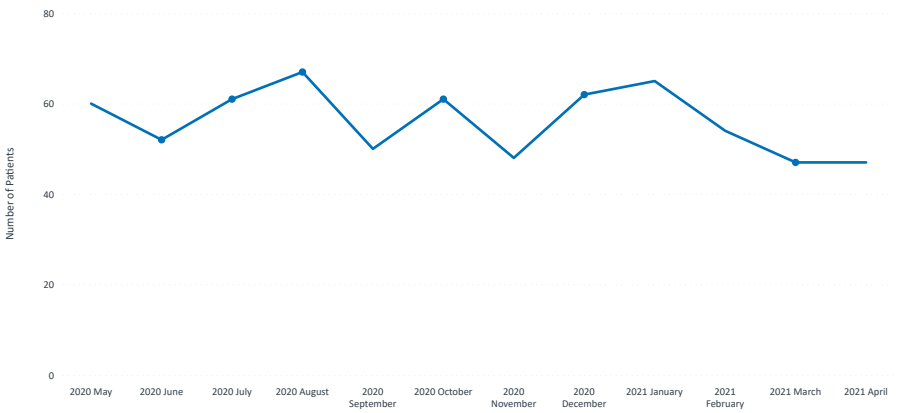
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Southern)

Southern - Deaths

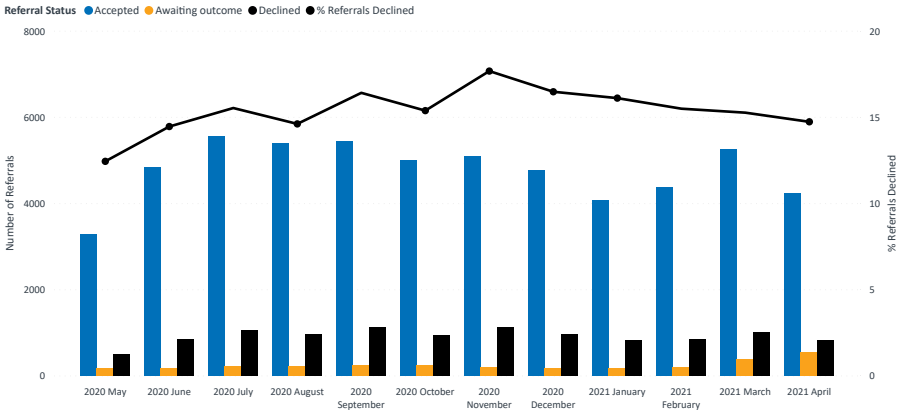
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths

Number of patients deceased by discharge month.

Southern - Referrals Accepted / Awaiting Outcome and Declined

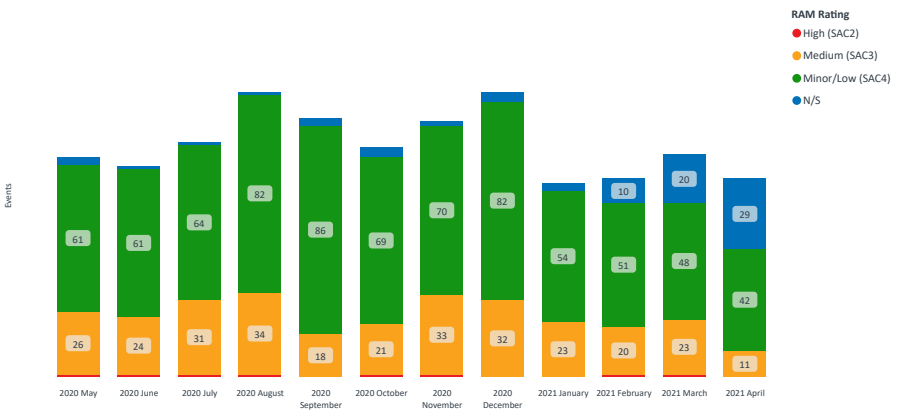


Referrals accepted (authorised), awaiting outcome or declined by month.

% 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).

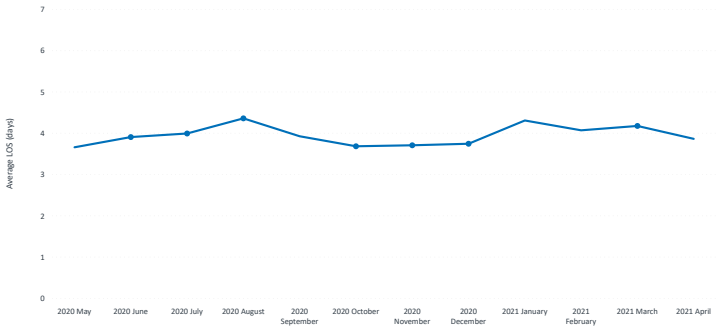
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls forms (visitor falls) which are not associated with clinical practice. These events are not assessed in the same way as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

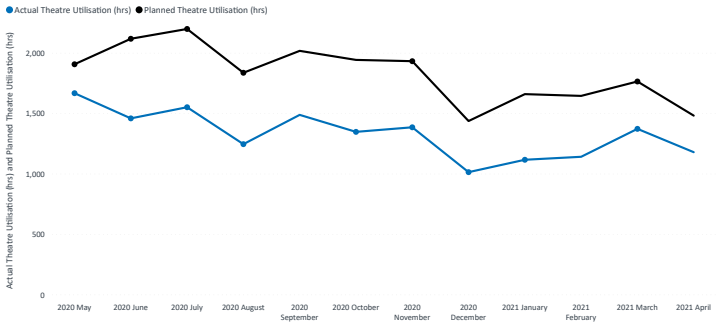


Average Length of stay

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



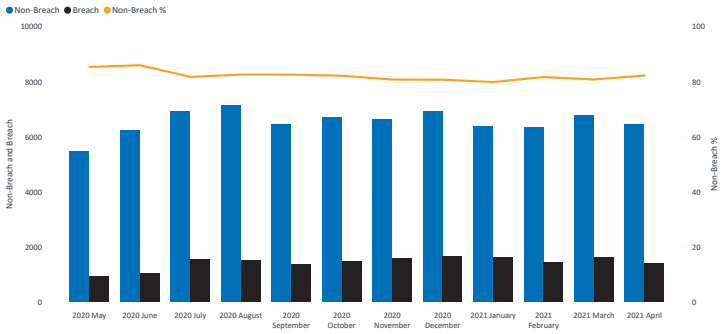
Actual Theatre Utilisation

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

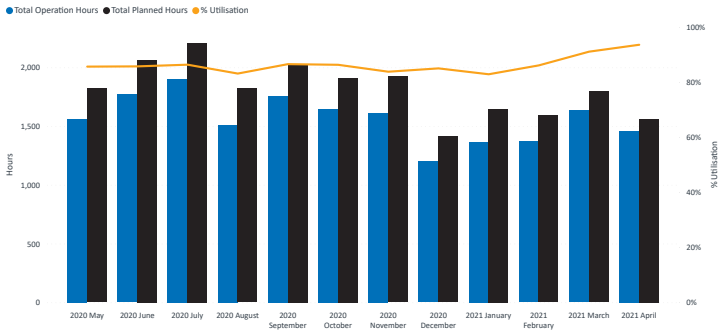
Southern - Monthly 6 Hour %



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 (%)



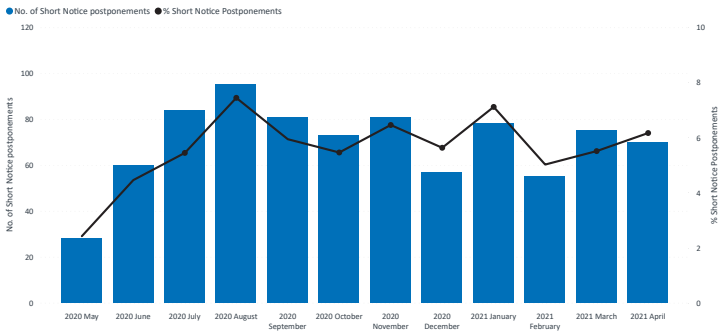
Average Theatre Utilisation (%)

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

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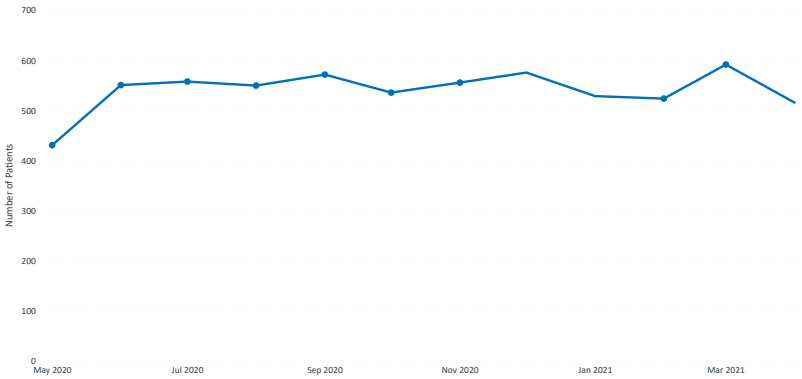
Executive Dashboard - Timely

(Southern)

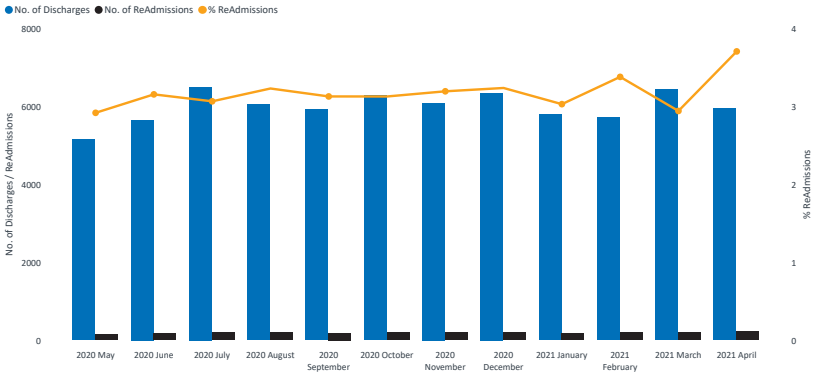
Southern - Number of Patients with LOS > 7 days



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

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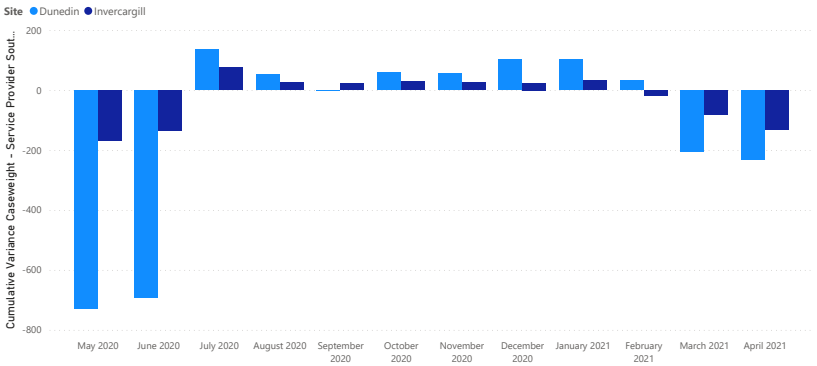
Cumulative Variance Caseweight - Service Provider Southern

BY CALENDARMONTHYEAR, SITE



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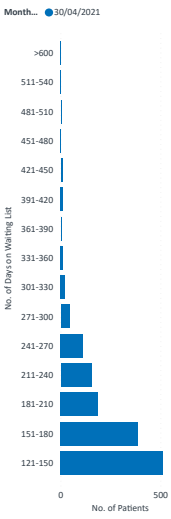
Southern - ESPI 2 Breaches

FOR THE LAST COMPLETED MONTH



Southern - ESPI 5 Breaches

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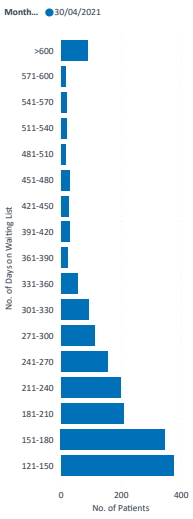


ESPI 2 and ESPI 5

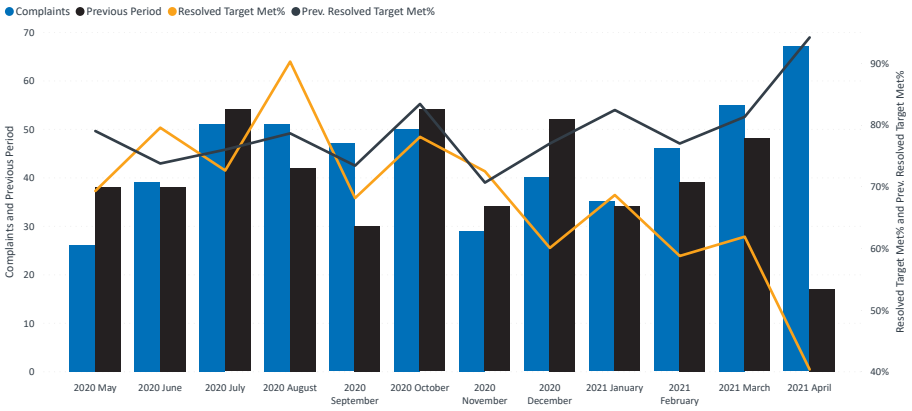
ESPI 2 and ESPI 5 waitlists organised into the given time buckets

Executive Dashboard - Patient Experience

(Dunedin)

Dunedin - Complaints and Previous Period

BY YEAR AND MONTH



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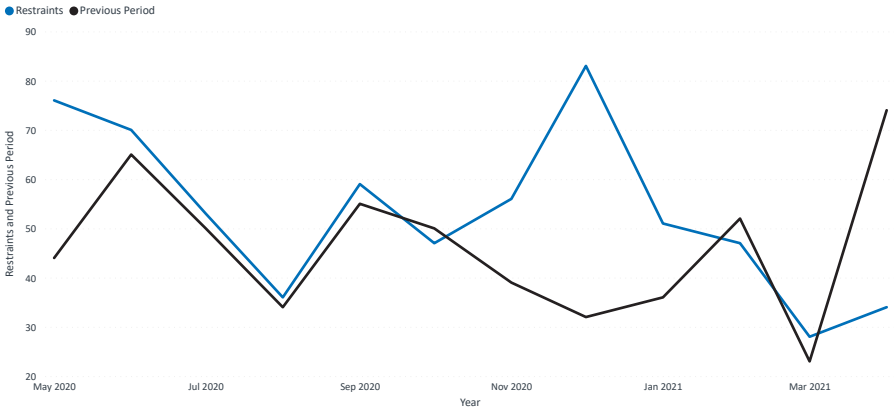
Dunedin - Restraints and Previous Period

BY YEAR AND MONTH



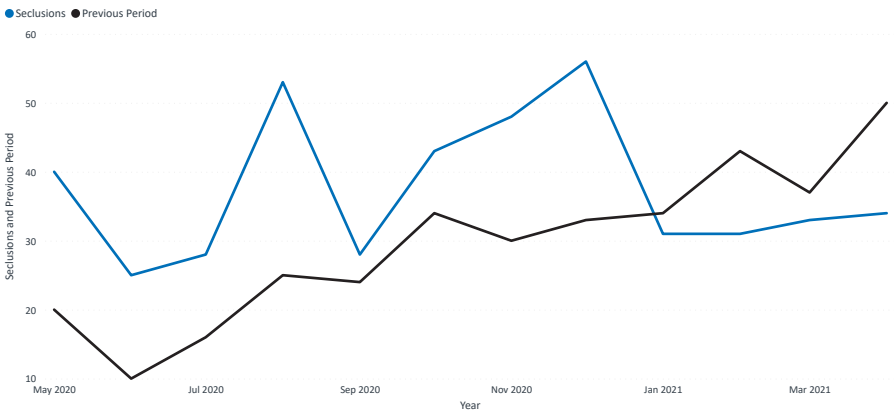
Restraints

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

Restraints data for Dunedin only.

Dunedin - Seclusions and Previous Period

BY YEAR AND MONTH



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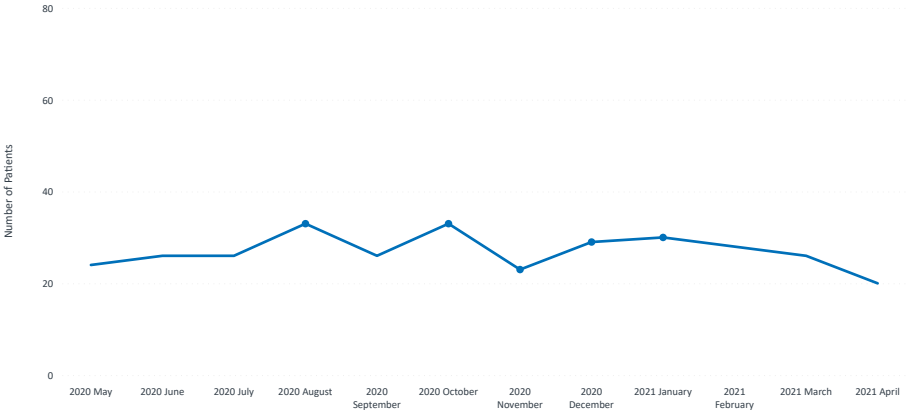
Executive Dashboard - Effectiveness

(Dunedin)

Dunedin - Deaths

NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



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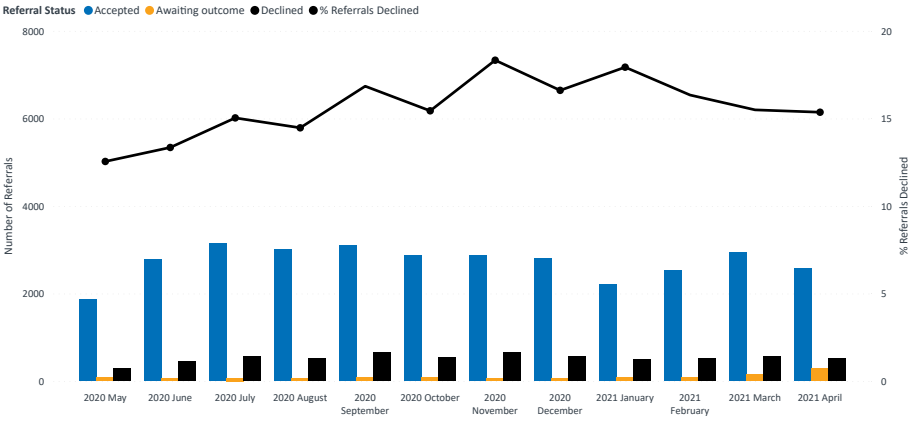
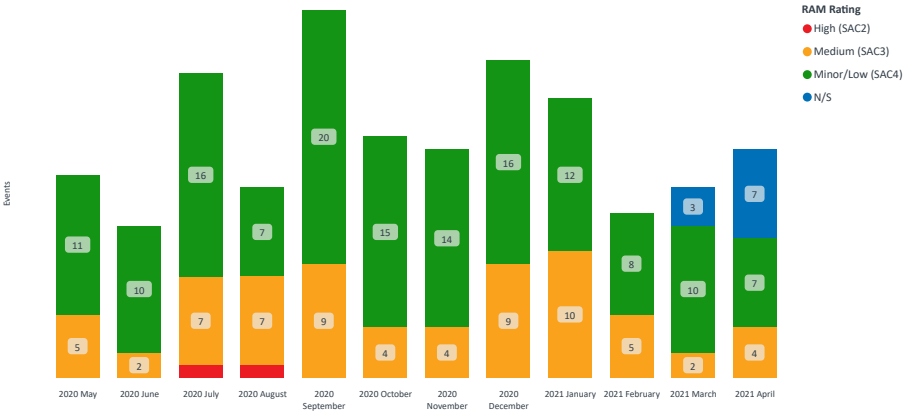
Dunedin Hospital - Referrals Accepted / Awaiting Outcome and Declined



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

Dunedin - Staff Events

BY RAM RATING, YEAR, MONTH



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The monthly number of reported staff adverse events
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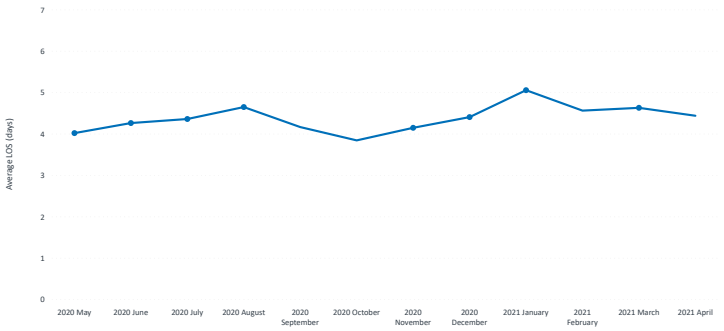
Executive Dashboard - Efficiency

(Dunedin)

Dunedin - Average LOS

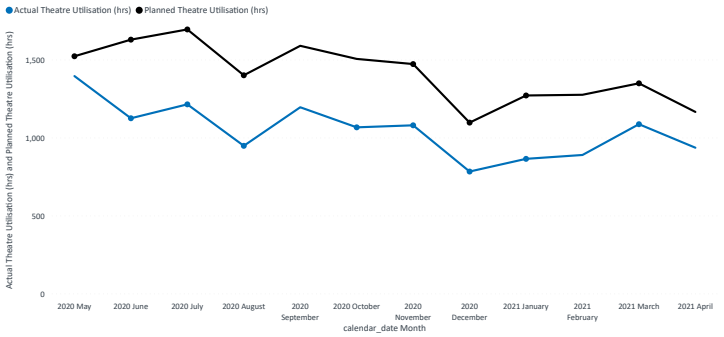
BY DAYS



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)



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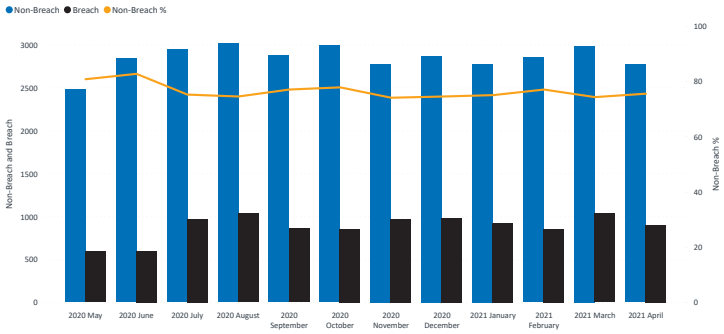
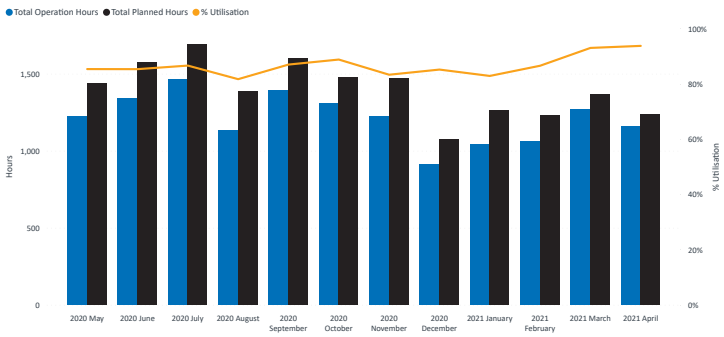
Dunedin - Monthly 6 Hour %



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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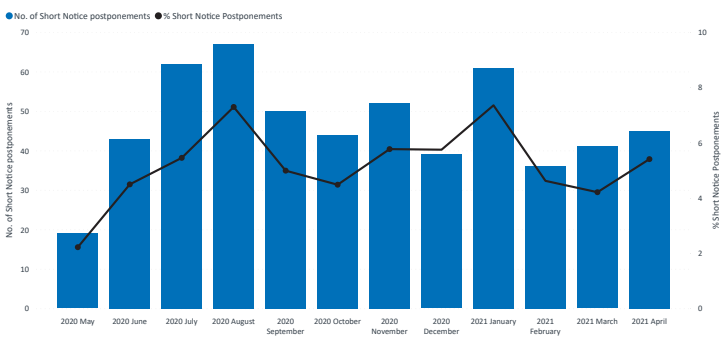
Dunedin - Short Notice Postponements



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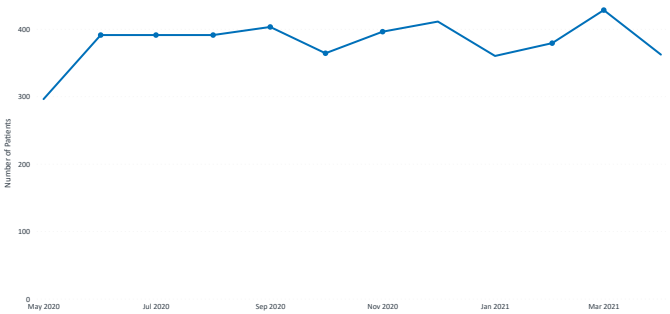
Executive Dashboard - Timely

(Dunedin)

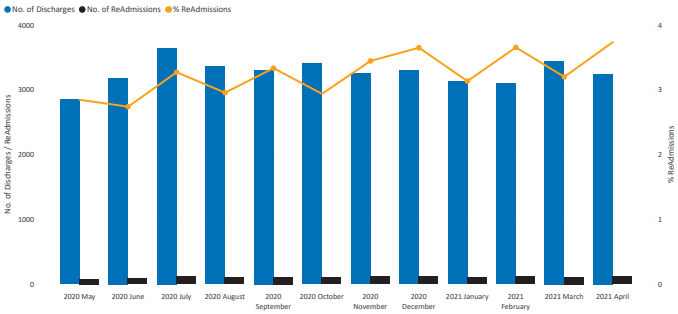
Dunedin - Number of Patients with LOS > 7 days



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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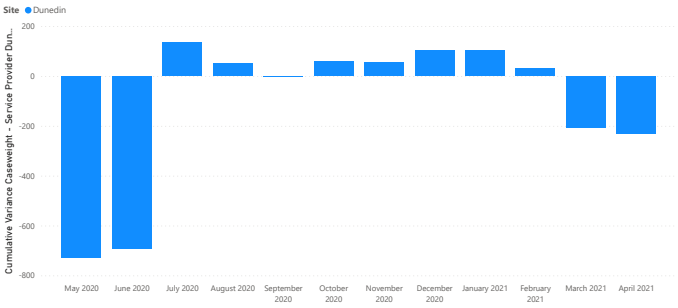
Cumulative Variance Caseweight - Service Provider Dunedin

BY CALENDAR, MONTH, YEAR AND SITE



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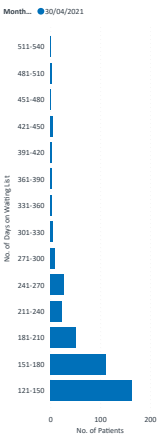

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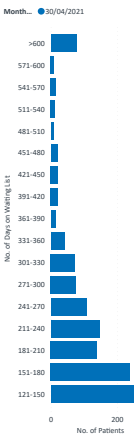

ESPI 2 and ESPI 5

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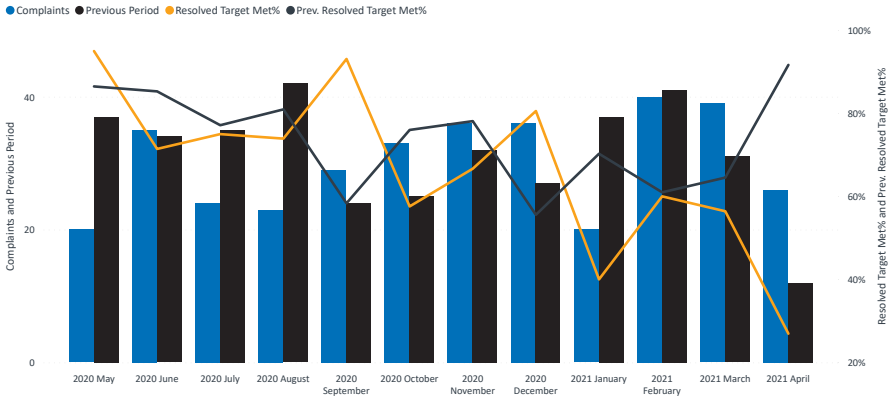
Executive Dashboard - Patient Experience

(Invercargill)

Invercargill - Complaints and Previous Period

BY YEAR AND MONTH



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Invercargill - Restraints and Previous Period

BY YEAR AND MONTH

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Southern - Seclusions and Previous Period

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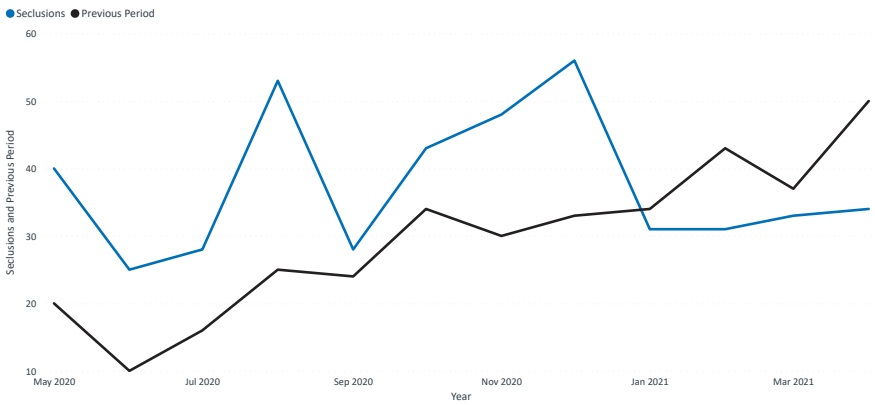

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(Invercargill)

Invercargill - Deaths

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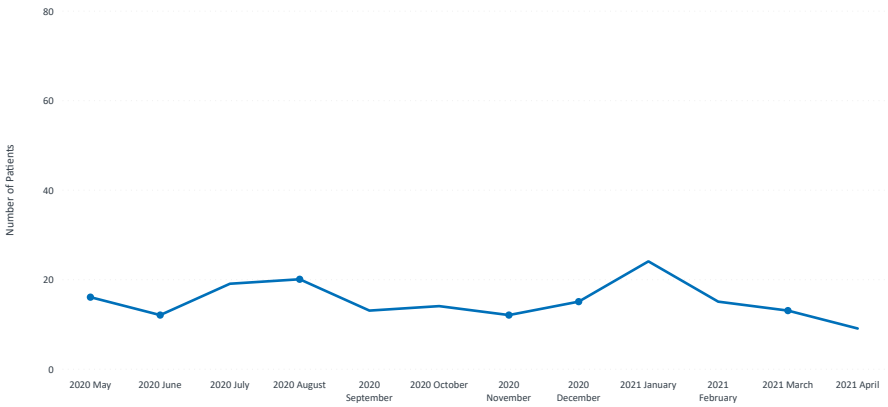

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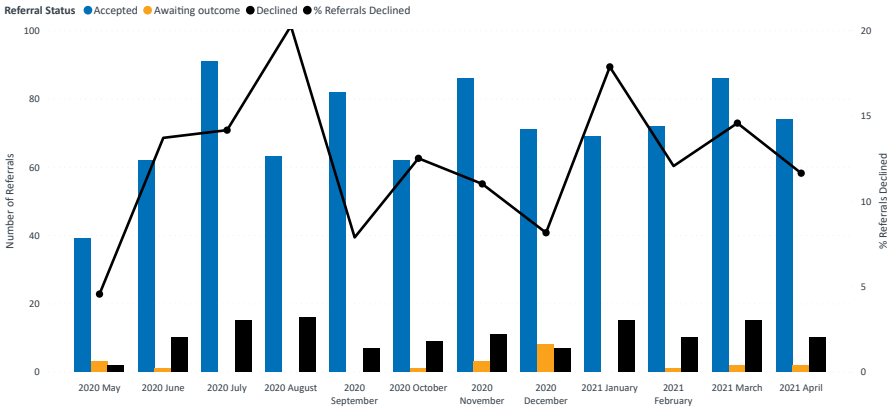

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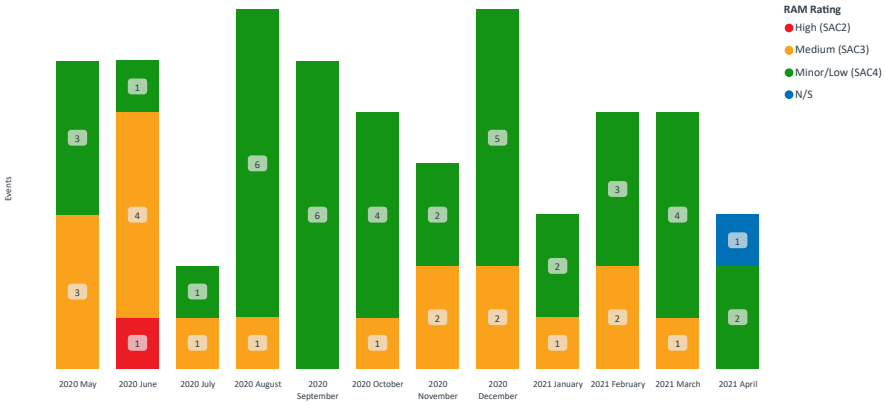
Invercargill - Staff Events

BY RAM RATING, YEAR, MONTH



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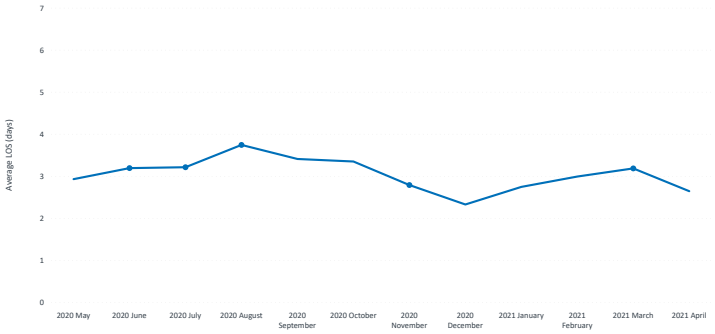
(Invercargill)

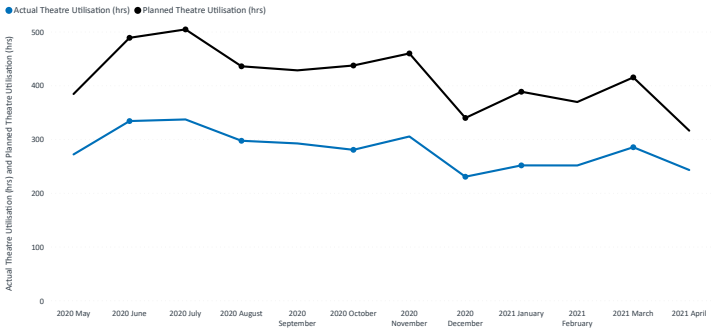
Invercargill - Average LOS (days)



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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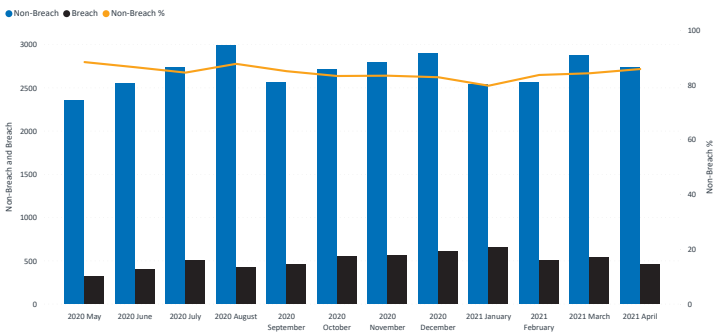

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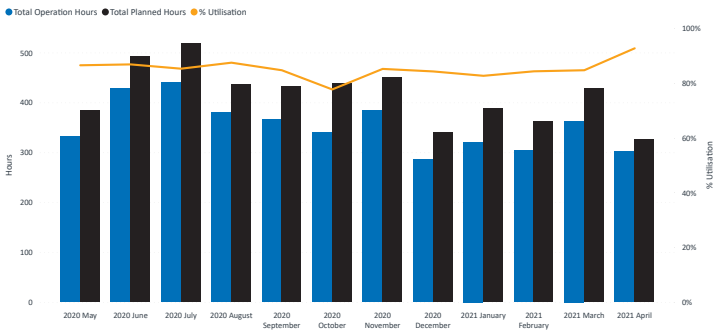

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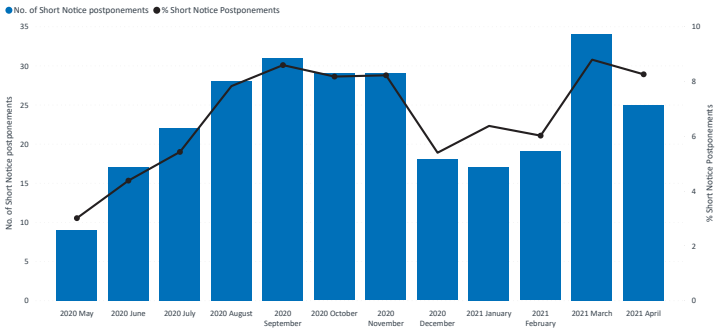

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(Invercargill)

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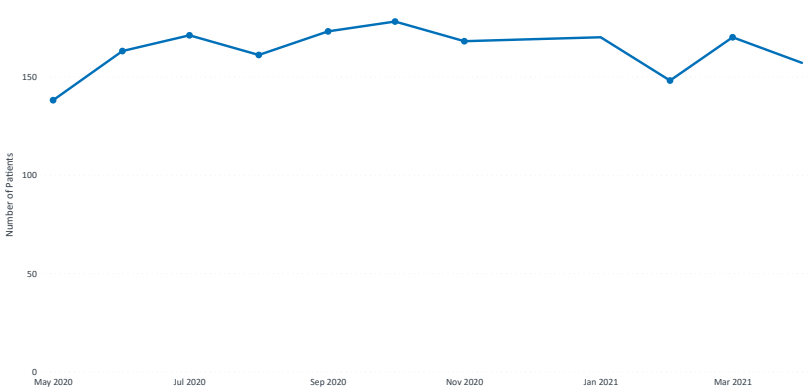
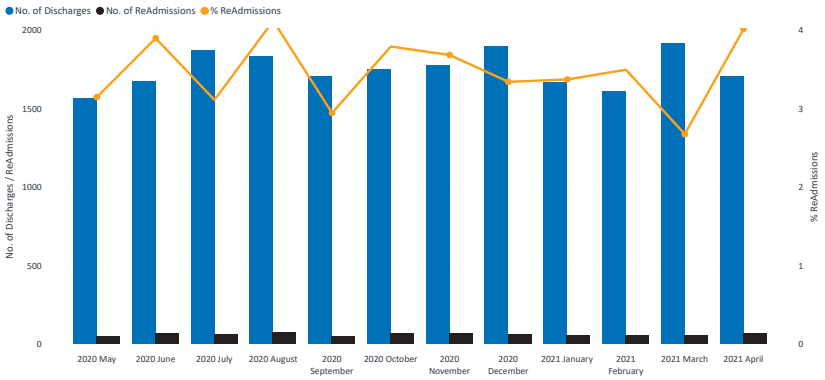


Number of Patients with LOS > 7 Days

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

Invercargill - Unplanned Hospital Readmissions within 7 days



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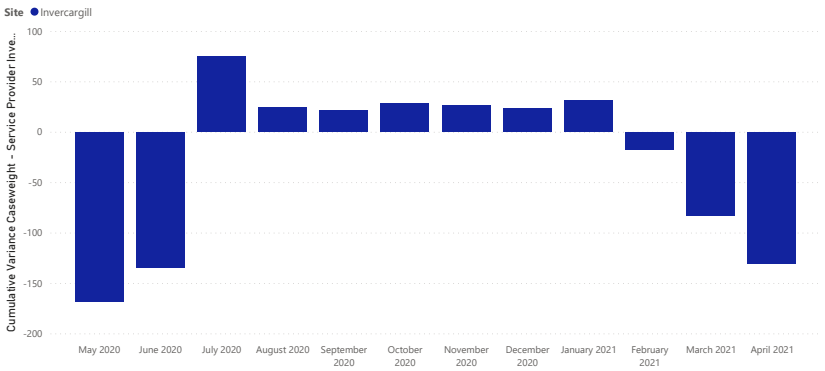
Cumulative Variance Caseweight - Service Provider Invercargill

BY CALENDARMONTHYEAR, SITE



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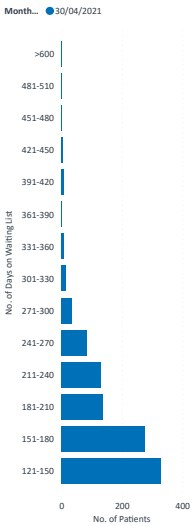

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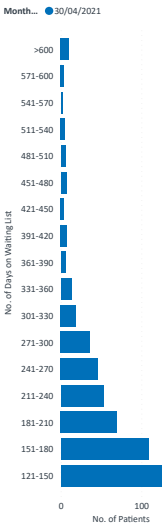

ESPI 2 and ESPI 5

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

Specialist Services monthly report for Apr 2021

Lead Executive: Patrick Ng

EXECUTIVE SUMMARY

- Recovering the radiation oncology waiting list and oncology more generally is a key focal area.
- And recovering elective surgery (case weight discharges) is another key focal area for the teams.
- Prework is underway on the assumption that a proposal will be requested for a new MRI machine at Dunedin hospital

Performance area	Previous month	Current month	Commentary
Case weights surgery	🔴	🔴	Lists are being fully booked in Dunedin and an additional acute list is being run in the weekend where possible and required. SCDHB ortho cases commenced.
Discharges	🟡	🟡	Day cases planned for the day prior to nursing strike which will help maintain discharge numbers despite CWD losses.
ED six-hour target	🔴	🔴	Benchmarking input sought from MOH which will assist us to complete the benchmarking and then start finalising the overall case.
Cancer target <31 days	🟡	🟡	Approach to FCT capture and reporting in Dunedin has been traced and understood. Now planning to trace and understand the CDHB approach and work out how the prospective versus retrospective approaches result in different performance capture and reporting.
FSA (ESPI 2)	🔴	🔴	Review of Orthopaedic Southland ESPI 2 waiting list requested as it is apparent that some long waits are data errors.
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 outsourcing is being maximised including trying to access Southern Cross Chrristchurch capacity.
Medical imaging CT	🔴	🟡	CT staffing for new machine sought in budget prioritisation. Still working towards completion of installation of 2nd machine in August.
Medical imaging MRI	🔴	🟡	Performance improved from earlier in year. MRI capacity in Dunedin remains challenging. 2nd Dunedin MRI machine sought as part of CAPEX prioritisation.
Colonoscopy 14 days	🟢	🟢	Remains on target.
Colonoscopy 42 days	🟡	🟢	On target.
Colonoscopy 84 days	🔴	🟡	Surveillance still forecast to achieve compliance by September.

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.	Maximising local outsourcing. Timaru orthopaedics now underway. Working up an orthopaedic list for SC Christchurch.
Financial performance	Focus on achieving elective volumes per the forecast to minimise CWD revenue loss.	Confirm additional outsourcing volumes – this is required to improve revenue and will be forecast as additional outsourcing cost.
ICU air handling issues (for stage 2) slow to be addressed	Letter submitted to lead architect advising that we believe they have obligations to remediate the design.	Continuing to work with the mechanical engineers to get designs completed, peer reviewed and signed off for remediation. Progressing pre-legal mediation in parallel.

- **Planned Care Recovery**
- Recovery funding rules for 2021/22 have now been released by the Minisry and the team are working on planning to achieve the trajectories and compliance requirements. The new rules are focused on trajectories rather than volumes and the funding is split out by major activity (outpatient, inpatient, medical imaging) and by speciality translating into circa $24k of additional revenue available every month for every activity to be used to offset costs associated with achieving compliance for that activity..
- As well as maximising the surgery that can be accomplished in the current financial year the team is working up options for ongoing outsourcing to enable us to recover orthopaedic surgery backlogs over the coming financial year, including use of Southern Cross Hospital in Christchurch where appropriate cases can be done there. Mercy hospital have advised that additional inpatient beds will come on stream in the coming months and we are also looking at outsourcing planning to optimise how much outsourcing surgery can be done in the district before outsourcing elsewhere. If we can consistently outsourced planned surgery we will be able to utilise the hospital capacity to consistently manage acute demands with less overall cancellations. This has to be balanced with available budgets for outsourcing.
- **Oncology**
- Working against quantified plan for Radiation Oncology recovery with weekly re-direction of cases to St Georges to manage overall demand ont the RO service and match it to available capacity.
- Recruiting in additional nursing to medical oncology. Successfully recruited an additional typist.
- Working on acute whiteboard and looking to get an operational resource to develop an overall oncology improvement plan and implement it alongside existing team.
- Engagement with CDHB planned to systematically step through their FCT recording.

Gastroenterology

- New reports under development using the new decline codes which are being consistently used by the administration team. Reports completed in draft and show raw decline rate and underlying decline rate.
- Scopist capacity for Southand and nursing capacity for Dunedin identified and added to investment priorities for the 2021/22 financial year. Nursing required to achieve gastroenterology work and supply necessary training lists for General Surgery consistently.

SP&C Services monthly report for Apr 2021

Lead Executive: Rory Dowding

EXECUTIVE SUMMARY

Positioning Public Health services for the future	Previous month	Current month	Commentary
COVID-19 Response	↑	↑	▪ Queenstown airport opened to international flights for 'green zone' flights on 19 April for Quarantine Free Travel (Trans-Tasman bubble). ▪ The Meridian Covid-19 vaccination centre opened on 29 March and the Invercargill site opened on 12 April (super clinics). ▪ Southern DHB reached a milestone of 20,000 vaccinations in April. Most (78%) were completed in the super clinics. WellSouth's mobile outreach is conducting a growing number (22%) to rural areas and general practices. ▪ We expect first vaccination in all aged care facilities to be completed by the end of May. ▪ Workforce planning and sourcing still remain a challenge combined with a highly manual process ▪ We have gone live with ServiceNow and Homecare Medical Limited (HML) to book all appointments from 17 May forwards.
Psychosocial Response planning	↑	↑	▪ The Central Lakes psychosocial mental wellbeing recovery plan continues to be a focus with active engagement with community leaders, health professionals, the business community, Māori and Pacifica, migrants and others to listen to their concerns and ideas.
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. ▪ Catch up MMR is on hold until Oct 21.
Maternity	↑	↑	▪ A paper was intended to be presented at the April Board meeting but the timeframe has been extended to enable more detailed analysis. Once the paper has been endorsed by the Board, the next steps to developing the agreed primary birthing services in the area can begin. ▪ From July 2021, SDHB will be leasing the Charlotte Jean premises in Alexandra, with the service continuing as normal but managed by Southern DHB. ▪ A new Maternal and Child Hub is to open in Wanaka at the end of April

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 means some Business as Usual (BAU) and programme work has stopped..	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

- A combined IGC/CPHAC was held on 7 April and the draft was submitted to the Board on 8 April.
- The Ministry of Health provided feedback on the first draft of the 21/22 Annual Plan on 7 April. Overall MoH deemed that our initial draft plan provided a good response across most of the Minister's priorities. The Ministry has provided some detailed technical feedback and has also provided updated guidance on a number of areas.
- There are a small number of areas where our initial draft annual plan did not provide the expected information, including financials, FTE movement and sustainability. MoH has asked for an update for each these areas by Friday 7 May. The full final draft plan will be submitted to MoH on 25 June, incorporating feedback from the Ministry of Health and from the CEO/Board/IGC.

Aged Residential Care

- As of the end of April, there are no patients waiting in hospital for residential psychogeriatric beds, and only one resident waiting at another level of care in residential care.
- Nevertheless, the DHB continues to experience elevated levels of occupancy in Aged Related Residential Care (ARRC), primarily at Hospital and Psychogeriatric levels of care. Use of Power BI has provided some high level insights but we do not yet know what is driving these changes:
  - Fewer people are entering ARC at Rest Home level care
  - More people are entering ARC directly to Hospital level care
  - More people at Rest Home level care are moving to Hospital level care

Refugee Quota Programme

- While Primary Care continues to be the most utilised service, this is the first quarter in which we have seen DHB services collectively provide more healthcare appointments than the PHO. Whether or not this is indicative of a negative trend, or failure, to deliver healthcare in a preventative and primary care setting requires further investigation.
- The refugee resettlement programme has resumed. Currently, there are limited intakes, as the COVID pandemic is being managed. A prospectus for 2021-22 will be released in May 2021, to include nationalities, intake volumes, and cohort volumes for respective resettlement cities.

SP&C Services monthly report for Apr 2021

Lead Executive: Rory Dowding

EXECUTIVE SUMMARY

Public Health Service

COVID-19 impacts

- Some community service delivery programmes in Population Health continue to be disrupted whilst staff are deployed to support the roll out of the New Zealand Covid-19 Vaccination Campaign within our district. Roles include; vaccinators, vaccination trainers and administration staff. As the Southern DHB newly recruited staff are being trained in these areas, Population Health staff will be released to Business as Usual (BAU).
- Measles Mumps Rubella (MMR) Campaign for 15-30 year olds is on hold within the Southern DHB. However, General Practices and Pharmacies continue to vaccinate
- Outreach clinics that were paused due to Covid-19 Vaccination programme have partially resumed in April. Quarter 3 reporting indicates equity gap of 10% for 8-month old immunisations for Māori which is an increase of 7% from Quarter 2, this is correlated to a decrease in overall 8 month vaccinations from 91% to 85%.
- Sexual Health: Senior staff are concerned of a potential spike in teen pregnancies and Sexually transmitted infections (STI's) due to the redeployment of Public Health Nurses out of Youth Health and to the COVID-19 Vaccination Clinics.

Drinking water

- Feedback has come from the Ministry and Taumata Arowai that the Water Services Bill may not come into effect until closer to September this year. The impact of this is that Public Health is likely to be continuing to manage drinking water until closer to the end of 2021.

Community Oral Health Service

- Spacial Equity Project: Work continues in this area, with a brief presentation planned for CPHAC in June.
- Arrears: Arrears across the district continue to be high and there is inequity across the district. Forward planning involves a reassessment of staffing and distribution and review of the service

Pharmacy

- Pharmaceutical Data and Analytics - SDHB Pharmacy advisor has been seconded to COVID Vaccine programme, with recruitment underway for backfill.

Rural health

- The government decision to open the borders to Australia has resulted in increased preparedness for managing the potential risk of COVID positive patients arriving in Queenstown. Border staff have been vaccinated as have health care professionals working in the hospital and in primary care.
- Opportunities to increase access to Outpatient Specialist services for the Queenstown population are being explored, in conjunction with colleagues in Southland. A Nurse Practitioner who specialises in diabetes has been recruited to work across primary and hospital services in Queenstown and will also work with the specialist nurse in Central Otago to provide a comprehensive service to this high risk cohort of patients.
- Radiology solutions for rural hospitals have resulted in two rural hospitals contracting directly with a private provider, whilst two other rural hospitals will continue to employ radiology staff directly, but link to SDHB for some aspects of the service and to access professional support. The fifth rural hospital will continue with the sub-contract arrangement it currently has in place.
- Central Lakes Localities Network - Continues to work on projects to improve health services in Central Otago and Queenstown Lakes areas. They respond to issues that are flagged by the community.

People and data & digital monthly report for Apr 2021

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

- All teams have been under pressures this month with significant demands on the services. This has mainly been due to our response to the Covid vaccination centers and significant CAPEX projects like the new recruitment system and FPIM nearing completion.
- Executive Director, People, Culture and Technology is currently developing a transition plan of key responsibilities.
- There are still a number of concerns being raised within the H&S reports of physical abuse to staff. There will be formal reports and recommendations for improvement provided to the Exec/FARC and the board.

	Previous month	Current month	
Workforce & HS/W			
HR Dashboard Development			Report will be generated monthly and feedback included. More narrative will be added of the progress against actions from previous month reporting. Focus on Sickness, Absence and Turnover
Workforce Strategy and Action Plan			Actions have been updated within the Annual Plan
HS/W			Reporting to FARC and HS Governance group progress already. Draft report received from the Mental Health Audit currently being reviewed by CE and acting ED Mental Health.

Current Issues	Update/Achievements	Upcoming key deliverables
Resignation of Executive Director	Working with the CE to determine suitable cover	Development of a transition document and draft JD's to replace this role.
Public Service Pay Guidance	Guidance received from the ministry	Negative Impact on staff culture significant
Workforce Planning	Jo Schmelz has been working on the covid response but now is back with the NDH team.	Status report to come from Jo via NDH team reporting
Employment Related Matters/Cases	Are managing 87 employment related matters up 12 from last month. Plus 10 additional disciplinary investigations.	Detail reported in the HR dashboard
Volume of BAU workloads and Resource to support	Benchmarking complete	Budget rounds is the only opportunity to address this plus top slice from CAPEX resource appropriately to provide support

Proposals for Change

HR is supporting managers with the following **proposals for change**:

- *Radiology (implementation)*
- *Persistent Pain Service (decision pending)*
- *General Surgery, Orthopaedics and Plastics (consultation)*
- *Administration Lakes District Hospital (development)*
- *Medicine, Women's & Children's (development)*

Immunisation Clinics Workforce

- We have had in excess of 800 expressions of interest logged (some of these include duplicates).
- We have so far identified 312 people across Dunedin and Invercargill where our primary focus is right now for telephonic interviews
- 271 have been interviewed
- 148 offers have been extended
- 92 have accepted which equates to 53.7 FTE
- 43 Nursing Students through the Polytechnic who will be supplementing clinics during peak periods

Green Healthcare Strategy

The steering group continues to meet quarterly and progress is being made against the following focus areas. The ministry have released some additional funding to assist DHB's to reduce Carbon omissions so we will be applying for access to this funding. This could assist funding to change the coal boilers in Southland.

- Carbon footprint
- Energy Supply and Efficiency
- Waste
- Travel
- Procurement
- Built Environment

Staff Engagement Survey

The 2020 Staff Engagement Survey results were discussed at ELT and shared at the Board meeting in April.
Next steps:
Results will be communicated to all Staff in May.

- Themes of focus areas are:
  - Senior leaders communicating well and living the values
  - How change is managed
  - Addressing performance issues
- There will be co-ordinated response via three layers of the organisation to the three focus areas above.
  - Exec Response of actions (triggered and will be collated electronically once this run sheet has been sent to the Exec for feedback)
  - People Forum (at their next meeting how can this forum assist with actions to support)
  - T3,4,5 Manager's response to the three themed areas plus additional actions for priority concerns with their services.
- The tool for tracking and reporting should be the tool that we used for the staff engagement survey.
- In parallel and connected
  - Weekly new pulse checks relating to staff wellbeing and the Aukaha Kia Kaha Be Well program have started. The results of the pulse checks are shared with the OD and HR teams to support managers with addressing areas of concern.
  - Chief Medical Officer working on response to SMO engagement day actions

People and data & digital monthly report for Apr 2021

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

- Digital programme of work for the NDH progressing well, just need confirmation from the MOH re funding 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)			Asbuilt RFP closed and are preferred supplier. Funding required for Asbuilt contract from NDH project costs for change. Project on hold until funding can be identified. Mike C meeting with Mike B re funding as part of change management for the NDH.
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 was completed on the 29th April.
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. All projects in the strategy will fall within the detailed business case for the NDH.
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 exec and board in May/June for T1.2	Executive and board approval
Local & Regional Digital Collaboration and Delivery	Meeting with the Chairs and CE's of the South Island re two options for digital services being delivered into the future.	Recommendations are being considered by the DG Digital and Data to ensure alignment with reform principles.
Recruitment of roles (Digital)	It has taken longer than expected to recruit key roles for the T1.1 team who are responsible for developing the detailed business case.	Recruitment for T1.2 will start sooner given lessons learnt from T1.1 recruitment process.

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 April 2021

Lead Executive: Nigel Trainor

EXECUTIVE SUMMARY

The SDHB financial results are covered in a separate paper.
The 2021/22 proposed financial budget is progressing and a draft has been sent to the MOH. We are now aware of the Govt budget announcements and to confirm the revenue base and from this any adjustments required to the cost structure.
The FPIM project to replace the legacy Finance & Procurement system is on track with NZHP giving sign off to go live.
Facilities continued focus on changes in both Dunedin and Southland hospital, this is for the new CT, MAU, ICU and in Southland planning for changes in ED and a case for a fifth theatre.
Payroll is working with the national processes to progress Holiday Pay rectification.

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. While the overall result will be adverse to budget, there are a number of costs that ensure patient delivery is improved
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 project has had sign off from NZHP to go live as at 1 June 2021 as planned. Training continues to be rolled out.
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.
ICU rectification	Meeting with key architect and engineers	The urgency to rectify the HVAC systems in the ICU are the subject of a meeting with the Architects and Engineering consultants to life the urgency in the rectification design .
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.

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: Quarter Three 2020/21 Reporting: Southern DHB Annual Plan Report to the Ministry Of Health

Proposed by: Rory Dowding, Acting Executive Director, Strategy, Primary and Community

Meeting of: Board, 2 June 2021

Recommendation

That Board notes the content of these papers.

Purpose

To provide a summary of DHB Annual Plan Reporting to the Ministry of Health for Quarter Three 2020/21

Specific Implications for Consideration

Financial

- Recovery due to missed targets may have financial implications.

Quality and Patient Safety

- Reports may signal need for improvements in service quality.

Operational Efficiency

- Reports may signal need for improvements in operational efficiency.

Workforce

- Recovery due to missed targets may have workforce implications.

Equity

- Gaps in equity are highlighted in some areas. Gaps need to be addressed to meet targets and ensure that there is equitable service delivery in the Southern district to improve outcomes for Māori and other vulnerable populations.

Other

- Not identified

Background

Annual Plan Quarterly Reports are prepared quarterly to demonstrate progress against Annual Plan actions. Reports are submitted to the Ministry of Health as part of the performance monitoring requirements.

Discussion

- The document, *Annual Plan Quarterly Report, Quarter Three 2020/21* summarises Annual Plan Reporting to the Ministry of Health.
- Due to staff secondment to the COVID-19 Vaccination Programme, Annual Plan reporting has not been undertaken for a number of Improving Child Wellbeing actions.

Next Steps & Actions

Southern DHB will submit the quarter four Annual Plan report to the Ministry of Health on 20 July. The document, Annual Plan Quarterly Report-*Quarter Four 2020/21* will be submitted to ELT following submission to the Ministry of Health.

Appendices

Appendix 1 Annual Plan Report Q3 2020/2021

Annual Plan Quarterly Report
Quarter Three 2020/21

Overview

Southern DHB submits quarterly reports to the Ministry of Health against the actions within the Government Planning Priorities section of the Annual Plan.

Quarterly Annual Plan reports are provided for the following Planning Priorities:

- Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System
- Give Practical Effect to He Korowai Oranga – the Māori Health Strategy
- Improving Mental Wellbeing
- Improving Sustainability
- Better Population Health Supported by Primary Health Care
- Improving Wellbeing Through Prevention
- Improving Child Wellbeing- Improving Maternal Child and Youth Wellbeing

Each report includes an indication of whether actions are track, according to the RAG Guidelines below. Comments are added where actions have not been achieved for the quarter.

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

Annual Plan Reporting Quarter 3 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

Acute Demand		
Performance improvement of our 6 hour ED target		
Strategies identified to address urgent care gaps		Alliance South has been put into abeyance. WellSouth are progressing with a possible option in Invercargill to address the after-hours access issues. This may take the form of a nurse practitioner led service being established.
ED Performance Improvement Steering Group provides guidance		Steering Group & TOR ratified, implementation generalism in progress.

Rural Health		
Findings from the Review of the Central Lakes/Queenstown Locality shared		Review completed. The findings will be presented at a Colloquium in mid April, and will then be disseminated to a wider audience.
Programme of work to refresh and refocus the Rural Hospitals Alliance - Work programme monitored on a quarterly basis to determine progress towards goals		Radiology project completed. Patient Transfer Service project will commence next quarter. Shared services have been established between Waitaki District health Services Ltd, and Central Otago health Services Ltd. Some collaboration across all Rural Trust Hospitals on Collective Agreements has been achieved.
Identify barriers to use of telehealth and work with clinicians and providers to seek solutions		Data gathered and barriers identified. Working party established to review

Planned Care		
Achieve case weight and discharge target for Q3		As of end of Q3 we are 370.9 caseweights and 357 discharges behind the population target. This past quarter has seen many elective cancellations due to bed block and acute pressure. A senior leadership taskforce was set up in December to study the issues and supply solutions. Actions to improve our performance include improving our patient flow with better discharge processes, increasing acute theatre capacity and increasing our levels of outsourcing.
Part one: Implementation of the recovery plan concludes		Actions for recovery are being actioned and results monitored at the weekly service ESPI 2 and 5 meetings
Part one: Acuity tool rollout continues		This roll out has continued.
Part one: Prioritisation tool rollout continues		This programme of work is continuing with ENT and Gynaecology.
Part one: Implementation of revised ESPI 2 and ESPI 5 plans once agreed with the Ministry.		Revised targets are still being negotiated with the MOH.

Annual Plan Reporting Quarter 3 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Healthy Ageing		
Test co-location of community teams in a single locality as a proof of concept		
Design of new model of Home and Community Support Services in conjunction with key stakeholders		Delayed to quarter 4
Piloting and proof of concept undertaken with a view to new contracts being in place Q1 2021/22		Delayed to quarter 4
ARRC Steering Group identifies and implements improvements		
Identify and address the drivers of acute demand for people 75 plus presenting at ED - PDSA used to test new HOME Team innovations		
Participation in the South Island survey (dementia education)		
Co-located teams established re approaches for responding to a future public health emergencies.		

Healthy Ageing (continued)		
Promote HealthPathways for frailty in older adults when required		Delayed to quarter 4

Delivery of Whanau Ora		
In collaboration with Kaupapa Māori Health Providers, review Southern DHB Māori health contracts with a whānau ora lens		In conjunction with contract review (see below)
MOU in place		MOU with Southern Whanau Ora policy is planned – to occur in Q4
Contracts reviewed		Contractor employed to review Maori health provider contracts with aim to moving to high trust contracts in 21/22.
Support provided , including through current and future investment, with whānau, hapu and iwi, and identify opportunities for alignment		

Annual Plan Reporting: Quarter 3 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Bowel Screening and Colonoscopy Wait Times		
National Access Criteria utilised		National access criteria utilised – Andrew Connolly overseeing
Quarterly waiting list review		Waiting list review undertaken – still actively working towards a solution
Regular review of participation data to direct activities and ensure equity gaps do not develop and take action if they do		Participation for the southern region still remains high
Target active follow-up of patients for Māori populations		WellSouth's outreach team still contracted and participation in the south is still high
Target promotional activity to areas of high Māori populations		Through WellSouth, the DHB's bowel screening team works with community-based Māori health providers to promote the programme to the Whānau they support. The team continues to engage with local providers
Target active follow-up of patients for Pacific island populations		WellSouth's outreach team still contracted and participation in the south is still high
Target promotional activity to areas of high Pacific island populations		WellSouth, the DHB's bowel screening team works with community-based Pacifica health providers to promote the programme to the communities that they support. The team continues to engage with local providers.

Bowel Screening and Colonoscopy Wait Times (continued)		
Active promotion of Bowel Screening Programme with GPs, NGOs		Paid advertising is still going ahead as planned.
Review of facility and personnel resourcing and resource utilisation		Endoscopy user group has been meeting regularly to try get traction and resolve resource issues

Annual Plan Reporting: Quarter 3 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

New Zealand Cancer Action Plan		
Work with Cancer Control Agency on implementing FCT indicator on patient's records undertaken during Q3		FCT data is continually being reviewed. Although the achievement rate is poor for the 62 day target, SDHB patient numbers being captured for FCT are proportionally higher than some of the larger DHBs. The SI FCT Leads Group intend to investigate. Confidence with FCT flagging is an issue as administration staff come and go – at times flagging patients drops off. Maori patients who breach the FCT target are being notified to the Maori Leadership Group for investigation.
Cancer pathways – Implement strategies for early stage breast cancer		SBCS fractionation for breast cancer is now consistent and is optimising throughput
Implement Improving the Cancer Pathway for Māori Plan		The Maori Cancer Nurse Specialist Job Description is being finalised, to be advertised and recruited in May.
Monitor and navigate Māori newly diagnosed with cancer		
Analyse journey and wait times for 20 Māori patients with lung cancer		Cancer Control Agency & SDHB respiratory physician, GM, CNC have a meeting set for 11/3/21 to analyse findings
Report of end of treatment services provided		The Southern Regional Hub (SRH) is planning a pilot on survivorship to support transition at end of treatment in one DHB. There is no update but it is remaining on their workplan and they will be identifying an appropriate tumour stream to pilot in due course
Expand EXPINKT exercise program to Queenstown Lakes area		This is yet to occur

New Zealand Cancer Action Plan (continued)		
Commence VC clinics beginning in Southland Q3		VC clinics have commenced in Southland
Measure data and identify any areas for improvement		Aiming to commence tumour pathway projects starting with lung cancer. Lung cancer survival is the lowest at SDHB is the lowest in NZ. The pathway work aims to streamline, standardise and improve time to diagnosis and treatment.
Analysis (DN and INV)		Bowel and lung QPI being recorded
Work with Cancer Control Agency to explore evidence based equity tools/processes		The Māori Health Directorate meets monthly with the Cancer Control agency and rates of uptake into services are reviewed. The Cancer Control Agency endorses SDHB Maori CNS role.
Work with MoH, Cancer Control Agency to Identify local actions in the Cancer Plan		Yet to commence but planning is occurring for the lung cancer pathway. Added the following deliverables: • Develop tumour stream specific improvement plans and report progress for bowel, lung and prostate cancer • Develop a lung cancer service improvement plan • Develop a prostate cancer service improvement plan • Work with Te Aho o Te Kahu to plan and implement the adoption of the cancer related Health Information Standards Organisation (HISO) that will be issued via Data and Digital

Annual Plan Reporting: Quarter 3 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Workforce		
Review and support planning processes re public health needs		
Develop appropriate change management methodology and tools for Southern DHB		Working with MOH and ELT to develop tools and framework
Improved workplace culture by Q3		COVID-19 Vaccination roll out on top of BAU noticeable workload pressures impacting culture.
Improved employee engagement by Q3		COVID-19 Vaccination roll out on top of BAU noticeable workload pressures impacting culture. Staff Survey results showed positive engagement.
Improve productivity through technological enablement and systems automation - improved productivity by Q3		New recruitment system went live.
Nurse practitioner (NP) funding allocated		All applications received for attendance at national NP or related conferences approved. Due to COVID-19, there have been no international requests for funding this quarter due to border restrictions.
HSW –annual training day		Delayed until Q4, due to lack of capacity (vacant positions) and high-priority operational outputs.
HSW – First annual report complete		Likely to be completed FY22

Workforce (continued)		
HSW Continuing improvement process		District-wide 'security for safety' review complete; information security review complete.
System implemented for transfer of staff health records		Currently implementing MedTech Evolution.
EOCs implemented as required		EOC not required Q3
SDHB Health Emergency Plan maintained		
Support provided for staff with COVID related needs		Current focus is response to vaccination roll out.
Implement a Māori Response Action Plan as required (COVID)		Southern Māori COVID-19 Resurgence Plan is in place and COVD vaccination implementation plan is in development in partnership with four lead Maori health providers – who will vaccinate Maori and Pacific populations.

Annual Plan Reporting: Quarter 3 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Workforce (continued)		
Health Literacy Action Plan		
Community pharmacists supported in SDHB contracting to deliver influenza vaccine		Vaccine roll out to be advised by the MoH due to COVID-19 rollout
GP portal enrolment increased		Increasing use is now BAU
Consumer portal access expanded		Increasing enrolment is ongoing
Cultural education programme executed		
Patient participation and partnership model implemented		
Continued improvements of Southern district website		
Health Info localised and updated		

Improving Quality		
Improving Equity		
Number of diabetics referred into secondary care		In planning stages at LDT
Improving community, whānau and patient engagement		
Quarterly updates sent through to ELT outlining where engagement is occurring with clinical services, opportunities for future engagement and what support staff need to engage with community, whānau and patients		Engagement with community, whānau and patients continues to occur throughout Southern health system. This is continually monitored and fed through to ELT and other groups.

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Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Data and Digital		
My Lab -Procurement of initial technology show case partners		In discussion with initial partners but awaiting confirmation on plan for the venue.
My Lab - Regular and ongoing reporting to the SPG		SPG does not exist anymore and has been replaced by the Executive Steering Group (ESG).Mike Barnes (NDH Lead) is actively progressing funding for the site. A vendor has been selected for the geo-spatial workup
Continued recruitment of key roles to the Early Works Team		The Early Works Team has been disbanded upon completion of the Indicative Business Case. Recruitment of the roles is now to the wider Digital Team. Project Manager, Lead BA, BA, Solutions Architect and Senior Procurement Specialist roles have all been filled. Project Coordinator and Clinical Lead recruitment are in progress. These resources will be working on the Digital Detailed Business Case.
Activity undertaken to expand access to HealthOne		Work continues in this space. Jack Devereux is a member of the PPSG HealthOne Steering Group
FPIM complete		FPIM is on track to go live 1 June 2021
Complete FAX end of life project by Q3		Resource constraint and project complexity has meant delay but the project is up and running with a new end date to be advised.

Delivery of Regional Service Plan (RSP) Priorities		
South Island Regional Alliance activity		
Continue to participate in the SI Cancer Service Reducing Inequities		Māori Health Leadership team continues to participate in the NZ Cancer Action Plan activities for the South Island Services
Delivery of Regional Service Plan (RSP) Priorities – Hepatitis C		
Provide education and advice on hepatitis-C for General Practice across Southern DHB, including rural sites		Continuing to have education sessions

Implementing the New Zealand Health Research Strategy		
Continued agreement with the University of Otago		
Policy and process development		

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Care Capacity Demand Management (CCDM)		
Governance - Completion of reports		Completed Bimonthly Report & loaded on SharePoint
Governance - Reports to partners		Completed via updates to CCDM Council and Patient Acuity/TrendCare meetings
Governance - Annual plan status reported		Work in progress to finalise CCDM Annual Plan including TrendCare and Allied Health by 30 April as per our annual planning cycle.
Governance - Monthly education reports		Completed via updates to CCDM Council and Patient Acuity/TrendCare meetings and line manager reports.
Governance - Reports on CCDM implementation		Reported via updates to CCDM Council and CCDM/TrendCare Steering group meetings. Updates to staff via monthly posters, SharePoint and at Local Data Councils
Governance - Local Data Councils meet		Reported against at CCDM Council; CCDM /TrendCare meetings; MHAID Steering group meetings and via monthly line manager report.
Validated Patient Acuity - Reports		Monthly Patient Acuity/TrendCare meetings continue
Annual DB TrendCare Business Rules review		TrendCare Business Rules are current and are due for review in June 2021 as per the CCDM / TrendCare Annual Plan.
Validated patient Acuity tool implemented for Allied Heath		Procurement process completed and preferred vendor for data activity tool identified. Business case near completion, implementation planning commenced
Allied health Core Data Set (CDS)		Allied Health CDS gap analysis completed. Further actions to be held pending work to implement data activity tool.
CDS report		PowerBI dashboard has moved into the production phase and should be available to staff by 30 June 2021. Demonstrated to CCDM Council in March. End of shift survey reports circulated to CCDM Council including Union partners, DON's, DOM.

Care Capacity Demand Management (CCDM) continued		
CDS stocktake		19 measures available on the PBI dashboard. An additional 2 measures are being captured in the End of Shift Survey on TrendCare; surveys were undertaken June and Oct 2020 and is scheduled again for May 2021. Due to a current vacancy and little variation in response rate and satisfaction, the surveys have not been done quarterly. Measures of 'extra shifts' and 'roster gaps' have not been automated on PBI as yet.
FTE Calculation – Data inputs collected		Completed in Q2
FTE - data entered		Data entry completed in Q2 for MHAID wards (8), Maternity wards (4) and 4 general wards. Data for some wards has been modified following feedback from CNM's / CMM's and from roster testing (see below).
FTE – Roster testing		Roster testing undertaken for the remaining 3 of the initial 4 wards. The remaining 16 wards have not had roster testing completed due to ongoing discussions & moderation and analysis to determine an appropriate deficit percentage for each shift.
FTE - Report drafted		No further reports drafted
FTE - Roster and FTE implemented		7.7 additional FTE from the 20-21 budget currently being recruited and new rosters being implemented across 3 wards. 1 did not require any change in FTE.
FTE - Variance monitored		Delayed until new rosters are fully implemented in those wards with additional FTE approved.
VIS tool implemented		Allied Health: VIS tool implemented in acute wards in Dunedin and Southland Hospitals. Discussions underway to determine how best to represent Allied Health indicators on CaaG screens Indicators and action plans developed in partnership with the 8 MHAID wards. Education undertaken in first 3 weeks of March and staff are beginning to use the tool. The remaining 3 wards have also begun to use VRM.

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Care Capacity Demand Management (CCDM) continued		
Variance response management –action plans reviewed		Wards with VRM in place have been reviewing plans annually.
Measurable reduction in variance, both positive and negative		Total number of significant negative shifts across the SDHB has ranged from 690 in January to 731 and 738 in Feb & March respectively. This is an increase of 166 on the previous quarter. The number of significant positive shifts this quarter ranges from 1182 (Feb) – 1229 (Jan) and 1253 in March a reduction of 118 on the previous quarter. This takes into account formal minimum staffing levels in MHAID wards but does not take into account minimum staffing levels required for safety especially on PM and N shifts in other areas or staffing required in high acuity areas e.g. HDU/ICU/NICU etc.

Annual Plan Reporting: Quarter 3 20/21

Minister of Health's Planning Priorities: Give Practical Effect to He Korowai Oranga – the Māori Health Strategy

Reducing Health Inequities The Burden of Disease for Māori		
Long term conditions		
Identify Māori aged 50 years and older by General Practice		
Undertake assessment using the WellSouth Call Centre, providing free GP visit and screening services, with referrals made as appropriate		
Respiratory admissions in children - The WellSouth PHN and Southern DHB Māori Health Directorate will establish a new service targeting respiratory admissions for Māori children age 0-4 years in Dunedin (EOA)		
Māori respiratory admissions identified		
Assessments completed		
Referrals made		

Māori Health Action Plan – Shifting Cultural and Social norms		
Te Reo Māori will be incorporated into the Southern Health website and strategic documents		

Māori Health Action Plan – Strengthening System Settings		
Māori representation and participation across South Island Alliance groups to progress and improve health equity		

Cardiovascular disease		
Māori representation and participation across SI Alliance groups to progress and improve health equity		

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Annual Plan Reporting: Quarter 3 20/21

Minister of Health's Planning Priorities: Give Practical Effect to He Korowai Oranga – the Māori Health Strategy

Engagement and Obligations as a Treaty Partner		
Reset the Southern DHB strategic direction of advancing Māori Health that incorporates and recognises Wai 2575 and upholds Treaty principles		The Southern DHB has engaged Synergia to support the development of a strategic refresh of our direction.
Southern DHB will enact Wai 2575 and the Treaty principles, into all operational policies and procedures, specifically Service Plans with a focus on Māori health priorities - Specific programmes of work identified and reported on by Q3		Additional equity investment solutions have been identified – for additional investment in Māori cancer and child/youth specialist positions designed in improve Māori health equity for our population. The Southern DHB is undertaking an independent review of mental health and addiction services. In Q3 this has included running three Māori mental health and addiction community consultation hui. The Chief Maori of Health has taken responsibility as the executive lead for mental health, addiction and intellectual disability services, aimed at improving theses services, leadership and reviewing long term mental health inpatients. In Q3 we have undertaken a review of our kaupapa Māori health provider contracts which aim to better align the DHBs strategic Māori health contracts to our DHB strategic priorities including long term conditions and navigation. CPHAC has produced a paper on water fluoridation for targeted communities.

Annual Plan Reporting Quarter 3 2020/21
Minister of Health's Planning Priorities: Improving Mental Wellbeing

Mental Health and Addiction System Transformation		
Placing People at the Centre		
Lived experience networks established in Waitaki and Central Lakes		Lived experience workshops held in Waitaki, Central Lakes, Dunedin and Invercargill as part of the Mental Health and addictions Systems Review.
Two listening groups are convened		Four listening groups were convened over this quarter.
HQSC programme milestones are met towards zero seclusion		Programmes continue to meet HQSC requirements
Embedding a wellbeing and equity focus		
Training sessions are held to ensure staff understanding of the refreshed guideline		Training sessions held for new nursing graduates and on line resources/documentation updated.
Increase access and choice of services across the continuum		
Training model revised		Nurse Educator for Mental Health Crisis Programme runs regular training sessions in base hospital EDs and is starting to extend training to rural based EDs.
Analysis and recommendations completed by the end of Q3		Timeline for completion of the Review has been amended will be undertaken over Q3 and part of Q4.

Mental Health and Addiction System Transformation (continued)		
Expand primary care services		
Report on activity- Health Improvement Practitioners, Health Coaches, Community Support Workers		Programme continues to be embedded across 16 general practices. Discussions are underway with MoH to extend the programme to other practices in 2021/22.
Public health actions		
Measure resiliency in Southern Youth – Action plan developed and implemented		While COVID has delayed the roll-out of this programme, the post COVID mental health issues have rekindled interest in it. It is being rolled out in participating schools in term two. Data from earlier surveys has been used by schools to make environmental adjustments aimed at improving student wellbeing.
Suicide Prevention		
Collection of suicide/self harm data		Data collected regularly and systematically by WellSouth. Data is used to inform discussions as part of monthly monitoring meetings between SDHB and the WellSouth Primary Health Network.

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Minister of Health's Planning Priorities: Improving Mental Wellbeing

Mental Health and Addiction System Transformation (continued)		
Workforce		
Workforce development on NLG agenda		A funding bid has been developed for consideration as part of the 2021/22 SDHB budget. Peer Workforce Development is emerging as one of a series of key themes in the DHB's Mental Health and Addictions System Review.
Work in partnership with workforce centres		Regular forums and contact with mental health workforce centres
Workshops designed and delivered Q2 – Q4		Progressing actions from the November workshop in relation to community based DHB MH&A staff potentially being co-located in the Te Kaika hub.
Peer workforce plan endorsed for implementation		Plan has been endorsed by the Network Leadership Group.
Assist kaupapa Māori organisations to respond to RFP for He Ara Oranga implementation		A new kaupapa Maori service has been commissioned as a result of a successful response to this RFP. Te Mahana was launched by Nga Kete Matauranga Pounamu Charitable Trust in March 2021
Forensic services		
Participate in New Zealand Forensic Advisory Group (NZFPAG)		Our forensic leadership team attended the forum this quarter.

Mental Health and Addiction System Transformation (continued)		
Commitment to demonstrating quality services and positive outcomes		
The number of Māori on Compulsory Treatment Orders is monitored and reduced		Following the review of the Southern DHB Maori Directorate Maori health staff have been allocated to the range of MHAID services, while maintaining a team base. Although many orientations to their respective new services have been interrupted by the COVID period, the majority are settling into their roles, and we hope with this approach we will achieve better integration and access to cultural care, particularly where Maori may present in crisis, and in the CMHT settings. MHA client numbers by ethnicity (including Māori) continue to be incorporated into SMO annual performance reviews to raise awareness of personal and relative numbers of Māori under the MH Act. While this data is subject to ongoing scrutiny and monitoring, the Zero Seclusion strategy group is also currently being re-energised, with a continued focus on the point of admission through the crisis teams and CMHT's, and emphasis on the quality of EWS and RPP's. It is hoped the combination of this focus and increased cultural access may help to reduce use of the MH Act at the point of relapse or crisis and/or during the course of their inpatient stay overall, but in particular for Maori. The DAMHS is undertaking a review of Maori who have been on section 29's for longer than 5 years.

Annual Plan Reporting Quarter 3 2020/21
Minister of Health's Planning Priorities: Improving Mental Wellbeing

Mental Health and Addiction Improvement Activities		
Improvement in number/quality of transition plans		Q3 status is 83% compliance
Supported decision-making prioritised		The Mental Health Advance Preferences/Statements (MAPS) group has been expanded to include representation from our Maori Health Team. Subsequently a series of hui have been held to design a Maori centred MAP.
Review of opportunities to support delivery of services as close to home as possible		Will feature as part of the Southern System Review for Mental Health and Addiction Services
Use of seclusion reduced		The clinical group overseeing this programme continues to work the HQSC and the various clinical areas to reduce the use of seclusion. This is challenging but the continuing trending down of average hours of seclusion episodes as well as the number of unique individuals is positive.
Single Session Family Therapy training delivered		The initial roll out of training for single session family training has been completed with plans now being developed for 2021. Focus continues on ensuring the needs of children and families are thought about at all levels of the service. The KPI Whanau Engagement continues to be reported to help identify gaps across the service. Family participation is collected and this data is looked at month by month to consider potential development. To further support improved outcomes, the plan to refresh CAPA in the Invercargill CAFS team is well underway with Champions identified, the team as completed a training audit and liaison with other services around the country is underway. Our NGO partner, ABLE continues to work alongside with a range of activities, including promoting resources and developing community networks.

Mental Health and Addiction Improvement Activities (continued)		
Single Session Family Therapy training delivered (continued)		The South Island forum to share learning experiences and ideas supporting good practice was held and ABLE and SDHB presented jointly on the work that has occurred.

Maternal Mental Health Services		
Implementation of Maternal Mental Health model of care		The final draft of the plan has been completed and is with the System Review Team for review as part of their considerations.
Maternal and mental health pathway developed and live by Q3		The final draft of the plan has been completed and is with the System Review Team for review as part of their considerations. Development of mental health pathways will be developed for subsequent use.

Addiction		
Social detoxification service at a local level is enhanced and expanded by the end of Q3		RFP for this service has been released to the market. Responses will be evaluated in May 2021.
NLG will develop a whole of system CEP workforce plan by Q3		Is under consideration as part of the SDHB Mental Health and Addiction System Review.
Māori Mental Health Staff have increased role within MDTs		Completed. Our Maori mental health team are now aligned within our MDTs.
Participation in development of National AOD model of care		Latest information available indicates that expected consultation by the MoH will occur in Q4.

Annual Plan Reporting Quarter 3 2020/21
Minister of Health's Planning Priorities: Improving Sustainability

Savings Plans – In Year Gains		
Pharmaceuticals		
Outlier providers have education and support to have reduced outlier status Q3 and ongoing		All resource has been allocated to COVID-19 immunisation response
Target initiatives progressively rolled out Q2 and ongoing		All resource has been allocated to COVID-19 immunisation response
Procurement and clinical supplies		
Monthly reporting against the workplan for FY20/21 targeted to deliver expenditure management benefits from clinical and non-clinical products/services		The procurement activity has continued. The forecast benefit delivery continues to be unfavourable to budget.

Management of workforce and annual leave		
Monthly reporting against plan		Mandatory training for all managers ongoing Leave reports are generated and available to managers on a monthly basis through PowerBI. As above, this is being managed closely by the Specialist Services team but due to travel restrictions the use of annual leave has not improved or changed. Holiday Act remediation work is progressing as per schedule of program.

Valuing Patients Time		
Ongoing monitoring and reporting to ELT in respect to VPT baselines and targets		Regular reporting continues to the Board on a monthly basis with a refreshed suite of metrics. A newly established Patient Flow taskforce is now leading this work.
Mental Health		
Implementation plan including model of care changes endorsed end of Q3		Savings target for the Mental Health and addictions Directorate has been achieved. System Review is making good progress with planned co-design workshops currently underway.

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Minister of Health's Planning Priorities: Improving Sustainability

Savings plans -Improved Out Year Planning Processes		
Draft 2021/22 Service Plans and Annual Plan & Budget completed by 10 February 2021		Draft 2021/22 service plans were prepared to support submission of draft 2022 Annual Plan and Budget to Ministry of Health on 5 March 2021
Develop analysis of population, services and workforce to improve understanding of demand for healthcare services now and into the future. The initial focus being on Southern DHB services and workforce which supplements the wider Health Needs Assessment – Workforce Plan Q3		Due to competing demands and resource constraints – focus has had to be on supporting the COVID-19 immunisation program of work.

Savings plans -Working with Sector Partners to Support Sustainable System Improvements		
DHB leadership involvement in Whāngaia Ngā Pā Harakeke (police initiative to reduce family harm)		
Evidence of strategies that support the improvement of health care in Puketai Care and Protection Residence		

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Minister of Health's Planning Priorities: Better Population Health Supported by Primary Health Care

Performance area – Diabetes and other Long Term Conditions		
Diabetes		
Number of diabetics referred into secondary care		Still developing our data intelligence to inform LDT.
Regular reporting to the LDT		
Targets met in line with national requirements by the end of Q3		Trend is improving but has not yet reached target.

Primary Health Care Integration		
Reports to ALT as per HCH collaborative		ALT has been terminated so no longer able to report to them. This project is now sitting with CEO and Maori Health Directorate to progress.
Concept designs completed Q3 for second two hubs		Complete. Te Kaika General practice plans for health hub are well progressed.

Pharmacy		
Support community pharmacists in their contracting with Southern DHB to deliver influenza immunisations for those over 65 years – reporting Q3		BAU

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Minister of Health's Planning Priorities: Improving Wellbeing Through Prevention

Antimicrobial Resistance (AMR)		
Whole of system approach to AMR		
Work with ARRC IPC team members re Multi-Drug Resistant Organisms (MDRO)		
Surveillance and research		
Active surveillance and review of data		
IPC surveillance		Ongoing
Infection prevention and control		
Active surveillance		
Antimicrobial stewardship		
Implement IV to oral switch programme		Implementation ongoing
Audits conducted		Audits ongoing
Pharmacists work with GPs		
Regular meetings of Antimicrobial Stewardship Steering Group		Updated TOR complete and approval from Clinical Council. New membership to be established Q4
Reporting to clinical governance and senior leadership		Under Development
Work programme for Antimicrobial Resistance (AMR) services		

Communicable Diseases		
Timely response to COVID 19 (Includes quality improvement plan) – ongoing activity		The rollout of the COVID vaccine has compromised existing resurgence planning. Work is being done to widen the pool of case managers in particular.
Notifiable Disease Surveillance Report released		Work is underway on this.

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Sexual Health		
Recommendations following assessment of district staff mix implemented		
Implementation of Syphilis plan		On hold, due to operational pressures and reduced manager resource to lead.
Regular updates on Syphilis Plan to the Sexual Health Steering Group		On hold, due to operational pressures and reduced manager resource to lead.
Recommendations implemented to reduce barriers for Māori young people to access sexual health services		
Establish a Sexual Assault and Treatment (SAATs) six month pilot (Sep 2020 – Mar 2021) to assess and treat historical assault/abuse presentations – clinic processes established and weekly clinics held		
Health pathways developed		
SAATs pilot evaluated/re-evaluated		

Environmental and Border Health		
Implement a quality improvement plan (developed in 19/20 year) for Southern DHB processes for issuing permits pursuant to Section 95 of the Hazardous Substances and New Organism Act 1996 for the use of 1080 and cyanide for the control of vertebrate pests- pathway developed		
Evaluate improvements completed		Unable to be scheduled until the VTA season starts which won't be until Q4
Engage with Te Ao Marama and Aukaha in relation to environmental health decision making		As a matter of routine we provide advice on resource consent applications that they had been asked to comment on. Work was done on Te Ao Marama to understand the views of the Southland Runaka regarding an intention to remove kaimoana from the recreational water MOU.

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Environmental Sustainability		
Energy Supply and Efficiency		
Collaboration agreement with Energy Efficiency & Conservation Authority (EECA)		
Reduce electricity through behaviour education campaign Q1-Q4		In development for completion in Q4
Waste		
Waste audit/stocktake		Waste volumes stocktake completed for Q3 – slippage in behaviour and treatment of waste and investigation underway.
Upgrade and standardise recycling facilities		Phased roll out
Behaviour education campaign on waste minimisation		Completion of action delayed to q4 - mitigation in place;
Travel		
Increase active transport for staff (cycling and waking thru education campaigns		
Procurement		
Develop sustainability criteria for procurement policies, tender documents and contracts		
Investigate high use of nitrous oxide (N20) at Dunedin Hospital		

Environmental Sustainability (continued)		
Built Environment		
Environmental sustainability Design Plan implemented Q1-Q4		Functional brief developed for NDH Design Team
ESD policy established		To be developed Q4
Engagement of staff and culture change		
Require all new policy and policies up for review to address principles of Green Healthcare outlined in Green Healthcare SDHB policy		Discussion with internal policy team to adopt practice for Q4
Green Healthcare Workshops		Ongoing – now BAU
Research links with others Q1-Q4		Not formally established, work in progress Q4
Promote strategy within the wider health care sector		Communications plan being developed q4

Drinking Water		
Facilitate stakeholder meetings with Iwi and Regional and Local Government in Southern District to address public health risks associated with Recreational water and Drinking Water quality.		No recreational water stakeholder meeting scheduled this quarter.
MOU signed		The need for a recreational water MOU is being revisited in the context of the National Policy Statement for Freshwater 2020 places the onus for monitoring and risk communication squarely on Regional Councils

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Cervical Screening		
Support from Navigators on patient continuum of care		
Southern DHB Cervical Screening Service to regularly engage with kaupapa Māori health services		
Identify/engage with key industries to promote cervical screening		
Steering group meetings regularly occur		On hold, due to operational pressures and reduced manager resource to lead.

Smokefree 2025		
Increase the number of secondary care referrals to the Southern Stop Smoking Service by taking an opt off referral approach in secondary care – report Q3		66 Referrals. These numbers are even lower.
Undertake an updated smoking prevalence analysis for the Southern District. Data will be disaggregated by ethnicity, locality and age		Work scheduled but has not yet started

Breast Screening		
Engagement with kaupapa Māori health providers		

Healthy Food and Drink		
Implement Healthy Food and Drink Policy in Early Learning Services, primary, intermediate and secondary schools		Eligible schools = 57 (decile 1 to 4; Māori+pasifika rolls > 35%; schools with need identified by MoE) Eligible ECE= 55 (EQI 1-4; Māori+pasifika rolls > 35%) Numbers are the same as for last quarter. Ongoing support is provided to develop and implement healthy food and drink policies. The Ministry of Health Healthy food and drink toolkits were just released and will be promoted in the next quarter.
Healthy food and drinks policy (HF&DP) clause appended to contracts		

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Minister of Health's Planning Priorities: Improving Child Wellbeing

Maternity and Early Years		
Engagement continues on development of Maternal, Child and Youth Health and Wellbeing model of care for the Southern district		Planning Day has not yet occurred
Pregnancy and Parenting course – incorporation of culturally appropriate content into the pregnancy and parenting sessions. Content developed with Pacific Trust Otago (PTO)		To be finalised Q4
Safe sleep policy implemented within SDHB		To be progressed Q4
Assess the Community Breast Feeding Support Service pilot located at Pacific Trust Otago to understand the challenges Māori women, Pacific women, refugees, and other women experience in establishing and maintaining breast feeding		Not reported
Hold a breast feeding hui with key stakeholders		Not reported
Recommendations made on increasing community based support		Not reported

Maternity and Early Years (continued)		
Work with WellSouth PHO Health Promotion team to support and enhance the Breast Feeding Peer Support programme		Not reported
WCTO providers to provide list of late referrers		Not reported
Contact late referrers		Not reported
Quality improvement project identified and undertaken following discussion at WCTO Quality Improvement Framework Steering Group meetings		Not reported
Review Southern Health He Hauora, He Kura Pounamu website to ensure information is up to date		Not reported
WCTO Steering Group meets quarterly		Not reported
Evaluation of PTO Community Oral Health Service outreach clinic		Unable to recruit dental therapist. Plan to commence in Q1.
Implementation of Maternal Care Child Protection Wellbeing (MCWCP) steering group recommendations		Implemented: New Midwifery Coordinators appointed, Terms of Reference and Memorandum of Understanding signed. Still in progress: Consistent documentation and data collection; MoU signed for all partners.

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Minister of Health's Planning Priorities: Improving Child Wellbeing

Immunisation		
Increase clinical governance to streamline Vaccine Preventable Disease (VPD)		
Vaccine Preventable Disease Steering Group (VPDSG) meets quarterly		
Quality assurance plan implemented		The plan will be progressed in Q4.
Immunisation data checking via NIR to support early enrolment with general practice		
Data checking by National Immunisation Register (NIR) team		
NIR advises general practices of unenrolled babies		
General practices refer unimmunised babies to immunisation outreach service		
Measles Immunisation Campaign for 15 to 29 year olds and active recall of children 5 to 14 years who have not had any or had only one measles, mumps & rubella (MMR) vaccine		
MMR vaccines delivered to target groups and data collection processes are in place		Work on hold due to COVID-19 vaccination programme. Will recommence in Oct 2021 as per MoH direction.
Evaluation processes established and information is collected		Work is in process

School Based Health Services (SBHS)		
Youth training tool in place and training of public health nurses commenced		On hold due to COVID19 vaccination programme. To recommence Q4.
School based health services delivered in decile 1-5 schools		
The Youth Service Level Alliance Team will meet no less than two monthly to monitor service delivery, identify gaps in service provision and make recommendations		
Quarterly MoH reporting on SBHS		To be reported Q4

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Minister of Health's Planning Priorities: Improving Child Wellbeing

Family Violence and Sexual Violence (FVSV)		
Regular attendance at Whāngaia Nga Pa Harakeke with the VIP coordinator		Not reported
Engagement with kaupapa Māori providers		Not reported
Draft plan for Elder Abuse		Not reported

FOR APPROVAL

Item: Primary Maternity Facilities – Central Otago / Wanaka

Proposed by: Rory Dowding, Acting Executive Director Strategy, Primary & Community

Meeting of: Board, 2 June 2021

Recommendation

That Board notes the work undertaken with Central Otago and Wanaka based midwives to design and agree core principles that will support the implementation of a sustainable model of care in new maternity facilities.

That the Board notes the increased estimated expenditure for the two unit model.

That the Board notes the project team have critically re-assessed the financial impact of a one unit model vs two unit model.

That the Board notes the project team's confidence to progress with the two unit solution and the level of support the current workforce have indicated.

That the Board notes the project team wish to progress with a two facility solution for Central Otago and Wanaka.

Purpose

1. To seek Board approval to progress with a two unit primary maternity facility solution for Central Otago and Wanaka.

Specific Implications for Consideration

2. Financial

- The model chosen for the new facilities relies on several existing funding streams, section 88 funding and some new investment from the SDHB. This new investment estimate figure has been revised from $173k to $648k for the two unit model.
- The expenditure estimate for the one unit model has been revised, with new investment required of $215k (previously zero).
- There is no change in the estimated capital outlay since the paper was previously presented.

3. Workforce

- Sufficient workforce support has been achieved to support the progression of this work.

4. Equity

- A two unit solution will help ensure increased and more equitable access for rural women to primary birthing support and care.

5. Other

- Next steps will include progressing with a Business Case for the capital build expenditure and an RFP process for selecting a service provider.

Background

6. On the 8th of December 2020 the Board noted the contents of the Decision Paper: *Where should we locate Primary Maternity Facilities in Central Otago/Wanaka* and conditionally endorsed the recommendation to proceed with implementing option 4 which locates primary birthing units at Wanaka and at Dunstan Hospital in Clyde.

7. The conditional endorsement read "this two unit model can only be sustainable if the DHB can work with local LMC midwives and other local providers to implement a workable model of care, which means that midwives deliver both the LMC care and the core midwifery services that are required to successfully support running the unit". It was noted that if this agreement cannot be achieved then there will be a need to further consider the single site options of either Cromwell or Dunstan.

Discussion

Workshops

8. To advance discussions with the current LMC workforce about the development of a model of care, four workshops were scheduled. Two were held in Central Otago and two in Wanaka. Facilitated by an independent facilitator, these workshops aimed to design a set of shared principles that the workforce would agree to working in a unit under. Twenty midwives were involved across the workshops.

9. At a high level the principles include:

- Agreement that a high quality service will be delivered by the units
- Acknowledgement that partnership with the workforce throughout the design and implementation is key to our success
- Agreement that it will be a midwifery led model
- Agreement that staffing levels will be safe and sustainable
- Agreement that rostering will reflect the skills of the different teams, both Core midwives and Case Loading Midwives
- Employment arrangements/ terms that contribute to workforce wellbeing such as level, pay parity with the MECA and MERAS endorsement

10. A full set of the principles are included as Appendix 4. These will be shared as part of the RFP process to select a provider for the units.

Matters arising

11. As part of the work to design and agree the principles (and subsequent further work) two key matters were raised that we would like to make the board aware of:

    Financial – The additional investment estimate figure has been revised from $173k to $648k for the two unit model:

    - The model of care proposed by the DHB project team included flexible rostering where the case loading midwifery team would provide some cover of the inpatient care within the unit. In workshops with the midwives, there were a range of views on the acceptability of some limited sharing of roles. To avoid the need for any flexible sharing of roles, there would need to be an increase in FTE. Without this increase to resourcing, some attendees could not see a role for themselves in the new unit, this is reflected in the post workshop surveys. In addition, the initial paper assumed insufficient leave cover for the caseloading midwife team. Feedback from the midwives at the workshops was clear that this leave needs to be amended to make the model sustainable. This changes to the model are significant and increased the estimated workforce expenditure by $445k (two unit total).

    - An increased overhead allowance has been estimated due to the previously mentioned workforce. Impact is increase in expenditure estimate of $89k.

    - Community Care costs were previously estimated at 30% of Section 88 revenue. The project team acquired improved information, including a MoH report that quantified LMC operating costs, which allowed for a higher quality estimate. Impact is reduction in expenditure of $98k for the two unit model.

    - An Improved estimate of the level of existing expenditure that will cease due to new operating model has favourable financial impact of $127k.

    - Depreciation costs were not included in the original paper presented to the Board. This adds $164k to the two unit model costs.

Risks that cannot be fully mitigated:

- Concerns were raised with the project team about risks that will still exist, despite new primary maternity facilities, due to the distance of our remote rural primary maternity services from specialist obstetric and neonatal care. These risks are inherent in having a significant birthing population living at distance from base hospital. There will still be unpreventable obstetric emergencies that will occur in our remote rural areas. This is noted throughout the work that has been undertaken to date with community members and practitioners advocating for consideration of specialist services located in the Central/Lakes region. Consideration of specialist services has not been within the remit of the Primary Maternity Strategy.

Post Workshop Survey

12. A survey was sent to workshop attendees to gauge their level of commitment and interest in progressing this work.

13. In response to the question "Would you like to continue to partner with the DHB to progress this work?" 94% answered yes. This represents 16 of 17 responses.

14. In response to the question "Can you see a role for yourself within a new facility that operates under the principles developed?" 82% responded yes and 18% responded no. This represents 14 yes and 3 no responses.

15. In response to the question "Do you support progressing with two units for the Central Otago/ Wanaka region?" 82% responded yes and 18% responded no. This represents 14 yes and 3 no responses.

16. Taking the above results into consideration along with the work undertaken throughout the workshops, the DHB project team have confidence that there is majority support in the current workforce for supporting two facilities and that midwives will want to work in facilities in case loading roles that require them to deliver both the LMC care and support running the unit.

Validation of costing estimates

17. Initial costings presented to the Board in December were estimates based on models of care that have not been tested within the Southern District Health Board. This model relies on integrating effectively several different funding streams and developing new ways of working. Similar models are in place in some areas in New Zealand, and our assumptions were based on the information we had at the time.

18. We have now undertaken enhanced consultation with key stakeholders in Central Otago. We have completed more detailed analysis using rosters that we developed and were presented at the workshops.

19. The updated workforce expenditure calculations have been validated by the DHB Finance team. The feasibility of the roster was not part of the finance assessment.

20. The capital cost has not been updated since previously tabled, noting discussions with NDH team confirming validity of previous estimates. If anything the existing estimates are thought to be slightly conservative.

21. Changes to Section 88 funding have yet to be confirmed by the Ministry of Health. We anticipate an increase to funding. This may offset some of the new funding we are seeking but we are not able to quantify this at this stage.

Reiteration of rationale for the Two Unit option

22. The largest and fastest growing birthing population in the Central Otago region are in the Upper Clutha area

23. Overwhelming feedback from the public consultations identified distance from a Primary Birthing Centre as the greatest risk. A single Primary Birthing facility for Central Otago and Wanaka will not sufficiently address this risk.

24. Women in the Upper Clutha are at greatest risk currently, as they are furthest from a base hospital (3.5 hours), and one hour from any Primary Birthing facility.

25. We need to make it safer for this growing population to birth in a supportive Primary Maternity facility, closer to home.

It is recommended:

26. **That Board notes** the work undertaken with Central Otago and Wanaka based midwives to design and agree core principles that will support the implementation of a sustainable model of care in new maternity facilities.

27. **That the Board notes** the increased estimated expenditure for the two unit model.

28. **That the Board notes** the project team have critically re-assessed the financial impact of a one unit model vs two unit model.

29. **That the Board notes** the project team's confidence to progress with the two unit solution and the level of support the current workforce have indicated.

30. **That the Board notes** the project team wish to progress with a two facility solution for Central Otago and Wanaka.

Next Steps & Actions

31. The next steps for this work include:

- Progressing to RFP for service provision. An Expression of Interest process was completed in January 2021 and there were three expressions of interest received.
- Development and approval of a business case for the associated capital spend. It is anticipated that this will be provided to the Ministry of Health by 20 July 2021 to progress through to the Capital Investment Committee in time for their 25 August 2021 meeting.

Appendices

Appendix 1 High Level Principles – Workshop Output

Appendix 1 - Principles to inform the model of care for a new facility:

1) **To sustain workforce wellbeing, employment arrangement must supply:**

- Advance/lead time on rostering
- Annual Leave
- Sick Leave
- Study Leave
- Education opportunities
- Mandatory education provided locally
- Pay parity with MECA or MECA agreement
- MERAS endorsement

2) **High quality service:**

- Purpose built facility
- Fit for purpose equipment and consumables for each employee
- Capable and confident midwives who are able to focus on and maintain a high quality of inpatient care
- Well connected with other maternal and child health services in the area
- Consideration is given to colocation with other health services
- Technology enabled – midwifery decision

3) **Partnership is key to our success:**

- Local midwives to inform Service Provider/RFP process
- Local midwives to inform Operating model
- Local midwives to inform Unit Design
- Community involvement in Design Processes
- Regular communication with stakeholders
- Agreed messaging at critical points

4) **Midwifery led model:**

- Midwife manager
- Midwife/Nurse staffed unit that maximises the midwifery positions
- Continuity of care is delivered, relationship with a primary midwife will be maintained
- Shared unit philosophy
- Agreed models of practice
- Clearly defined roles between midwifery manager and provider management

5) **Staffing levels will be safe and sustainable:**

- Caseload size in line with NZCOM advice
- Regular review points
- Appropriate job sizing
- Open and committed employer

6) **Rostering will reflect:**

- MERAS negotiated conditions
- FTE can be split
- Unit open a minimum of five days a week
- Rostering has the ability to adapt to the workforce
- Case loading team – ability to come together weekly
- Case loading team – can provide on call for the unit back-up
- Core – midwives only work every second weekend
- Core – equitable distribution of day and night shifts
- Core – night shifts are rostered in a 2/3 row

FOR INFORMATION

Item: Patient Flow Update Report May 20th, 2021

Proposed by: Patient Flow Taskforce

Meeting of: 2 Jun 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, 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

PATIENT FLOW IMPROVEMENT PROGRAMME

Month #4 Progress Update

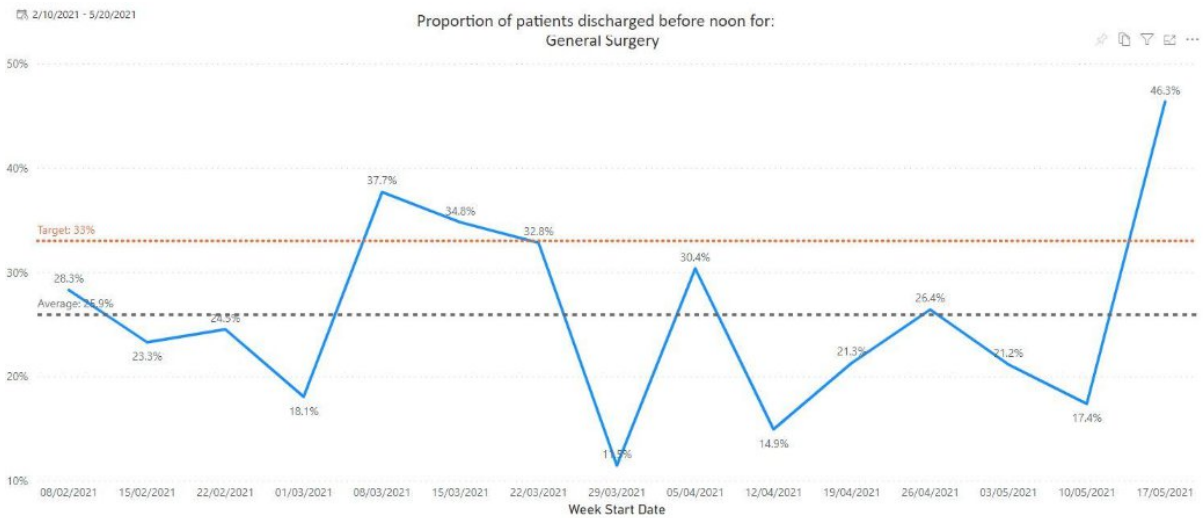
Summary of Patient Flow Taskforce activity to date:

- Comms/Engagement: Ongoing – weekly newsletters to staff outlining feedback, activity and the wins we are seeing in teams. The fortnightly stand-up open to any Executive and Directorate leaders and others to join is ongoing. A workshop (3 hours) has been booked for June 24th being led by the taskforce with the Ops/SLT management teams to work through a handover plan with them whereby the patient flow framework can become standard operating procedure.

- Wellbeing initiatives have ramped up further – free yoga and now barre base classes are on offer to staff alongside mindfulness sessions. The pulse checks got underway, and we have had two go out to staff so far, with an overall rating of 3.5 out of 5 on the scale of how people are feeling. The common theme around workload pressures, short staffing etc being evident.

- 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 2 clinical groups has been created and the links to these sent out to those groups. Further work has identified a need for more specific run-chart style weekly reports to be provided by ward and by service. The initial piece of work to create this off the data in the PowerBi dashboards is quite significant (x 21 reports a week). The request is with IS currently and this may be something we need to outsource initially for setup. Further an electronic whiteboard for radiology is also sitting in request currently.

Image below: Example of a run-chart style showing Dunedin hospital before noon discharges for General surgery.



- Significant current workstreams:

  - **Discharge Summaries**: A large piece of work that is underway being led by Nigel Millar working with Sue Smith and IS as well. An information gathering exercise has been done and the idea is to prototype a new version in one service or area first and work iteratively to get to a more streamlined version.

- **Transitions:** Several meetings have been had with ARRC teams to investigate and trouble-shoot the various issues with transitioning our older patients from hospital care into ARRC care. Issues regarding ACC, PPPR processes and pharmaceuticals are all elements that hold up transitions. Further work in these spaces is ongoing. A piece of work being led by the physio team to identify all patients over a month period that might be eligible for a transition type bed in the community is being undertaken, based on the hypothesis that there is fewer complex patients currently taking up hospital beds because of living alone but also not being able/ready/eligible for rest home care. The results of this audit will be brought back to the taskforce when ready.

- **Orthopaedic waitlist (OWL) programme**: Programme underway. Provision of a 6-week targeted exercise programme to those on the waitlist for surgery. This assists in ensuring patients stay more well when waiting for surgery and reduce the risk of having to delay surgery because the patient might not be fit enough.

- **Standard Operating procedures**: Further work in this space has occurred and previous written SOP's have been surfaced. These are being reviewed for relevance and updating.

- **Clinical criteria for Discharge**: refreshed training and resource pack had been developed and rolled out to clinical teams but limited embedding to date. Ongoing work needed here.

- **Rapid Rounds**: This is ongoing and whilst marked improvement has been seen, an issue was identified at the time of RMO rotation which occurs every few months. Essentially it disrupts the process significantly and so a process of proper ward induction for the RMO's is being worked on. RMO's need to be supported in their introduction to a ward by a senior clinician so they can bring all the relevant information to the rapid rounds.

- **Complex Care team**: this has been identified as an area that needs strengthening with more resource – currently only 1 person is dedicated to this, but with the rise in complex care and bariatric patients this is an area that will only have increasing need. A proposal has been drafted for ELT consideration as a first step.

Latest key metrics snapshots (as @ 20 May):

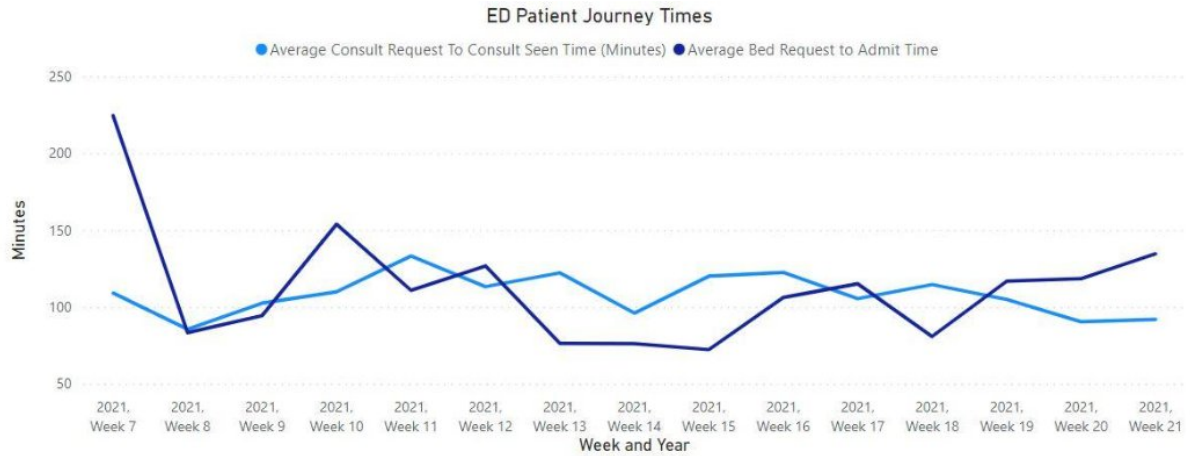


Fig 1. Southland: Weekly consult to bed request average times

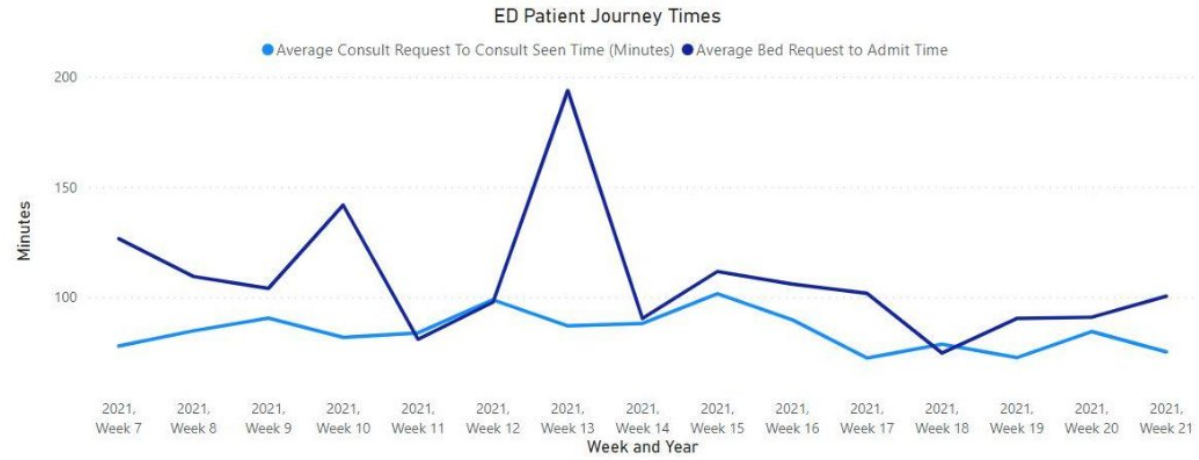


Fig. 2 Dunedin: Weekly consult to bed request average times

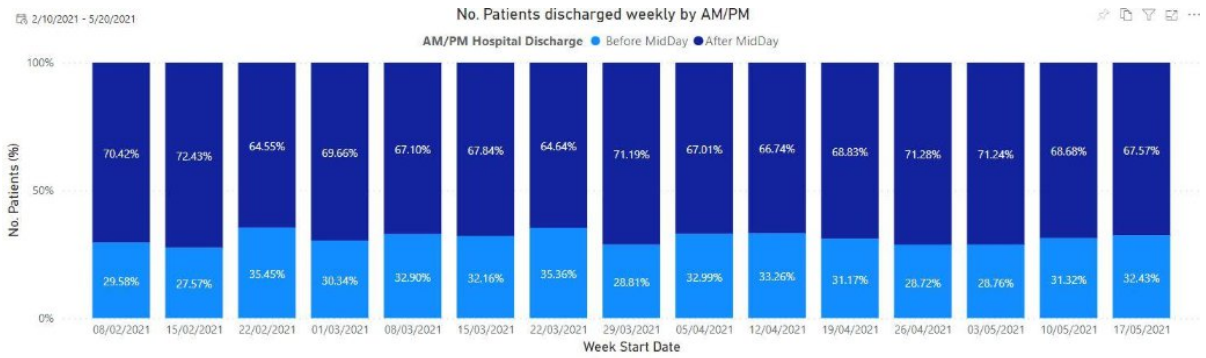


Fig. 5 Southland: Before Midday Discharges weekly average

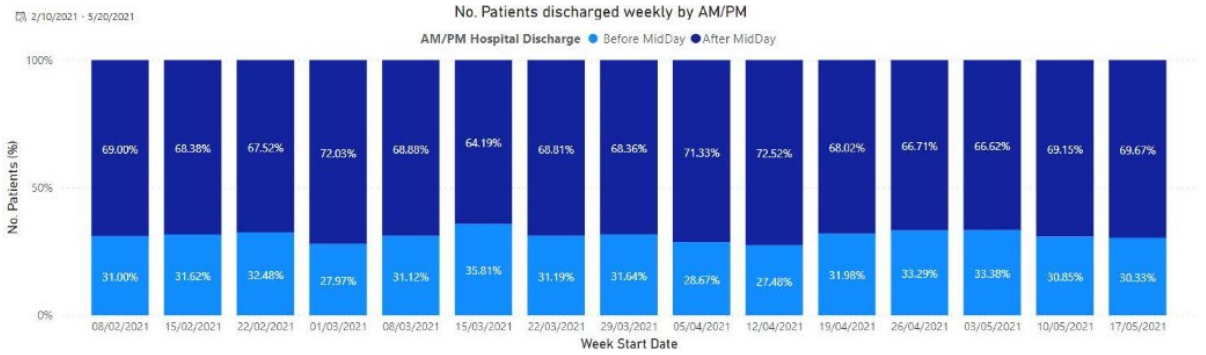


Fig 6. Dunedin: Before Midday Discharges weekly average

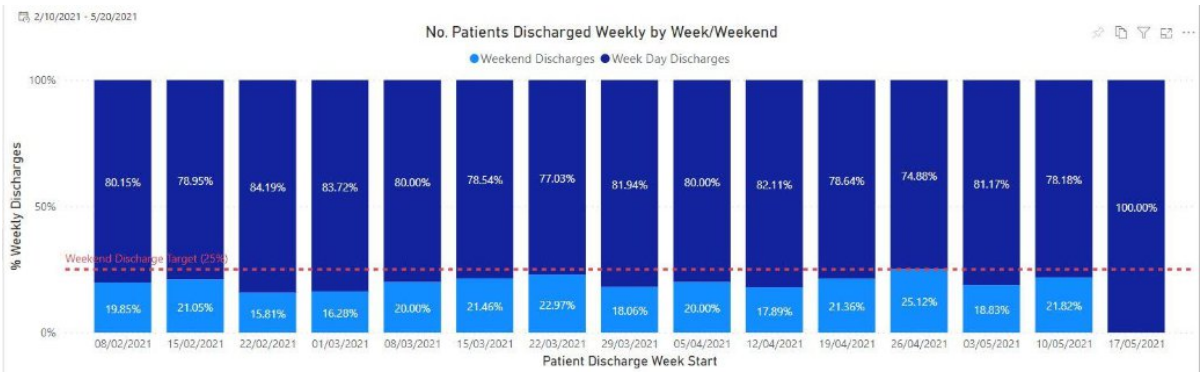


Fig. 7 Southland: Weekend Discharges weekly average

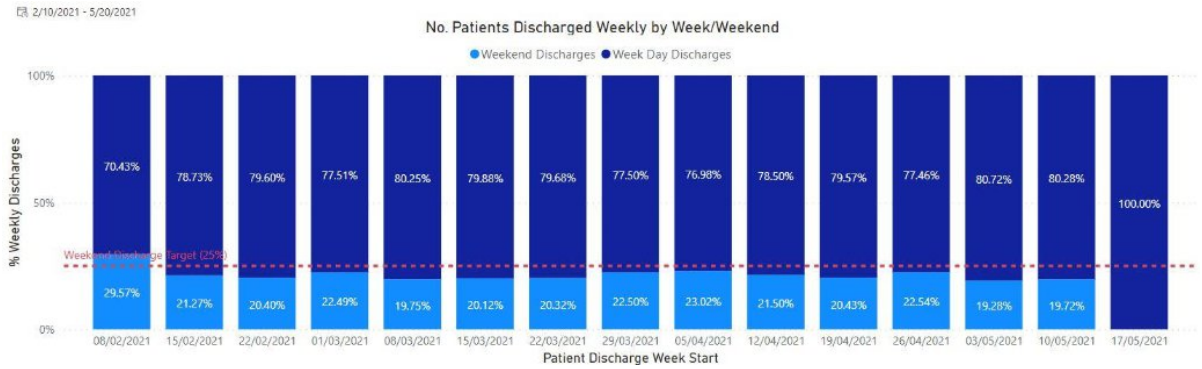


Fig. 8 Dunedin: Weekend Discharges weekly average

- **Next Steps:**

Transitions is ongoing and further work with the ARRC team is progressing.

Discharge Summaries is ongoing – this will be 6-month piece of work (approx.) and will need project support.

Complex care is ongoing as mentioned above.

Planning around how we move from the taskforce working so heavily in this area to the work being the standard operating of the management staff is beginning and a workshop has been scheduled as a first step towards this.

Ongoing work in the metrics space to get the data out to the clinical teams.

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

a) 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.

e) Constraints in IS team are slowing down throughput – extra screens on wards, run chart reporting etc.

f) Issue with the readmissions data has been flagged and a request to look at fixing this is underway.

Colonoscopy Report to 28 May 2021

The purpose of this report is to put some facts around the clouds of opinion that are circulating and to inform Board members of the current state of the Service.

Colonoscopy is required in several circumstances:

Symptomatic – subdivided into Urgent and non-urgent
Surveillance
Screening
Miscellaneous including for non-cancer indications

Most DHBs will "assign" Miscellaneous to one of the other three broad categories but SDHB does not – this is NOT the "old cat C in drag" – it does not contain cases that are symptomatic. This is regularly reviewed. The largest category in this Miscellaneous group is asymptomatic patients with a positive family history of bowel cancer. Whilst I personally think it's easier to have these all in the Surveillance category, it is NOT a hanging offence to have them in this additional boutique category as long as timeliness is met.

Review findings accepted by the Board are being implemented:

- No symptomatic patients in Staged or Planned category (the so-called cat C)
- All GI specialist referrals are accepted
- Electronic referral pathway is established
- The booking and recall system is substantially improved
- GI specialists are defined

In addition, work is in progress on other recommendations including regarding how the clinicians interact and communicate, how cancer services approach a positive diagnosis and so forth.

Timeliness:
This remains excellent for three categories – Symptomatic categories 1 & 2 and the Screening patients.

Surveillance remains behind on target times, but the improvements are significant, and it is expected the service will be meeting or exceeding timeframes by September/October 2021.

I cannot provide data on miscellaneous Staged /Planned but no concerns have been raised.

Whilst timeliness is important for all patients, as a generalization there is far less clinical risk for most surveillance cases than for symptomatic cases. For example, some surveillance is correctly scheduled for five years after the last colonoscopy and the clinical risk of being 4 months overdue is substantially less than being 4 months overdue on a Cat 1 symptomatic colonoscopy and so forth. To emphasize this in the last two years only two cancers were found at surveillance out of many hundreds of surveillance colonoscopies. Work is currently in action regarding what processes should occur when a concern about symptom development comes up regarding a patient on the Surveillance waiting list.

Referral Processes:
Referrals come from two sources:

1. Gastrointestinal specialists
2. Other

GI specialist referrals MUST be accepted for colonoscopy unless there is an overwhelming reason to discuss a change in the request -f or example if the health status of the patient had significantly deteriorated between the request and the proposed date of the colonoscopy. Should the Gastroenterology service strongly feel a different investigation may be clinically better my clear expectation is that a mature discussion between colleagues will take place, but at present this seems to be conducted predominantly via email. I continue to address this issue. There is a nuance in this as there are also some examples of colonoscopy requests being handled by flexible sigmoidoscopy, which is often perfectly clinically acceptable, but this should be discussed between the referrer and the gastrointestinal specialist who wishes to change the referral.

Note: Other medical staff can request a colonoscopy and have that request accepted as a GI specialist referral as long as the request is annotated as being on behalf of the Gi specialist. The e-referral system now makes this annotation much clearer.

“Other” refer to all referrals from clinicians who are not designated as GI specialists. Most of these are from General Practice. All “Other” are assessed against the National Direct Access Criteria. These criteria mean a referral can be submitted without the need for a Gastrointestinal or Surgical clinic review.

Direct Access referrals are triaged by a Gastrointestinal Nurse. Because this process is against the National Criteria the nurse triage process is binary – the referral either meets the criteria or it does not. Where it does not, the referral is then reviewed by another nurse, a gastroenterologist and a GI specialist surgeon. These three do this independent of each other; if any one of these three says the referral should be accepted it is accepted.

However, there are also other important steps that occur other than just “colonoscopy or not”.

Outcomes of the referral review are:

1. Scheduled for a colonoscopy
2. Insufficient information provided so more sought from the referrer
3. Scheduled for a clinic review (gastrointestinal or surgical)
4. Change the “best” test to a CT colonography or gastroscopy
5. Not required
    a. Cancelled by referrer
    b. Cancelled by patient (generally went Private)
    c. Asymptomatic and do not meet the nationally applied criteria for surveillance
6. Truly declined without further SDHB input at present (see below)

Timeliness of referral grading and of the review of those not immediately meeting the Direct Access Criteria is excellent. Almost all new referrals are triaged within 48 hours and the review process is completed on average within 5 days.

Decline Rate:

GI Specialist Referrals: To address historical issues of declining GI Specialist referrals we ruled these referrals will be accepted.

We have reviewed all concerns raised by Surgeons since 1 January and also reviewed all electronic referrals by GI specialists since the e-referral process for DHB based clinicians was introduced on 1 March 2021.

We have identified SEVEN referrals that were declined against the explicit "rules". However, two were rapidly identified as wrongly declined and colonoscopy was arranged. Interestingly in the other five, a second review by a surgeon and a gastroenterologist both felt the request was not necessary therefore whilst the wrong process was applied, it seems a logical review indicated the original referral was not necessary.

Direct Access (i.e. Not GI specialist referrals): Since mid-April we are now able to electronically track what happens to each referral. We do this on a Weekly basis.

We have robust data now from the week starting **18 April 2021 to end of the week ending Friday 21 May:**

I have summarized this here – it is for both sites combined.

In the five weeks from 18 April we have received AND completed the triage/review/ decision process on 634 referrals.

At triage (the BINARY process vs. Direct Access Criteria) 119 were "Declined". This 18.8% and is the oft-quoted example by some individuals of a terrible problem with access.

HOWEVER: the following then occurred:

- Six were cancelled either by the referring doctor or the patient themselves
- Nineteen were asymptomatic and the request was for Surveillance.
- Eight were already accepted for colonoscopy via the Bowel cancer screening programme
- Four were directed to CT colonography or gastroscopy
- 17 were scheduled for gastroenterology clinic review
- 9 were scheduled for a general surgery clinic review
- 8 referrals were returned to the referrer seeking more information to allow a decision to be made

Therefore, of the original 119 "declines" the "True Decline" (after all the triage and review processes considered in each case against the points above) is 48 patients. These are cases to whom the SDHB advised that no SDHB steps are necessary at this time. Cases referred to Clinics are automatically accepted.

Therefore, the True Decline rate is 48/634 is 7.6%.

This very thorough data analysis is now all electronically based and will be run each week allowing such an analysis to be monitored prospectively.

It will also allow far better analysis of any concerns as they arise.

It is vital to be clear: Colonoscopy is not without risk therefore careful consideration does need to be given to each request. Second, there will unfortunately always be cases where the decision was, in hindsight, incorrect, but this is the same for all DHBs. The key is to maximize our abiltiy to see the right patients as often as possible and minimize the need for regret in hindsight. We must also be clear that unnecessary colonoscopy of course uses a resource that another patient could access so the importance of consistent assessment of referrals is clear.

Note referrals of course arrive on different days of the week etc. and the figures above refer to all referrals where outcome is determined. At any one time there are referrals moving through the system. The rate of movement is pretty constant therefore the "awaiting decision" group often feeds into a subsequent week's completed figures. In other words, the data over time is complete.

Acute Presentations:
We are actively reviewing each acute presentation to see if any case was declined a colonoscopy or review preceding the acute presentation. This is an exacting and time-consuming process, but it is already raising important points. It is important to note we cannot answer every relevant question about these cases as yet. The Invercargill surgical service has separately reviewed all the acute presentations this year to date.

Current points of note:

1. Acute presentations in Invercargill are lower than anticipated
2. There are a number of younger patients

The younger patients are a concern as in the absence of a strong family history these cases may well be more likely than not to be considered at low risk of cancer and either not referred early or potentially declined if referred.

Data on acutes to date 01/01/2018 and 30/04/2021:

247 identified from clinical Coding, 81 excluded due to various things such as coded acute but were elective, presented when on holiday from another region etc.

This leaves 166

Of the 166, we have **identified 139 had not had any prior contact with or referral to SDHB bowel cancer services**. Of the remaining we have referral details on 26 (one missing)

- 21 had been referred to Gastroenterology services
- 5 had been referred to outpatient Surgical services

Note 2021 is only of course year to date. The approach is similar to the referral analysis above – "true decline" vs other services etc.

	Year				
	2018	2019	2020	2021	Total
No referral to SDHB	**43**	**49**	**29**	**18**	**139**
Ref to gastro service	5	8	6	2	21
Accept col	1	1	2		4
Accept CT		1			1
Accept CTC			1	1	2
Accept FS			1		1
Accept FSA	1	1	1		3
Accept gas		3			3
Declined	2	2	1		5
Pt admitted	1			1	2
Ref surg services	2	1	2		5
Totals	**7**	**9**	**8**	**2**	**26**

Col - colonoscopy
CT - abdominal CT (probably for investigation of weight loss)
CTC – CT colonography
FS - flexible sigmoidoscopy
Gas – gastroscopy
FSA - out-patients.

Note referrals were not specifically for a colonoscopy – referrals were to the gastroenterology service as a whole. We do not as yet know specifics about colonoscopy itself. This data of course does need a lot of analysis as timeliness to these events such as clinic review is not known. Given each of these 26 patients had cancer the benefit of hindsight says each would have benefited by a colonoscopy, but that considerable benefit of hindsight needs careful review alongside symptoms and details in the referral etc.

Given the above caveats it would seem likely that cases declined review and / or colonoscopy and then subsequently presenting with cancer are much lower than was the case when various reviews were done. However, I stress the data is still being dissected.

I believe the "true decline" numbers will be a bit higher than the five identified, but undoubtedly better than the historic levels of concern. It is important to note the Invercargill surgeons have concerns over some cases from 2021 although their total acute cancer presentation has fallen to only 7 this year, when they were reporting much higher acute numbers in previous years. The Invercargill cases from this year need to be looked at from the perspective of "true decline" vs another service in the DHB and of course if that decision was reasonable etc., but nonetheless it highlights the benefits (and need) to continuous monitor and reflect on all acute cases.

Bowel Cancer Screening

The purpose of Screening is to detect polyps before they turn malignant, to detect cancers at an earlier stage than would be the case if only symptomatic cases were offered colonoscopy and to achieve these things without adversely affecting the delivery of care to others. This latter point is the main bone of contention for some commentators and interested parties.

Bowel cancers are staged 1-4 with Stage one being best and stage four indicating the cancer has spread to other sites in the body (for example liver and lungs) Stage closely correlates with ability to cure. Finding polyps before they turn to cancer is a cure. Polyps are abnormal growths of bowel tissue – some of which will turn to cancer.

The key question is therefore whether or not the introduction of screening degraded diagnosis of colorectal cancer for symptomatic patients in SDHB? The answer in my mind is a resounding "no".

To 3 May 2021 the Bowel cancer screening program in SDHB has seen 2301 colonoscopies performed, all in patients with positive screening tests and has now detected 242 cancers. Of the first 230 screen-detected cancers (not all 242 yet have had definite surgery etc.), 32.7% were stage one (compared with only 11% in the symptomatically investigated patients). This is approximately 90 patients in Stage One who each have a 90% chance of cure because of screening. These Stage One cases also represent people unlikely to have met the Nationally agreed criteria for Direct Access colonoscopy as most were asymptomatic (see below)

Perhaps as important is the fact around 60-65% of cases in the screening programme have had polyps detected and of these a high proportion are now in surveillance which will materially reduce the chances of these patients developing bowel cancer. Essentially all colorectal cancers start as non-cancerous polyps so removal of these prevents cancer but new ones can grow, hence why follow-up is necessary.

What then if Screening was not introduced in 2018? I'm my view it is highly likely outcomes from colorectal cancer in SDHB would be significantly worse than they are now. For example, let us assume all 230 screen-detected cancers ultimately appeared in the symptomatic colonoscopy

categories 1 or 2 and apply a crude extrapolation of the maths from the symptomatic figures we have: it would mean only 25 of the 230 were still Stage One (i.e 11%) at diagnosis so the other 65 who were Stage One with Screening would have a materially worse outlook from the get-go.

Another issue is how many of the screened cases would have required a colonoscopy anyway? Some would undoubtedly have qualified for Direct Access scopes and I think it is reasonable to conclude a moderate proportion of those screened would have ultimately been referred for a symptomatic colonoscopy, but as noted above the proportion with higher stage cancer would have significantly increased and, in my view, the total number of cancers would have exceeded the screen detected total given the high detection of pre-cancerous polyps in the screened group. In other words, a lot more of those in the screened group would ultimately have developed cancer without the screening programme.

Did screening stop others getting a colonoscopy? I believe the answer is "no". My perspective has long been the application of the Direct Access criteria has been the major reason some cases were denied a colonoscopy when they needed it. The Direct Access criteria are rigidly applied and therefore if more capacity had been available for symptomatic colonoscopy I cannot see how access criteria would have been "relaxed" anyway. This is why we have driven the Review process.

Timeliness for symptomatic cases is very good both for Urgent and non-urgent cancers – a very high % are done within the mandated timeframes and those not done in the timeframes are not waiting much longer get a colonoscopy (in other words the overdue times are short and overdue volumes are low).

Growth in Colonoscopy Delivery

The table below is by Financial year (July 1- June 30) so note screening started in final quarter of 2017-18 FY.

It can be seen that service growth has occurred and I'd especially highlight the 2019-20 figures when of course we had the final quarter or so severely disrupted by Level 4 and 3.

1 July – 30 June	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Colonoscopy	2041	2325	2853	2750	3209
Flexi Sig	380	467	545	500	547
TOTAL	**2421**	**2792**	**3398**	**3250**	**3756***

* Represents 11 months, extrapolated figure for the full FY is estimated to be 4097

Historical Concerns have been acknowledged

As noted above, in my opinion, the historic major "delivery" issue at SDHB regarding colonoscopy has not been timeliness once accepted onto the colonoscopy waiting list - it has been acceptance onto the list in the first place. This is an issue the Endoscopy Oversight Group is grappling with and significant progress has been made; no, it's not yet perfect, but progress nonetheless.

The stringent application of direct access criteria was a major impediment to some patients obtaining a scope and this caused unacceptable delays in cancer diagnosis – well publicised cases are evident. Screening has actually removed this impediment for some patients (i.e. for all those screened) but more importantly the work of the Endoscopy Oversight Group has resolved to a large extent the issue of specialist GI doctors having their colonoscopy requests blocked.

Work to be Done
Work continues to increase capacity – a clearer picture of this is now at hand. This is a key issue going forward as there is a need to resource the colonoscopy service more effectively to allow for greater discretion on acceptance of referrals for colonoscopy. However, significant progress has been made on relaxing the stringent criteria by the introduction of a mandatory review process for any Direct Access referral that is declined on the entry criteria. And all GI specialist referrals are automatically accepted (and we actively monitor this). This has resulted in additional scopes being performed for symptoms vs. historical performance.

Options to further improve access for those not meeting the Direct Access criteria and by ensuring high resource-use include an additional gastroenterologist (or surgeon with ring fenced scoping capacity) at Invercargill, additional staffing to resource more sessions at Dunedin, improved access to CT Colonography and improved timeliness to First Specialist Assessment (FSA) especially in General Surgery for colorectal referrals. Growth in CT colonography capacity is required.

With regard to FSA timeliness, screening has likely helped as some of those screened would have had overt GI symptoms including rectal bleeding – these would have historically been referred for First Specialist Appointment therefore the fact that these had all had a colonoscopy as screening cases likely actually materially improves FSA planning in General Surgery (magnitude of impact is unknown, but even if still need seeing in a clinic, the fact they have had a colonoscopy and no cancer detected is a great aid in accurate prioritisation). Service sizing is a necessary piece of work.

Surveillance times need to improve further, but the DHB expects timeframes to be met by September/October. Surveillance is designed to detect polyps prior to cancer development and in fact in that last 24 months or so only two surveillance cases had a cancer detected – this is extremely good as it is impossible to have zero cancer risk. I understand both were “early” cancers.

Miscellaneous Work

- EOG and the CMO have discussed Quality reporting to feed back to individual clinicians their performance.
- Refinement of the at-risk Family referrals – especially as to where these cases are placed – i.e. into Staged/Planned or Surveillance categories
- Continued review of the Acute presentations
- Continued monitoring of Decline rates and processes
- The pathway from diagnosis to treatment

Andrew Connolly
Chair, Endoscopy Oversight Group
28 May 2021

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 Minutes b) Community & Public Health Advisory Committee ▪ 1 June 2021 Verbal Report c) Iwi Governance Committee ▪ 1 June 2021 Verbal Report d) Hospital Advisory Committee ▪ 3 May 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.
Presentations – Oncology and Mental Health Review	To allow activities to be carried on without prejudice or disadvantage	Sections 9(2)(ba) and 9(2)(j) of the Official Information Act.
Primary Maternity Facilities: Central Otago/Wanaka – Financial Assumptions	Commercial sensitivity	Sections 9(2)(i)
Contract Approvals ▪ Rural Hospital Agreements ▪ Off-site Teleradiology Reporting Services Agreement – I-MED NZ Ltd ▪ Outsourced Surgical Services - Southern Cross	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.
Capex – Region Wide Security Upgrade	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.
Digital Indicative Business Case	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.
Cyber Security	To prevent use of information for improper gain	Section 9(2)(k) of the Official Information Act.
Budget 2021/22	Annual Plan is not public until tabled in Parliament.	Section 9(2)(f) 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 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

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.