Southern DHB Board Meeting

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

03/08/2021 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, 3 August 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:

- Moana Theodore - Royal Society Te Apārangi Council removed
- Ben Pearson - 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	Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)		
	16.04.2021	Honorary Fellow, Royal New Zealand College of General Practitioners		
	16.04.2021	Fellow, New Zealand College of Public Health Medicine		
	16.04.2021	Wife, Alison Douglass, is a member of the Health Practitioners Disciplinary Tribunal		
	25.06.2021	Director and Shareholder, Kiwood Limited	Nil (farm forestry plot).	
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	Member, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company).	
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	
	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	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
	25.06.2021	Trustee, New Zealand Brain Tumour Trust		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
	12.01.2021	Nga Kete Matauranga Pounamu Trust Board Member		
Jean O'Callaghan	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	
Tuari Potiki	09.12.2019	Employee, University of Otago		
	09.12.2019	Chair, Te Rūnaka Otākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil, does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.123.2019	*Shareholder in Te Kaika		
	24.06.2021	Te Rau Ora Directorship		
	24.06.2021	Needle Exchange Services Trust (NEST) member		
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings Ltd	Corporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	~~15.01.2019~~	~~Member, Royal Society Te Apārangi Council~~	Removed 01.07.2021	
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	17.08.2020	Health Research Council Fellow		
Andrew Connolly (Advisor)	21.01.2020 (updated 02.06.2021)	Employee, Counties Manukau DHB. Currently seconded to Ministry of Health as Acting Chief Medical Officer		
	21.01.2020 (updated 02.06.2021)	Clinical Advisor to the Board, Waikato DHB		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	Advisor to Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020 (Updated 28.01.2021)	Chair, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		
	18.06.2021	Treasury: Health Reform Challenge Panel		
Benjamin Pearson (Crown Monitor)	21.07.2021	Consultant Paediatrician, South Canterbury DHB		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Hamish BROWN	25.02.2021	Portobello Maintenance Company	Nil, Body Corporate for residential area.
Kaye CHEETHAM		Nil	
Rory DOWDING	18.01.2021	Change Quest Ltd	Stepfather (Ross Hanson) and his trading entity (Change Quest Ltd) are at times employed as a contractor to SDHB HR Directorate
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 Health Services Ltd~~	Removed 28.06.2021.
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	28.06.2021	Director, Te Kura Taka Pini Limited	100% owned by Te Rūnanga o Ngai Tahu.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	

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
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	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)
Hywel LLOYD	16.06.2021	GP, Mosgiel Health Centre	
	16.0.2021	Wife, Nurse, Paediatric Outpatients	
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.

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
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	27.01.2021	Daughter, is a junior doctor in Auckland and is involved in orthopaedic and general surgery research and occasionally publishes papers	
	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.
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, 6 July 2021, 9.30 am
Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Pete Hodgson	Chair
	Prof Peter Crampton	Deputy Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	
	Miss Lesley Soper	
	Dr Moana Theodore	
In Attendance:	Mr Andrew Connolly	Board Advisor *(by Zoom)*
	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 Jenny Hanson	Director of Nursing, Medicine
	Ms Greer Harper	Principal Advisor to the Chief Executive
	Dr Hywel Lloyd	Interim Executive Director Quality and Clinical Governance Solutions *(until 1.05 pm)*
	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/Acting Executive Director MHAID
	Mr Nigel Trainor	Executive Director Corporate Services
	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.

2.0 APOLOGIES

There were no apologies. It was noted that Ms Hanson was deputising for the Chief Nursing and Midwifery Officer, who was on leave.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

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

5.0 MATTERS ARISING

Community Dialysis Chairs, Southland

The Executive Director Specialist Services (EDSS) reported that the dialysis chairs would be arriving mid-July and should be opened at the end of July 2021, subject to the Invercargill City Council granting consent for the plumbing work.

6.0 ACTION SHEET

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

Clinical Council

The Chief Executive Officer (CEO) reported that interviews for the new Clinical Council Chair were being held the following day.

Amenable Mortality Rates for Māori

The Chief Māori Health Strategy and Improvement Officer reported that he was recruiting an expert to undertake this work.

Water Fluoridation

The Chair reported that he had contacted the Otago mayors and would be meeting with Ayesha Verrall, Associate Minister of Health, by Zoom on 8 July 2021 to discuss water fluoridation.

It was agreed that the Chair would also contact the Southland mayoral forum chaired by Tracy Hicks.

Mental Health Inpatient Occupancy

The Board received a report on Mental Health, Addiction, Intellectual Disability (MHAID) Directorate inpatient occupancy (tab 5). The CEO advised that the target had been set at 100% and a more realistic target would be set for 2021/22.

7.0 ADVISORY COMMITTEE REPORTS

<u>Community and Public Health Advisory Committee</u>

The unconfirmed minutes of the Community and Public Health Advisory Committee (CPHAC) meeting held on 1 June 2021 were taken as read. Mr Tuari Potiki, CPHAC Chair, commented that:

- Water fluoridation would be an ongoing issue for CPHAC and Dr Beaglehole would be attending the Committee's next meeting;

- The Committee was keeping an eye on the number of GPs in the district and the primary care Māori enrolment rate.

Disability Support Advisory Committee

The unconfirmed minutes of the Disability Support Advisory Committee (DSAC) meeting held on 1 June 2021 were taken as read.

Disability Support Advisory Committee Terms of Reference

Dr Moana Theodore, DSAC Chair, presented recommended amendments to the Committee's terms of reference (tab 6.2).

It was resolved:

"That the Board approve the recommended changes to the Disability Support Advisory Committee's terms of reference."

M Theodore/K Crowther

Staff with Lived Experience of Disability

The CEO reported that Mr John Marrable had been appointed to a 0.2 FTE Disability Lead position.

Committee Membership

It was agreed that Dr Lyndell Kelly and Mr Terry King be appointed to the Disability Support Advisory Committee.

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 5 July 2021, during which she informed the Board that a range of issues were covered by the Committee, including resourcing of physical beds, improvements in day surgery and day stay admission, patient letter improvement, staff recruitment, enhanced generalism, caseweight delivery, colonoscopy, radiology strategy, and Specialist Services' financial position.

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 7) was taken as read. The CEO commented on his report as follows.

- *Financial Performance* – Further advice had been received from Pharmac since the report was written that would deteriorate the financial position by $2.5m.
- *Performance* – Planned care continued to be a challenge, particularly because of staffing shortages.
- *Top Five Risks* – This section of the CEO report would be updated following receipt of feedback from the Board's risk workshop.
- *New Zealand Nurses Organisation (NZNO) Industrial Action* – A ballot on further strike action was being undertaken.
- *Staff Shortages* – The CEO was concerned about staff vacancies, including those in Aged Residential Care facilities.
- *Southland Site Planning* – A medium and long term plan was required for Southland Hospital. The work being undertaken by Sapere would support the

long term plan (stage 3) and work was under way on some shorter term tactical projects (stage 1), which were included in the 2021/22 Annual Plan, eg expansion of the Emergency Department, a fifth theatre, and opening the 12 beds in the Assessment, Treatment and Rehabilitation (AT&R) Unit.

- *Southern Locality Networks* – WellSouth Primary Health Network and rural hospital trusts have been having discussions on locality networks within the Southern district, however the Rūnaka were not yet ready to engage.
- *Primary Maternity Facilities* – The Charlotte Jean Maternity Hospital had transitioned to the Central Otago Maternity Hospital.
- *2021/22 Annual Plan* – The final draft Annual Plan would be submitted to the August 2021 Board meeting.

Management responded to questions on the shortage of psychogeriatric beds, Southland Hospital facilities, the Māori workforce strategy, and the Violence Intervention Programme.

Southland Site Planning

It was agreed that management would draft a document clarifying stages 1 and 2 (short and medium term) of planning for Southland.

During discussion it was noted that a complete picture of the realities and future needs of the whole district was required, particularly for the handover to Health NZ, and that this would be informed by the work being undertaken by Sapere and the Strategic Refresh.

Cancer Services

The Board received a verbal update from Mr Connolly on colonoscopy services, during which he advised that:

- Southern DHB ranked in the top half, if not the top third, of best performing DHBs in the country in this area.
- The staged or planned colonoscopy category was being phased out over the next three months.
- Timeliness was excellent, particularly for symptomatic patients. Nursing shortages meant that surveillance had not progressed as far as wished but the waiting list was only about 20% of what it was 6-8 months ago.
- The integrity of the data had increased significantly.
- The additional resources in the 2021/22 draft budget for the service was welcomed by the endoscopy group.
- Agreement had been reached on how individual practitioner's quality performance data would be fed back as part of a collegial learning exercise.
- Recruitment of nursing staff was an issue.
- The decline rate was now down to 6.8%.
- The improvements made were a credit to the service.

The Board acknowledged the achievements that had been made and thanked Mr Connolly for his assistance.

COVID-19 Vaccination Programme

The Board noted the COVID-19 vaccine patient analysis dashboard appended to the CEO's report and requested that it continue to receive updates to monitor progress.

The Board noted with pleasure the quality of the COVID-19 vaccination rollout and extended its congratulations to staff.

Allied Health

The Board received a verbal update from the Chief Allied Health, Scientific and Technical Officer on Southland Hospital physiotherapy equipment storage and staff recruitment issues, and what was being done to address these.

Physiotherapy Pool, Dunedin

The Chair reported that he had received a letter from Neville Martin, Secretary/Treasurer of the Otago Therapeutic Pool Trust, requesting that the $100k per annum fee they pay to Southern DHB be waived while they did some fundraising.

The Board requested that management prepare a briefing on the physiotherapy pool for consideration at its next meeting.

9.0 FINANCE AND PERFORMANCE

Financial Report

The Executive Director Corporate Services (EDCS) presented the Financial Report for the period ended 31 May 2021 (tab 8.1) and commented on the major variances to budget.

The EDCS reported that the forecasted deficit for 'business as usual' (BAU) was still $15m and the additional unbudgeted costs for COVID-19, Holidays Act compliance and accelerated depreciation on Dunedin Hospital would bring it up to about $27m. There was a risk, however, that pharmaceutical costs (-$2.5m) and electives could deteriorate this position.

Management responded to questions on the financial results and FTE numbers.

Volumes Report

The volumes graphs (tab 8.2) were noted.

Quality Dashboard

The Interim Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) presented the Quality Dashboard for May 2021 and a report on the concerns raised by consumers through feedback processes (tab 8.3), then responded to questions.

Performance

The Principal Advisor to the CEO presented a report on the development of a Performance Dashboard (tab 8.4) during which she advised that it was a complex process but good progress was being made.

The Board requested that, if possible, national benchmarking information be included in the report.

Annual Plan Strategic Progress Report

The Board considered reports summarising progress towards achieving the strategic intentions in the 2020/21 Annual Plan (tab 8.5), during which:

- Management responded to questions on the Green Healthcare Strategy and phasing out the coal boilers in Southland;
- Concern was raised about the number of Specialist Services performance indicators with a red status, and it was suggested that the ED six-hour target become the next area to be focused on.

The CEO informed the Board that the Health, Safety and Welfare indicator would move from a red status as the Mental Health audit recommendations were implemented.

10.0 STRATEGIC REFRESH

A report of progress made, in collaboration with Synergia, on Southern DHB's Strategic Refresh was circulated with the agenda (tab 9) and taken as read.

Prof Crampton reported that the project was well under way and progressing well. He drew the Board's attention to the following key areas of focus:

- Mana whenua partnership
- Equity
- Localities
- Systems of care

Prof Crampton informed the Board that work would continue on:

- Developing the partnership relationship with Iwi
- Ongoing engagement with the sector
- Analysis of a large amount of data
- Thinking about how the work undertaken will be framed up and communicated.

Prof Crampton was thanked for his involvement in the Strategic Refresh work.

11.0 PATIENT FLOW TASKFORCE

The following staff from the Medical Team joined the meeting for this item: Dr Dion Astwood, Consultant, Kate Findlay, Allied Health Clinical Co-ordinator, Kathy Jansen, Charge Nurse Manager, Rachel Wallace, Discharge Planner (via Zoom), and Lucy Prinsloo, Charge Nurse Manager, Medical Ward, Invercargill (via Zoom).

A progress report from the Patient Flow Taskforce was circulated with the agenda (tab 12.2) and the Board received a presentation from the Medical Team (tab 16.1). This included an overview of Medical Ward rapid rounds in Invercargill and Dunedin, the benefits realised from this process, and the challenges they faced.

The Chief Medical Officer drew the Board's attention to the graph showing a reduction in *mean time from bed request to bed*.

In concluding the discussion, the Chair thanked staff for their efforts and reiterated the Board's commitment to the initiative and its ongoing desire to see progress.

12.0 MĀORI WORKFORCE DEVELOPMENT

The Chief Māori Health Strategy and Improvement Officer presented a paper on Māori Health workforce development (tab 10) and, subject to the support of the Iwi Governance Committee (IGC), recommended that a Senior Māori Workforce Development Manager be appointed.

During discussion it was suggested that:

- If the IGC does not support the proposal, it be brought back to the Board;
- The position be funded as part of "business as usual", rather than utilising the investment funds available to enhance equity initiatives;
- The Māori Health Directorate was under-resourced and the appointment of a Manager of Māori Health at Southland Hospital and a community based Māori cardiac nurse would add benefit to their team.

It was resolved:

"That the Board support the intent to appoint a Senior Manager Workforce Development to strengthen the future Māori workforce capacity across the Southern health system."

13.0 CLINICAL COUNCIL

An update on Clinical Council activities was circulated with the agenda (tab 12.1) and the Board received a presentation from the Interim Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) overviewing the Council's current and future activities (tab 16.2), including a summary of the "deep dives" it had undertaken into issues on the Clinical Risk Register.

During discussion, the Board:

- Noted that several clinical committees reported into the Clinical Council and requested that the Interim EDQ&CGS highlight any key issues that the Board should be aware of;
- Thanked the Interim EDQ&CGS for his presentation and noted he would be reporting to the Board bi-monthly.

14.0 STATEMENT OF PERFORMANCE EXPECTATIONS 2021/22

The 2021/22 Southern DHB Statement of performance Expectations was circulated with the agenda (tab 13) for the Board's review.

It was resolved:

"That the Board approve the 2021/22 Southern DHB Statement of Performance Expectations."

15.0 NEW DUNEDIN HOSPITAL CHANGE PROGRAMME

The CEO presented an update on the Transformation Programme required to meet the investment objectives of the new Dunedin Hospital Detailed Business Case (tab 14).

It was noted that the report was being further developed and would be a standing Board agenda item.

It was resolved:

"That the Board:

- **Note the update;**
- **Approve the draft status**
- **Note that further updates will be dashboard based."**

PUBLIC EXCLUDED SESSION

***At 1.05 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda**.**	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 5 July 2021 Verbal Report b) Hospital Advisory Committee ▪ 5 July 2021 Verbal Report c) Community & Public Health Advisory Committee ▪ 1 June 2021 Minutes d) Iwi Governance Committee ▪ 1 June 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 – 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.
Contract Approvals ▪ MBIE and ACC Revenue; WellSouth Primary Health Network ▪ Age Related Residential Care, Respite Services, Long Term Support Chronic Health Conditions, and Short Term Palliative Care ▪ Pay Equity – MHAID and Health of Older People	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 Requests ▪ Medical Assessment Unit ▪ New Sterile Services Supply Unit in Oncology Building – Additional Costs	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
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.

P Hodgson/T King

The Interim Executive Director Quality and Clinical Governance Solutions 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 3.55 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 26 July 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	Further refinement date now indicated and work is progressing.	~~August 2021~~ October 2021
July 2021	(Minute 8.0)	If possible, national benchmarking to be included in reporting.	PA CEO	National benchmarking is able to be included. The Team are exploring which datasets are available and would be appropriate to include (Health Round Table or Health, Quality Safety Commission data for instance).	
Feb 2021	**Southland Site Planning** (Minute 9.0)	Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed.	CEO	Will not be completed by September. Target date will be discussed and agreed with Sapere	Sept 2021
	(Minute 8.0)	Document to be drafted setting out stages 1 and 2 (short and medium term).	CEO	Complete and included in Board pack for 2 August meeting.	Complete
Nov 2020	**Amenable Mortality Rates for Māori** (Public excluded 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.	CMHSIO EDSP&C	Report included in agenda pack. Complete	August 2021
March 2021	**Māori Workforce** (Public excluded minute 15.0)	Board to be provided with staff ethnicity data, if possible by profession, directorate, and recruitment rate.	EDP&C	The HR Dashboard now reflects the Māori workforce breakdown. This information is being pulled out to report to the Board	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
May 2021 June 2021	**Quality Dashboard** (Minute 8.0) (Minute 6.0)	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. Completion date to be supplied for adding calibration points and staff information to the dashboards.	EDQCGS EDQCGS EDP&C	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.	 October 2021
June 2021	**Community Dialysis Chairs, Southland** (Minute 5.0)	Board to be advised of opening date.	EDSS	Update 21 July 2021: ▪ The chairs have been delivered. ▪ The plumber will be on site the week of 26 July 2021 to install plumbing and pumps for the dialysis units. ▪ Building and Property are still awaiting consent for the additional hand basin. They are following up with the Invercargill City Council (ICC) regularly and will advise as soon as consent has been received. The consent from the ICC is the only issue that is now preventing the service from commencing. We have asked our Building and Property colleagues to visit with the ICC to encourage them to progress with this as soon as possible and to advise whether it would be beneficial for one of our Executive to visit with them to request that the consent is worked through as soon as possible.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
June 2021	**COVID-19 Vaccination** (Minute 8.0) (Minute 8.0)	Numbers to be reported by age, ethnicity and gender. Board to be provided with ongoing reports.	PD DHD PD DHD		
July 2021	**Water Fluoridation** (Minute 6.0)	Chair to contact the Southland mayoral forum chaired by Tracy Hicks.	Chair	Complete	
July 2021	**Physiotherapy Pool** (Minute 8.0)	Briefing on the physio pool to be prepared for the next meeting.	EDCS	Paper included in agenda pack.	Complete

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) MEETING, 2 AUGUST 2021

6.1

- Verbal report from Tuari Potiki, CPHAC Chair

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC) MEETING, 2 AUGUST 2021

- Verbal report from Moana Theodore, DSAC Chair

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 5 July 2021, commencing at 9.00am in the Board Room, Level 2, Main Block, Wakari Hospital Campus, Dunedin

Present:	Mrs Jean O'Callaghan	Chair
	Dr Justine Camp	Committee Member *(by zoom)*
	Dr John Chambers	Committee Member
	Hon Pete Hodgson	Board Chair and Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member
	Dr Moana Theodore	Committee Member
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Simon Donlevy	General Manager, Medicine Women's & Children *(by zoom)*
	Ms Jenny Hanson	Acting Chief Nursing & Midwifery Officer
	Dr Hywel Lloyd	Acting Executive Director Quality and Clinical Governance Solutions
	Mr Gilbert Taurua	Chief Māori Health Strategy & Improvement Officer and Interim Executive Director Mental Health
	Mr Patrick Ng	Executive Director Specialist Services
	Dr Nigel Millar	Chief Medical Officer
	Ms Kaye Cheetham	Chief Allied Health Scientific and Technical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Rory Dowding	Interim Executive Director Strategy, Primary and Community
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting. A special welcome was extended to Dr Hywel Lloyd, Acting Executive Director Quality and Clinical Governance Solutions, Ms Jenny Hanson, Acting Chief Nursing and Midwifery Officer and Mr Simon Donlevy, General Manager, Medicine Women's and Children. An opening karakia was provided by Mr Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer/Interim Executive Director Mental Health.

2.0 APOLOGIES

Apologies were received from Board Advisor, Mr Andrew Connolly and Mrs Jane Wilson, Chief Nursing and Midwifery Officer.

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. Dr Lyndell Kelly requested that her interest as a member of the NZ Brain Tumour Trust be added to the register.

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 3 May 2021 be approved and adopted as a true and correct record of the meeting."

5.0 MATTERS ARISING

There were no matters arising that were not already included in the agenda.

6.0 REVIEW OF ACTION SHEET – INFORMATION PAPERS

The Committee considered the information papers attached to the Action Sheet and the verbal update from the Executive Director, Specialist Services (EDSS), Mr Patrick Ng. An update was provided on the provision and challenges with Positron Emission Tomography-Computed Tomography (PET-CT) and it was noted that there are no known publicly provided PET-CT facilities in New Zealand.

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

The Committee considered the report and the verbal update provided by the EDSS.

A summary of the next actions was provided:

- There is to be a focus on the day of surgery admittance versus day surgery at Dunedin Hospital. There may be an opportunity to provide more day surgery in Dunedin Hospital.
- HAC is to be provided with the number of resourced and physical bed numbers for Southland Hospital. The report for HAC is to include the figures for Dunedin and Southland Hospitals and include Mental Health beds.
- An update is to be provided on the current state of Aged Residential Care by the Interim Executive Director of Strategy Primary and Community (EDSPC).

The Quality and Improvement Manager, Mr Patrick O'Connor, joined the meeting at 9.37am.

Letters Process (tab 5.2)

The Committee considered the report and the verbal update from the Acting Executive Director Quality and Clinical Governance Solutions (EDQCGS), Dr Hywel Lloyd and the Quality and improvement Manager, Mr Patrick O'Connor. The challenges with rationalisation of the template letters due to compatibility issues with IPM were outlined and the advice from the Information Technology (IT) team is that the work be undertaken as part of the Patient Information Care System (PICS) project in late 2021/early 2022. The Committee expressed concern at a further hold-up with the process around letters with on-going concerns from

patients around content and timeliness and requested that the matter be progressed prior to the next meeting.

A summary of the next actions was provided:

- Rationalisation of the template letters is to commence immediately.
- Equity is to be a consideration as a recognised part of the process.
- HAC is to be provided with an update on a proposed service by service approach and what can be achieved ahead of the commencement of the PICS project.
- The report to the September 2021 HAC meeting is to include the actions taken to date in relation to progress with the letter improvement process.

The Quality and Improvement Manager left the meeting at 9.53am.

Recruitment Update (tab 5.3)

The Committee considered the update on recruitment to long-term vacancies and the verbal update by the EDSS. In discussion the following was highlighted.

- The challenge with recruitment to nursing vacancies across the district.
- The Acting Chief Nursing and Midwifery Officer, Ms Jenny Hanson, advised that Southern DHB is working closely with the Southern Institute of Technology and the Otago Polytechnic on "Return to Nursing Programmes".
- In relation to Physiotherapy vacancies, the Chief Allied Health Scientific and Technical Officer, Ms Kaye Cheetham, provided an update on the challenges, with a large differential between salaries in private and public. An update was provided on recruitment successes to some of the 8.5 FTE vacancies for Physiotherapists at Southland Hospital. Other steps taken to mitigate the staff shortage included outsourcing and providing assistance from Dunedin staff.
- The need for HR to keep a focus on vacancies and be proactive and aware of upcoming retirements and resignations and undertake advance planning for recruitment.
- The CEO advised on the nationwide shortage of nurses in aged residential care facilities – believed to be 750 FTE at the current time. He also advised his concern with surgical beds closed in Dunedin currently with staff shortages and the impact of the closing of the border due to COVID-19, which has impacted recruitment.
- The pay parity issues for nursing between Australia and New Zealand and also between the public health system in NZ and Aged Residential Care facilities in NZ.
- Recruitment strategy, mitigation and proactive approaches and processes and the need to commence discussions with staff in key roles who are close to retirement age. Utilise a "grow your own" approach.
- The need to be more innovative with models of care, using health care assistants and a team based model, particularly in a ward environment.
- Suggestion that SMO appointments could be made prior to them finishing their training and be dependent on them meeting certain criteria.
- An update was provided on the work progressing with Kia Ora Hauora in terms of growing the Māori Health workforce and the training incubator programme.

The Board Chair advised the need for flexibility with recruitment and to look at what can be done locally to grow the workforce. The Otago Polytechnic has increased their nursing student intake from 110 to 135 and the Southern Institute of Technology has increased their nursing student intake from 90 to 150 this year.

The Polytech has undertaken to increase student numbers further if instructed to by the Ministry of Health (MoH). Both institutes advise the need for good quality clinical placements during training and Southern DHB needs to be part of that solution.

The EDSS responded to concerns raised around the outsourcing of recruitment.

The importance of Human Resource (HR) staff ensuring correct process for Visa requirements for overseas applicants was highlighted.

A summary of the next actions was provided:

- Hamish Brown, Project Director Dunedin Hospital Development and Transition Support and the Dunedin Hospital New Build team to present to HAC on the work they have done around workforce modelling for the future.
- The EDSS is to work with Tanya Basel, Executive Director People and Capability, to present to the HAC on a regular basis on the wider recruitment processes, including equity requirements being met.
- The Clinical Chiefs are to advise on how flexible Southern DHB is being in terms of providing good clinical placement opportunities.

It was resolved:

"That the Hospital Advisory Committee recommends that the Board have a focus on the recruitment processes and look at the wider issues such as growing the workforce, having good clinical placements and encouraging clinical services to have a five year workplan that includes workforce."

Enhanced Generalism/Medical Assessment Unit (MAU) (tab 5.4)

The Committee considered the report on enhanced generalism and the Medical Assessment Unit and noted the verbal update by the EDSS advising that it was anticipated that the decant would be completed and the build commenced in approximately two months. An update was provided on the challenges with the decant process, reflected in the risk register attached to the report. The Board Chair requested clarification in order for the Board to be in a position to approve expenditure related to the MAU and a discussion is to take place at the Board excluded session of the meeting on 6 July 2021.

7.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director of Specialist Services Report

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

Equity

An update was provided on the equity working group and the workplan included in the report. The EDSS requested members' feedback on the presentation "Equity in Outpatients", put together by the working group and included in the report. The presentation is to be presented to all clerical teams running outpatient services and is intended to raise awareness of equity issues. Work is being done to "normalise" equity reporting across all services and this will be reflected in the HAC report. Committee member, Dr Moana Theodore, is to forward documentation to the EDSS relating to Māori experiences with the health system and barriers to service and

unable to attends (UTA). Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer (CMHSIO), acknowledged the work done by equity champion, Janine Cochrane, General Manager, Surgical Services and Radiology and advised on the reduction in Southland UTAs through the employment of a 0.5 kaiawhina, focussing on that area. The Board Chair acknowledged the work being done and the importance of the equity work being rolled out through mainstream services. In response to Committee member, Dr Justine Camp, the CMHSIO advised the need to look at the provision of Pacific services in Dunedin and confirmed that a recruitment process is underway for kaiawhina services in Dunedin, taking the learnings from the progress made in Southland. Discussion was held on the success of the Cancer Co-ordinator/Navigator roles, with very few UTAs in the Oncology area. The CMHSIO advised that it is hoped that the triage tool used for cancer services can be adopted for use in other areas. A request was made for the Iwi Governance Committee (IGC) to receive a copy of the equity information and presentation.

Surgical Performance - Case Weight Discharges (CWD)

The EDSS provided a verbal update on CWD performance against plan and responded to members' queries. He advised on the high cost impact when elective activity is postponed at peak times due to acute demand.

Outpatient Performance ESPI 2

The EDSS provided a verbal update on ESPI 2 Outpatient Performance and work being done with the relevant specialties to address breaches.

Inpatient Performance ESPI 5

The EDSS responded to a query around Theatre capacity at Dunedin Hospital noting the expansion of capacity at Mercy Hospital and outsourcing to Timaru Hospital. Some low acuity capacity will also be sourced through Queenstown commencing in December 2021. It is expected that the timing for the additional Theatre in Southland will be known in two months' time. The EDSS advised that intervention rates data indicate there is some fine tuning that could be done and this will be investigated and reported back to the HAC. The Interim Executive Director Strategy, Primary and Community (EDSPC), Mr Rory Dowding, advised that discussions are being held with Specialist Services in terms of requirements for next year, taking patient need into account. There is a risk of losing Theatre Nurses to private providers.

Emergency Department (ED)

The EDSS provided a verbal update, noting that his report should be updated to include the word "Daily" on the right hand column of the tables on page 13 (Average Daily Presentations). An update was provided on the benchmarking work completed by Ernst Young at Southland Hospital. Their report is currently being drawn up and it is believed that it is likely to indicate the requirement for an increase in treatment spaces from 21 to 26. Any suggested changes will improve flow and have a positive impact on the 95% target. Clarification was provided on the reference to Ambulatory Sensitive Hospitalisations (ASH) in the first paragraph on page 14 of the EDSS report.

Radiology

The EDSS provided a verbal update.

Oncology

The EDSS provided a verbal update on the key areas being worked on within the Oncology services and responded to queries. He highlighted the importance of recruitment, the benchmarking work underway and processes for outsourcing. Discussion was held on the merits and challenges for patients and their whānau with outsourcing to Christchurch. The EDSS advised that travel is funded for a support person to accompany the patient and work is being done with the Community Health Council to ensure the best support possible is being provided for the patient and their whānau in line with the agreed approach. A survey will be undertaken to assess the outsource experience for patients and their whānau and where improvements can be made.

Colonoscopy

The EDSS provided a verbal update, with a particular focus on the new section included in the report related to 'colonoscopy decline rates', and responded to members' queries. Wait times are not currently included in the report. A brief discussion was held on staffing and recruitment within the service.

Financial Performance Summary

The EDSS presented the Specialist Services financial results (tab 6.2) for the month of May 2021, outlined the contributing factors to the adverse $1.9M variance for the month and responded to members' queries.

An update was provided on the potential recruitment of a Neurosurgeon with an offer made. The challenges with recruitment in this area were outlined and it was noted that the position is a joint role with both Southern DHB and the University of Otago (UoO).

***It was resolved**:*

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

CONFIDENTIAL SESSION

At 11.30am the CMHSIO provided a closing karakia and 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:*
Previous Public Excluded Meeting Minutes	*As set out in previous agenda.*	*As set out in previous agenda.*
Executive Director of Specialist Services Report *1. Faster Cancer Treatment*	*Feedback is provided in confidence.*	*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: 3 August 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) meeting month the Chief Executive report assumes Board members would have reviewed the CPHAC 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 four papers on the agenda under finance and performance:

- Finance report
- High Level Volumes
- Performance Dashboard
- Quality Dashboard.

Financial performance for the month of June is a deficit of $5.222 million compared to a planned deficit of $3.088 million, and hence an unfavourable result against plan for the month of $2.134 million. Provisional year end results are therefore $28.405 million deficit against a planned deficit of $10.917 million, resulting in a year to date deficit against plan of $17.488 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 $19.344 million compared to a planned deficit of $10.917 million, so an adverse result of $8.427 million. The result for the month was extremely disappointing and impacted materially by the following factors.

- The result is slightly worse than we were expecting with very adverse result associated with Pharmaceuticals caused by high costs being incurred in the month of June as well as a wash up by Pharmac in June for 2019/20 results of $1 million, and a further claw back of additional funding provided for Covid related pharmaceutical impacts of circa $1.7 million (in addition to that previously advised and withdrawn).
- Personnel costs are particularly concerning**,** with nursing FTEs still being considerably higher in April through June. This is still being investigated.
- Outsourcing of additional planned care activity in the month of June also had a detrimental expenditure impact of circa $2 million.

The adverse results were partially offset by being able to recognise additional planned care revenue.

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

- Total case weighted discharges were down 17 or 0.4% for the month compared to the plan, and up 1,157 or 2.04% year to date. For the full year medical is 1,251 or 6.1% ahead of plan, maternity 557 or 10.6%, but surgery was 651 or 2.1% behind plan.
- Raw discharges are up 271 or 5.5% for the month against plan, and up 2,452 or 4.2% for the full year. 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 429 or 13.5% below planned levels for the month and 7,899 or 20.4% below plan year to date. It should be noted that the plan of 38,690 beds is based on 100% occupancy of the 106 beds. At 30,791 this represents an average occupancy of 79.6%. It should be noted that bed days are marginally lower than the previous year at 20,941 which is 99.5% of last year.

The Performance Dashboard update has been included as a separate agenda item (item 008.5), there is still a lot more work required on this. This should be read in conjunction with the high level volumes reporting which will be incorporated into the dashboard in due course.

2. Top Five Risks

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 This category also captures outcomes from delays in care such as is being experienced in Oncology and previously Colonoscopy, Urology etc	Need to improve feedback loop and extend to near miss events Southern has developed a track record of addressing significant issues, however, has not historically been utilising information effectively enough to

		ensure that they are forward looking to identify emerging issues in a more timely manner
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, information technology (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	Delegation 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

Further strike notice was received on 14 July for a full withdrawal of labour from 11:00am Thursday 29 July to 11:00am Friday 30 July. The strike notice was withdrawn on 16 July.

4. Appointment to Chair of the Clinical Council

I am pleased to announce that Dr David Gow, Neurologist, has been appointed as the new Chair of the Clinical Governance Group. David joined Southern DHB in 2014. He had previously been a consultant at the Salford Royal in the United Kingdom (UK). In his role in the UK, David developed local clinical governance structures, led directorate level clinical governance groups, sat on divisional risk and assurance committees, and introduced safer ward round processes. He was also the Clinical lead for Neurology which had a catchment area of 4.5 million people. David had an outstanding understanding of Clinical Governance and a vision for what the Clinical Council should be which I am sure he will share with the Board in due course.

5. Aged Residential Care (ARC) Registered Nurse (RN) Workforce

Aged care facilities continue to struggle with RN staffing and continue to notify the DHB when contractual obligations cannot be met. Mitigations are put in place, but the stress on the staff is significant. Our ARC Nursing Workforce Steering Group has been actively seeking and following up on actions to address the issue including:

- Identifying internationally qualified nurses (IQNs) in Southern who might be interested in the Competency Assessment Programme (CAP) course
- Providing information for those IQNs about how to access the CAP course
- Ensuring all DHB RN recruitment considers the flow on effects on the aged care sector
- Showcasing positive attribute of aged care to new RN graduates
- Reviewing how new RNs are mentored in ARC.

The ARC Nursing Workforce Steering Group has excellent participation from the ARC Sector, tertiary education, Southern DHB, and the Chief Nursing and Midwifery Officer's office.

6. Aged Residential Care Bed Availability

Bed availability in aged residential care continues to be problematic, exasperated by the RN shortage.

Waiting Lists for Aged Residential Care as at 30 June 2021 were:

	In Hospital	At Wrong Level in ARC	At Home in Community/ Hospice	Total
Psychogeriatric Care (D6) District	3	4	1	8
Hospital Level Care (Dunedin)	7	4	3	14
Hospital Level Care (Southland)	1	0	0	1
Secure Dementia Care (Southland)	7	1	2	10

Southern DHB and Canterbury DHB are collaborating to better understand drivers of high utilisation of psychogeriatric beds in both DHBs compared to other NZ DHBs.

7. Surgery

Elective surgical delivery continues to face significant challenges, primarily caused by nursing vacancies which is impacting on the higher elective case weight cases being completed (as these require multiple night inpatient stays). It has been reported to us that day surgical cases are being substituted where possible to ensure that theatres remain productively utilised. We have commissioned a piece of analysis to confirm that theatres are continuing to be productively utilised (theatre utilisation should be maintained at circa 82-85% irrespective of whether they are used for elective surgery or acute surgery), and our focus needs to be on recruiting nursing into key locations (including the surgical high dependency unit (HDU) and the surgical wards) so that elective surgical delivery is compromised as little as possible. To this end a meeting was held between the Human Resources team and the Operations team to agree on a recruitment campaign with the aim of attracting more nursing outside of our graduate recruitment cycles to minimise vacancy gaps as much as possible.

The Chief Nursing and Midwifery Officer and the Executive Director Specialist Services (EDSS) will engage in this process as well to work on maximising all opportunities to recruit. This will become increasingly relevant as the Care Capacity Demand Management (CCDM) rosters are progressively agreed to and implemented.

For the first two weeks of July circa 813 case weights of surgery were delivered. Although the current year plan has not been finalised it will be similar to the previous years' plan. The plan for the same period last year was 863 case weights suggesting that we have under delivered against plan by circa 5.5% year to date. This is concerning, but it should be noted that most DHBs are being adversely impacted by demand pressures placing huge strain on ability to deliver planned care.

Work has also occurred on initial modelling to demonstrate that additional acute surgical capacity would create a net financial benefit. The surgical team is proposing an additional 28 hours of acute surgical capacity (one session run longer Monday to Friday by four hours plus a Saturday shift). The EDSS has assisted the team to develop an initial model to determine the costs and benefits associated with supplying this additional acute capacity. On the basis that the additional capacity is utilised to the same extent as the existing theatre lists are (circa 85%), which requires that short notice elective cases are used to 'top up' when acute demand does not require the additional capacity, and on the basis that, because we are obliged to deliver acute surgery, the opportunity cost of not supplying sufficient acute capacity is the cancelled elective cases which must then be offset by outsourced elective surgery (which is budgeted for in outsourced clinical services), then ultimately completing more elective surgery in house means less elective surgery delivered as outsourced. Allowing for the surgical and perioperative staff required to complete surgery in house, we would need to recruit more of these staff onto our rosters but the total cost of delivering surgery internally (excluding implants and prosthesis) is circa one-third of the cost of private surgery. This has been worked up on the assumption that acute patients do not require additional inpatient beds, and that, as we are completing their surgery faster their length of stay will be reduced and the length of stay reductions can be cycled into the additional elective cases this will enable us to complete.

There is a little more work required to finalise the model but the financial savings and quality and safety benefits (particularly completing acute surgery within clinically indicated timeframes) are likely to be compelling. The ideal way to implement additional acute capacity is to recruit additional staff to provide additional roster coverage. This is likely to take time and will impact upon the timing of the benefits occurring. Our next step is to work out a phased model that realistically sets out when the staff can be onboarded (and when these costs will be incurred) and when the additional capacity can kick in. Pragmatic phasing is likely to involve staffing and running the Saturday list first and then systematically introducing the additional Monday to Friday capacity. Once the modelling has been completed, we will seek endorsement from our Executive Leadership Team colleagues, but it will be planned in a manner that allows it to fund itself from the savings achieved by completing more in house and less externally.

8. Outpatient (ESPI 2)

Key focal areas include orthopaedics, ear, nose and throat (ENT) in Southland, and gynaecology in Southland.

Orthopaedics' use of the prioritisation tool in Dunedin has assisted the service to drop from a peak of circa 240 breaches in April to circa 150 breaches currently and the service is continuing to manage the rate at which referrals are accepted whilst applying consistent outpatient capacity to continue to bring the breaches on the waiting list down.

Per earlier reports, the ENT service in Southland has accumulated a backlog due to carrying vacancies in the service over a number of months with only occasional locum support available. With Dunedin now having recovered their ESPI performance and with the recent start of a Southland ENT surgeon a combination of redirection to Dunedin and the application of the Southland surgeon to the wait list is now being applied to reduce the long waits on the wait list. Another surgeon is due to start in Southland in the coming months which will mean that the service is fully recruited to.

The gynaecology service has had recent success with recruitment and has reduced their breaches from a high of 229 in April to 165 currently. The service is concerned that the underlying capacity to complete all outpatient activity, including first specialist appointments (FSAs) is insufficient to manage the ongoing demands on the service and has been utilising the prioritisation tool to assess what the underlying capacity is within the service compared to the referrals being received into the service. An analysis of the initial data that has been captured from the use of the prioritisation tool will be undertaken in the coming weeks.

9. Inpatient (ESPI 5)

Our most significant challenge (and therefore core focus) for inpatient surgical recovery is in orthopaedic surgery. Work is occurring to finalise the recovery plan in July. The plan will continue to focus on utilising South Canterbury to delivery circa three surgeries per week, targeting the outsourcing budget to the early part of the year so that revenue earned from COVID recovery (across all services) can be targeted towards additional orthopaedic surgery outsourcing at the latter part of the year (which will also be aided by the Southern Cross Hospital in Queenstown coming on stream in either December or January). Given the disruption to orthopaedic surgery if there is insufficient nursing or cancellations to prioritise acute surgery it is sensible to try to permanently increase the rate of outplaced or outsourced orthopaedic surgery at both hospitals within the confines of the available budget and we will incorporate this thinking into our planning.

10. Radiology

June radiology results appear to be a marginal improvement on May, with a computed tomography (CT) 42 day target result of circa 67% across the district and a magnetic resonance imaging (MRI) result of circa 45%. Key to improving CT performance is the installation and implementation of the second CT scanner. Building work continues to be on schedule to be completed at the end of July and the arrival and installation of the scanner is tentatively scheduled for 9 August. Recruitment is underway for the additional staff required to operate the 0800hrs to 1700hrs Monday to Friday shift on the new CT scanner. Site visits are underway in support of the procurement exercise for a second MRI machine, with the last site visit scheduled to occur on 9 July. The intention with the site visits is for the vendor to confirm that their machine will be able to be installed within the confines of the space that is available in the radiology service.

A new vendor (i-Telerad) is now providing after hours radiology services. There were risks associated with the transition from the old provider (Everlight) to the new provider, but the programme manager has managed these well and the new service is now operational. The new service provides enhanced functionality and prioritisation capabilities and will also result in a lower overall cost for this service.

11. Emergency Department (ED)

ED presentations for the first two weeks of July are up on the month of June. In Dunedin, average daily presentations were 120, in July they were 123. Presentations were up more significantly in Southland in July, with average daily presentations at 119 compared to 111 in June and a longer term average of circa 107 presentations per day. On one exceptional day in Southland the ED saw 149 presentations. The high presentation numbers have further translated into higher admission numbers which in turn has led to inpatient bed occupancy frequently running in the 90s for Dunedin and mid 90s or above for Southland. Some relief is available for Southland as additional inpatient beds have been budgeted for in 2020/21, and the site Acting General Manager is currently assessing how the additional bed capacity can be best utilised.

Work has continued on the business case for Southland, with the benchmarking work now concluded and high level pricing work completed for two ED expansion options (one within the footprint, into the co-located fracture clinic space as originally planned, the other into the ambulance bay outside the current footprint of the hospital). The case can now be written in a fully completed draft and tested with the CEO prior to going further. Initial meetings have now occurred with the Programme Manager employed by WellSouth to develop their after hours services business case as the same manager is formulating our combined programme of work which will investigate and progress with options to reduce the ED presentations that could otherwise be redirected to primary care.

12. Oncology

Work continues on the oncology work programme. We are now consistently outsourcing four radiation oncology first specialist appointments (and subsequent treatment) to St Georges in Christchurch, utilising our contract. In the coming 6-12 months (whilst we recruit for additional radiation oncologists) it is likely that we will need to outsource at an average rate that is closer to six per week. We have signalled this to St Georges, but they have indicated that they need more certainty before they are prepared to commit to additional volumes. We are working on a longer term forecast that will provide this certainty at the moment, but we have also engaged with Ikon, the second (unsuccessful respondent to the request for proposal (RFP) process) about also taking some of our volumes and have sent a test cast to Ikon. Assuming that the processes work and the experience is positive we will look at utilising them as a second provider to assist us with managing the overall demand placed on our service during times when we aren't able to provide sufficient capacity to match demand.

We have discussed the potential scope for a 10 year strategy for our oncology services with senior members of Te Aho o Te Kahu – Cancer Control Agency and have determined an overall approach with our preferred consultant for the engagement. The overall approach will focus on reviewing how our services compare with the other centres and determining the immediate resourcing and service decisions that need to be made to allow us to compare with our peers. This approach will deliberately step away from devising a 10 year strategy, forecasting growth in demand and proposing new / contemporary models of care, as we believe that work being undertaken by Te Aho o Te Kahu will provide this direction. If we ask our consultants to work in these areas it will extend the brief and therefore the cost of the engagement, and it will risk moving us in a direction that is inconsistent with any future national direction that is determined by Te Aho o Te Kahu. We believe this approach will get the balance right and we will also ask that the work is completed in a regional context. This should allow both ourselves and the future Health NZ to understand where Southern DHB's radiation oncology service sits relative to others and what the immediate priorities are, beyond the 2021/22 workforce investment we are about to make.

We have confirmed a hire into the reporting role which will allow us to start investigating all 62 day 'breaches' more thoroughly so that we are appropriately identifying when the patient has either chosen to delay their treatment or there is a complex plan required. We believe that better and more consistent use of the reason codes (which requires more effort to be put into investigation) will result in our reported faster cancer treatment 62 day result aligning more closely with our peers.

13. Gastroenterology

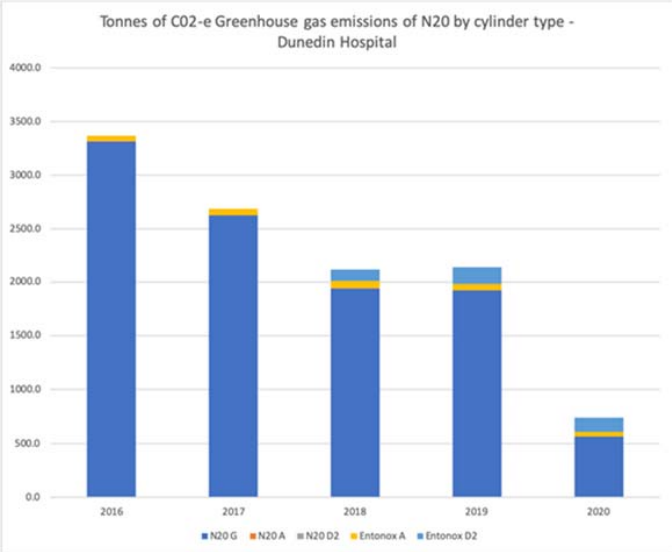
Good colonoscopy performance has been achieved in the June month with symptomatic urgent, symptomatic non-urgent and bowel screening targets being achieved across the district. The Southland surveillance wait list still needs to be caught up and the team are working to utilise all available session capacity in Southland and to send surveillance scoping to Dunedin when capacity allows as part of the plan to recover this remaining wait list within the coming months.

14. Environmental Sustainability

Reduction in Nitrous Oxide (N20) Usage

In 2016 we used a large amount of N20 at Southern DHB mainly due to large G cylinders supplying our piped to wall outlet N20. Since then our facilities team have pressure tested the pipes which showed no leaks. Testing of some of the wall outlets in our operating theatres suggested they may be leaking, so they replaced all the seals in the wall outlets in theatres. It has been confirmed through analysis that the time between changing manifold banks of the G cylinders had increased significantly after the seals were replaced, and usage

has significantly decreased with 56 G cylinders being used in 2020 compared to 308 in 2016. This resulted in a massive reduction in N20 usage (shown in the graph below) – approximately 2,600 tonnes C02 equivalents – about the same as a Toyota Corolla driven 15 million km (167g C02/km). This has also resulted in a saving of approximately $150,000 per annum. The next step is to expand the outlet tests to other locations. We now are using N20 at a level that puts us in the middle of the road compared to other DHB whereas we used to be a complete outlier – so this is great! We owe a debt of gratitude to Dr Matt Jenks who has spent a considerable amount of personal energy getting to get to the bottom of the problem.



Boiler Conversion

Nigel Trainor, Executive Director Corporate Services, is working with Pioneer Energy and the Energy Efficiency and Conservation Authority (EECA) to progress a case for funding the conversion of the coal boilers at both Dunedin and Southland Hospitals to wood biomass. There is funding available through EECA to undertake this activity which will be a real boost for carbon reduction. The two biggest carbon challenges we have had are the boilers, and the Nitrous Oxide use so it will be a great achievement if we can eliminate both of these.

Transport Pool Vehicles

Work is to commence on how we convert the remaining car fleet from fossil fuel to electric vehicles.

15. Mental Health, Addictions and Intellectual Disability (MHAID) Directorate

Ahuru Mowai Forensic Step Down Beds

After many months of planning and preparatory work this facility, based in Mosgiel, opened on 16 June. The opening, attended by leadership and staff from both the MHAID Directorate and Pact, was very successful with many positive comments about the home-like environment. Planning for the first resident, currently in Ward 9A, to stay is well underway.

Health Quality Safety Commission (HQSC) visit

The service invited the HQSC to visit Southern to help progress the three projects

- Zero seclusion: safety and dignity for all
- Connecting care
- Learning for adverse events and consumer experience (LAECE)

Our aim was to proactively engage, talk about what we are doing and what more we could be doing learning from their experiences in other DHBs.

The project teams found the visit particularly helpful both in terms of reinforcing that projects overall are progressing well and taking on some of the learnings for the HQSC team.

Tourism Recovery Fund – Psychosocial Mental Wellbeing Recovery

A collaboration group including Southern DHB, WellSouth, Queenstown Lakes District Council, Southland District Council, Central Lakes Family Service and Mana Tahuna has been meeting with a focus on mental wellbeing recovery. More latterly Southland District Council have been invited to join the group. The focus on the group is psychosocial mental wellbeing recovery-the group meets regularly to monitor use of services, support communication and wellbeing initiatives. Priorities have been identified on the basis of information collected i.e. small business/employees, youth, migrants, elderly and new mothers. A blueprint has been developed to establish a process for supporting the community (identify what is needed, what is available, procurement and measurement of outcomes). A workshop is planned mid-July to confirm the process.

Collaboration to Transform the Way in Which Mental Health and Addiction Services Are Delivered

A contract is now in place with the Ministry to support collaborative system design that involves all stakeholders to support the implementation of He Ara Oranga mental health and addiction system transformation. This contract includes funding for DHBs to expand and support the implementation of system changes and will intersect with the implementation of Independent Review of the Southern Mental Health and Addiction System when this review is finalised.

RFP – Community Based Withdrawal Service

We received two proposals for consideration by the close off of the RFP which was 21 May 2021. The evaluation panel subsequently met to discuss and score the proposals against the pre agreed criteria.

The panel had a number of further questions related to the proposals that have subsequently been asked and answered. The panel have scored one provider reasonably higher than the other and are scheduled to meet on 25 June 2021 to agree a preferred supplier.

Both proposals have indicated a cost of service delivery which is beyond the budget available and we are proposing to approach the preferred supplier for their "best and final offer" for service delivery.

We are still aiming to have a new service commissioned in September 2021.

Aggression in the Workplace

The main area of concern at the moment is Ward 9b on the Wakari site and the Inpatient Mental Health Unit (IMHU) in Invercargill. There are two main contributors to aggression:

1. Acute admissions mostly substance affected. Anecdotally, drivers are increasing supply of methamphetamine and other illicit substances due to borders opening with Australia and the number of Australian deportees (501s) setting in the district and being more organised in their illicit substance sale and supply however hard to quantify but monitoring situation.
2. The '14 patient group' of people with severe mental illness and distress causing aggression who are unable to be moved and are mainly inpatients within ward 9b. Feedback from staff on ward 9b is for more Personal Protection Equipment (PPE) to protect arms from scratches and bites. Jackets are being ordered, but also require changes to uniform policy (will be done retrospectively as staff are able to wear sleeves under uniforms), physical changes to ward environment to enable more quiet space and

separation of people and the additional staffing which has now been signed off will assist with people feeling safer.

Feedback from the IMHU is different as this is more about proactive treatment and overcapacity which is being addressed at a medical and Multi-Disciplinary Team (MDT) level.

Data is currently being gathered for Ward 10a in relation to aggression in the workplace, staff injuries and staff safety and how that relates to the security presence on the ward funded by the Ministry for two patients in two different time periods.

A number of injuries have been sustained during the process of restraint of late. The Safe Practice Effective Communication (SPEC) trainers are reviewing these incidents to ensure correct holds and restraint procedures followed or if adaptations are required.

MHAID are reintroducing the Clinical Nurse Specialist/Educator review of staff injuries to ensure timely and extensive review of incident, nursing practice, physical environment, patient factors and resourcing.

Integrated Mental Health and Addiction Primary Mental Health and Addiction System

Last month we advised that the Ministry of Health had signalled that this Access and Choice programme is to be extended. Additional funding has been provided to add a further 5.1 FTE for Health Improvement Coaches in 2021/22 (bringing the total to 15.2 FTE) and a further 7.7 FTE for Health Coaches/Support Workers (bringing the total to 22.9 FTE).

The contract for this additional provision was 'fast tracked' and executed by the Board at its meeting in early May. The associated Letter of Offer to WellSouth Primary Health Network has also been subsequently executed.

The GP practices that have been identified for the extended programme include:

- Gore Health
- Gore Medical
- Aurora
- Mosgiel Health Centre
- Cromwell Medical
- Invercargill (2 practices).

The new Health Improvement Coaches are scheduled to begin training in late June with the extended programme commenced in early July.

16. Review of Māori Health Provider Contracts

The Māori Health Leadership Team has engaged Janice Donaldson from Canterbury in her role with the South Island Alliance to review our kaupapa Māori provider contracts. Janice has extensive Māori health experience and current contract knowledge responsible for the Canterbury DHB Māori health contracts. Janice firstly undertook a desktop review of all our provider contracts. The contracts being reviewed are our mauri ora, tamariki ora, mental health and nurse practitioner contracts. A draft report is being prepared for our consideration in the context of an uplift in equity funding over the last two financial years.

17. Māori Cancer Hui

Te Aho o te Kahu (TAOTK – Cancer Control Agency) and Ngā Kete Mātauranga Pounamu Charitable Trust is facilitating a Māori community cancer hui at Murihuku Marae on 17 July after it was shifted from June. The overall goal of these hui is to understand the perspective of whānau Māori with lived experience of cancer in order to inform future work of TAOTK. These hui also provide a platform for TAOTK to listen to Māori voice and identify what Māori solutions are to issues of patient and whānau experiences across continuum of cancer pathways. A kaupapa Māori approach will be used to privilege the voice of Māori patients and whānau in this space. Thus, the planning and delivery of this hui will be respectful of Māori social norms and processes and will be guided by the voice of Māori leadership.

18. Waitaki Family Violence

The Chief Māori Health Strategy and Improvement Officer is to present a plenary session at the upcoming Safer Waitaki Family Harm Conference 2021 being held in Oamaru 22-23 July. The plenary session will look at the Health and Disability System Review, the subsequent health reforms under the Department of the Prime Minister and Cabinet, Transition Unit and then will take a look at what are being called community wellbeing networks or localities. The presentation will then look at what this means for the Waitaki District, it will propose some key features for a planned local wellbeing network and then consider the potential opportunities on how these networks could better response to family/whānau harm in the Waitaki.

19. Māori and Pasifika Data Review

The Hospital Advisory Committee (HAC) were provided some observations specific to first specials appointments (FSAs) for Māori and Pasifika patients. Rudimentary analysis of first specialists' appointments indicated that Pasifika patients appear to get almost one-third less referrals accepted at triage relative to their share of the population. We have meet with General Manager for Medicine, Women's and Children's Health and our Business Analyst – Demand and Capacity recently to review both Māori and Pasifika access to cardiology and respiratory services, relative to their share of the population. Our General Manager Surgery and Radiology has expressed a particular interest in equity issues so we will ask her to take a lead on equity improvement with the Executive Director of Specialist Services and the Chief Māori Health Strategy and Improvement Officer. As we start to systematically understand how referral and intervention rates compare, we will then start to engage on how to make improvements and we will provide regular updates to HAC.

20. Information Analyst Equity

The Māori Health Directorate is supporting the appointment of an Information Analyst role that will be a key contributor in the Business Intelligence (BI) and Analytics team. The particular focus of this role will be to use analytics and data to make recommendations to address the equity and Māori health challenges in Southern Health. We are looking for someone with strong analytical and data visualisation skills to work as integral member of our team. To produce analytical artefacts and draw conclusions and recommendations from the intelligence and information gained. This will be completed through leading and contributing to various quantitative and qualitative analytical projects and reporting/BI dashboards. To support work through data quality and validation checking and data cleansing and transformation from source systems/data sources as required. The interviews are being conducted the week of 12 July.

21. Psycho-Social Te Anau/Milford and Queenstown Lakes District

The Māori Health Directorate is supporting Adel Cox on the development of the Psychosocial Support Project which has recently negotiated a contract under the Ministry for Business, Innovation and Employment (MBIE). The project will deliver psychosocial support to promote and protect the social and mental wellbeing of people within these targeted communities, to assist with addressing the ongoing negative effects of COVID-19 and the tourism sector more broadly. The package includes business advice and psychosocial support targeted to these communities. The contract agrees to deliver psychosocial support to the communities of Queenstown Lakes and Te Anau/Fiordland. The directorate is supporting by leading out a discussion with Papatipu Runaka around this project, which might include a role in the governance and service delivery aspects of this project. Matapura Ellison will support this Runaka engagement on behalf of the Southern DHB in his role as kaumātua.

22. Workforce Planning for the New Dunedin Hospital

Our initial workforce modelling is under way for the Inpatients Building.

The Outpatient modelling is being used to inform a range of decisions and problem solving including building occupancy (therefore informing lift and evacuation strategy and planning), staff amenities such as lockers and storage planning, travel planning and ongoing work continues on collaborative workspace, specifically planning the best ratios of open workstations to quiet focus spaces.

Other significant work has included supporting design and planning for the Intensive Care Unit (ICU), ED and Neo-natal ICU (NICU) and some initial planning with new models of care for departments like medical physics.

23. Organisational Development Team

The Organisational Development (OD) team has a number of streams of work underway, including:

- Pilot for Emerging Leadership and Succession Planning being scoped out in Strategy, Primary and Community (interprofessional initiative between OD, Allied Health and Nursing initiated this month)
- Team development workshops held with NICU, CVIP team, Urology Outpatients and Women's and Children's Social Work team.
- OD Team also provided mediated support within NICU.
- Disability Awareness workshops implemented this month. 'The Accessibility Game' series of workshops will be held throughout the year. Collaboration with the Disability Committee continues.
- The final two School for Change Agents workshops were held this month – action learning groups to take forward with OD support.
- Team have met with Catalyst to start the process of moving away from Ko Awatea and towards HealthLearn. A small working group now taking forward.
- Two employee wellbeing training providers have met with the team this month and provided demos on their resources and toolkits – Chnnl and Akoako – pilot sites are being considered for both across the southern system – Dunedin, Invercargill, and Lakes. The intention is to provide proactive wrap-around wellbeing support for the organisation using enabling technology.
- Essential Corporate Training is currently being reviewed and more dates have now been organised for Success Factors, Appraisal Training, Performance Management and Courageous Conversations.

- The LEADS programme is underway this month including the prerequisite aspects of self and 360 assessments. Face to face workshops were postponed until July due to difficulties with external providers and travel (bad weather).
- Speak Up Refresh is still on track with the recent development of Restorative Practice Workshops – the first one will be held in July.
- Action plan in support of the Staff Engagement Survey outcomes is in progress – this involves a continuance of initiatives already underway, some new initiatives and also a plan to run some focus groups with General Managers. This will be combined with the workstream around Essential Corporate Training Review too.

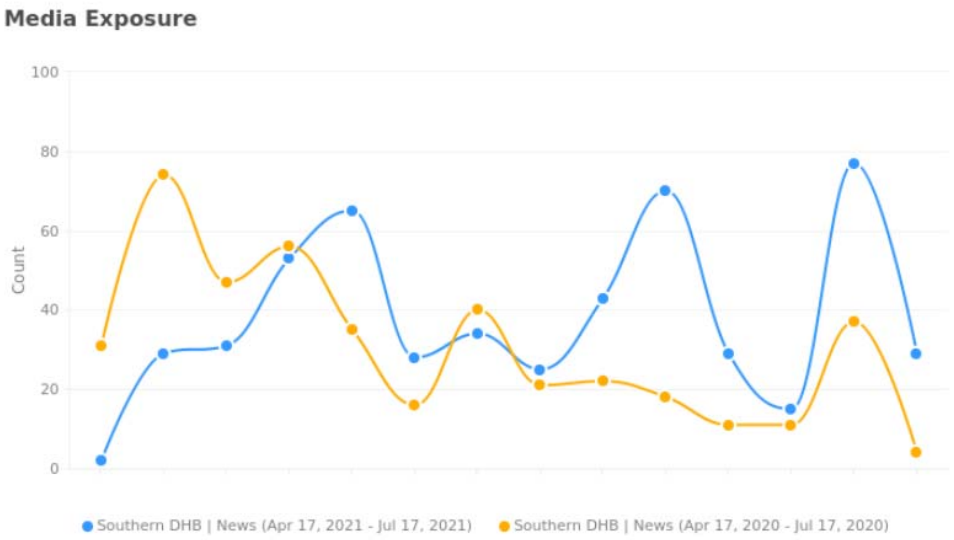
24. Communications

Media volumes have been consistent and busy, exceeding the same period in 2020.

The rollout of the COVID vaccine programme remains an intensive area of focus for communications, as we have moved into vaccinating group 3 population and preparing to open booking for group 4. This includes positive coverage of clinics for our disabled community and completing vaccination of aged residential care residents. As we look to ramp up the programme across all parts of the district, we are providing briefings to mayors and chief executives of district councils to ensure they have an understanding of activity in their areas. We also briefed the Queenstown Chamber of Commerce and business leaders in that community as part of a wider engagement involving the Department of Prime Minister and Cabinet.

Other areas of media interest and communications activity have included respiratory syncytial virus (RSV) in our hospitals communities, MBIE funding to deliver psychosocial support in Queenstown and Fiordland, delays in provision on cancer care, historic colonoscopy issues and a leaked report regarding DHB performance.

Internally, communications have intensified on areas including our digital transformation projects, the outpatients building for the new Dunedin Hospital, progress in delivering the Disability Strategy and the Aukaha Kia Kaha programme focusing on staff wellbeing.



Chris Fleming
Chief Executive Officer

26 July 2021

Appendices

Nil

FOR APPROVAL

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

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

Meeting of: Board Meeting, 3 August 2021

Recommendation

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

Purpose

1. **To provide the Board and Finance, Audit & Risk Committee with the financial performance of the DHB for the month and year to date ended 30 June 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

Appendices

Appendix 1 **Financial Report for the Board**

Appendix 1: Financial Report for the Board

Southern DHB Financial Report

Financial Report for:	30 June 2021
Report Prepared by:	Finance
Date:	13 July 2021

Report to Board

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

The net deficit for the month of 30 June 2021 was $5.2m, being $2.1m unfavourable to budget. The result includes Business as Usual net deficit of $3.9m and COVID-19, Holidays Act 2003, New Dunedin Hospital Accelerated Depreciation and Digital Hospital Project Costs net deficit of $1.3m.

The net deficit year to date was $28.4m, being $17.5m unfavourable to budget. The result includes Business as Usual net deficit of $19.3m and COVID-19, Holidays Act 2003, New Dunedin Hospital Accelerated Depreciation and Digital Hospital Project Costs net deficit of $9.1m.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 30 June 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						
103,819	96,462	7,357	F	Government & Crown Agency	1,187,928	1,155,951	31,977	F	1,089,019	1,155,951
381	877	(496)	U	Non-Government & Crown Agency	12,489	10,528	1,961	F	11,047	10,528
104,200	97,339	6,861	F	*Total Revenue*	1,200,417	1,166,479	33,938	F	1,100,066	1,166,479
				EXPENSES						
43,596	40,690	(2,906)	U	Workforce Costs	481,056	462,125	(18,931)	U	484,392	462,125
5,286	3,162	(2,124)	U	Outsourced Services	47,751	43,556	(4,195)	U	41,837	43,556
9,491	7,896	(1,595)	U	Clinical Supplies	111,249	96,871	(14,378)	U	99,345	96,871
6,242	5,146	(1,096)	U	Infrastructure & Non-Clinical Supplies	62,390	60,354	(2,036)	U	63,258	60,354
41,531	39,885	(1,646)	U	Provider Payments	489,317	474,021	(15,296)	U	466,737	474,021
3,276	3,648	372	F	Non-Operating Expenses	37,059	40,469	3,410	F	34,951	40,469
109,422	100,427	(8,995)	U	*Total Expenses*	1,228,822	1,177,396	(51,426)	U	1,190,520	1,177,396
(5,222)	(3,088)	(2,134)	U	**NET SURPLUS / (DEFICIT)**	(28,405)	(10,917)	(17,488)	U	(90,454)	(10,917)

Revenue was $6.9m favourable to budget for the month.

Government Funding includes IDF favourable variance $0.6m, $2.7m Planned Care revenue recognised with the expectation we have achieved the 95% Ministry of Health required volumes. In addition there is unbudgeted revenue of $1.5m for Outpatient Improvement Action Plan activity plus $0.4m for Mental Health funding, offset by a reduction of $1.7m previously recognised in Community Pharmaceuticals (refer YTD below). Unbudgeted COVID-19 revenue includes $1.1m Vaccination Programme, $1.0m Surveillance & Testing and $0.8m Incremental Costs.

The revenue for COVID-19 Surveillance & Testing has been recognised to match expenditure. The recognition of $1.0m 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.

Non-Government revenue includes Non-Resident revenue at $0.3m unfavourable to budget with two patient invoices reversed due to a change in eligibility ruling by the MoH.

Expenses were $9.0m unfavourable to budget for the month.

The Workforce costs were $2.9m unfavourable inclusive of $0.6m additional Holidays Act 2003 provision, $0.6m SMO costs for CME carried forward and $0.8m of Vaccination programme costs.

Nursing personnel were unfavourable $1.5m and 170FTE in June ($10.7m and 84FTE unfavourable YTD) due to the following;

- Covid Vaccination Program commenced April with 12FTE increasing to 56FTE in June
- Ordinary time 60FTE over budget due primarily to:
    - Unmet savings in Operations and Mental Health (30 & 29 FTE respectively)
    - NICU 2.7FTE over budget with unit at high capacity due to being the only level 3 unit with capacity. As a result babies were taken in from Canterbury and South Canterbury requiring additional resource
    - Health Care Assistants are 49 FTE unfavourable in a number of areas including Operations, Mental Health, Rehabilitation and Vaccination clinics. Patient watch hours were recorded as 16.5 FTE. This continues to impact on Medical Ward 8A in Dunedin and Southland Medical and Surgical wards.
    - Other wards were over their budgeted FTE, driven by patient watches and approved CCDM increases.
- Sick leave unfavourable by 15.4FTE, again slightly higher than the year to date average. This is not unexpected as vigilance to the possible spread of any illness means those unwell stay home.

The Clinical Supplies were $1.6m unfavourable, reflecting higher Treatment Disposables and Pharmaceuticals expenditure, being partially offset by lower Implants & Prostheses costs.

Provider Payments were $1.7m unfavourable, reflecting unbudgeted Mental Health expenditure (offset by additional revenue), higher Community Pharmaceutical expenditure, COVID-19 Surveillance & Testing expenses, IDF Personal Health expenses and Residential Care costs.

Revenue (Year to Date)

Overall, Revenue is $33.9m favourable to budget year to date.

Government and Crown Agency revenue is $32.0m favourable, including additional funding for COVID-19 $15.7m, Primary Mental Health & Addiction $4.8m and Clerical Pay Equity $0.8m. These revenue streams have a direct connection to expenditure.
Advice received from Pharmac that the expected Community Pharmaceutical increases were less and therefore that required an additional revenue reduction of $1.7m in June. The MoH has instructed the $1.7m reduction be held in DHB balance sheets for future release.
Previously Bed capacity limitations have impacted on the achievement of Planned Care delivery however significant additional outsourcing activity in June 2021 has resulted in meeting the 95% target thus we have recognised the $2.7m revenue, while we await the final wash up. The total Planned Care revenue has been recognised at budget.
Final assessment of Improvement Action plan activity for the various Outpatient categories including First Specialist Appointments and Diagnostics has also seen the recognition of $1.9m of revenue.

The Capital Charge funding has been reduced by $2.1m to align with the change in the Treasury rate from 6% to 5%.

The IDF favourable variance $2.8m and Haemophiliac Blood product rebates $2.2m.

Non-Government & Crown Agency revenue is $2.0m favourable to budget. The recognition of the donated clinical equipment and PPE from the Ministry of Health of $3.2m has more than offset the reduced Non Resident revenue of $0.6m.

Expenditure (Year to Date)

Total Expenses year to date is $51.4m unfavourable to budget.

The Workforce costs are $18.9m unfavourable year to date. This includes $7.6m of Holidays Act 2003 liability, $4.1m for COVID-19 response and $0.9m for New Dunedin Hospital which was not budgeted. The $6.2m unfavourable Business as Usual includes clerical pay equity payments and increased workforce costs associated with locum cover, increased FTE to match acuity, patient watches, reduced annual leave taken, increased overtime and other leave.

Outsourced Clinical Services are $4.4m unfavourable year to date reflecting additional costs incurred for delivery of patient and elective services.

Clinical Supplies are $14.4m unfavourable year to date for hospital clinical activity to deliver Business as Usual. The major contributors remain Treatment Disposables (particularly blood products), Instruments & Equipment and Pharmaceuticals, although the Pharmaceuticals are partly offset by $1.1m of additional revenue.

Provider Payments are $15.3m unfavourable year to date; comprising payments to NGOs supporting COVID-19 activity, including $9.2m COVID-19 testing in the community, $3.2m for Mental Health & Addiction and $1.8m for Community Pharmaceuticals. The Disability Support payments for Residential Care are $2.5m 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 June 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	1,187,928	12,838	2,651	-	-	-	-	1,172,439	1,155,951	16,488	F
Non-Government & Crown Agency	12,489	3,156	-	-	-	-	-	9,333	10,528	(1,195)	U
Total Revenue	1,200,417	15,994	2,651	-	-	-	-	1,181,772	1,166,479	15,293	F
EXPENSES											
Workforce Costs	481,056	2,118	1,958	7,550	-	892	239	468,299	462,125	(6,174)	U
Outsourced Services	47,751	(3)	70	-	-	-	-	47,684	43,556	(4,128)	U
Clinical Supplies	111,249	581	15	-	-	-	-	110,653	96,871	(13,782)	U
Infrastructure & Non-Clinical Supplies	62,390	271	459	-	2,084	263	254	59,059	60,354	1,295	F
Provider Payments	489,317	10,806	149	-	-	-	-	478,362	474,021	(4,341)	U
Non-Operating Expenses	37,059	-	-	-	-	-	-	37,059	40,469	3,410	F
Total Expenses	1,228,822	13,773	2,651	7,550	2,084	1,155	493	1,201,116	1,177,396	(23,720)	U
NET SURPLUS / (DEFICIT)	(28,405)	2,221	-	(7,550)	(2,084)	(1,155)	(493)	(19,344)	(10,917)	(8,427)	U

Financial Position Summary

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

Actual 30 Jun 2020 $000		Actual 30 Jun 2021 $000	Budget 30 Jun 2021 $000	Actual 31 May 2021 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	7,582	7	19,424	7
49,819	Trade & Other Receivables	62,421	48,830	57,346	48,830
6,095	Inventories	6,159	5,235	6,060	5,235
86,925	*Total Current Assets*	76,162	54,072	82,830	54,072
	NON-CURRENT ASSETS				
326,463	Property, Plant & Equipment	325,558	355,122	326,174	355,122
3,307	Intangible Assets	6,258	20,149	6,138	20,149
329,770	*Total Non-Current Assets*	331,816	375,271	332,312	375,271
416,695	**TOTAL ASSETS**	407,978	429,343	415,142	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	16,259	-	16,259
64,666	Payables & Deferred Revenue	71,552	64,494	70,199	64,494
962	Short Term Borrowings	235	955	234	955
88,645	Employee Entitlements	95,139	85,533	97,899	85,533
154,273	*Total Current Liabilities*	166,926	167,241	168,332	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	856	1,018	865	1,018
75,528	Holidays Act 2003	82,596	-	82,017	-
19,810	Employee Entitlements	19,411	19,810	19,810	19,810
96,429	*Total Non-Current Liabilities*	102,863	20,828	102,692	20,828
250,702	**TOTAL LIABILITIES**	269,789	188,069	271,024	188,069
165,993	**NET ASSETS**	138,189	241,274	144,118	241,274
	EQUITY				
485,955	Contributed Capital	486,556	531,750	487,265	531,750
108,500	Property Revaluation Reserves	108,500	108,502	108,500	108,502
(428,462)	Accumulated Surplus/(Deficit)	(456,867)	(398,978)	(451,647)	(398,978)
165,993	*Total Equity*	138,189	241,274	144,118	241,274
	Statement of Changes in Equity				
172,410	Opening Balance	165,993	206,398	165,993	206,398
(90,454)	Operating Surplus/(Deficit)	(28,405)	(10,917)	(23,183)	(10,917)
84,744	Crown Capital Contributions	1,308	45,793	1,308	46,500
(707)	Return of Capital	(707)	-	-	(707)
165,993	Closing Balance	138,189	241,274	144,118	241,274

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 30 June 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	1,181,727	1,156,983	24,744	1,156,983	1,086,952
Non-Government & Crown Agency Revenue	10,275	10,296	(21)	10,296	10,735
Interest Received	385	232	153	232	308
Cash was applied to:					
Payments to Suppliers	(724,320)	(679,364)	(44,956)	(675,364)	(674,080)
Payments to Employees	(455,545)	(495,569)	40,024	(499,568)	(425,100)
Capital Charge	(7,898)	(12,605)	4,707	(12,605)	(9,651)
Goods & Services Tax (net)	2,118	(486)	2,604	(486)	493
Net Cash Inflow / (Outflow) from Operations	6,742	(20,513)	27,255	(20,512)	(10,343)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	6	-	6	-	4
Cash was applied to:					
Capital Expenditure	(29,814)	(72,294)	42,480	(72,294)	(32,033)
Net Cash Inflow / (Outflow) from Investing Activity	(29,808)	(72,294)	42,486	(72,294)	(32,029)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	601	45,793	(45,192)	45,763	4,744
Cash was applied to:					
Repayment of Borrowings	(962)	(250)	(712)	(220)	(765)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	(361)	45,543	(45,904)	45,543	3,979
Total Increase / (Decrease) in Cash	(23,427)	(47,264)	23,837	(47,263)	(38,393)
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	7,584	(16,252)	23,836	(16,252)	(48,281)

Cash flow from Operating Activities is favourable to budget by $27.3m. Revenue received is broadly ahead of budget as noted above. Payments to Suppliers is higher than budgeted with the creditors being paid within 10 working days of invoice received as per instructions from the Public Service Commission. 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 $42.5m. The Capital Expenditure cash spend reflects project delays and the timelines for scoping, procurement, approval and supply chain delivery for capital expenditure.
Cash flow from Financing Activities is unfavourable to budget by $45.9m. 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 $23.8m.
Capital Expenditure Summary

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

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	8,076	26,987	18,911	U	12,243
Clinical Equipment	14,237	16,211	1,974	U	13,100
Other Equipment	852	902	50	U	405
Information Technology	2,727	9,513	6,786	U	3,433
Motor Vehicles	14	-	(14)	O	3
Software	3,907	18,681	14,774	U	2,848
Total Expenditure	29,813	72,294	42,481	U	32,032

At 30 June 2021, our Financial Position on page 5 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $331.8m, which is $43.5m less than the budget of $375.3m.

Land, Buildings & Plant variance of $18.9m 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 $21.6m reflects delays to date in the South Island Patient Information Care System (SIPICS) and Vocera Hands Free Clinical Communications projects. In addition, the Patientrack project was cancelled.

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

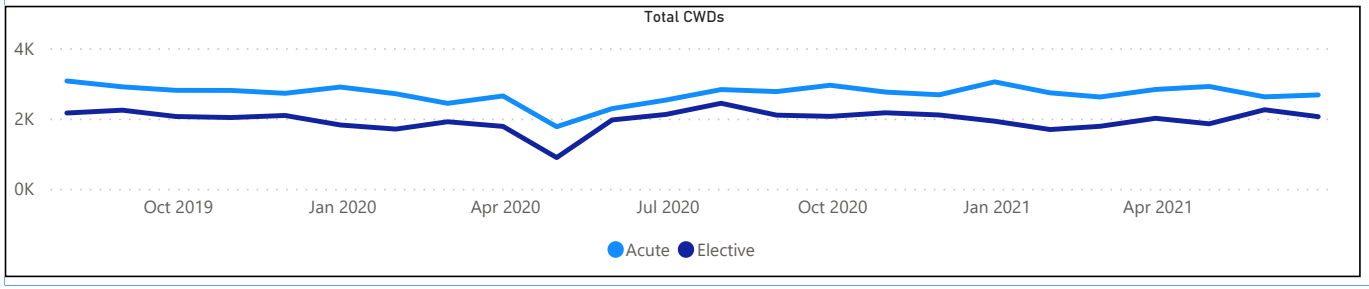
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year On Year YTD Variance
Surgical Caseweights												
Surgical Elective	1,312	1,446	-134	-9	1,386	-74	15,694	16,243	-549	-3	14,938	756
Surgical Acute	1,100	1,162	-62	-5	1,139	-39	14,452	14,554	-102	-1	13,475	977
Total	**2,411**	**2,608**	**-197**	**-8**	**2,525**	**-114**	**30,146**	**30,797**	**-651**	**-2**	**28,413**	**1733**
Medical Caseweights												
Medical Elective	357	291	66	23	313	44	4,158	3,453	705	20	3,696	462
Medical Acute	1,470	1,409	60	4	1,305	164	17,681	17,135	546	3	16,847	833
Total	**1,827**	**1,701**	**126**	**7**	**1,619**	**208**	**21,838**	**20,588**	**1,251**	**6**	**20,543**	**1295**
Maternity Caseweights												
Maternity Elective	385	347	38	11	418	-33	4,569	4,205	364	9	4,113	456
Maternity Acute	103	88	16	18	81	22	1,257	1,064	193	18	1,228	29
Total	**488**	**434**	**54**	**12**	**499**	**-11**	**5,826**	**5,269**	**557**	**11**	**5,341**	**485**
Total	**4,726**	**4,743**	**-17**	**0**	**4,643**	**84**	**57,810**	**56,653**	**1,157**	**2**	**54,297**	**3513**

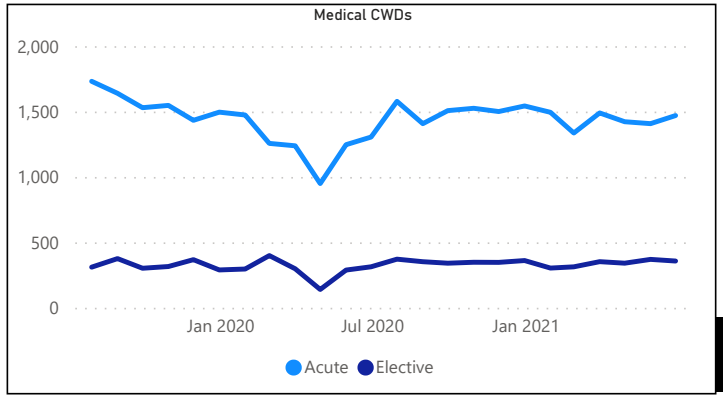
TOTALS

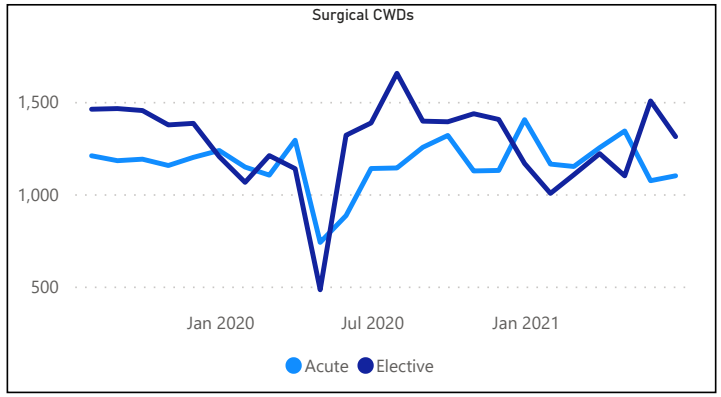
Acute	2,672	2,659	14	1	2,526	147	33,390	32,753	637	2	31,550	1840
Elective	2,054	2,084	-30	-1	2,117	-63	24,420	23,900	520	2	22,747	1674
Total	**4,726**	**4,743**	**-17**	**0**	**4,643**	**84**	**57,810**	**56,653**	**1,157**	**2**	**54,297**	**3513**

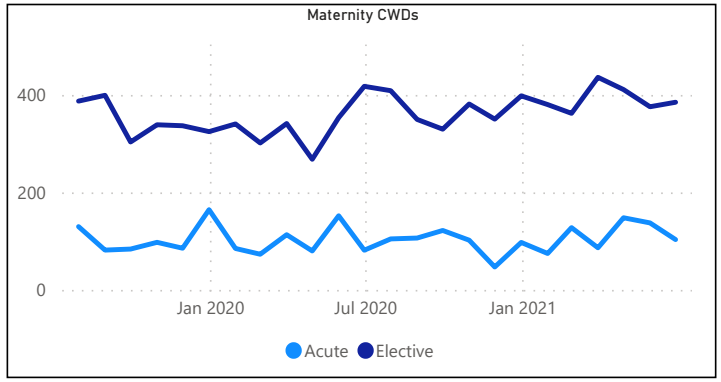
TOTALS excluding Maternity

Acute	2,569	2,571	-2	0	2,444	125	32,133	31,689	444	1	30,322	1811
Elective	1,669	1,737	-68	-4	1,699	-30	19,852	19,695	156	1	18,634	1218
Total	**4,238**	**4,308**	**-70**	**-2**	**4,143**	**95**	**51,985**	**51,384**	**600**	**1**	**48,956**	**3029**









8.2

SERVICE PROVIDER RAW DISCHARGES

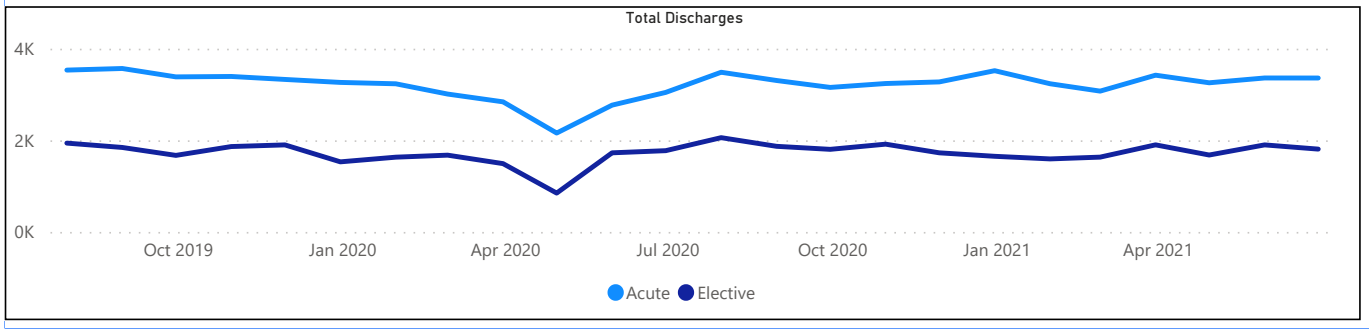
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Surgical Discharges												
Surgical Elective	877	1,014	-137	-14	975	-98	10,758	11,384	-626	-5	10,177	581
Surgical Acute	811	753	58	8	824	-13	9,783	9,427	356	4	9,079	704
Total	**1,688**	**1,767**	**-79**	**-4**	**1,799**	**-111**	**20,541**	**20,811**	**-270**	**-1**	**19,256**	**1285**
Medical Discharges												
Medical Elective	406	331	75	23	363	43	4,747	3,994	753	19	4,030	717
Medical Acute	2,452	2,257	195	9	2,140	312	28,818	27,397	1,421	5	27,408	1410
Total	**2,858**	**2,588**	**270**	**10**	**2,503**	**355**	**33,565**	**31,391**	**2,174**	**7**	**31,438**	**2127**
Maternity Discharges												
Maternity Elective	525	464	61	13	436	89	6,034	5,626	408	7	5,689	345
Maternity Acute	97	78	19	24	82	15	1,089	949	140	15	1,043	46
Total	**622**	**542**	**80**	**15**	**518**	**104**	**7,123**	**6,575**	**548**	**8**	**6,732**	**391**
Total	**5,168**	**4,897**	**271**	**6**	**4,820**	**348**	**61,229**	**58,777**	**2,452**	**4**	**57,426**	**3803**

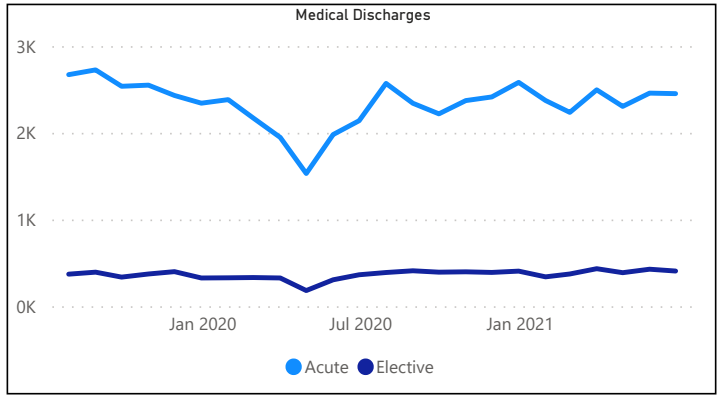
TOTALS

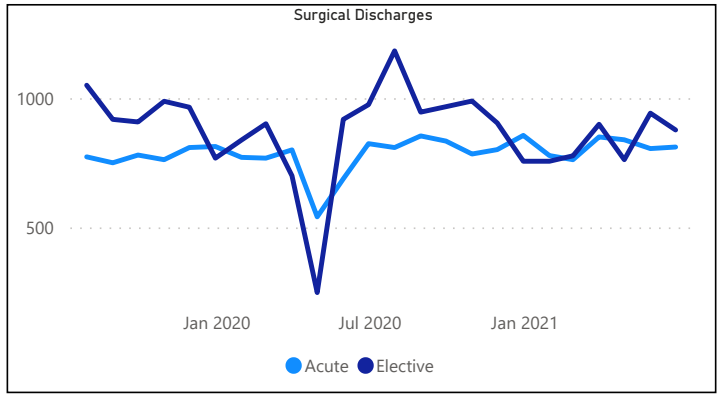
Acute	3,360	3,088	272	9	3,046	314	39,690	37,773	1,917	5	37,530	2160
Elective	1,808	1,809	-1	0	1,774	34	21,539	21,004	535	3	19,896	1643
Total	**5,168**	**4,897**	**271**	**6**	**4,820**	**348**	**61,229**	**58,777**	**2,452**	**4**	**57,426**	**3803**

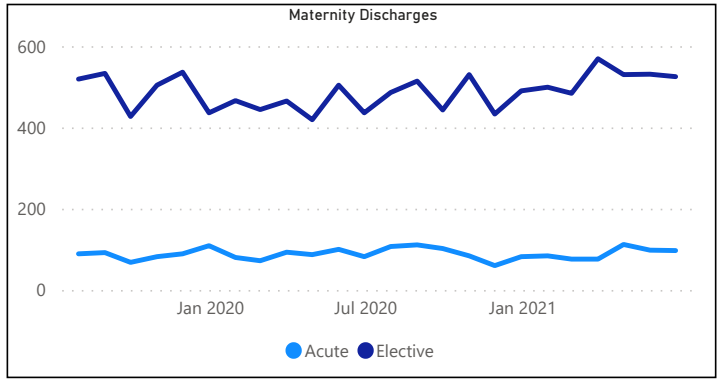
TOTALS excluding Maternity

Acute	3,263	3,010	253	8	2,964	299	38,601	36,824	1,777	5	36,487	2114
Elective	1,283	1,345	-62	-5	1,338	-55	15,505	15,378	127	1	14,207	1298
Total	**4,546**	**4,355**	**191**	**4**	**4,302**	**244**	**54,106**	**52,202**	**1,904**	**4**	**50,694**	**3412**



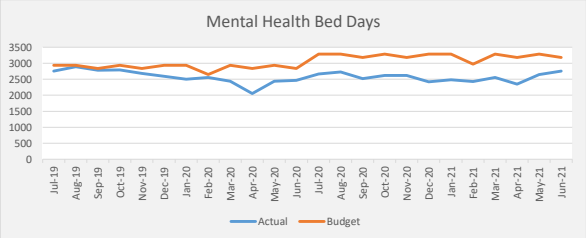




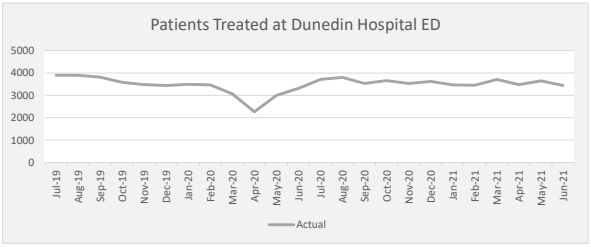


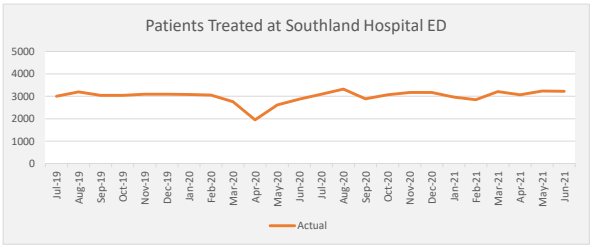
OTHER ACTIVITY

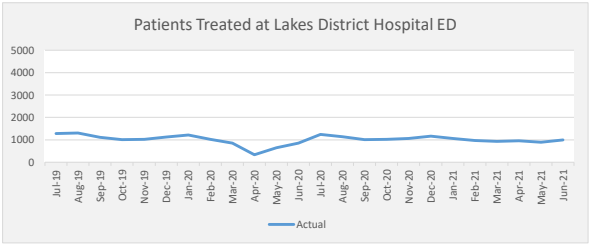
Jun-21				Jun-20	YEAR ON YEAR		YTD 2020/2021				YTD Jun-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,751	3,180	(429)	-13%	2,468	283	Mental Health bed days	30,791	38,690	(7,899)	-20%	30,941	(150)

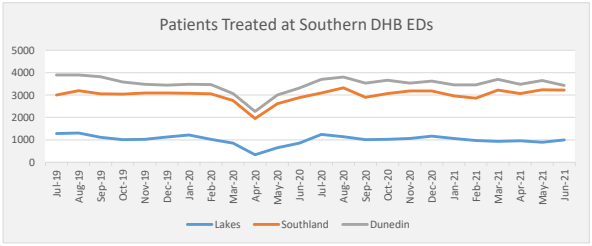


Jun-21	Jun-20	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Jun-20	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,433	3,314	119	Dunedin	43,030	40,703	2,327
997	851	146	Lakes	12,436	11,745	691
3,219	2,878	341	Southland	37,279	34,806	2,473
7,649	7,043	606	**Total ED presentations**	92,745	87,254	5,491









FOR INFORMATION

Item: Quality Dashboard – June 2021

Prepared by: Hywel Lloyd, Executive Director Quality & Clinical Governance

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – August 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 has 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

Discussion

9. Complaints remain at a high level with Surgical and Radiology Services under extreme pressure. While this is mostly due to resourcing issues the Consumer Experience Team is planning a deep dive analysis on complaints to identify any quick wins, if possible, and help Services respond to complaints in a tinely manner

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.

Next Steps & Actions

Give a clearer picture as to when the imaging graph will be corrected. IT are continuing to work with the Vendor. The timeframe for the fix is uncertain

---

Appendices

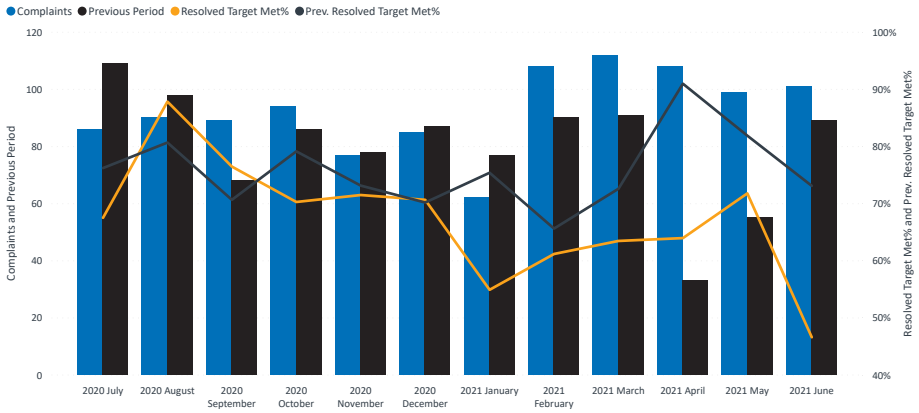
Appendix 1	**Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital**

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.

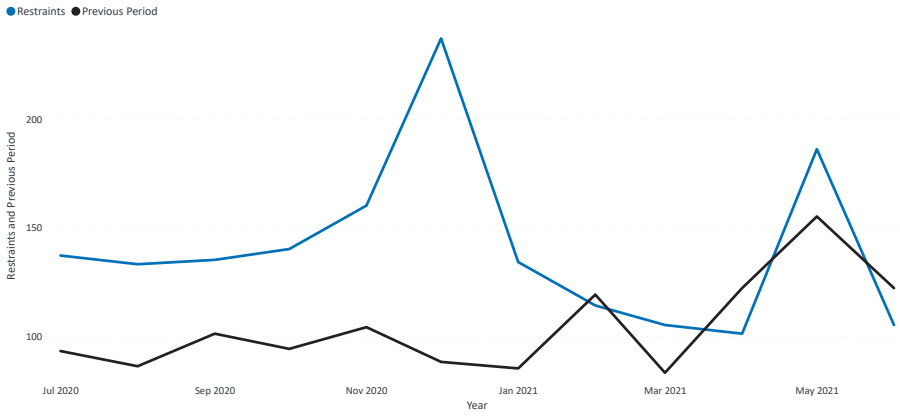
Resolutions

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.

"Complaints remain at a high level with Surgical and Radiology Services under extreme pressure. This is mostly driven by resourcing issues. From a complaints perspective this has been escalated to the Community Health Council, Clinical Council, Executive Leadership Team and the Board.
The Consumer Experience Team is planning to do a deep dive analysis on complaints to identify any quick wins, if possible, and help Services respond to complaints in a proper timeframe"

Southern - Restraints, Previous Period

BY YEAR, MONTH

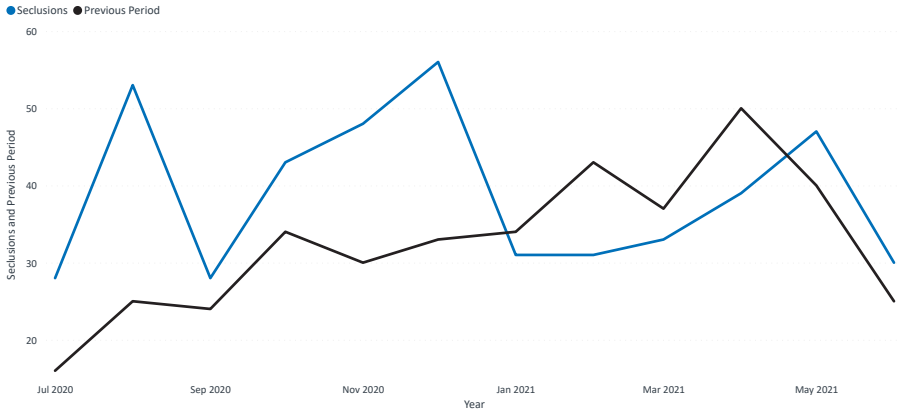


Restraints

Safety 1st data. The number of restraint events per month.
Restraints data includes Dunedin, Invercargill, Wakari & Lakes.

Southern - Seclusions, Previous Period

BY YEAR, MONTH



Seclusions

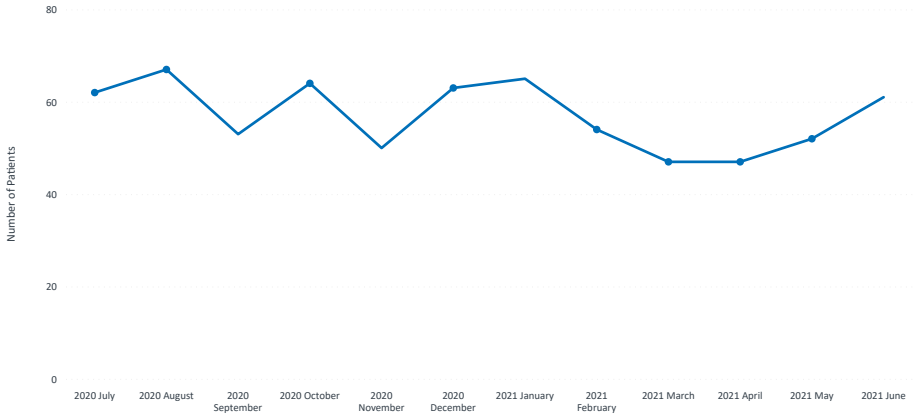
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Southern)

Southern - Deaths

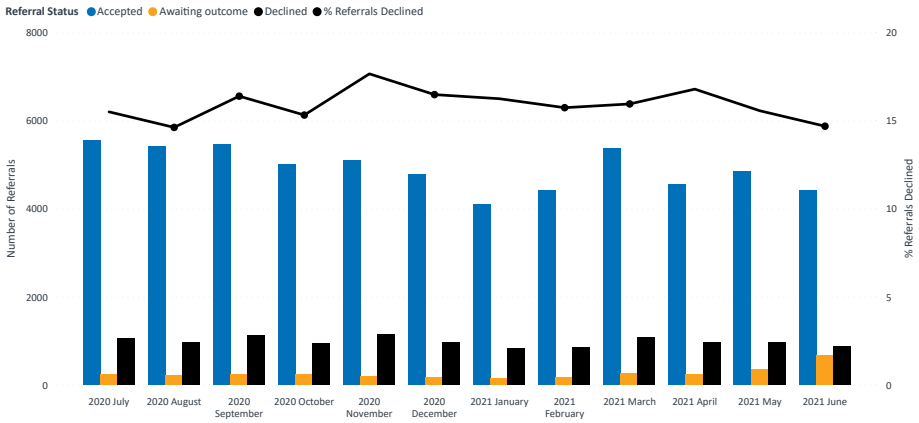
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths

Number of patients deceased by discharge month.

Southern - Referrals Accepted / Awaiting Outcome and Declined

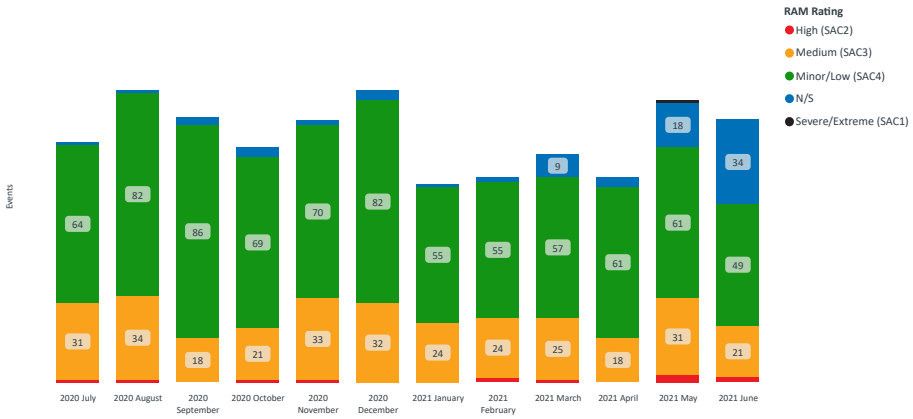


Referrals accepted (authorised), awaiting outcome or declined by month.

% referrals declined

Southern - Staff Events

BY RAM RATING, YEAR, MONTH



Safety 1st data.

The monthly number of reported staff adverse events

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

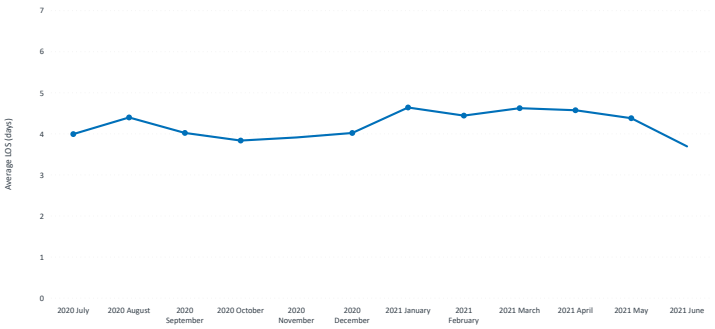
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls forms (visitor falls) which are not associated with clinical practice. These events are not assessed in the same way as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

Executive Dashboard - Efficiency

(Southern)

Southern - Average LOS

BY DAYS

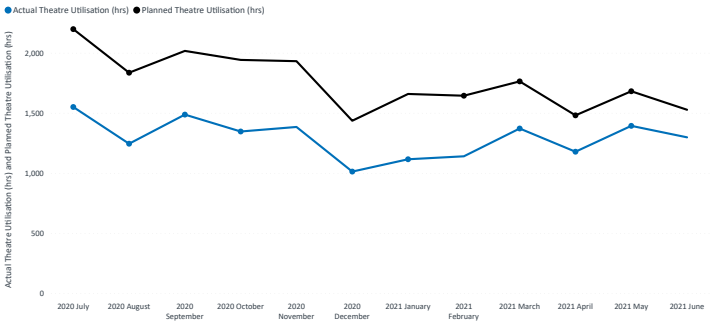


Average Length of stay

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

Southern - Planned vs Actual Theatre Utilisation (hrs)

BY HRS



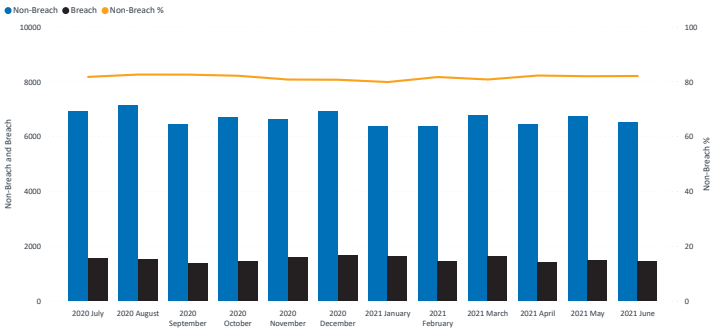
Actual Theatre Utilisation

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

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

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

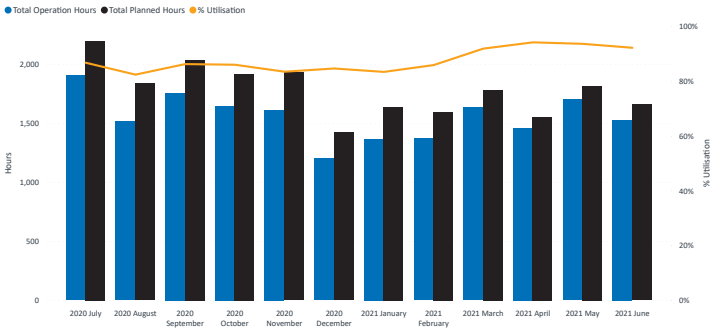
Southern - Monthly 6 Hour %



Monthly 6 Hour %

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

Southern - Average Theatre Utilisation (%)



Average Theatre Utilisation (%)

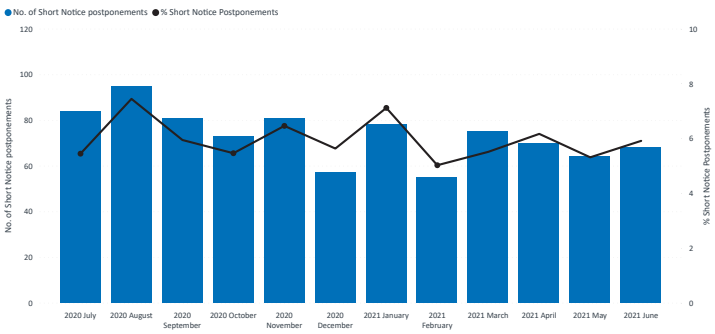
Numerator: Planned and acute operations from when the patient is brought into operating theatre to the patient leaves

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

Denominator: Planned session time

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

Southern - Short Notice Postponements



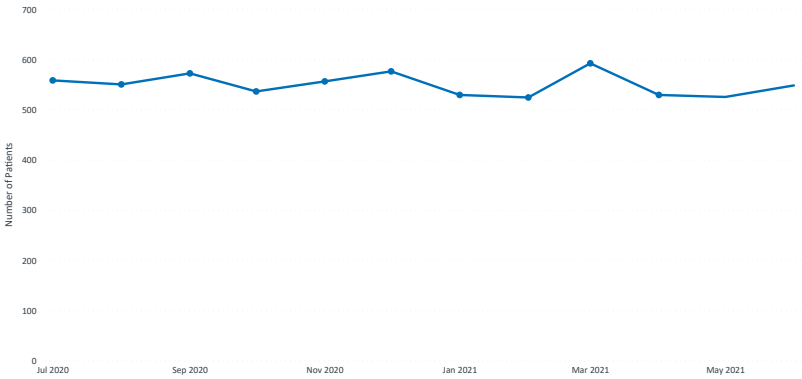
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Southern)

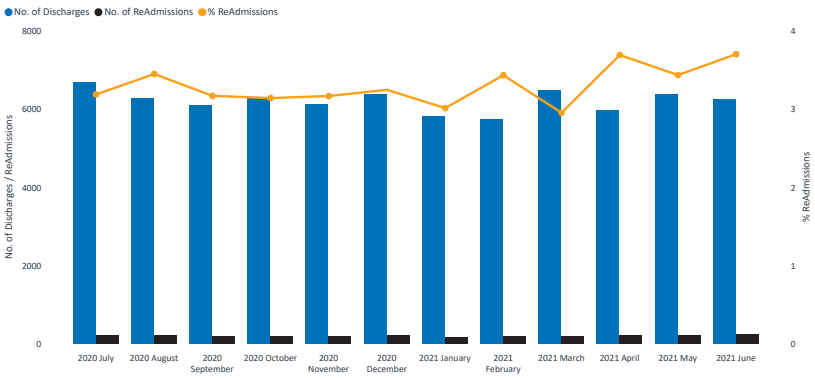
Southern - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

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

Southern DHB - Unplanned Hospital Readmissions within 7 days

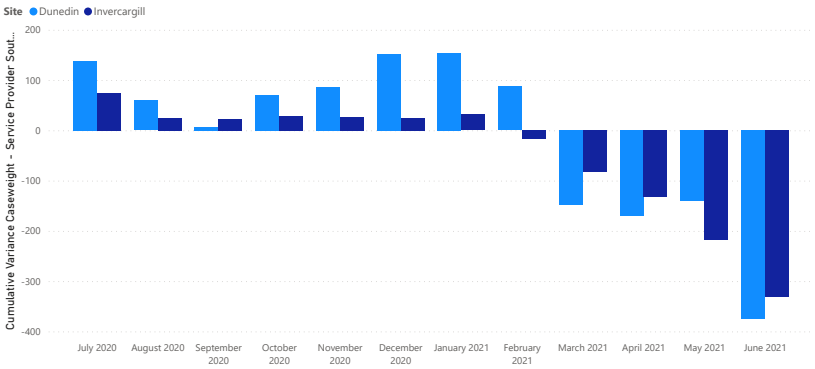


Unplanned Hospital Readmissions within 7 Days

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

Cumulative Variance Caseweight - Service Provider Southern

BY CALENDARMONTHYEAR, SITE



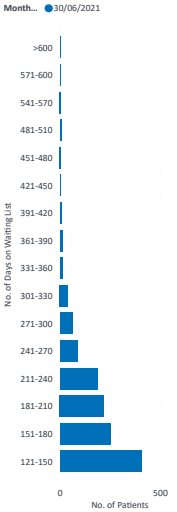
Cumulative Variance Caseweight

Column chart has cumulative variance case weight for Service provider which compares case weight with production plans based on MoH targets and work done in Southern DHB facilities, the Southern DHB's own population minus outflows plus inflow.

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

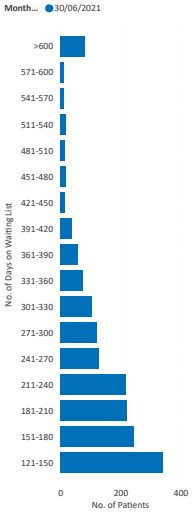
Southern - ESPI 2 Breaches

FOR THE LAST COMPLETED MONTH



Southern - ESPI 5 Breaches

FOR THE LAST COMPLETED MONTH



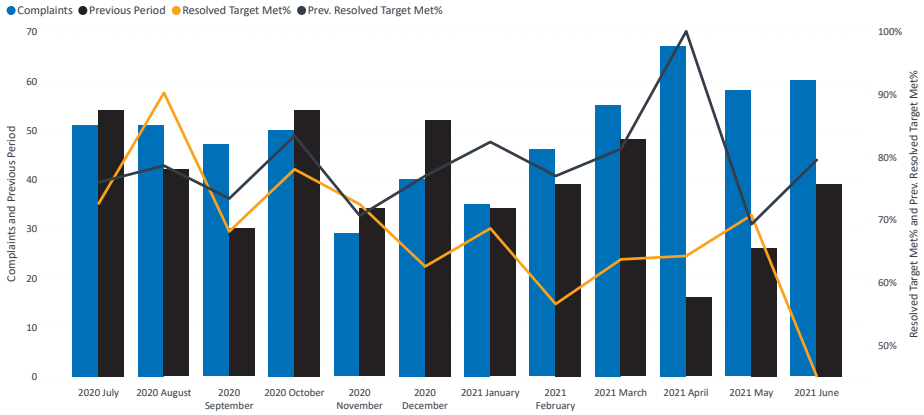
ESPI 2 and ESPI 5

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

Executive Dashboard - Patient Experience

(Dunedin)

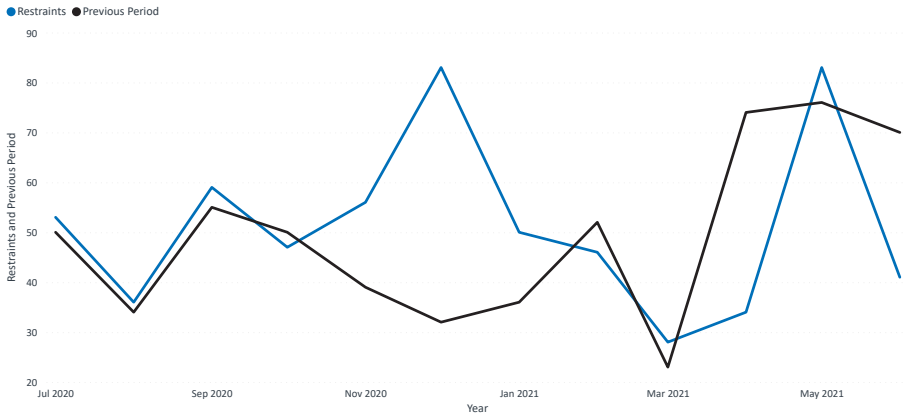
Dunedin - Complaints and Previous Period
BY YEAR AND MONTH



Safety 1st data.
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.

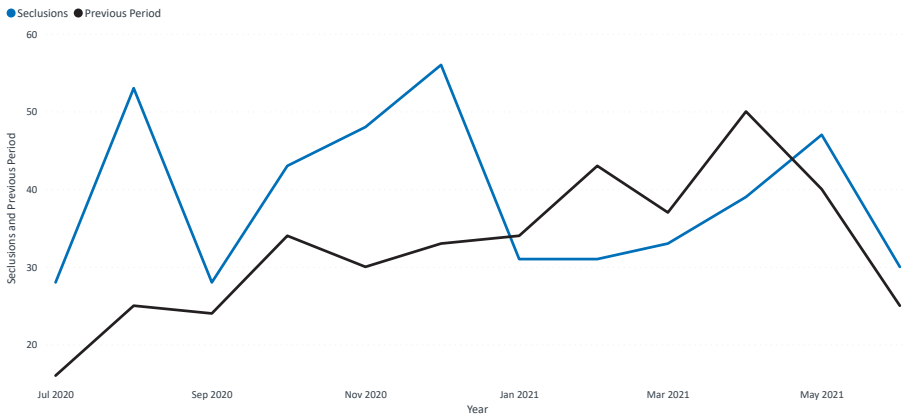
"Complaints remain at a high level with Surgical and Radiology Services under extreme pressure. This is mostly driven by resourcing issues. From a complaints perspective this has been escalated to the Community Health Council, Clinical Council, Executive Leadership Team and the Board.
The Consumer Experience Team is planning to do a deep dive analysis on complaints to identify any quick wins, if possible, and help Services respond to complaints in a proper timeframe"

Dunedin - Restraints and Previous Period
BY YEAR AND MONTH



Restraints
Safety 1st data. The number of restraint events per month.
Restraints data for Dunedin only.

Dunedin - Seclusions and Previous Period
BY YEAR AND MONTH



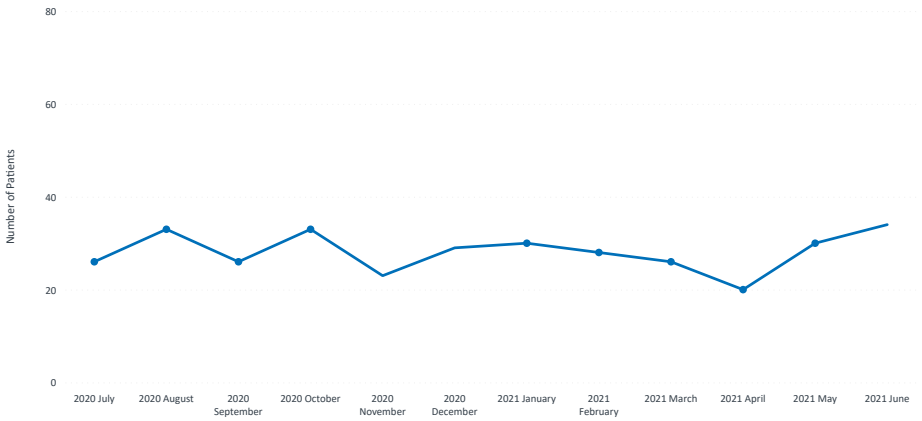
Seclusions
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Dunedin)

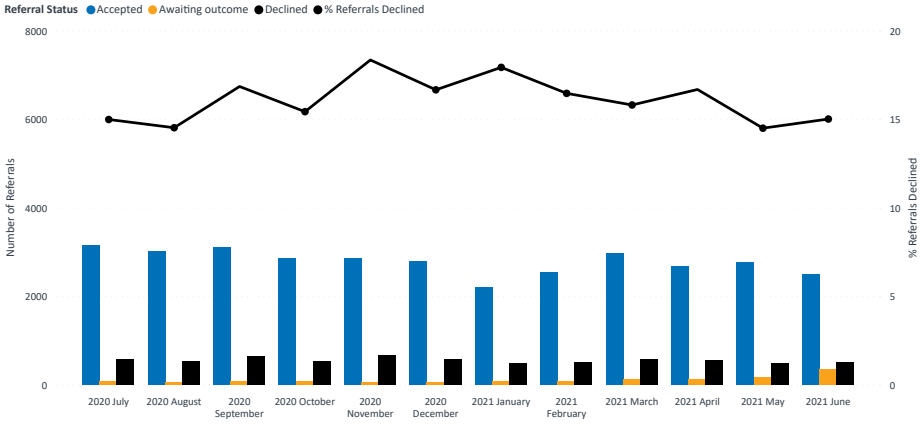
Dunedin - Deaths

NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths
Number of patients deceased by discharge month.

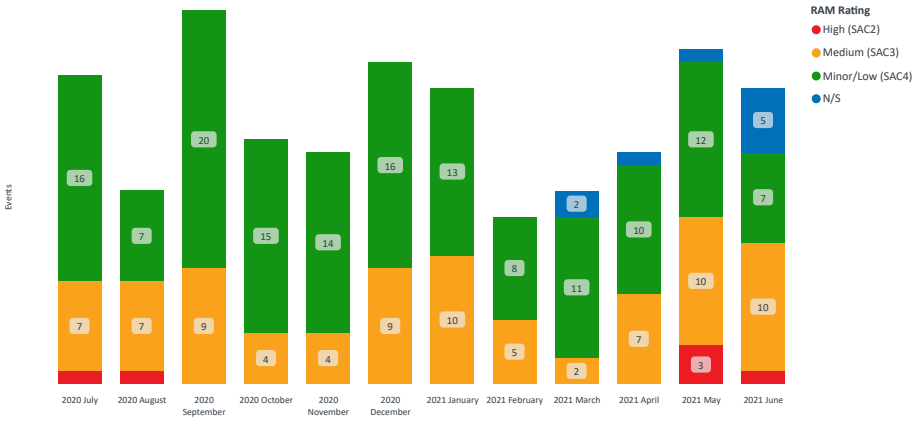
Dunedin Hospital - Referrals Accepted / Awaiting Outcome and Declined



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

Dunedin - Staff Events

BY RAM RATING, YEAR, MONTH



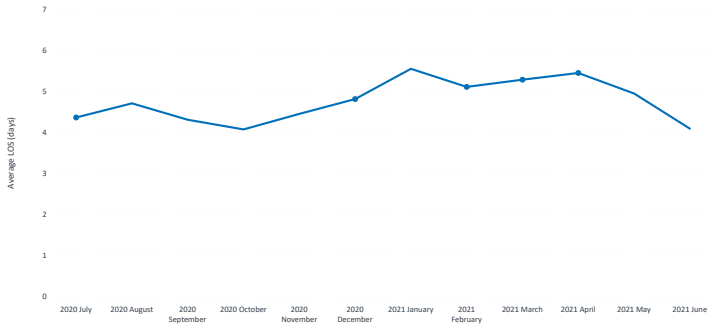
Safety 1st data.
The monthly number of reported staff adverse events
Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

Executive Dashboard - Efficiency

(Dunedin)

Dunedin - Average LOS

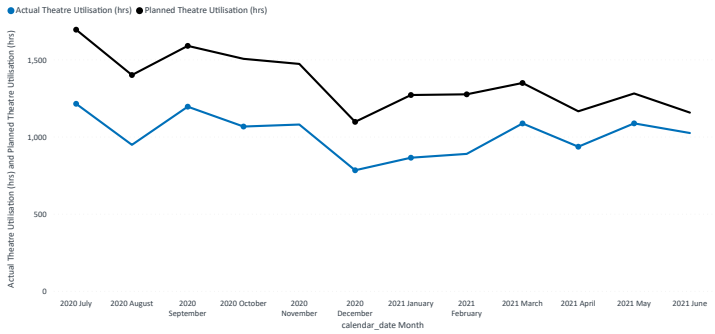
BY DAYS



Average Length of stay

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

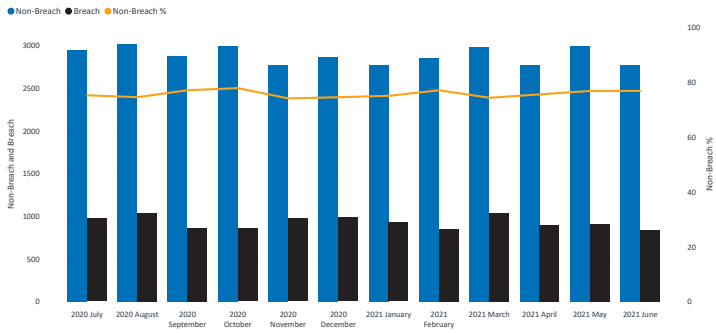
Dunedin - Planned vs Actual Theatre Utilisation (hrs)



Actual Theatre Utilisation

Actual theatre utilisation given by
CaseLength Time = Anaesthetic Time + Procedure Time
Anaesthetic Time = Time duration between "Anaesthetic Start Time" and "Patient Ready for Procedure Time"
Procedure Time = Time duration between "Procedure Start Time" and "Procedure Complete Vs the scheduled / planned theatre time given by the scheduled session time

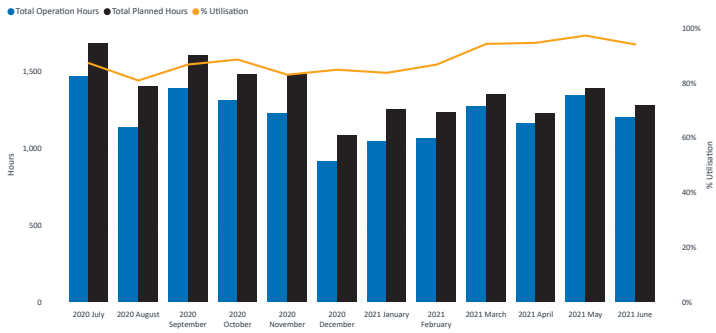
Dunedin - Monthly 6 Hour %



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 (%)



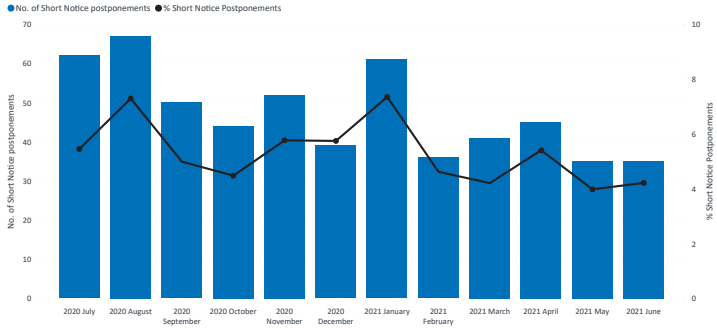
Average Theatre Utilisation (%)

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

Dunedin - Short Notice Postponements



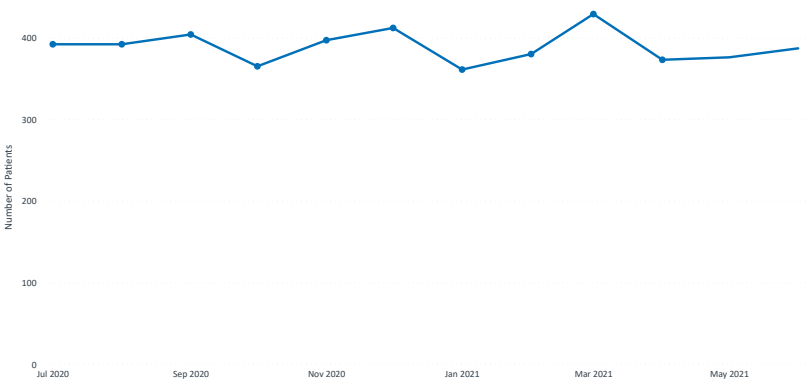
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Dunedin)

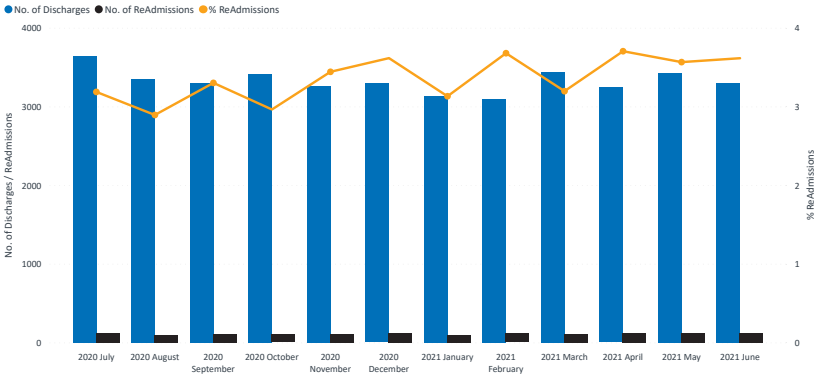
Dunedin - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

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

Dunedin - Unplanned Hospital Readmissions within 7 days

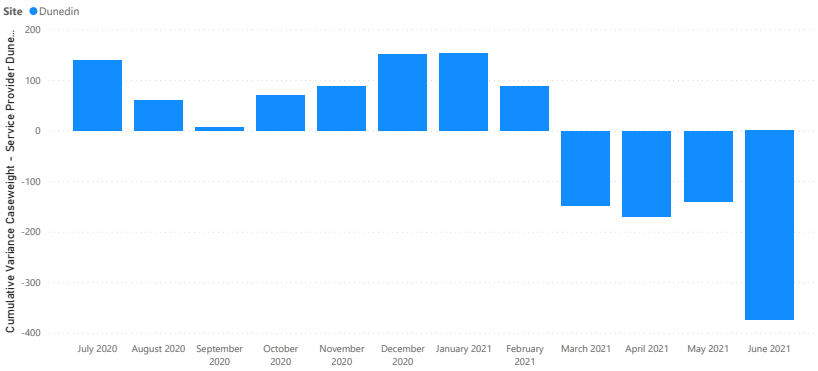


Unplanned Hospital Readmissions within 7 Days

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

Cumulative Variance Caseweight - Service Provider Dunedin

BY CALENDAR, MONTH, YEAR AND SITE

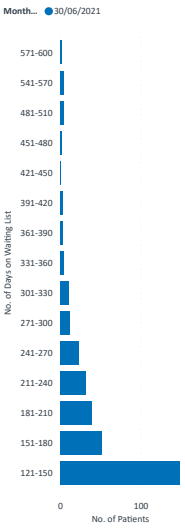


Cumulative Variance Caseweight

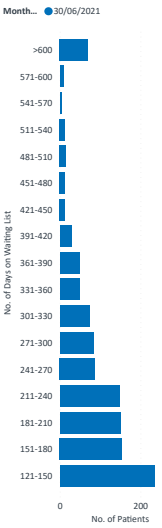
Column chart has cumulative variance case weight for Service provider which compares case weight with production plans based on MoH targets and work done in Southern DHB facilities, the Southern DHB's own population minus outflows plus inflow.

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

Dunedin - ESPI 2 Breaches f...



Dunedin - ESPI 5 Breaches f...



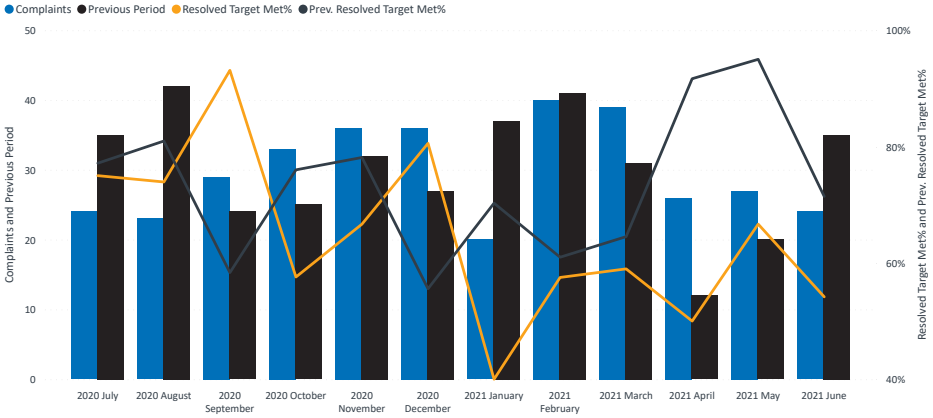
ESPI 2 and ESPI 5

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

Executive Dashboard - Patient Experience

(Invercargill)

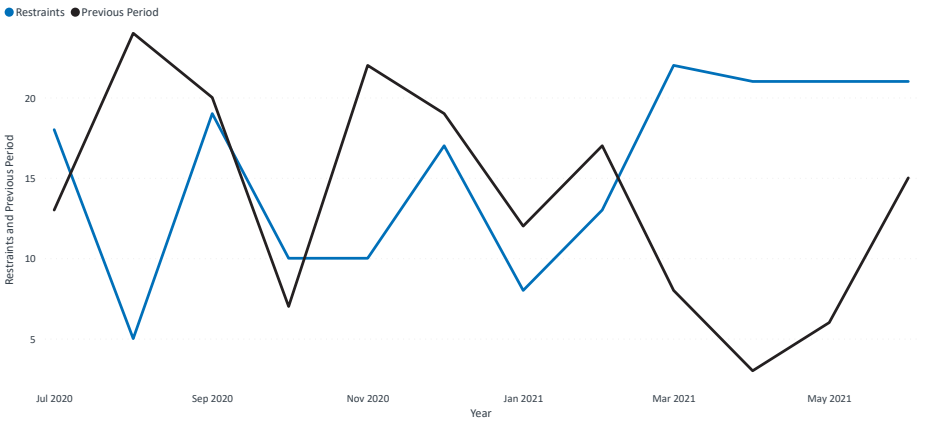
Invercargill - Complaints and Previous Period
BY YEAR AND MONTH



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.

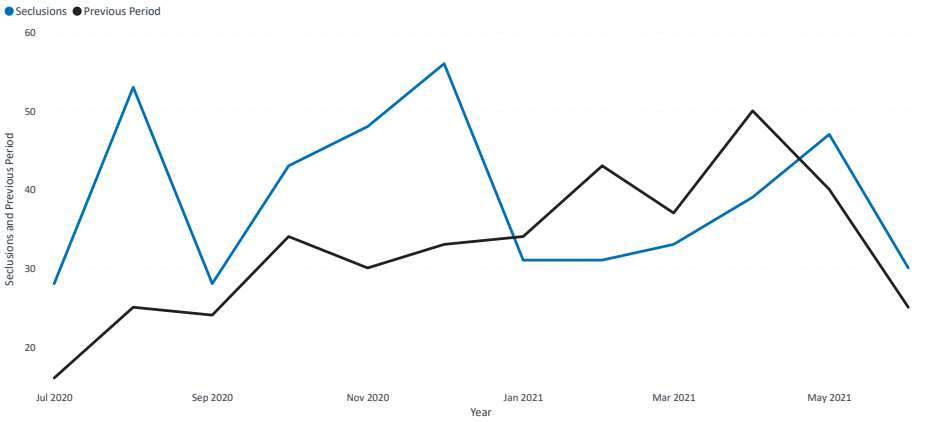
"Complaints remain at a high level with Surgical and Radiology Services under extreme pressure. This is mostly driven by resourcing issues. From a complaints perspective this has been escalated to the Community Health Council, Clinical Council, Executive Leadership Team and the Board.
The Consumer Experience Team is planning to do a deep dive analysis on complaints to identify any quick wins, if possible, and help Services respond to complaints in a proper timeframe"

Invercargill - Restraints and Previous Period
BY YEAR AND MONTH



Restraints
Safety 1st data. The number of restraint events per month.
Restraints data for Invercargill only.

Southern - Seclusions and Previous Period
BY YEAR AND MONTH



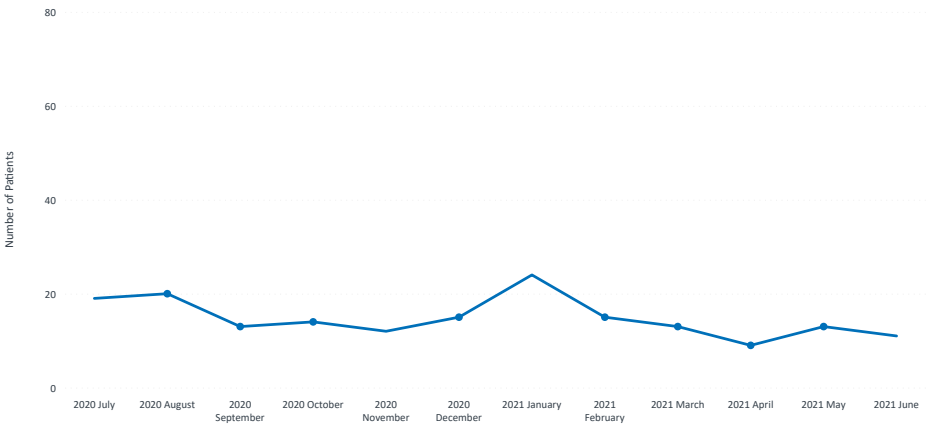
Seclusions
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Invercargill)

Invercargill - Deaths

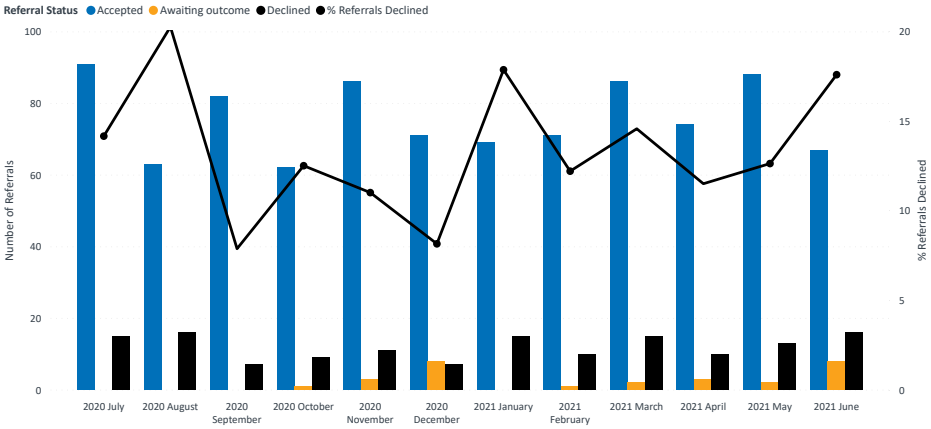
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths

Number of patients deceased by discharge month.

Invercargill Hospital - Referrals Accepted / Awaiting Outcome and Declined

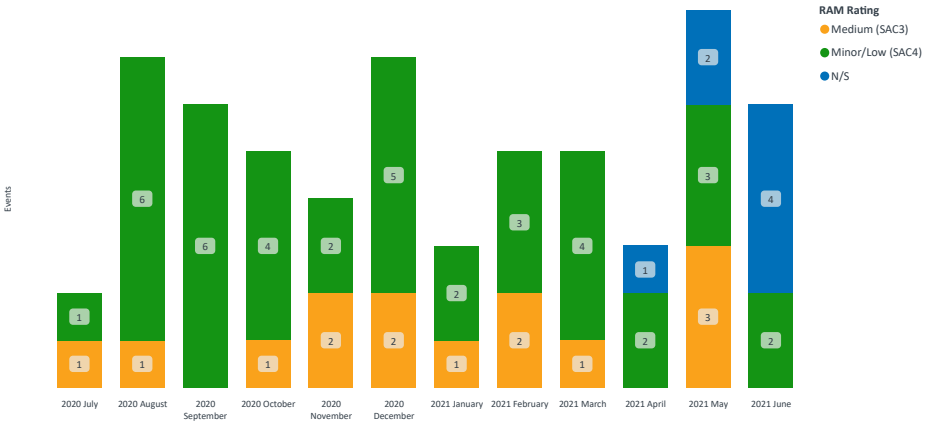


Referrals accepted (authorised), awaiting outcome or declined by month.

% referrals declined

Invercargill - Staff Events

BY RAM RATING, YEAR, MONTH



Safety 1st data.

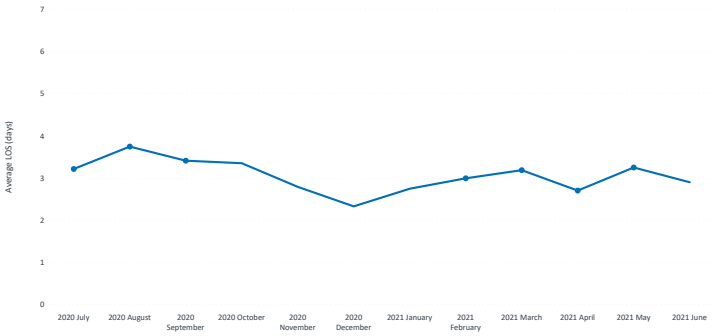
The monthly number of reported staff adverse events

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

Executive Dashboard - Efficiency

(Invercargill)

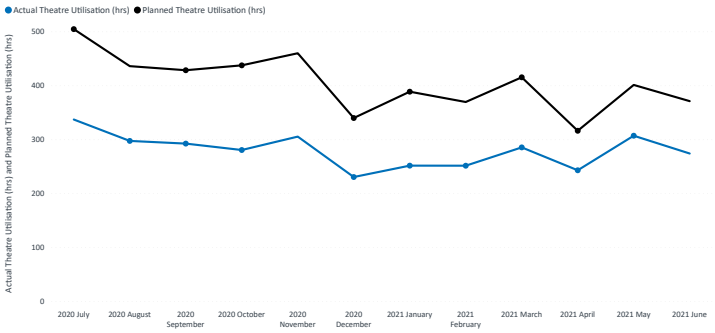
Invercargill - Average LOS (days)



Average Length of stay

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

Invercargill - Planned vs Actual Theatre Utilisation (hrs)



Actual Theatre Utilisation

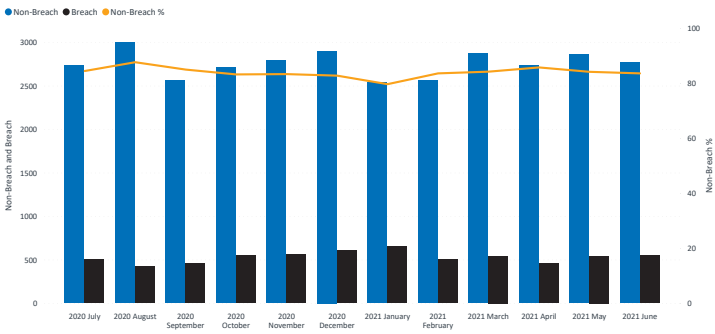
Actual theatre utilisation given by

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

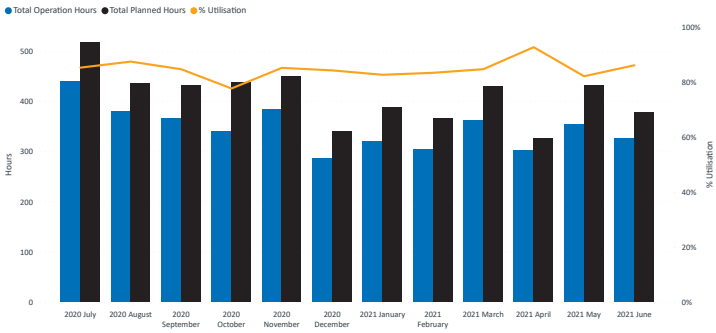
Invercargill - Monthly 6 Hour %



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

Invercargill - Average Theatre Utilisation (%)



Average Theatre Utilisation (%)

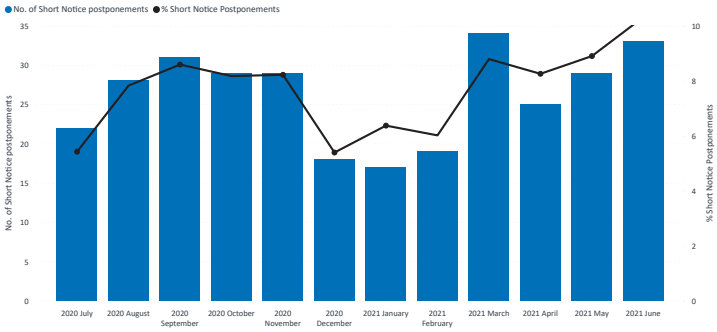
Numerator: Planned and acute operations from when the patient is brought into operating theatre to the patient leaves

"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

Invercargill - Short Notice Postponements



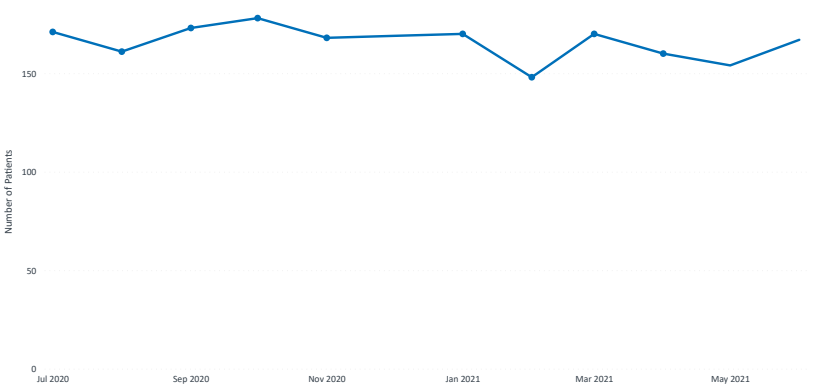
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Invercargill)

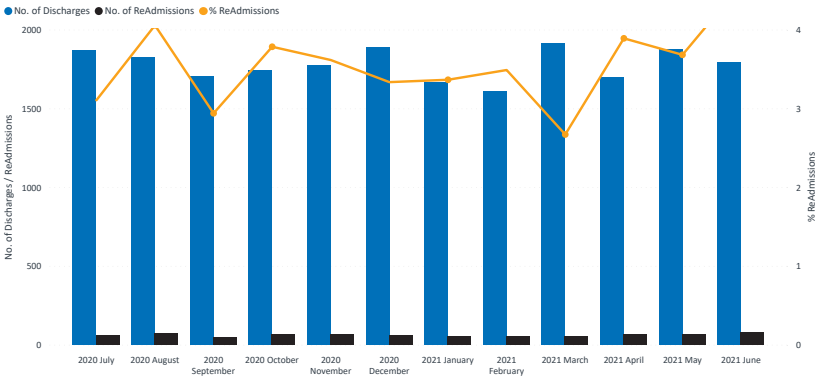
Invercargill - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

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

Invercargill - Unplanned Hospital Readmissions within 7 days

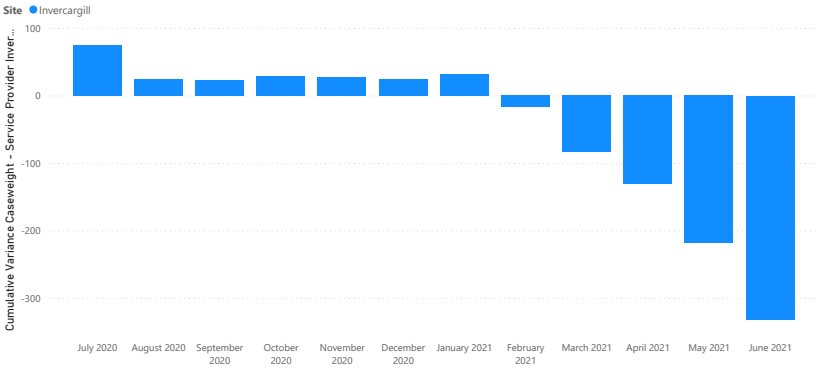


Unplanned Hospital Readmissions within 7 Days

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

Cumulative Variance Caseweight - Service Provider Invercargill

BY CALENDARMONTHYEAR, SITE

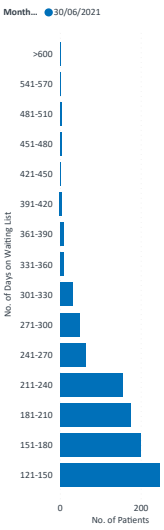


Cumulative Variance Caseweight

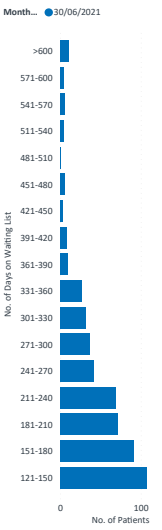
Column chart has cumulative variance case weight for Service provider which compares case weight with production plans based on MoH targets and work done in Southern DHB facilities, the Southern DHB's own population minus outflows plus inflow.

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

Invercargill - ESPI 2 Breache...



Invercargill - ESPI 5 Breache...



ESPI 2 and ESPI 5

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

Specialist Services monthly report for June 2021

Lead Executive: Patrick Ng

EXECUTIVE SUMMARY

- Oncology performance. Radiation Oncology wait list down from circa 157 prior month to 125. Working on reducing further with ongoing outsourcing.
- Strong elective surgery recovery (only 1.6% below plan) despite nurse strike, but this was dependent on high outsourcing.
- Ongoing nurse / bed resource issues. Nurse and Allied vacancies remain a key risk for our organization.

Performance area	Previous month	Current month	Commentary
Case weights surgery			Our final CWD was within 285 CWD of our full year plan of 17,500 CWD. This was ahead of our forecast but required high outsourcing volumes.
Discharges			Discharges followed same pattern as CWD delivery. Outsourcing was required to achieve this. This was ahead of forecast despite the nursing strike not being in plan.
ED six-hour target			Full draft of Southland B/C for ED expansion underway. Work progressing on de-canting plans for MAU for Dunedin. Both will materially improve respective ED target performance.
Cancer target <62 days			Investigation resource commenced in July. Some additional investigations occurred in June which has already lifted June performance to circa 80% compared to circa 71% prior year to date.
FSA (ESPI 2)			ENT Southland remains key challenge. Redistributing volumes to Dunedin where possible. 2nd surgeon starts in August.
Elective treatment< 4 months			Timaru orthopaedics solution still in place and working. High outsourced volumes in June to earn elective revenue. Nurse vacancies re-surfacing as a risk area. Outsourcing likely to be a key part of orthopaedic recovery in 21/22.
Medical imaging CT			Performance improved from earlier in the year (67% for June). 2nd machine for Dunedin remains on track for commissioning in early September.
Medical imaging MRI			Implementation of 2nd MRI will be a priority once CAPEX confirmed and tender process almost completed to select a preferred vendor. Likely to be commissioned early calendar year 2022.
Colonoscopy 14 days			Achieved above target.
Colonoscopy 42 days			Achieved above target.
Colonoscopy 84 days			On target in Dunedin. Catch up still required in Southland. Some Southland volumes are now able to be transferred to Dunedin (this continues to be dependent on nurse availability).

Current Issues	Update/Achievements	Upcoming key deliverables
Elective surgical delivery	Timaru orthopaedics continuing. Further orthopaedics outsourcing planning for 21/22. Work commencing on proposal for better acute capacity.	Bring forward an acute proposal which is supported by clinical colleagues seeking to expand internal elective-acute list capacity. Work is continuing on this.
Nursing FTE.	Analysis of nursing FTE growth from March to June identified reduced annual leave taken, growth in patient watches and sickness causing overall growth, despite vacancies.	Our key action/s are to review leave management and target those areas where there are not roster gaps for additional leave to be taken.
Elective surgical productivity.	Despite recovering elective performance in June, underlying elective delivery is below par (we were heavily dependent on outsourcing) and we have key nurse vacancy issues.	Full analysis of June delivery underway (separating outsourcing and nurse strike impacts) to validate that we have maximised use of elective sessions and that our key focus must be nursing vacancies.

Generalism

- IT team support requested to develop initial suite of dashboard measures to track key performance metrics for benefit realisation, including time in ED until consultant review, internal medicine length of stay and rate of internal medicine admission versus sub-speciality admission. The dashboard will be progressively built upon and future measures when the MAU is built will include time from presentation in ED to admission into MAU and time in MAU prior to discharge.

Oncology

- Recruitment campaign confirmed and being built. Anticipate commencing recruitment with the campaign next week.
- Refining scope of EY work (narrowing it to current state and immediate gaps and actions so as not to conflict with the strategy work underway nationally by the cancer control agency). Working on getting the initial exercise undertaken as soon as possible.
- Proof of concept undertaken with referral of a patient to Ikon in Wellington. Looking to use Ikon to supplement St Georges capacity when we need additional capacity (including now whilst one of our RO undergo treatment).
- Work underway to improve investigation prior to submitting FCT 62-day performance. June reported performance has lifted 8% compared to year to date with additional investigation occurring.
- Awaiting benchmarking information on our FTE from Cancer Control Agency. We'll start active follow up this week. Good collaboration meeting held with our Radiation Oncology peers in Christchurch.

Gastroenterology

- Good performance for the month in symptomatic colonoscopy screening.
- Category C is being progressively removed as those in the category get their scans (no patients booked to category C since decision to remove it in June).
- Some ability to move surveillance backlog to Dunedin now but further progress on this dependent on successfully recruiting scoping nurses so that more sessions can be run. Recruitment is underway.

SP&C Services monthly report for June 2021

Lead Executive: Rory Dowding

EXECUTIVE SUMMARY

Positioning Public Health services for the future	Previous month	Current month	Commentary
COVID-19 Response			▪ The week beginning 28 June, Southern DHB reached a milestone of 80,139 vaccinations. Most (57%) were completed in the large DHB run clinics in Dunedin and Invercargill. Increasing numbers (43%) are being undertaken by primary care into rural areas. ▪ We are well into tier 3 with 22,000 (of 100,000) vaccinations completed. In June, our biggest challenge has been managing the constrained vaccination supply which saw us shift from achieving 130% of our previously submitted production plan to target 90%; this is a shift from 10,500 vaccinations per week, down to 7,500 vaccinations per week. We anticipate being able to deliver at full capacity again from 26 July. ▪ Our Māori and pacific rollout is underway, with 1,275 vaccinations already completed by the providers. Two general practice-based clinics have been established, with one located in Caversham and the other in Invercargill. Our Māori health providers have delivered successful outreach clinics in Alexandra, Gore and Invercargill. ▪ We are developing a plan to transition to the new National Booking system (NIBs) from 7 July.. ▪ Vaccinations is underway in ARC facilities; this is onsite, with vaccine delivery through General Practices, pharmacies and flying squads.
Immunisation			▪ Measles Mumps Rubella (MMR) Campaign for 15-30 year olds is on hold within the Southern DHB but staff still use available platforms to promote vaccination, e.g. outreach appointments. General Practices and Pharmacies continue to vaccinate. The team is seeking Ministry of Health direction on recommencement dates
Maternity			▪ Southern DHB has commenced service provision at Central Otago Maternity Hospital as at 1 July. ▪ Lakes Maternity Midwifery Co-ordinator is supporting the development of the Primary Birthing Unit in Alexandra, by mentoring the Clinical Lead at Central Otago Maternity Unit. ▪ Business Case being developed for submission to MoH. Strategic and Economic case has been developed, and engagement with QS etc underway.

Current Issues	Summary of risk	Mitigation strategies
ARC RN staffing	Aged care facilities continue to struggle with RN staffing	ARC Workforce Steering Committee developing strategies to recruit and retain RNs in aged care including a Rotational Programme and working closely with the new graduates training.
WellSouth PHO - Invercargill and Wanaka After Hours Primary Care	Clinical safety compromised if no overnight primary care is available to the population of the Invercargill and Wanaka	Engage with key stakeholders: WellSouth and Local General Practices (GPs). Hold contract holders to account.

Strategy and Planning

Annual Plan

- The Southern DHB Statement of Performance Expectations was published on our website on 29 June.
- The full final draft plan was submitted to MoH on 2 July and MoH feedback is expected by 23 July

Service Plans

- The planning sessions previously established with Finance and with Māori Health have been suspended as staff were prioritised to COVID vaccination programmes. These will be re-established over the next month, in preparation for 2022/2023 planning guidance and facilitation for the services.
- Service planning was discussed at the Clinical Directors annual meeting in Balclutha (27 May 2021); key points included understanding the process and the language of service planning, involving the team, alignment with the budget process and strategic goals, and regular checking in on how things were going.
- The Strategic Refresh currently underway will provide guidance for service planning 22/23.

Health Needs Analysis

- Phase one of project is largely complete. Eighty-three indicators, in four key domains (demography, health drivers, health status and health service) where selected. The majority of the data has been acquired and analysed. Narratives for each indicator are in draft form – eight indicators are in advanced stages and have been reviewed by a representative for the Maori Health Directorate for the prototype. Data quality assurance across the indicators is in progress.
- Phase two is underway. The web-based prototype, using eight select indicators, is live on the Southern Health website. Consultation has occurred to gather feedback on the prototype via Community Health Council members, Runaka, primary care, allied Health, rural teams, the Maori Health Advisor and DHB staff. The feedback is being collated and the team are making updates. In general, the feedback was positive with constructive solutions to make improvements to navigation, content, the data portal and the overall experience.

Locality Planning

- SPC have responded to a request for information from the MoH Transition Unit to enable them to "To understand and catalogue existing DHB practice and enablers that could support a population health approach to localities."
- Our response provide a range of information in relation to: Locality planning and needs assessment; partnership with Māori; community engagement; cross-sectoral working; integrated models of care; Pacific providers and data intelligence & governance.

SP&C Services monthly report for June 2021

Lead Executive: Rory Dowding

Public/Population Health Service

Sexual Health

- Work has begun to assess providing mail out Sexually Transmitted Infections (STI) testing to rural residents in Southern to reduce inequities in access. This is an exciting opportunity to explore increasing equitable access to STI testing for those in rural settings

Drinking water

- Work continues with the Dunedin City Council (DCC) around the lead in water issue and bringing it to a conclusion. Despite an extensive investigation, they could not find a definitive cause. Based on all the work carried out, the likely cause of most of the lead getting into the water was from pipes and fittings in homes and businesses, not from the DCC network.

Vaping Project

- The Vaping Project is now live, with the pharmacies involved in the pilot able to access vaping kits. This project is aimed at providing vaping starter kits to long term mental health patients, and other long-term users of tobacco, so that they can use vapes instead of smoking tobacco when in our care. There are also two General Practices involved who are able to refer their patients to the pharmacies for their free vaping starter kits; the Southern Stop Smoking Service also has stocks of the starter kits. The aim is to support long term patients and improve their health by reducing the use of tobacco.

Breastfeeding

- A breast-feeding hui is being planned for the end of August.
- The South Island Alliance (SIAPO) has established a group to look at breast feeding as rates across the South Island do not meet targets.

Community Oral Health Service

- The Southland Dental Unit's increasing General Anaesthetic list continues to grow with more than 200 Southland children on the list. This has occurred due to the impact in the Theatre/Endoscopy suite caused by Anaesthetic Technicians or staff off sick, or space being at a premium.
- Meetings between the District Oral Health Service Manager and the Theatre Manager have been undertaken to discuss the impact of this to the growing dental list.. Proposals to reduce the growing General Anaesthetic list have been put forward for consideration.

Aged Residential Care

- Aged care facilities continue to struggle with RN staffing and continue to notify the DHB when contractual obligations cannot be met. Mitigations are put in place, but the stress on the staff is significant. Our ARC Nursing Workforce Steering Group has been actively seeking and following up on actions to address the issue.
- Bed availability in aged residential care continues to be problematic, exasperated by the RN Shortage. Southern DHB and Canterbury DHB are collaborating to better understand drivers of high utilisation of psychogeriatric beds in both DHBs compared to other NZ DHBs.
- The levels of occupancy in Aged Related Residential Care (ARRC) have reversed and we are seeing an overall decline in bed utilisation. Total utilisation is back to levels seen in mid-2019, albeit with a slightly different mix. Rest Home level continues with a gradual reduction.

Rural health

Lakes District Hospital

- Additional medical shifts have been rostered to cover the evenings at Lakes District Hospital to manage the increase in presentations to the Emergency Department in winter.
- Recruitment to a nursing position in Outpatients has commenced to enable patients who receive IV infusions to receive this service at Lakes. Patients have previously travelled to Invercargill, Dunedin and Clyde (Dunstan Hospital) for this treatment. Dunstan Hospital is at capacity and cannot accommodate Queenstown patients any more. The clinical demand for these treatments are increasing, which puts a strain on the system.
- Lakes Midwives and local Lead Maternity Carer (LMC) midwives have started working with core midwives and midwifery and quality leaders in Southland and Dunedin to streamline the process of transfer of women to base hospital, when clinically indicated. Barriers to the process have been identified and a new pathway is being developed that will support a more straight forward and thus safer system for women.

Rural hospitals

- The Rural Trust Hospitals have been offered a new one year Heads of Agreement contract. Two of these have been signed and we await the return of the other two.
- The Rural Trust Hospitals Chief Executives are working with Southern DHB, WellSouth and others, to plan a Summit to discuss the opportunities for the development of Localities in the region. An initial meeting involving the Transition Agency and Ministry of Health was held in Balclutha in early June

Refugee Quota Programme

- The refugee resettlement programme has resumed. There is currently negotiation between Dunedin public sector agencies and MBIE to ensure there are ample sized cohorts of Afghan refugees resettling in Dunedin to establish community. This is due to the concern of an 'Auckland Drift' – refugees migrating to Auckland and other cities shortly after arriving in New Zealand. WellSouth is exploring this issue.
- These issues are not limited to Dunedin. There are concerns for the small resettlement cities on the South Island – Blenheim, Ashburton, and Timaru, as well.
- MBIE has announced new standards and certification requirements for interpreters. All interpreters working in the public sector will be required to have certification through the National Accreditation Authority for Translators and Interpreters (NAATI) of Australia. This will commence in 2024. And while a few years away, these requirements could have a profound impact on the Southern DHB interpreting service as no interpreters working for Southern DHB are NAATI certified and there is no tertiary interpreter training outside of Auckland.

Frail Elderly Project

- SPC has undertaken the Frail Elderly Project project to develop integrated services incorporating admission avoidance for frail elderly in Mosgiel (DN).
- The Frail Elderly Project is currently in the formative stages. A Steering Group has been created which will start to identify the areas where we need to gather and analyse further data.

Q & CG monthly change report June 2021

EXECUTIVE SUMMARY – HYWEL LLOYD

Recommended Work Plan for SDHB Risk Management and Implementation of Safety1st Risk Register Module submitted to Executive Leadership team. The aim is to provide a work plan that can be systematically progressed and support a successful implementation of Safety1st Risk Register. Impatient survey indicated an improvement of patient experience in Southern report above average responses for 30 out of the 35 questions up from Aug 2020 10 of 29 question . Increase in patient complaints with theme of poor access to services.

SERVICE UPDATES	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
Consumer Experience			Disability working group is progressing the disability plan. Patient letter quality continues to be an issue. Increase in complaints about access to services . Improved inpatient experience.
Quality & Performance Improvement			The improvement team have a full catalogue currently. Service level accountability framework to be reviewed with support from Leena Singh and new Clinical Council chair
Patient Safety & Risk			The Risk register has had further delays in moving to Safety first. The quality of the mitigating plans within the register requires improvement. Finance Audit & Risk Committee requests Clinical Council sign off that all risk is recorded.
Emergency Management			Poor directorate response to Business Impact Assessment request for cyber attack. COVID-19 resurgence plans require a review and refresh.

QUALITY IMPROVEMENT ACTIVITIES	
ALL	All QI initiatives are progressing well, with no blockages requiring Executive Leadership Team action.

CURRENT ISSUES	SUMMARY OF RISK	MITIGATION STRATEGIES
Risk of cross infection managing patients with infectious diseases	Airborne Isolation Rooms have poor compliance with current standards	Dunedin: Installation of three Negative Pressure Units - suboptimal, but better than neutral pressure.
Cyber attack on IT systems	Business Impact Analysis for IT. Only BPS and Procurement have produced the requested BIA for a Waikato IT event	Current IT security policies
Poor system response to COVID-19 Resurgence	Health Services will not undertake a fast co-ordinated response to a COVID-19 outbreak	Resurgence Plans need to be reviewed and refreshed.
No Clinical Governance for whole of system	There is no current clinical governance across primary & community and hospital based services	Relationship building and clinical governance conversations between SDHB and WellSouth continue.

Risk Management Maturity Journey:
The Risk register development is progressing, the move to safety1st is delayed. The mitigating plans require more detail to identify metrics to better understand declining and increasing levels of risk.

Clinical Governance & Service Level Accountability:
The Service level accountability (SLA) framework is to be reviewed with input from Leena Singh and the new Clinical Council chair. The SLA will merge with the performance and accountability framework proposed through Leena's report.

Disability Strategy:
The disability working group led by John Marrable(contracted 0.2))has completed their second meeting. The group are progressing the Disability action plan.

People and Capability monthly report for June 2021

Lead Executive: Tanya Basel

EXECUTIVE SUMMARY

- Transitioning from Mike Collins to Tanya Basel taking on the ED role for People and Capability.
- Occupational Health and Safety Directorate review of the incident on 3 May in Ward 9B is complete. Report and recommendations to be discussed at HSW Governance Committee
- Building Internal change capability is a work in progress and HR is partnering with the Principal Advisor to the CEO in this regard.

	Previous month	Current month	
Workforce & HS/W			
HR Dashboard Development			Data Errors on the dashboard has come to light. The information being provided does not align with Financial data sets and requires investigation.
Workforce Strategy and Action Plan			Good progress is being made against the action plans for workforce.
H&S			Reporting to FARC and HS Governance group progress continues.

Current Issues	Update/Achievements	Upcoming key deliverables
Children's Act checking	In the past 3 months over 2,000 employees had their CA renewed.	Bulk rechecking and process will be reviewed to ensure we are able to smooth the peak for next check.
Pay Equity	• Clerical/Admin: role mapping complete • Allied Health: interviews underway for 17 roles covered by the claim. • Nursing & Midwifery: Outcomes of interviews being processed.	• National support hub continues to work on roles that don't fit the national profiles
Employment Related Matters	• 97 employment related matters are being addressed through various HR processes • Cases have increased by 34% year on year.	• New HRBP appointed and due to start on 12 July 2021.

Recruitment and Immigration Challenges

- Recruitment to the COVID-19 Vaccination Program has been positive.
- Except for SMO's, all other workforce groups has seen an increase in vacancies in the past 2 months.
- Nursing recruitment remains constrained for key areas e.g. ED, Southland.
- Immigration challenges for existing staff needing to apply or extend visas where positions need to be re-advertised to prove there are no suitable New Zealanders that can do the role before they will support the visa application.
- SMOs: time to place has reduced recently and we have had some success in appointing into some of the hard to fill positions.
- Restrictions on Immigration / Border closure (Immigrants must come to NZ on a visitor visa, in the hope it can become a work visa on arrival)
- Corporate vacancies are especially being impacted by the government pay freeze and the impending Health NZ changes

	FTE Vacant	Number of vacancies	Change
Admin	34	55	
RN / RM	176.25	269	
AHS&T	98.025	122	
SMO	40.95	50	
RMO*	40.6	41	
Mgmt	48.3	52	
Support	15.75	29	
June	454.34	618	
May	414.87	566	

Enabling our People – Strategic Intent

- Pilot for Emerging Leadership and Succession Planning being scoped out in Strategy, Primary & Community (interprofessional initiative between OD, Allied Health and Nursing initiated this month)
- Disability Awareness workshops implemented this month, "The Accessibility Game" - series of these workshops will be held throughout the year. Collaboration with the Disability Committee continues.
- The final 2x School for Change Agents Workshops held this month - action learning groups to take forward with OD support.
- Two employee wellbeing training providers have met with the team this month and provided demos on their resources and toolkits - Chnnl and Akoako - pilot sites are being considered for both across the southern system - Dunedin, Invercargill, and Lakes. The intention is to provide proactive wrap-around wellbeing support for the organisation using enabling technology.
- LEADS programme underway this month including the prerequisite aspects of self and 360 assessments.
- Action plan in support of the Staff Engagement Survey outcomes is in progress – this involves a continuance of initiatives already underway, some new initiatives and also a plan to run some focus groups with General Managers.

Digital monthly report for June 2021

Lead Executive: Nigel Trainor

EXECUTIVE SUMMARY

- The Digital team is in the final stages of being finalized since it's shift into the Corporate Services Portfolio. Projects are progressing well however resource constraints, recruitment gaps continue to be a challenge.

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 DG & CIC approval complete. Now pending cabinet approval. June '21, Board approved T1.2 funding. Sapere engaged and work commenced on the detailed business case. EY engagement extended to complete requirements & cost model work. Digital Infrastructure consultant RFP tracking to plan, Board approval in Sept '21.
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. Pending confirmation of FY21/22 Capex budget.
South Island PICS			Team currently being recruited, steering group established and project milestones being confirmed.

Current Issues	Update/Achievements	Upcoming key deliverables
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), remains on-track
- 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, mock attack workshop scheduled 27/07/2021
- SI PIC's approval of SIPICS business case approved by Joint Ministers, planning underway
- Wireless improvements completed
- FPIM implementation live as at 01/07/2021
- Scanning Solution to digitize records draft business case under review
- Recruitment Upgrade complete
- Exec review of Human Capital System Upgrade
- iMedX (digital transcription) rollout phase 3 complete.
- Windows 10 rollout BAU handover complete
- Allied Health information system, RFP complete & vendor selected, draft business case ready for Exec post Capex budget finalization
- MSO365 phase II – Project approved, new resource recruitment underway
- Printer replacement – Project planning underway, targeting rollout of new hardware by Dec '21
- Vocera handsfree comms – Business case approved, project planning underway
- Cherwell Reinstall – Business case approved, project planning underway

Finance monthly report for June 2021

Lead Executive: Nigel Trainor

EXECUTIVE SUMMARY

SDHB went live on FPIM on 1 July 2021, the cut over was described as text book.
We are expecting the rectification design on 3 Aug 2021 for the Dunedin Hospital level 5 ICU HVAC.
Draft design plan for the 5th Theatre and changes to the ED are progressing with excellent staff engagement
The new CT in Dunedin Hospital is tracking well, but will be held up by the shipping of the machine.
Decant plan for the space to be occupied by the MAU are progressing
Steering group for the NDH Digital transformation meet and progress is being made of the DBC, however the financial component will need discussion with the MOH and potentially the Treasury.
SDHB year end financial outturn was disappointing due to Pharmac, outsource and staff costs.

Key Projects	Previous month	Current month	Commentary
Financial sustainability			The month of June 21 seen an increase in FTE across a number of areas and being adverse to budget, together with additional outsourcing of planned care and late adjustments advised by Parmac.. This created a Year end result of $19m BAU plus additional one offs to finish with a $28m deficit overall.
Holidays Act 2003			The Holidays Act project continues 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. The MOH have appointed KPMG to work with all DHBs to oversee the project.
FPIM: Finance Procurement & Information Systems			FPIM did go live on 1 July.
New Dunedin Hospital Business Case			Cabinet have approved the detailed business case in principle

Current Issues	Update/Achievements	Upcoming key deliverables
Savings plans	The delivery continues to be "at risk".	The NZHPL & Pharmac procurement activities A number of procurement savings have been achieved through the procurement process
FPIM go live date	Date set at 1 July 2021	The team anticipate a smooth go live onto FPIM
Holidays Act 2003	The project is gaining momentum.	A number of national decision are yet to be made. The MOH have set up a programme office to assist with working through the issues to resolution

Budget 2021/22

- The MOH have agreed to the 2021/22 budget, we are just checking that the draft budget aligns to the 2020/21 actuals, which this may see some changes to various lines the budget result of $24.3m deficit will remain unchanged.

Facilities

- The team are working to a 20-week timeline for the development and delivery of the new CT. At this stage this looks to be a month late due to the timing of the CT arriving into port. The facility changes are on target.
- The MAU planned for in Dunedin hospital is tracking with the decanting of existing departments plan nearly complete, a lease for the move of a MH Community Service currently operating out of the Fraser building has been signed.
- The ICU rectification project is being closely monitored with progress being made. We are on tract to receive a rectification plan from the consultants on the 3 Aug.
- The decant of the space in Oncology for the relocation of Sterile services in Dunedin is well under way.
- A plan for the changes in Kew are being advanced. This is developing into an excellent plan to reduce the facility pressures.

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: Performance Dashboard Development Progress Update 2021

Proposed by: Principal Advisor to CEO

Meeting of: Board, 3 August 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 the development of the Performance Dashboard.

Specific Implications for Consideration

1. **Operational Efficiency:** System performance information located centrally in PowerBi allowing for more transparency & visibility

Background

There was an agreed need at a Board level for a more effective way in which to access performance information relating to our system. Given adoption of PowerBi internally, an initiative was started at the end of 2020 to build a Performance Dashboard that would house 28 key indicators and be a platform that the Board, Exec and other staff could access to find information they needed all in one place.

Discussion

The build of the dashboard has taken longer than we initially anticipated due to various factors, but progress is being made as demonstrated in this update. Feedback, suggestions and questions are welcome.

Next Steps & Actions

The dashboard build is ongoing.

Appendices

1. **Performance Dashboard Progress Update July 2021**

PERFORMANCE DASHBOARD INITIATIVE

Summary of progress to date:

To date the following tiles in the performance dashboard have been completed/still to complete:

*UAT = User acceptance testing

Measure (complete or in process of)	Stage
6 Hr Target	Built/Complete
Resourced Occupancy	Built/In UAT needing sign off
Physical Occupancy	Built/In UAT needing sign off
ED Attendances (Rebuild of PoC)	Built/Complete
ESPI 5	Built/Complete
ESPI 2	Built/Complete
CCDM Shifts Below Target	In UAT /sign off requested
CCDM Bed Utilisation	In UAT/ sign off requested
CCDM Care Hours Variance	In UAT/ sign off requested
CCDM Patient Acuity	In UAT/sign off requested
CCDM Variance Indicator Score	In UAT/sign off requested
Caseweights	Exists in a different reporting format and needs to be integrated into this platform
Planned Care Caseweights	Exists in a different reporting format and needs to be integrated into this platform
Planned Care Discharges	Exists in a different reporting format and needs to be integrated into this platform
Raw Discharges	Exists in a different reporting format and needs to be integrated into this platform
Head Count (HR Dashboard)	In UAT/sign off requested
FTE (HR Dashboard)	In UAT/sign off requested
Follow up metric	In progress – working on code now, same dataset as caseweights
HCSS	Built, handover to IS in progress
High-Cost Procedures	Coding underway, in progress
Measure (yet to build)	
Output per FTE	Not Started
Community Pharms	Not Started
Hospital events as per Escalation Plan	Not Started
High cost Pharms	Not Started
FSA's	Not Started (poor data integrity)
Average length of stay	Not Started
Worked vs Contracted FTE	Not Started
Primary Care (Enrolled Pop)	Not Started
IDF's	Not Started
Mental Health Bed Days	Not Started

Next Steps:

Since the last update, three tiles have been given sign-off by the business owners as indicated above and snapshots of these measures are provided below. The monthly narrative to be provided by the business owners is yet to be incorporated but we plan on having this beginning to be available in the next month of reports.

Getting sign-off from the business owners has taken longer than anticipated. Currently this group of people is 1-3 people in our organisation so represents a bottleneck and there are two further groups of metrics out for sign off now – CCDM metrics and the HR metrics.

In the last Board meeting it was asked whether we could look to incorporate national benchmarking data into this dashboard. This is possible in theory and so the team are exploring options at the moment, either Health Round table data or Health, Quality and Safety Commission data could potentially be used.

Figure 1:

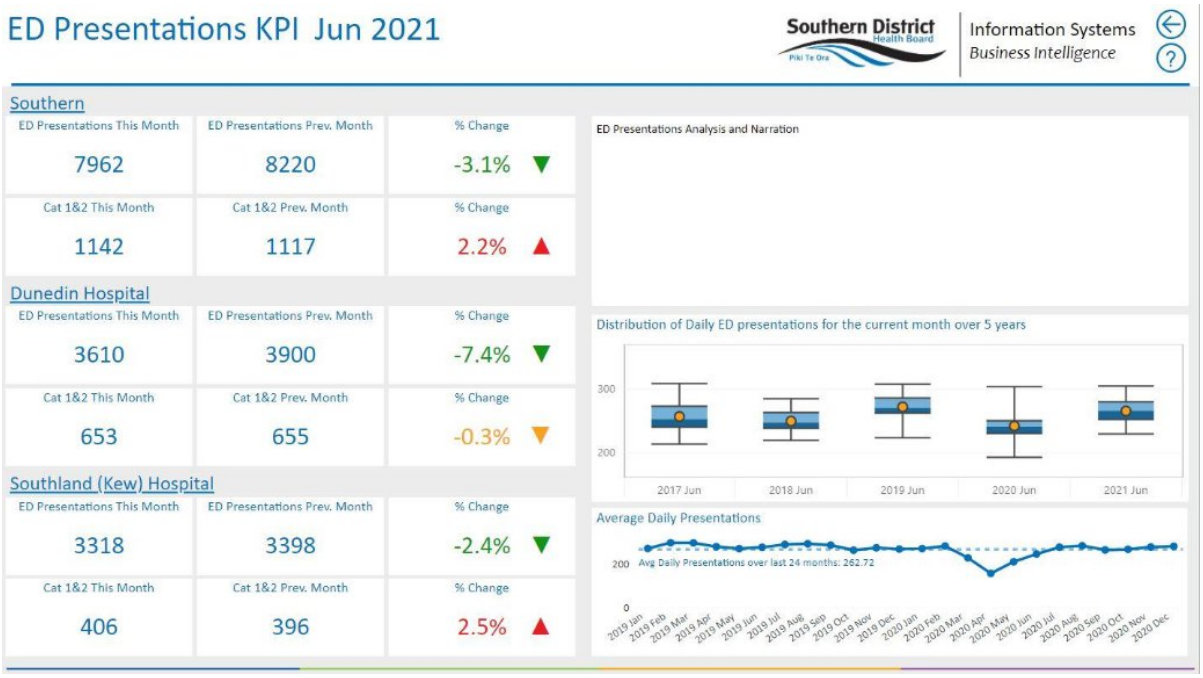


Figure 2:

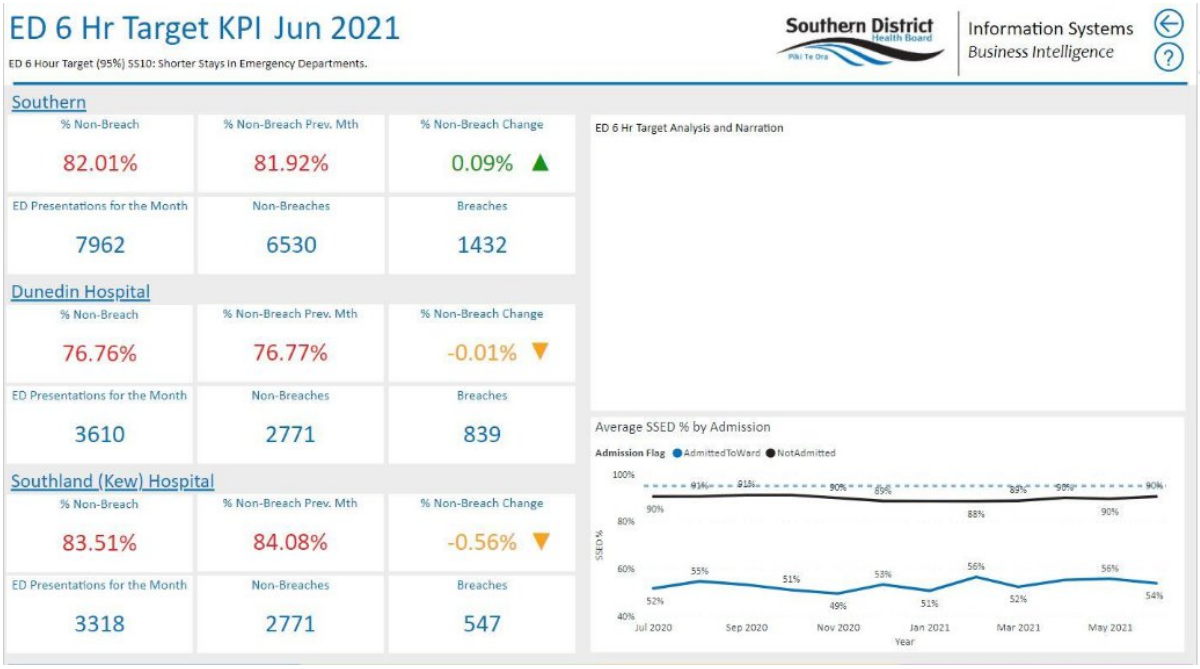
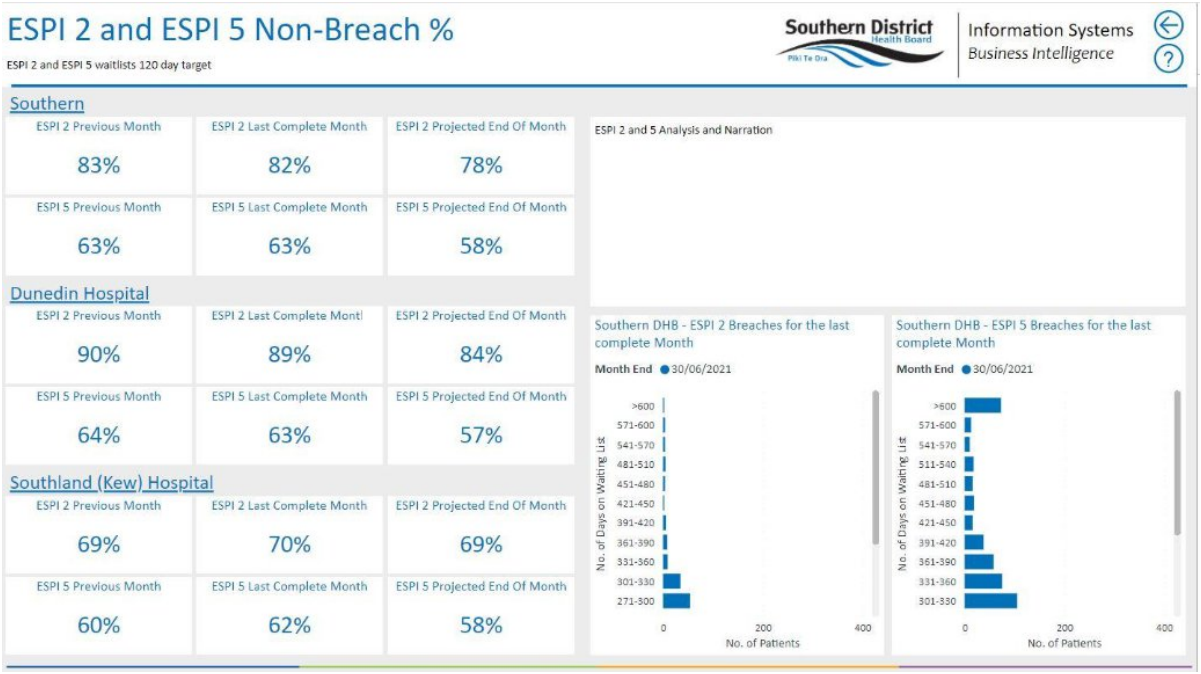


Figure 3:



Risks/dependencies/constraints:

- Since we started on this initiative in November of last year, we have encountered some IS resourcing challenges which has slowed progress, and this still represents an ongoing challenge, however a new Team Lead has joined the reporting team and is having a positive impact already. We have now committed to the development of the Performance & Accountability framework which also has a strong data component and will impact the resource in this team.

- There is a bottleneck getting sign-off from the business owners given they are a small group of people with competing priorities.

FOR INFORMATION

Item: **Strategic Refresh Update July 2021**

Proposed by: Strategic Refresh Steering Group, Southern District Health Board

Meeting of: Board, 3 August 2021

Recommendation

That the Board notes the content of these papers, and supports the course of action to date.

Purpose

1. To summarise progress that SDHB in collaboration with Synergia have made on the Strategy Briefing project.

Background

2. SDHB embarked on an important piece of work refreshing the 2015 Strategic Plan. The evolving situation with regard to the Health reforms have intensified the need and importance of this work. Synergia are our chosen partner in this project and are leading the ongoing project rollout.

Discussion

As per the progress update.

Appendices

Synergia Board progress update July 2021

SOUTHERN DHB STRATEGIC REFRESH

July update to the Board

1. KEY POINTS

- The project continues to proceed in an environment of some uncertainty and rapid change, with health reforms structural change and the Transition Unit providing ongoing guidance for the future health system, particularly related to localities. More clarity is slowly appearing as more information and insight comes out of the Transition Unit related to its plan for the new system. This gives our work more direction and guidance.
- The Southern sector is responding well to positioning of this project to be supporting the Southern system to be proactive and responsive to the opportunities with the health reforms.
- The project is generally on course, with considerable sector engagement completed, and is ongoing. Data has been provided by the Ministry of Health and work has begun to explore the analysis of this.
- The project workstream related to engagement with Māori has begun and is beginning to increase in intensity. This area of work is critical to the final output of this project, to ensure the advice and recommendations we are providing are informed by and aligned to the aspirations of iwi and Māori in the Southern region.

2. POSITIONING OF PROJECT

The project has been described as a 'strategy refresh' however, there was concern that this positioning was a little confusing for stakeholders, as the DHB will be disestablished in a year and Health NZ/ Māori Health Authority will lead strategically across the country.

The project steering group discussed this issue and agreed that the work should be framed as a "Strategic Briefing for the Southern Health System". The audiences for this

work are the DHB, the southern health system itself (providers and workforce), Health NZ and the Māori Health Authority as incoming kaitiaki for the system.

The purpose of this work is to develop clear guidance on needs, future system design and infrastructure, as well as strategic priorities for action as defined by those in the Southern Health System. A key aim is to provide proactive advice to the incoming Health NZ and Māori Health Authority leadership.

3. IWI MĀORI ENGAGEMENT

Synergia, in partnership with Associate Professor Matire Harwood, will be working with the Iwi Governance Committee and other providers to explore locality establishment, the role of Iwi in localities and future Māori service provision. This work is expected to ramp up over the next two weeks and will inform all other components of the project.

This work includes:

- Meeting with the Iwi Governance co-chairs to discuss the approaches for engagement.
- Engagement with iwi and non-iwi Māori providers across the region to understand their perspectives of what should be included in the briefing document, their experiences of the system, desired approach to locality leadership and development and systems of care.

4. BOARD WORKSHOP

A Board workshop on the strategic briefing is proposed for late August. The aim is to provide a more in-depth update as to the key activities, emerging themes and findings of the project to date, and to then understand Board perspectives on strategic issues and priorities. The Board is an important stakeholder in this work, and it is desired that the Board and the Iwi Governance Committee jointly endorse any and all outputs of this work.

5. LOCALITY DESIGN AND DEVELOPMENT

Through broad sector engagement across the region, work has been done to explore the leadership approach and infrastructure localities would require to function in the manner outlined by the Department of Prime Minister and Cabinet Transition Unit. This work is ongoing and will inform key recommendations and guidance in our final briefing as to the structure, leadership and infrastructure required for the establishment of effective, high performing localities and networks in the Southern region, taking into account the specific context, strengths and challenges of this region.

6. SYSTEMS OF CARE

Synergia is working with DHB and WellSouth clinical leaders using joined-up, whole of system data to explore shifts in systems of care needed to support improved equity, care closer to home and reduced hospital demand, particularly in the context of the New Dunedin Hospital. We expect this work to lead to guidance around systems of care, the future role of integrated clinical leadership and the used of integrated data to support whole system design and monitoring. This work is ongoing and expected to involve more detailed engagement with clinical leaders across the system.

7. NEXT STEPS

The work over the next month will include:

- Increased focus on engagement with iwi and Māori providers across the Southern System.
- Ongoing engagement with the sector with a specific focus on clinical leaders to support the systems of care workstream.
- Focused data analysis on patient journey mapping across the system, using joined up DHB and PHO data to give a full picture of the Southern Health System.
- Focused communications with relevant stakeholders regarding the positioning and framing of this work.
- Development of the draft core concepts to be included in the strategic briefing.

FOR INFORMATION

Item: **SDHB Change Programme Report July 2021**

Proposed by: Principal Advisor to CEO

Meeting of: Board, 3 August 2021

Recommendation

That the Board notes the contents of this progress update acknowledging the iterative approach.

Purpose

1. To summarise progress of the SDHB's overall Change Programme.

Background

In March 2020 the SDHB approved a change programme. This update aims to provide a high-level portfolio overview of that change programme which is a combination of strategic change initiatives and our business-as-usual activity.

Discussion

This is the second iteration of this report and will continue to adapt and develop. Shortly we will move to using a SaaS cloud-based software platform (Cascade) to assist the organisation with the ongoing monitoring of this change programme which will offer an additional level of sophistication and transparency to our portfolio as monitored by the ePMO.

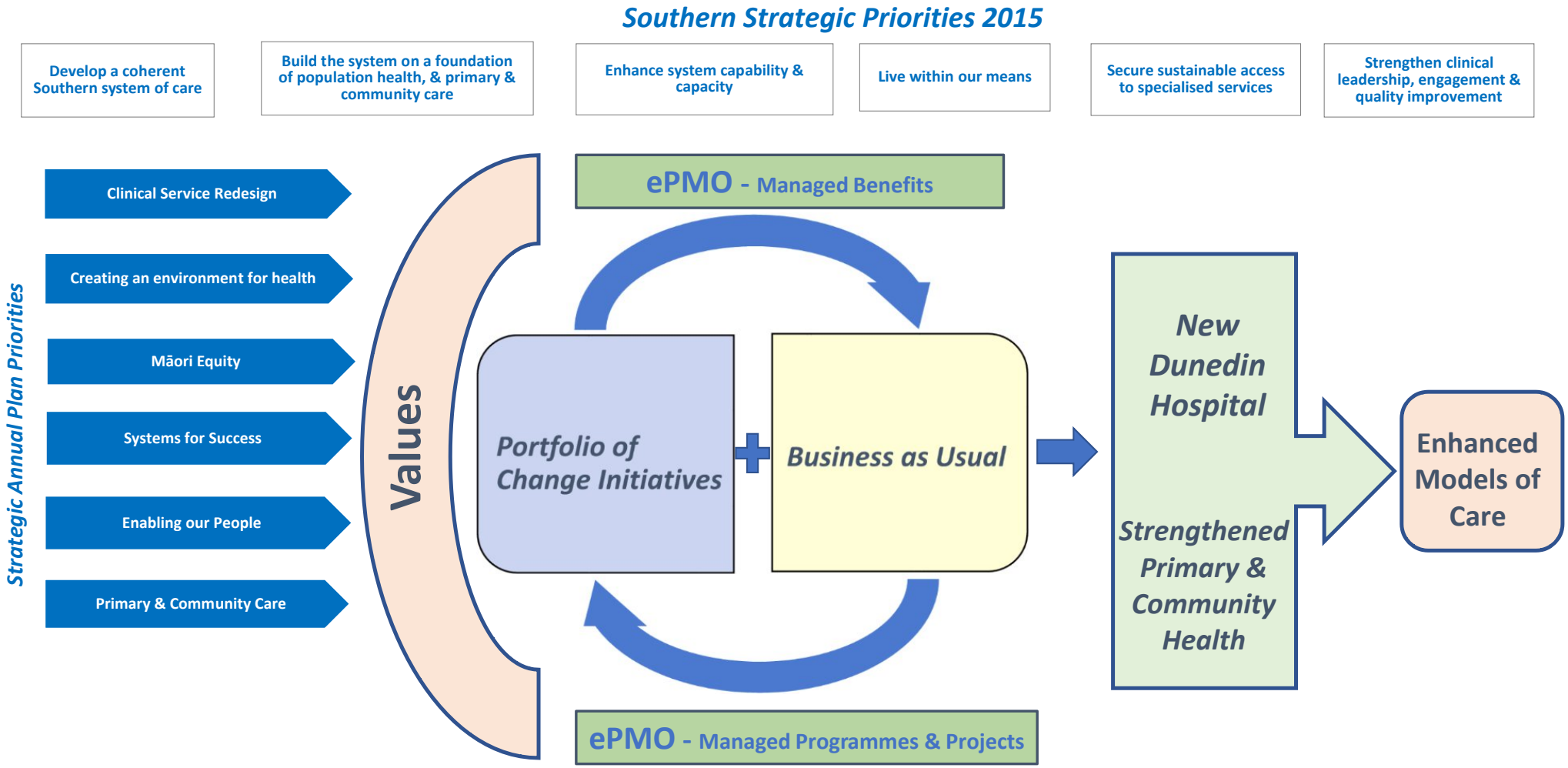
Next Steps & Actions

Continued monitoring of the change programme will occur and planning for moving into the new platform.

Appendices

SDHB Change Programme Update July 2021

Strategic Change Portfolio – Progress Update July 2021



Strategic Change Programme – Progress Update July 2021

Regional Lens & Alignment

Southern Strategic Briefing Project Underway

Southern Strategic Priorities 2015	*Strategic Annual Plan Priorities*	TRANCHE 1: 2021-23 SHORT TERM		TRANCHE 2: 2023-26 MID TERM	
		Well underway with benefits starting to be realised	**Underway with activity taking place**	**Planning Underway**	**Not yet Started / Concept Stage**
Develop a coherent Southern system of care	**Clinical Service Redesign**		• Dunedin & Southland Master Site-Planning • **MAU*** • **Oncology Sustainability Planning *** • **Patient Flow/Implementation of the SAFER Bundle*** • **Hospital escalation plan*** • Discharge documentation re-design • Operational Structure reset	• Generalism	• Implementation of MH review recommendations • Security Review • Operational Management system implementation (Integrated Operations Centre) • CETES (Clinical Engineering, Tech & Equipment Service • Acute Assessment & Planning Units • 23 Hour Unit
Build the system on a foundation of population health, & primary & community care	**Creating an environment for health**		• Health Needs Analysis • Primary & Community Work Programme		• Locality Network prototyping
Secure sustainable access to specialised services	**Māori Equity**	• Implementing Whakamaua: Māori Health Action Plan	• Equity actions improvement plan		• Maori Health Authority Commissioning
Strengthen clinical leadership, engagement & quality improvement	**Systems for Success**	• Virtual Health • FPIM Implementation • HRIS	• District-wide clinical partnerships • Transitions Improvement: Rural transfers & transfers to ARRC • Data & analytics reporting improvement plan • Risk Management maturity journey • Establishment of ePMO & Project Governance Framework	• Clinical Costing System * • Right-sizing Southland ED • PICS Implementation • Quality Improvement Framework • South Island Digital Transformation • Performance & Accountability Framework* • Production Engineering *	• Central Decision Support Model • Sustainability Improvement review recommendations (Singh review) • Transit Care Units (TCU) • Seven-Day Hospital
Enhance system capability & capacity	**Enabling our People**				
Live within our means	**Primary & Community Care**	• Workforce Modelling	• Wellbeing: Aukaha kia kaha programme • Strengthened Credentialing • **CCDM Implementation***	• Building internal change capability (L&D/ePMO) • **Disability Strategy Implementation***	• Implementation of MH Health & Safety review
		• Health Care Homes	• Frail elderly pathway • Primary care in Southland	• Maternity Central Otago • Health Hubs Implementation	

Key: * = Shift from last update & Highlighted = contributing towards the NDH

10

Strategic Change Portfolio – Progress Update July 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status Current	Month Status Previous	Additional Comments	Key Risks/Key Dependencies
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)						
Southern Strategic Briefing Project (nee refresh)	Oct 30th	Board/CEO			Project on-track with agreed reset of naming convention. Data & engagement tracking well.	
MAU	Aug 2022	EDFPF			De-canting of areas underway slightly delayed, but overall programme progressing	
Oncology Sustainability Planning	Ongoing	EDSS			Multiple workstreams in flight	Recruitment Success key dependency/risk
Discharge Summaries Re-design	Dec 2021	CMO/EDQCG				Availability of project resource dependency
Operational structure re-design	Sept 2021	CEO/ELT			Proposal for change in flight.	
Production Engineering	August 31st 2021	EDSS			CSO closed, only 1 respondent. Reset of planning for this is required.	New vacancies in team is a dependency now. Overall capability gap to drive this forward is a risk.
Clinical Costing System Implementation plan	Oct 30th 2021	EDFPF			On track, will be closed RFP process between 2 providers, project plan in production.	System integrations & resource management
Right-sizing Southland ED	30/08/21	EDFPF/EDSS			Work progressing, plan for improvement being validated against data	
ePMO & Project Governance framework	Oct 30th 2021	PACEO			Portfolio Manager recruitment underway with interviews booked with two candidates in coming week.	Onboarding of Portfolio Mgr. is dependency.
Quality Improvement Framework	TBC	EDQCG			This may merge into Performance & Accountability framework – to be determined.	
Building internal change capability	Ongoing	ELT/EDP&C			The Change Cycle Workshops for staff beginning week 26/7. Planning on a change climate assessment organisational wide is being planned.	Participation by staff is voluntary and time permitting
Patient Flow/Implementation of SAFER Bundle	Ongoing	ELT			Regular 6 weekly SLT patient flow workshops underway to keep momentum up.	Continued collaboration between medical, nursing & allied.
Health hubs Implementation	Dec 2021	EDSPC			Concept designs completed, next stage rollout in progress with chosen partner.	
MHAID Review	TBC	CMHS&I			Final edited report has been received and project plan for implementation being worked up.	
Security Review	Dec 2021	EDFPF			Report has been received, reviewing currently.	
MHAID H&S Review	TBC	CMHS&I			Decision by Exec & Board to prioritise MHAID review first with view that this will follow.	Dependent on MHAID overall review being implemented

Strategic Change Portfolio – Progress Update July 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)						
Hospital Escalation Planning/Standard Operating Procedures	Ongoing	EDSS			Dunedin is further embedded than Southland currently, but work progressing this is ongoing	
Health Needs Analysis	Dec 2021	EDSPC			Soft launch of 8/82 indicators complete with complete live site end of calendar year.	
Primary & Community Work Programme	Ongoing	EDSPC			Work is progressing but the COVID Vaccination programme has stalled progress in areas	COVID vaccination programme slowed progress
Equity Actions Improvement Programme	Ongoing	CMHS&I			As above	COVID vaccination programme slowed progress
Virtual Health	2023 embedded by	EDSS			New Telehealth implementation Manager has been appointed to re-invigorate this initiative.	Technology dependency & model of care embedding/patient education.
FPIM Implementation	1/07/21	EDFPF			Complete, go live achieved on July 1st	
HRIS	Ongoing	EDP&C			Success Factors has been implemented 1st part of 2 part implementation	
Workforce Modelling	Ongoing/No end date	EDP&C			Ongoing piece of work, iterative process	Health NZ reforms will have an impact from a wider environmental perspective.
Health Care Homes	2021-22	EDSPC			Third tranche completed in Q4.	
Risk Management Maturity	October 2021	EDQCG			The list of current clinical risks to be signed off by Clinical Council September Risk Register moved to Safety 1st by October.	

Strategic Change Portfolio – Progress Update July 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Month Status: Prior	Additional Comments	Key Risks/Dependencies
Tranche 2 (Mid to Long -Term Initiatives: 2-6 years)						
Maternity Central Otago	2024	EDSPC			Proceed with RFP & advancing of business case collaboratively with MoH. Components of BC have been agreed with Ministry.	
Dunedin & Southland Master Site-Planning	TBC	EDFPF			Initial planning meeting with partner Sapere week beginning 26/7 for Southland clinical services planning	
CCDM Implementation	TBC	EDSS & CNMO			$ for full implementation in next financial year, implemented in pockets	
Primary Care in Southland	31/10/21	EDSPC & EDSS			Joint work programme with PHO	Workforce risk specifically GP pool
Generalism	2023/2024	EDSS			Ontrack but large scale change programme	Dependency of MAU project
Digital Transformation (detailed business case)	September 2021	EDFPF				
PICS implementation	Q4 2024	EDSS			Programme manager re-assigned COVID programme	
Central Decision Support Model	N/A	PACEO			Conceptual stage – regional discussions South Island wide are occurring.	Robust data warehouse underpinning the model & capability uplift in analytics team.
Implementation of MH review recommendations	TBC	CMHS&I				On-Boarding of Exec Director MH.
CETES – Clinical Engineering, Tech & Equipment Service	2024/6	EDSS			New Build team/conceptual	
TCU – Transit Care Units	2024/5	EDSS			New Build Team/conceptual	
Seven-Day Hospital	2024/6	EDSS			Conceptual Stage	Workforce Implications as change in operating model.
Acute Assessment & Planning Units	2024	EDSS			New Build Team/Conceptual	
23 Hour Unit	2024	EDSS			New Build Team/Conceptual	

Strategic Change Portfolio – Progress Update July 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Key Business as Usual Enablers						
Performance & Accountability Framework	November 2021	ELT			Planning underway, initial workshops with leads had.	Timing around pulling data sources & leadership ownership.
Building our internal change capability	Ongoing	ELT			Planning stages. Additional MoH sustainability funding is available to support this. Will need to be agreement on the tools chosen to support this.	
Develop Service Planning further	Ongoing	ELT			Additional investment into service planning has been identified as a need.	Currently 1 FTE.
Health & Safety Workplan	Ongoing/No end date	GM H&S, EDP&C				
Wellbeing: Aukaha kia kaha programme	Ongoing/No end date	EDP&C				
Implementing use of Cascade – SaaS tool to monitor our execution of our Strategic Change Programme	September 2021	PACEO			Integration testing complete and good. Trial completed and order has been requested for Exec team access – rollout & uploading of our strategic documents/change programme is next along with training.	User adoption.

Legend

	Good Progress being made, on track, no major issues		Issues exist, significant delay in progress		Not started or due to start
	Issues exist or delay in progress		Item/Project Complete		

FOR INFORMATION

Item: **Southern District Health Board Review**

Proposed by: Chris Fleming, Chief Executive

Meeting of: Board, 3 August 2021

Recommendation

That the Board notes the content of these papers and supports the course of action to date.

Purpose

1. To provide an update to the Board on the actions to be undertaken post the review completed by Leena Singh in May 2021.

Discussion

2. As the Board are all aware, Southern District Health Board has been challenged over many years with financial, workforce, and clinical related challenges.

3. We have all worked, and continue to work, in a dedicated way to address these. We have made considerable gains in many areas – addressing areas from our primary and community strategy, getting the new Dunedin Hospital underway and tackling numerous longstanding service issues, and I thank you all for your individual and collective efforts. Of course, significant challenges remain, and to some extent our momentum has suffered with the severe disruptions we have experienced over the past 15 months.

4. As Chief Executive, I have been very conscious that, while addressing the immediate burning issues we are faced with, we must also have a longer-term focus and ensure that we are empowering staff, services and the organisation to operate in a truly sustainable manner (sustainability meaning clinical quality, access to services, workforce, and financial).

5. We have focused on numerous workstreams you will be familiar with (see attached one-page poster) and have embarked on a strategic refresh programme to ensure we are well positioned for the transition to the new entities anticipated with the Health and Disability Review.

6. In addition, in partnership with the Ministry of Health, I invited an external consultant Leena Singh to come into our organisation and undertake a review of our current situation. This was an opportunity to bring in a fresh set of eyes and gain an objective appraisal of where we should be directing our energies.

7. In developing this report, Leena reviewed the various documents and reviews that already exist and met with people across our provider arm (both Dunedin and Invercargill) to learn more. She then prepared a report identifying tangible improvement opportunities.

8. Having received this report, the next steps were to consider the findings, then discuss and agree those improvement opportunities which we would ask Leena to lead on our behalf, those which others within the organisation would lead, and potentially those we would note but not progress at this time.

9. The Executive Team and I received the report in early June and have been considering the recommendations. In reading the report there are statements which we do not necessarily agree with, but there are many themes contained in the report which indeed ring true. Rather than litigating detail in the report it is our view that we should pick up on the

recommendations, consider them and then take action to implement those recommendations accepted. As Chief Executive it was my view that the majority of the recommendations have some merit, so to this end I have been working through assigning Executive owners.

10. I think it is useful to highlight the key themes that have already emerged from the report. These include:

- The need for a structured performance and accountability framework
- Refining the organisational structure to ensure clear accountabilities
- The creation of a higher trust environment
- More effective utilisation of data and information
- Need to strengthen People and Capability functions
- Clarity around Clinical Governance and the role of Quality and Clinical Governance support teams
- Strengthening the budgeting process and ensuring activity performance is aligned to the budget.

11. If we were to single out key recommendations, they include:

- Designing, implementing, and embedding an accountability and performance framework
- Realigning the Executive portfolios to better focus on the key critical issues of each area. I think it is useful to highlight the key themes that have already emerged from the report
- Design and consult over the realignment of the provider arm structure to improve clinical engagement and integrated models of care
- Review the quality improvement teamwork functions and ensure that the resources are deployed to the greatest need for the DHB to enable improved clinical practice, operational efficiencies and financial payback.

We have asked Leena to work directly with key executives which include Patrick Ng – Executive Director Specialist Services, Rory Dowding – Acting Executive Director Strategy, Primary & Community, Dr Hywel Lloyd – Acting Executive Director Quality & Clinical Governance Solutions, Nigel Trainer – Executive Director Corporate Services, and Greer Harper – Principal Advisor to the Chief Executive, to develop the Performance and Accountability Framework to then be subsequently rolled out. Once the framework has been developed there will be a need to undertake a degree of competency assessments to ensure that if there are skills gaps throughout the organisation People and Capability can assist in developing solutions to provide our staff the opportunity to develop in these areas.

As Chief Executive I have developed a proposal for change which also looks at the alignment of roles and functions at both the Executive Leadership Team level as well as within the provider arm structure to improve clinical engagement and integrated models of care. This will be being consulted on during August with a goal of making structural decisions by early September for implementation.

The table attached shows the actions broken into the immediate (July to September) and then the medium term which is (October – June). It is important to recognise that while some of the actions in the medium term would preferably be carried out in a quicker timeframe, part of our problem as an organisation has been attempting to do too many things at once. It should be noted that many of the actions for the medium term actually require early actions be taken immediately and these are being progressed.

Progress will be monitored closely and we will bring things forward where opportunities present.

Appendices

Recommendations from Leena Singh’s Report

Strategy Map 2020.pdf

Recommendations from Leena Singh's Report – June 2021

Action Item	Action Required	Action timeframe	Action Owner	Comment
Within Three Months (July – Sept)				
1	All Datasets to be distinguished by Ethnicity and action areas of disparity	31 August 2021	Chief Māori Health	Plan to be in place by end of August 2021.
2	Realign Executive Portfolios to better focus on the key critical issues of each area. Consider aligning executive portfolios with Canterbury DHB	30 July 2021	Chief Exec	Revised exec structure been drafted, challenge of ED Quality & Clinical Governance Support to be considered through the development of the performance and accountability framework Proposal for change to be distributed in July 2021 and then implemented in line with due timeframes for consultation
3	Design and consult over the realignment of the provider arm structure to improve clinical engagement and integrated models of care Review the quality improvement team work functions and ensure that the resources are deployed to the greatest need for the DHB to enable improved clinical practice, operational efficiencies and financial payback.	31 August 2021	ED Specialist Services	Part of the revision of the exec structure also addresses this. Provider arm changes are incorporated into CEO's overall changes and will be implemented simultaneously. To be considered as performance and accountability framework is developed
4	Design, implement and embed an accountability and performance framework		EDCQG ED Corporate Services ED Strategy, Primary & Community PACEO	A coordinated stocktake of all of the relevant pieces from the Exec areas is to be undertaken in the next fortnight, as well as pulling together what current dashboards exist. In a fortnight's time we will workshop this with Leena reviewing what we have already that will feed into the new framework and draft up a new design.

Action Item	Action Required	Action timeframe	Action Owner	Comment
6	Improve risk identification, rollout the electronic reporting system as a matter of priority, embed a risk culture within the organisation Appropriately report risks to FARC and Board	30 September 2021 Completed	ED Quality and Clinical Governance ED Quality and Clinical Governance	Safety1st being implemented presently All critical and high risks now being reported to FARC
11	Partner financial analysts/management accountants with GMs to ensure robust and documented financial analysis occurs	Complete end Aug 2021	ED Corporate Services	Will be incorporated in re-structure.
14	Review and revise delegations to align with the accountability framework	September 2021	ED Corporate Services	To be submitted to September FARC meeting for approval
21	Establish, communicate and implement recovery plans for FCT and ESPI compliance along with ensuring the additional CT is fully utilised post commissioning		ED Specialist Services	Oncology improvement planning underway in partnership with the Cancer Control Agency. Weekly reporting is occurring and a work plan has been developed. Replacement Business Support Manager is being recruited on the basis of leading an ESPI recovery programme across both sites which builds on the prioritisation tool implementation that has occurred to date. CT build work is happening in parallel to the shipment of the CT machine so that the machine can be commissioned immediately upon arrival. Approval has been given for the additional staffing that is required to operate the extra shifts and recruitment is underway for these roles.

Action Item	Action Required	Action timeframe	Action Owner	Comment
22	Implement recovery plan for orthopaedics	Recovery Plan completed end of August 2021	ED Specialist Services	Orthopaedic cases being completed at Timaru hospital to assist with wait list. Discussions underway to complete higher volumes at Mercy Hospital in Dunedin in partnership with our orthopaedic surgeons to take advantage of additional beds being opened at Mercy (with available budgets). Overall recovery plan being developed for the district which incorporates these initiatives. Will present completed plan once fully quantified but work up these initiatives ahead of this.
25	Revise the AT roster to improve the health and wellbeing of the staff and improve theatre utilisation		ED Specialist Services	Delegated to GM Surgery & Radiology and update requested in July.
Three to Nine Months (October to June)				
5	Establish a clear clinical governance framework, embed discipline around meeting structure, action follow through and focus		Chair of Clinical Council (once appointed)	Clinical Governance Framework developed, however discipline of process and leadership of Clinical Council to be reviewed. EOI process for new Chair completed and interviews occurring in early July. Chair to be on ELT and attend Board meetings
7	Board to set the risk appetite for the organisation and executive to roll out to the organisation and embed into process and system			
8	Reconcile budget to activity, identify clinical and cost variation against peer DHBs and assign appropriate costs savings against those areas. Implement formal reporting structures to monitor and manage progress Hold Executives and managers responsible for ensuring	Stage 1 – Sept 2021 to have completed reconciliation Stage 2 – ? – peer review	ED Corporate Services CEO	Through performance and accountability framework

Action Item	Action Required	Action timeframe	Action Owner	Comment
	the achievement of targeted savings			
12	Look to Canterbury for their costing system and consider expanding it into Southern to assist in understand cost structures	Costing system selected end Oct 2021	ED Corporate Services	14 DHBs use CostPro, Canterbury uses an Australian product which does not have much DHB utilisation. Undertake a closed RFP process to ensure we get a good outcome.
15	Implement project discipline, require robust reporting around project milestones, financial performance against activity and benefit realisation	Have PM in place by end of August 2021.	PACEO	Establishment of ePMO – underway. Recruitment for Portfolio Manager in flight.
20	Prioritise data driven work practices, including production planning and forecasting	End of July – RFP closes End of August – selection of vendor	ED Specialist Services and ED Corporate Services	Production engineering resource being sourced through RFP currently and internal resource being reviewed also. Forecasting needs to be improved. Review of bed forecasting tools available elsewhere (Auckland) will occur as part of a visit to review their CCDM practice.
24	Appoint an HoD for ICU across both Dunedin and Southland and assign responsibility for improving clinical support and governance of both ICU		ED Specialist Services and Chief Medical Officer	Discussion required with CMO, EDSS and GM Surgery & Radiology. Discussion will be booked for early July and progress update provided once had.
26	Proceed with the planning of an expanded footprint in Southland ED in conjunction with the PHO and GPs around how to improve access outside of the core ED. Planning must include an emphasis on innovative models of care rather than just footprint. Investigate the possibility of an onsite GP service next to the ED with a combined triage and pathways		ED Specialist Services ED Strategy, Primary & Community	Floorplan developed and benchmarking has now been provided. Developing the overall business case for an August Board Meeting. PHO Programme Director has also been contracted to develop joint programme of work between the PHO and DHB with the aim of reducing presentations which should be attended to in primary care. PHO / Runaka led clinic being established as step 1, second step will be a new Community Health Hub focussed on Urgent Care / VLCA practice
27	Create a strategy and implement around a culture of performance and engagement to improve morale		ED People & Capability	

Action Item	Action Required	Action timeframe	Action Owner	Comment
28	Embed operational, strategic and compliance KPIs in all rural contracts, networking them together where practical		ED Strategy, Primary & Community	To be developed during the 2021/22 year for implementation for the 2022/23 year (from 1 July 2022).
Already in Place or Progressing				
10	*Implement annual asset replenishment targets, adjust frequently to ensure capital expenditure is spent within the financial year. Streamline and delegate the financial process of approval of capital items <$50k to service level*			*This is a part of the capital planning process, and wider Asset Management Plan development* *Process for capital approval contained within the delegations policy*
13	Focus on placing 80% of most commonly used data sets into Power BI, establish a data dictionary and rollout fully to all clinical leaders and service managers	Ongoing	ED Corporate Services	Progressively all data sets are being migrated to Power BI, and there is a data dictionary in place which needs re-socialisation and a process of agreement & embedding.
16	Incorporate the nursing and allied health model of care into the generalism work and roll out an integrated model.	Being implemented in line with the approved business case	ED Specialist Services	Already incorporated into the approved business case, and budgeted for. Nursing and allied components will be implemented to coincide with the completion of the new medical assessment unit.
17	Manage annual leave balances and have them incorporated as core KPI for managers	31 August 2021	ED People & Capability	Leave reporting now in place for all to utilise, roll out of leave management plans underway. Specific KPIs need to be agreed
19	Review all outside of MECA agreements and engage with the relevant services and union to realign pay rates with FTE support		ED Specialist Services / ED Strategy, Primary & Community / Mental Health	Only known arrangements outside MECA are Senior Doctors. Legal process already undertaken and identified that historical personal allowances (circa $1.6 million) are not able to be removed unless individual agreement reached. All additional hours have been turned into FTE and drive now needs to be to ensure

Action Item	Action Required	Action timeframe	Action Owner	Comment
				each SMO has a timetable which matches their contractual arrangements
23	Take a reflective look on the work performed on the patient flow taskforce group, embed established procedures into BAU and move to focus on the areas of production planning, community based beds/step down facility, frail pathways and stranded patients		Chief Medical Officer, Chief Nursing & Midwifery Officer, and Chief Allied Health, Scientific & Technical Officer	Workshop planned for 7/8 July with senior leaders on each site to establish patient flow work back into BAU. Group already established to look at frail elderly. Group working through the feasibility of interim care beds. Paper presented to exec on additional resourcing for stranded patient team
18	Centralise the management of the RMO unit	31 August 2021	ED Specialist Services	The centralisation of the RMO unit will be incorporated into the proposed position description for the General Manager's Dunedin and Southland Hospitals to align with the changes to the provider arm that are implemented coinciding with the CEO changes to structure.
30	Streamline the procurement approval pathway to Ensure timely decision making and implementation.		ED Corporate Services	
On Hold				
29	Investigate a combined Lakes/Dunstan/Private provider partnership for the lakes district improving access for the community with refined models of care including increased nursing support			Awaiting Strategic Refresh

Our pathway towards enabling

Better health, better lives, Whanau Ora

What have our people asked for?*

Southern Future
It's up to us

- better coordinated care across providers, with less wasted time
- care closer to home
- communication that makes sense and is respectful
- a calm, compassionate and dignified experience
- high quality, equitable health services.

*Southern Future listening sessions, 2016

THE SOUTHERN STRATEGIC HEALTH PLAN

How will we get there?

Improving experience and outcomes:

Creating an environment for health
The environment and society we live in supports health and wellbeing.

Primary & Community Care
Care is more accessible, coordinated and closer to home.

Clinical service re-design
Primary and secondary/tertiary services are better connected and integrated. Patients experience high quality, efficient services and care pathways that value their time.

Enabling success:

Enabling our people
Our workforce have the skills, support and passion to deliver the care our communities have asked for.

Systems for success
Our systems make it easy for our people to manage care, and to work together safely.

Facilities for the future
Including Dunedin Hospital, Lakes District Hospital redevelopment and community health hubs to accommodate and adapt to new models of care.

By 2026:
We work in partnership to create a truly integrated, patient-centred health care system

A health-enabling society, within which we deliver:

More accessible, extensive primary and community care with the right secondary and tertiary care when it's needed.

So that our people:

- are healthier and take greater responsibility for their own health
- stay well in their own homes and communities
- with complex illness have improved health outcomes.

Southern Health
He hauora, he kuru pounamu

FOR INFORMATION

Item: Patient Flow Update Report July 2021

Proposed by: Patient Flow Taskforce

Meeting of: Board, 3 August 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

The first two workshops with the SLT have been held with more planned. The feedback was overall positive despite Dunedin & Southland sites being different however there is a collective commitment to the ongoing patient flow work.

Next Steps & Actions:

- **A further two workshops have been planned for 6 weeks' time with these groups to continue the work. The other workstreams are continuing.**

Appendices

1. **Patient Flow Taskforce Progress Update**

PATIENT FLOW IMPROVEMENT PROGRAMME

Month #6 Progress Update - ***Summary of the two Patient Flow action planning workshops***

The recent activity within the patient flow programme has centred on the planning and delivery of two action planning workshops with the relevant SLT operational leads across the professional disciplines on the Dunedin and Southland sites.

The workshops were focussed on the following questions:

1) What do you need to know about the Patient Flow taskforce work?
2) How can we work together to embed what has been started?
3) Where are the future opportunities?

Within the workshops we also demonstrated the patient flow dashboards in PowerBi and encouraged people to bring their laptops so we could step through what data was available to them together – the feedback to this was very positive especially from clinicians on the Southland site who were very excited about the consultant level data that was available to them.

The team expressed being able to feel a definitive cultural shift as a result of the patient flow work where there is increased collective accountability and a sense that as a team we can take ownership of this and all play a part.

The future opportunities discussion centred around commitment to the following:

- Re-launch red2green (action to re-engage IS on this)
- Desire to reconvene as a group in an ongoing manner (6 weekly) to keep the momentum going around patient flow. The next two workshops have now been scheduled and the focus of those will be building a more detailed patient flow plan for the next 18 months including incorporating recent learning from the IHI patient flow conference.
- Creation of a group of data super users in clinical areas to champion the use of the patient flow data to create healthy awareness.
- Support for the rest home medication workstream – identification of 3 teams that would be ready to do the medimap training.
- Re-launch the 'end PJ paralysis' campaign
- Improving the induction for House Surgeons to include patient flow, especially their role in Rapid Rounds
- Accelerate the work to rethink and transform the discharge documentation – (Discharge Summaries)

The workshops on each site were different reflecting the local conditions and maturity of each in patient flow. In Southland, being smaller, there was a strong cohesive approach. The team asked to continue meeting regularly with a prime focus in Patient Flow and felt that there were ongoing benefits to realise. In Dunedin the challenges are more complex. There was a commitment to developing the opportunities to improve patient flow and a clear commitment to the programme. On both sits it was agreed that patient flow is an essential part of improvement and a perpetual programme.

FOR INFORMATION

Item: CCDM Diagnostic Report - Jane Lawless

Proposed by: Jane Wilson, CNMO

Meeting of: 2nd Aug 2021

Recommendation

That the Board notes the content of this report, and supports the CCDM Council to continue to progress actions on agreed recommendations and oversee the investment in CCDM in accordance with the 21/22 budget allocation.

Purpose

For information

Specific Implications for Noting

1. **Financial:** Proposed CCDM investment has already been considered and agreed as part of the 2021/22 Budget investments to address safe staffing concerns as noted in the report
2. **Operational Efficiency:** The report recommends other opportunities to improve operational efficiency by better matching workforce to demand
3. **Workforce:** A number of recommendations relate to improving workforce management and are already being progressed
4. **Equity:** Recruitment of additional CCDM nursing and midwifery FTE will focus on strategies to increase the Māori workforce

Background

The review was commissioned by the DHB Chief Nursing and Midwifery Officer in response to concerns that despite significant investments in nursing and midwifery staffing over recent years, the outcomes of the programme were not being achieved as expected. The purpose of the review was to determine whether the programme is being delivered as intended and to identify recommendations to optimise implementation. The report details the findings and recommendations of a diagnostic review of the implementation of the Care Capacity Demand Management (CCDM) Programme at Southern DHB.

The final report was shared in the first instance with the CCDM Council (including unions) as per our partnership agreement obligations under the Accord. Although limited in scope by the timeframe, a high level picture of the current status allowed identification of a range of recommendations for the DHB's consideration. This report, together with the recently completed draft FTE calculations, Safe Staffing Health Workplaces Unit (SSHWU) moderation of our FTE calculation processes and the Minister's Letter of Expectations were timely to help inform the 21/22 budget investment prioritisation.

Appendices

1. **CCDM Diagnostic Report – Jane Lawless**

Spotlight on CCDM

Diagnostic review of the CCDM Programme implementation in the Southern District Health Board: Report and Recommendations

February 14, 2021

Author: Lawless Consulting Ltd

About the reviewer

Jane Lawless is the Director of Lawless Consulting Ltd. Jane has extensive experience in nursing workforce modelling. Jane was the Director of the Safe Staffing Healthy Workplaces Unit from 2009-2013 following which she undertook contract work in the United Kingdom and Europe. Jane is currently involved in international research examining the impact of time pressure on Registered Nurse job performance.

Executive Summary

The report details the findings and recommendations of a diagnostic review of the implementation of the Care Capacity Demand Management (CCDM) Programme at Southern DHB. The review was commissioned by the DHB Chief Nursing and Midwifery Officer in response to concerns that despite significant investments in nursing and midwifery staffing over recent years, the outcomes of the programme, *safe and effective patient care on every shift, a safe and effective work environment for staff, and productive investment of resource* are not being achieved as expected. The purpose of the review was to determine whether the programme is being delivered as intended and to identify recommendations to optimise implementation.

Approach

The diagnostic review focused broadly on three areas; data veracity, implementation fidelity, and outcomes. **Data veracity** was examined to determine the degree to which the organisation can confidently use the current data to make decisions about staffing. Examining **implementation fidelity** related to establishing how the CCDM programme is being operationalised within the DHB. The **outcomes** that were reviewed included;

- how well the fundamental goal of delivering shifts staffed on target is being achieved
- other evidence that would indicate that the triple goals of safe and effective patient care, a safe and effective work environment

Following a general overview of ward-level data, three wards (selected by the DHB as broadly representative of how CCDM is being implemented) were the subject of a deep-dive diagnostic review of shift-level data. A wide range of data were examined to provide explanation for why shifts did or did not conform to target. The data were sourced from the DHB's routine data collection over the previous two years. The information was collated and triangulated in order to assess data veracity and construct an overall data picture. A number of staff interviews were conducted to provide clarification. Although limited in scope by the timeframe, a high level picture of the current status was discoverable, allowing identification of a range of recommendations for the DHB's consideration.

Summary of findings

The review concluded that although the CCDM programme is fit for purpose, and the basic structural elements are in place, there are system-wide implementation issues that need to be addressed (noting that not all wards will be impacted equally). The DHB's strong and ongoing commitment to the programme as the primary method for managing the nursing resource provides a sound base from which to progress. Southern DHB is 71% towards full implementation of CCDM as at the end of October Q1 report and the Safe Staffing Healthy Workplace (SSHW) Unit's feedback on the CCDM 2020 standards assessment noted that *"It's clear to see especially when comparing 2019, that the DHB has improved the implementation considerably and is doing well to achieve the June 2021 target of full implementation".* The issues identified with the way the CCDM programme is currently operating are not likely to be unique to the Southern DHB and some are beyond the control of the DHB to resolve internally.

Data veracity

The review found that in areas where compliance with data collection is high, the data is sufficiently robust to support decision-making. Notwithstanding, improvement is needed in the way data is presented and used. In particular, aggregation of data above the shift level is obscuring the data picture.

Implementation fidelity

Based on the evidence provided, there are areas of good compliance with implementation of the system, and areas that require attention and improvement. What was also evident from the review is that even were the CCDM system to be implemented completely as intended, this would not on its own result in the delivery of adequate nurse staffing to every shift. CCDM is not well interfaced with other critical operational functions, specifically management of patient demand and alignment with production planning. These factors combined with sub-optimum management of variability in patient demand and frequently maintaining hospital occupancy at very high levels are contributing to the mismatches that were observed between available nursing resources and patient demand. Also contributing and less readily resolvable is that central government requires the use of CCDM without committing to providing additional funding to resource identified deficits. This places the organisation in the position where resourcing constraints, demand targets and other important organisational priorities limit options to address inadequate staffing.

Outcomes

The review considered the degree to which the organisation is achieving its commitment to consistent provision of nurse staffing adequate to provide safe and effective care. Based on the evidence, there are currently too many instances of a poor shift-level match being achieved between service demand and the nursing resource provided. While this finding applies to both shifts over and under target, of most concern is evidence of times when wards are operating beyond maximum nursing capacity. This has associated safety and quality implications including exposing patients to potential and actual harm and places an unsustainable level of demand on nursing staff. The review notes that because consequences of inadequate staffing are often not immediate, it is difficult to ascribe a particular shift to a particular patient harm event. However it is not necessary to have this level of information to know that shifts below staffing target are not tolerable. There is compelling high-level research evidence that when shifts are below target, all patients are exposed to risk and some patients will suffer consequent harms.

Recommendations

The principal recommendation from the review is that the DHB prioritises treating the elimination of below target shift staffing as a central goal because of the association with patient risk and harm. Other actions can then be oriented around this purpose. This should improve not only the strategic and technical functioning and provide an improved data picture with regard to CCDM and nurse staffing, but will secure enhanced commitment from 'Board to Ward' regarding the imperative to protect patients from exposure to the risks associated with deficient nurse staffing. Shifts above target also merit attention because of the opportunity to redistribute resource more productively and equitably.

A range of actions to improve achievement of shifts on staffing target are suggested. Some of these are known to the organisation and have already been initiated, while others will require new actions if adopted. The recommendations are focused on improving the data, improving how the system is utilised, and actions to improve the integration of CCDM with other operational systems. The recommendations also cover areas of the organisation's operations that are not part of CCDM but which influence it's success.

Table of Contents

Spotlight on CCDM

The diagnostic review of Southern DHB's implementation of the CCDM Programme focused on three areas; data veracity, implementation fidelity, and outcomes. The three areas are reported together. **Data veracity** was examined to determine the degree to which the organisation can confidently use the current data to make decisions about staffing. Examining **implementation fidelity** related to establishing how the CCDM programme is being operationalised within the DHB. The **outcomes** that were reviewed included;

- how well the fundamental goal of delivering shifts staffed on target is being achieved
- other evidence that would indicate that the triple goals of safe and effective patient care, a safe and effective work environment for staff, and productive investment of the nursing resource are being delivered

The CCDM Programme

The Care Capacity Demand Management (CCDM) programme is a decision-support system designed for use by DHBs to predict, plan and deliver nursing and midwifery staffing. The primary purpose of the CCDM programme is to support the delivery of safe, effective, and productive nurse staffing on **every** shift. This is achieved through collecting and using data about patient demand and acuity to guide the yearly staffing cycle including; annually identifying the FTE requirement for each service (for recruitment and budgeting purposes), evidence-based demand planning and rostering, and productive deployment of nursing resources on the day care is delivered. The DHB has demonstrated an ongoing commitment to the programme as the primary vehicle to support safe and effective nurse staffing and is currently part-way through implementation. The DHB has made significant investment in the programme beginning in 2011.

Review Aims

- Investigate the quality and trustworthiness of the data generated by the CCDM programme for use in organisational decision-making relating to nurse staffing
- Identify progress in implementing the CCDM programme effectively
- Identify opportunities for improvement

Method

An initial high-level examination of ward data was undertaken. Following this, three wards selected by the DHB as broadly representative of how CCDM is being applied were examined in detail to support a deep-dive analysis of CCDM implementation. Existing organisational data provided by the DHB was used in the review and interrogated to the level of individual shifts. A limited number of staff interviews were conducted for the purposes of data clarification. The information was collated and triangulated in order to assess data veracity and the overall data picture.

Findings from these three wards are not wholly generalisable to other services. However, from discussions with staff involved with the programme, the findings relating to how CCDM is being implemented including; data collection, use of data, functioning of Local Data Councils (LDCs), and staffing calculation methodology, are likely to be relevant to the majority of inpatient services.

Metrics

The principal metric of interest in the review was the achievement or non-achievement of the staffing target for each shift, defined as shifts above or below target.

For inpatient services, the shift is the primary metric because this represents a circumscribed timeframe during which a group of nursing staff are accountable for the care of a group of patients. Multiple research studies have established that benefit or harm can accrue from the adequacy of nurse staffing on a single shift and that the risks associated with being cared for on poorly staffed shifts are cumulative.

A wide range of data were examined to provide explanation for why shifts did or did not conform to target. Shifts where workload demand was within an expected range and shifts where workload deviated from normal patterns were examined separately. The rationale is that when workload demand is as expected, failure to achieve a shift on target is most likely to be attributable to deficits in planning and establishing base staffing. When workload demand is significantly above or below predictions, the causes are more complex, may include factors outside the control of the CCDM system and require different remedies.

Shifts on Target

The primary organisational priority should be to eliminate shifts under target staffing and secondarily to minimise shifts over target. For the purposes of this review, a shift was deemed to be within the target staffing zone if two criteria were satisfied; 1) the nursing hours provided are no less than 8.5% of required, and 2) no more than eight hours greater than required. For example, a shift that required 100 hours of nursing time would be considered below target if less than 91.5% of the required hours were supplied, and a shift with greater than 108 hours supplied would be considered to be above target. Shifts that were staffed outside the target zone (either over or under) were considered to be in breach.

It should be noted that the Safe Staffing Healthy Workplaces Unit (SSHW Unit) considers shifts to be under or over target if they deviate from the required hours by greater than 8.5%. In the opinion of the reviewer, this is not the most appropriate metric for assessing above target shifts. The 8.5% buffer for below target shifts (negative shifts) is a built-in tolerance in the TrendCare system that reflects the many variables that occur on a shift that can add to workload and which are not amenable to hard measurement in the algorithms. The eight-hour upper limit used for this review relates to the indivisibility of a nurse's working hours (most commonly an eight-hour shift), particularly on shifts that have minimum staffing (such as night shifts). Part of a nursing shift is not readily removable and removing a whole shift will often tip the balance to becoming a shift under target. In addition, a modest amount of additional time on a shift can be productively invested in activities such as teaching, quality, enhanced patient care, or activities that sustain and build teamwork and culture. It is only when the eight-hour threshold has been exceeded that the time should be considered truly surplus to requirements as it represents a whole shift that could have been productively reinvested. Remedies include strategies such as the use of 'bridging shifts' where for example the shift is split across the Day and Evening shift to better match patient workload demand.

Significance of shifts above target

Shifts that are significantly over target represent a poor investment of health resources and lost productivity because staff time, once committed, cannot be reinvested at a future date.

Significance of shifts under target

Shifts that are under target have different consequences. By definition, a shift below target is one where there are now less nursing hours available than nursing work required. In this circumstance, not everything that needs to be done can be done. Nurses must make decisions about what aspects

of their work will be privileged and which will be sacrificed. When patient care is impacted, this is termed care rationing. Multiple research studies have associated below target staffing with care rationing and consequent patient harm. Harm can be experienced in a range of ways including; not having a good experience of care (such as unrelieved anxiety, unrelieved noxious symptoms, not feeling cared about or cared for, loss of dignity), actions or inactions that compromise a patient reaching their recovery potential (such as deconditioning, sub-optimum rehabilitation, or sub-optimum education), or direct harms (such as a pressure injury, nosocomial infection, fall, or medication error). Because consequences are often not immediate, it is difficult to ascribe a particular shift to a particular patient harm event. However it is not necessary to have this level of information to know that shifts below staffing target are not tolerable. It is enough to know that when shifts are below target, all patients are exposed to risk and some patients will suffer consequent harms that can in the most extreme cases include avoidable death.

Findings

Data veracity

The primary purpose of the review was to examine how CCDM is being implemented in the DHB. In order to identify whether any issues encountered were due to implementation issues or to the CCDM programme itself, two questions were addressed, one relating to the CCDM programme and one to implementation;

1. Is the CCDM system a valid method for estimating the staffing requirement for a shift?
2. Do the data that are entered into the system have integrity?

In answer to the first question, the SSHW Unit has commissioned two external reviews examining the validity of the CCDM system, both of which concluded that the system is fit for purpose. Therefore, the DHB can have confidence in the programme (noting that this only applies to areas that the CCDM system covers). With reference to the second question regarding data integrity, the conclusion from the evidence reviewed is that while there is room for improvement, in areas where compliance with data collection is high, the data is sufficiently trustworthy and robust to support decision-making. Notwithstanding, improvement is needed in the way data is presented and used in decision-making. In particular, aggregation of data above the shift level is obscuring the data picture. Aggregation of data has the effect of masking problems with particular shifts and of obscuring patterns. For services not covered by the CCDM methodology no conclusions can be drawn because of the absence of data.

CCDM implementation fidelity

Implementation fidelity relates to the degree to which the CCDM system is being implemented as intended. Based on the evidence provided, there are areas of good compliance and areas that require attention and improvement. Data from the three wards selected by the DHB as broadly representative of the way CCDM is being applied indicate that system-wide implementation issues may exist although not all wards will be impacted equally and the level of adherence to staffing target will vary based on multiple context-specific factors. Primary areas for attention include the way base staffing for wards is being established, improving the provision of mobilizable additional nursing resources on the day of care, and revising how data is being presented, analysed, diagnosed and acted upon. All of these are amenable to intervention and some are in the process of being addressed.

What was also evident from the review is that even were the CCDM system to be implemented completely as intended, this would not on its own result in the delivery of adequate nurse staffing to every shift. Currently, CCDM is not well interfaced with other critical operational functions, specifically management of patient demand and production planning. This combined with sub-optimum management of variability in patient demand and frequently maintaining hospital occupancy at very high levels is a leading contributor to mismatches between available nursing resources and patient demand. These factors are also amenable to intervention and there are successful examples from other DHBs that could be explored. What is also contributing and is less readily resolvable is how to address FTE deficits without access to additional funding. Currently, central government requires the use of CCDM without committing to providing additional funding to resource identified deficits. This places the organisation in the position where resourcing constraints, demand targets and other important organisational priorities limit options to address inadequate staffing.

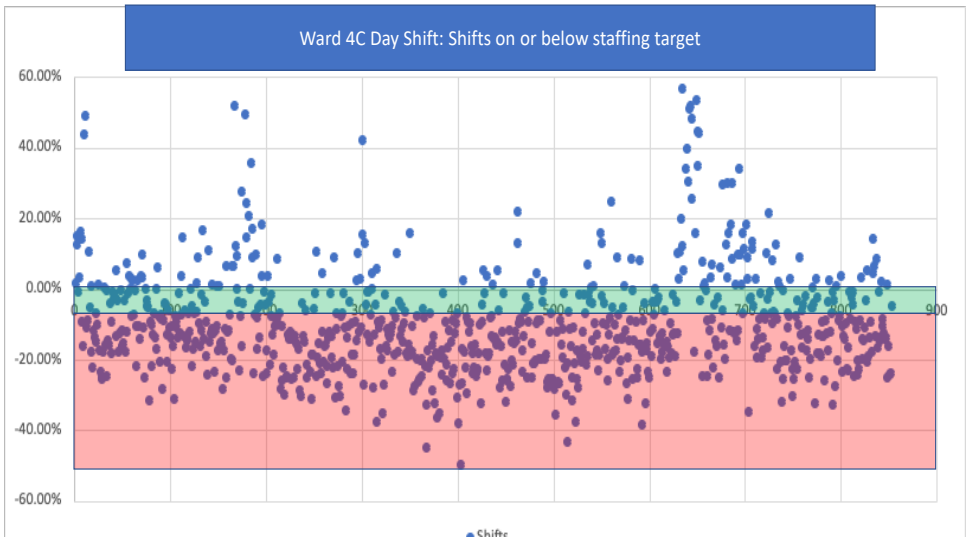
Outcomes

The review considered the degree to which the organisation is achieving its commitment to the outcome of consistent provision of nurse staffing adequate to provide safe and effective care (assessed as on target shifts). The conclusion from the wards reviewed is that the situation is currently unstable and there are too many instances of a poor shift-level match being achieved between service demand and the nursing resource provided. While this finding applies to both shifts over and under target, of most concern is evidence of wards operating at times beyond maximum nursing capacity

(see example, figure 1). This has associated safety and quality implications including exposing patients to potential and actual harm and places an unsustainable level of demand on nursing staff.

Ward 4C Day Shifts on or below target

This example shows data for the Day Shift on Ward 4C over a 28-month period identifying shifts on or below target. There are a high percentage of shifts that fall below the 8.5% threshold (shaded pink area), and of these many are in excess of 20% under target. Patient risk or benefit is known to be attached to each shift on which care is received. Research provides evidence that the number of sub-optimal/time deficient shifts a patient is exposed to and the degree of the deficit correlates with increased inpatient mortality (Ball 2017; Kuntz et al 2015; Needleman et al 2011). A patient experiencing 100% optimally staffed shifts has a different risk/benefit exposure to a patient experiencing a mix of optimal and sub-optimally staffed shifts. For these reasons, despite this being common practice, an assessment of whether nurse staffing is safe and effective cannot be based on averaging achievement across a 24-hour period or across time.



Example: Figure 1: 4C Day Shifts under staffing target July 2018-October 2020

Evidence synthesis

The review identified issues general to all three 'deep-dive' wards and issues that were ward specific. Not all of the issues are attributable to CCDM programme implementation but all impact nurse staffing.

Common findings from the three wards reviewed

Issues that were reported by more than one ward (some of which require further verification) included areas related to staffing establishment, service characteristics, responsiveness to variation in demand, data integrity, and impacts.

Staffing establishment

- Annual base staffing calculations are not consistently being applied as per SSHW methodology leading to a pattern of planned understaffing of some shifts
- Not all services are having annual calculations performed for reasons mostly related to readiness criteria
- Secondary adjustments to base calculations are being undertaken in the budgeting process based on funding rather than actual staffing requirement. Staffing calculations arrived at by the CCDM system should be viewed as a floor not a ceiling, i.e. not a starting point from which staffing can be reduced.
- Allowances in the calculation for leave may not be being correctly applied
- Detailed analysis of individual services (to establish skill-mix and to match nursing hours to patient demand) has been discontinued by the SSHW Unit[1]
- Delays in replacing staff (following resignations or maternity leave) were reported leading to roster gaps
- Rosters are being signed off with multiple gaps with no concrete strategy to back-fill these gaps due to inadequate baseline staffing
- Actual sick leave rates above the allowance allocated in the FTE calculation

[1] Originally the SSHW Unit recommended that wards undertake a detailed analysis of workload, workload patterns and context-specific variables. This process was useful to identify opportunities for system improvement and optimum skill-mix to match workload demand. A review commissioned by the SSHW Unit concluded that the time taken to complete this process did not represent value for money. In the view of this reviewer, where a ward appears to have sufficient staffing but is showing stress in monitoring metrics, undertaking a work analysis is indicated.

Service characteristics

- High levels of bed occupancy and service utilisation (churn), along with delayed discharges are adding to nursing workload.
- There are high numbers of patients being cared for outside of their 'home' ward (outliers) which has workload implications and quality and safety implications for patients
- The majority of shifts over staffing target are associated with low occupancy
- Some shifts show persistent patterns of understaffing
- Part-time staff working extra shifts to fill roster gaps

Responsiveness to variation in demand

- Many shifts where patient demand is high due to high levels of service utilisation do not receive adequate staffing responses
- Insufficient nursing resources allocated and/or available to provide flexible short-notice staffing
- Suboptimal integration between those with responsibility for nurse staffing supply and those responsible for planning and scheduling patient demand
- Ward Health Care Assistants (HCAs) frequently being allocated to patient watches leaving gaps with other areas of workload
- Significant amounts of CNM time being required to support clinical care leading to deficits in other areas of responsibility
- The number of inliers and outliers suggests that the bed footprint might not be right for some wards and/or pressure to avoid ED breaches means patients are being admitted into any empty bed
- Forecast upcoming patient demand is often not matched by sufficient action to assure sufficient skilled nursing hours will be available

Data integrity

- Patient safety watches and clinical specials are not captured accurately in TrendCare and this is a system rather than a user problem. For example, if a watch or special is requested but not provided, the hours required show in TrendCare, however there is no report that shows whether the patient watch requirements were met for these patients
- Discretionary time is not being captured accurately, particularly missed breaks and unpaid overtime. Unless time worked before or after a shift is approved as overtime, or a missed break is approved it is not currently captured. This means that any extra time invested by

nurses outside their contracted hours is not visible and therefore there is not a full accounting of nursing time invested in work.

- Some clinical time is not being captured accurately, for example Charge Nurses providing clinical care to patients. The Business rules state if more than 30mins clinical is delivered it should be entered into the allocate staff screen and captured.
- There has generally been poor compliance with current Variance Response Management (VRM) scoring requirements due to the time involved and perceived lack of value by nurses; however since there has been some investment in VRM nurses, compliance is reported to have improved
- Concerns of inaccuracy in primary data entry and/or secondary amendment of data were raised but were not further investigated or corroborated. The limited evidence provided for the review showed no indications that data regarding HPPD by patient type is inconsistent with TrendCare benchmarks, however, should further follow-up be seen to be merited, retrospective chart audit can be used to determine accuracy or inaccuracy.
- Based on the persistence of some staffing deficits observed in the data, a process to ensure that authorities and accountabilities are clear may be indicated. [2].
- Reported issues with the level of information, such as DHB comparative data and support provided by the SSHW Unit

Impacts

All three wards reported instances of care rationing, fundamental care deficits and patient harm incidents determined to be, or likely to be associated with nurse staffing deficits. Examples that have been reported to the organisation include; patients unable to be showered on multiple consecutive days due to paucity of nursing time, CNM reporting of patients waiting hours for their wounds to be redressed following ward rounds, pressure injuries tracked to low staffing, patients having to wait for meal assistance until relatives arrive, and patients unable to be assisted to mobilise.

- [2] Any shift not on target represents a failure. Review processes used to retrospectively interrogate why a shift was not on target should be able to identify reasons that are followed by future preventive actions. For example, if there is a chronic pattern of under target shifts in a particular service, the processes used to staff that shift should be reviewed, for example the FTE allocation, the demand scheduling, the rostering process etc to identify if staff who hold accountabilities for ensuring adequacy of staffing are fulfilling their responsibilities.

Reports logged by staff relating to workload-related patient and staff incidents are investigated by the CNMs and the DoNs and discussed at Local Data Council meetings. The reporting and investigation process is time consuming leading to delays in investigation, compliance and follow-through. It is not clear that all evidence is currently being captured through the Safety 1st process. It is important that the situational intelligence provided by nurses is formally captured, given due weight and responded to, ideally through a single process.

Individualised findings from the three wards

It is important to note when considering these data that no one source of evidence should be considered adequate to form a conclusion about the adequacy of staffing. The actualized HPPD is one data point that captures many aspects of nursing workload but does not provide the full picture. Staff reports on the adequacy of staffing should also be considered alongside contextual factors known to be associated with workload such as patient churn, timing of admissions and discharges, team skill-mix and the model of care. Nursing staff have important situated intelligence about how the service is functioning that needs to be given equal weight to 'hard' metrics.

Ward 4c

4c is situated within Dunedin Hospital with a primary focus on patients requiring inpatient services for conditions relating to Vascular, Urology, Breast and Plastic Surgery. The ward has 26 resourced beds.

Based on the evidence provided, acceptable levels of IRR and patient categorization are being maintained (noting that this information was not provided for all months and all wards). HPPD benchmarks for the main patient types are within the level of acceptable variation (noting that this information was not provided for all months and all wards). Evidence reported to the organisation by nursing staff regarding clinical and workplace safety and risk is largely consistent with the TrendCare and IPM data, i.e., both sources show evidence of workload pressure.

The level of patient churn (how many patients are utilising the resourced beds during each shift) is high (average discharges per day = 7.3). The most common scenario is utilization above 100% (high churn) on the day and evening shifts. While this level of churn is not atypical of surgical inpatient services, it becomes problematic when accompanied by high bed occupancy. Average bed occupancy is most commonly 100% (but there is a large degree of variability). The high churn/high occupancy combination has negative implications for nursing workload as nursing hours are diverted

unproductively to bed management. This 'low-value' work is not well captured in TrendCare but still needs to be performed and takes time away from patient care. A pattern of late discharges (latter part of the day shift or the early to mid-part of the evening shift) means that more patients are present for more of the shift adding to nursing workload. High bed occupancy at 0700 will be adding to access block. The high variability in service utilization and bed occupancy makes matching nursing resources difficult. There is frequently a high number of patients in the ward who belong to other services and a high number of 4C patients being care for in other wards. The reasons behind this were not investigated but may relate to a mismatch in the bed 'footprint' and organisational strategies to avoid ED time breaches. Caring for patients outside of their specialty adds to workload and increases clinical risk for some patients.

Day Shift

The Day Shift shows a chronic pattern of under target shifts suggesting that an increase in the base roster is required. High variability in patient demand is also a contributor to shifts being under target. There are infrequent shifts over target and the majority of these are associated with the COVID-19 lockdown (although there are other unexplained instances). This suggests that there is almost no excess nursing resource.

Evening Shift

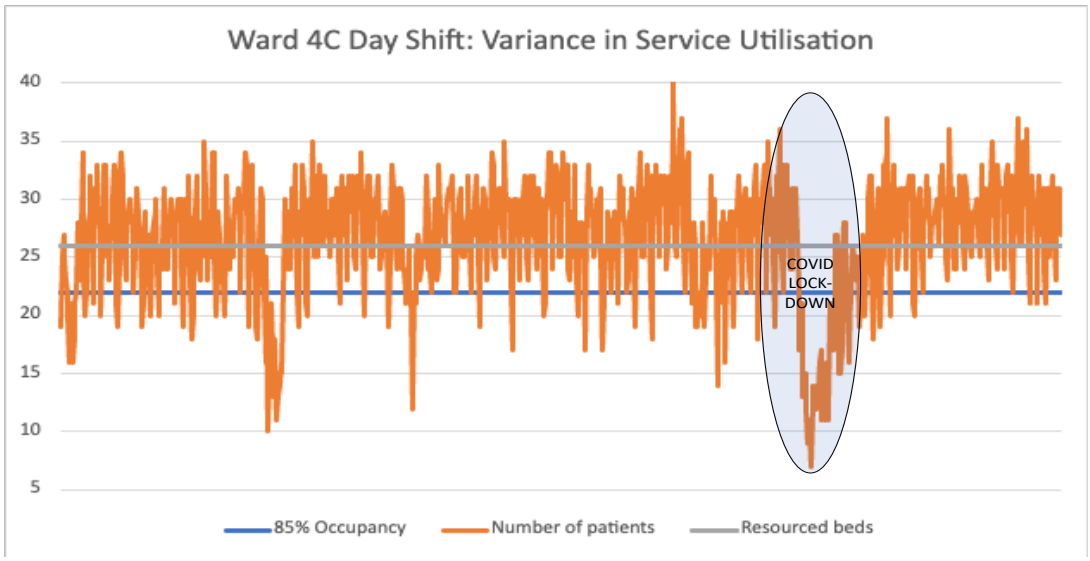
There is a pattern of shifts under target on the Evening shift. In addition, while not explicit in the data, the understaffed Day shifts will be transferring work to the Evening shift. Reducing variability in demand would improve this scenario. An increase in base staffing may also be required. The number of shifts above staffing target is small (except for the COVID-19 period). However, the number of shifts 1-8 hours over target is fairly frequent. Reducing variability in demand would help to address this.

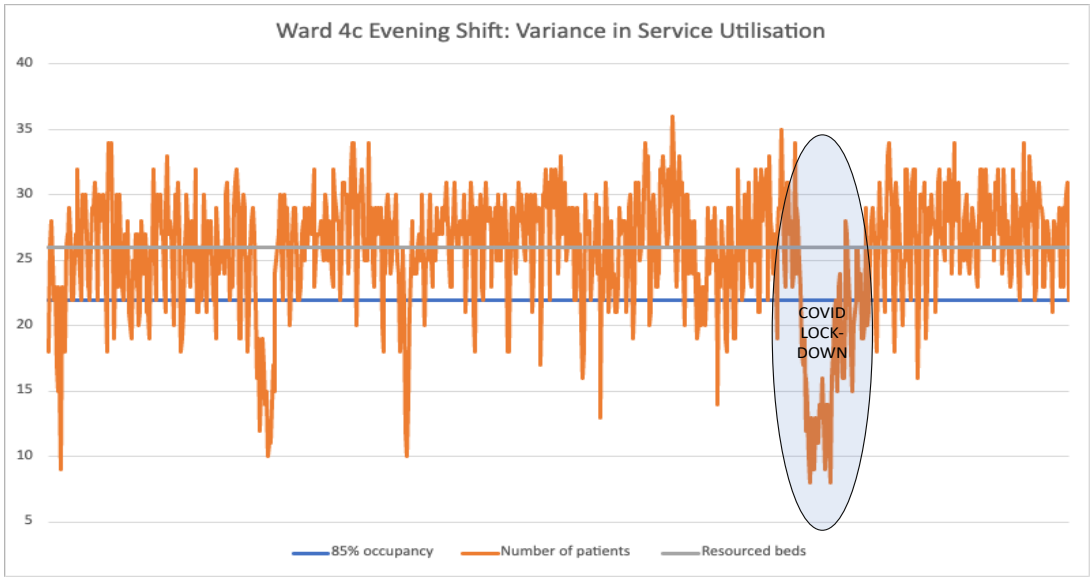
Night Shift

The dominant pattern on the Night shift is for shifts on or above target but the number of shifts under target is of concern. There is no discernible pattern therefore this would best be dealt with by reducing variation in demand and ensuring the availability of mobilizable extra hours when required. The majority of shifts fall within the range of tolerable excess hours (< 8 hours). The shifts with excess hours would best be dealt with by increasing demand as they are generally associated with low service utilization. Reports of pressure on this shift should include looking at the flow and timing of work, for example, are there sufficient staff in the first third of the shift, and considering the value of supporting workload by bringing on an HCA at 0530 (both typical demand peaks).

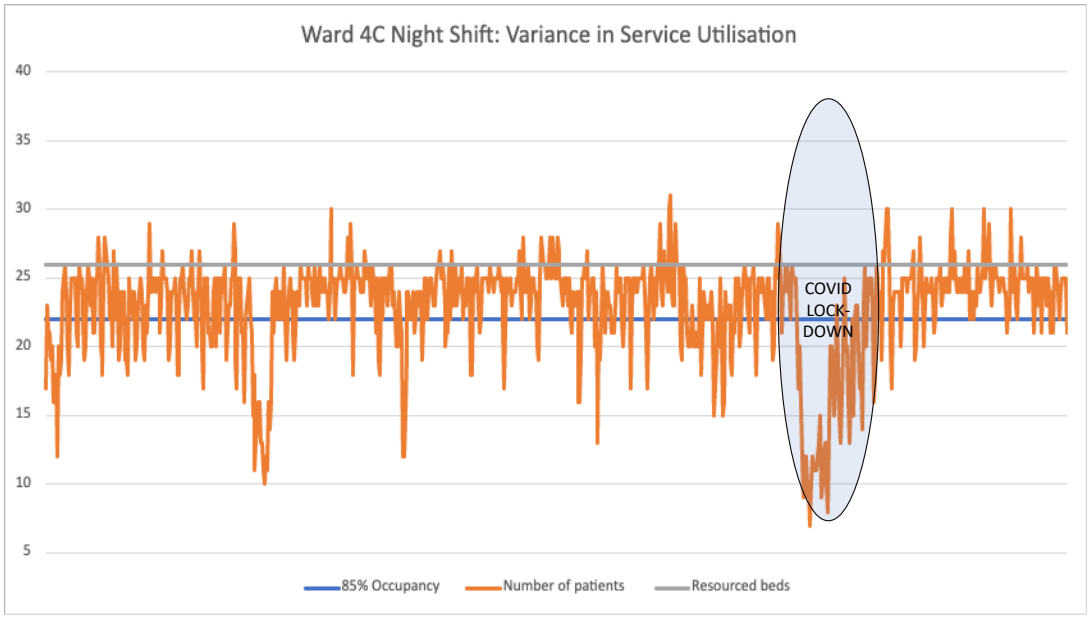
Variation in Service Utilisation

Service utilization is a measure of how many patients receive care over a shift and is a more sensitive measure of the nursing requirement for care than bed occupancy. The grey line in the following graphs shows the number of resourced beds (but does not capture bed flexing where beds capacity is increased or decreased based on demand). The blue line shows what 85% occupancy of the resourced beds would be[3]. The second dip in service utilization relating to the COVID-19 lockdown is an outlier.





[3] 85% bed occupancy is a widely recommended sector standard that allows for functional patient flow in services where patient turnover is high.



There are two areas of interest with service utilisation; the degree to which the number of patients exceeds the number of beds (churn), and the shift-to-shift variation. As would be expected, service utilization is highest on the Day Shift and lowest on the Night Shift. Utilisation routinely exceeds resourced beds by a significant margin. There is large shift to shift variability.

AT & R

AT & R is an eighteen-bed inpatient ward situated within Southland Hospital providing services to patients requiring inpatient rehabilitation.

Based on the evidence provided, acceptable levels of IRR and patient categorization are being maintained (noting that this information was not provided for all months and all wards). HPPD benchmarks for the main patient types are within the level of acceptable variation (noting that this information was not provided for all months and all wards). Evidence provided to the organisation by nursing staff regarding clinical and workplace safety and risk is not entirely consistent with the TrendCare and IPM data, suggesting that further investigation is needed to understand reported mismatch between the nursing resources provided and reported workload pressure. The nursing leadership reports that increasingly, patients being admitted into the ward fit an acute profile rather than a rehabilitation profile and have complex nursing requirements. This evolution of patient type is attributed to pressure on acute beds meaning patients may be transferred to AT & R prematurely. This may mean that the rehabilitation patient types being used to categorise patients in TrendCare

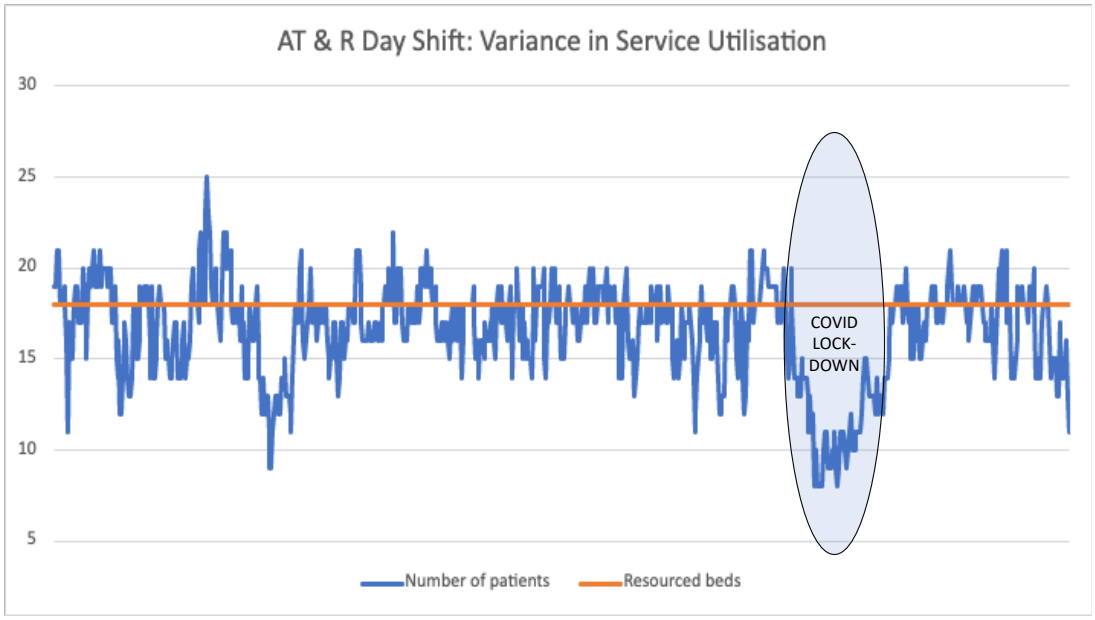
are not adequately capturing some patients' requirement for care. This may also be resulting in skill-mix mismatch if the clinical needs of patients is higher than is usual for rehabilitative care. It was also reported that the allied health model of service delivery means that for at least half of the time, there is limited input from allied health which has implications for the nursing workload and for the ability to provide rehabilitative services.

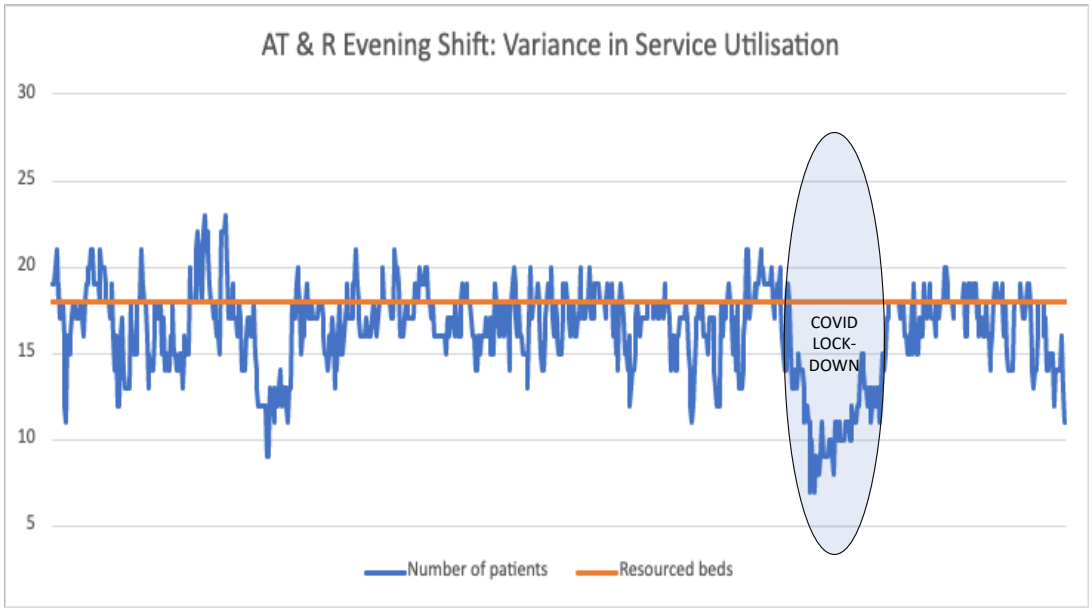
The level of patient churn (how many patients are utilising the resourced beds during each shift) is low (average discharges per day = 1.3). Average bed occupancy is 100% but there is also a large degree of variability with low occupancy not uncommon. Given the low level of patient turnover, the goal should be to maintain close to 100% occupancy. Eighteen beds is a smaller than average service and is not a good size for productively matching staffing as the relatively low number of total patients means that variation in occupancy can result in deficits or excess in nursing hours. Increasing the number of resourced beds would increase the productivity match between nursing hours and the hours required for patient care.

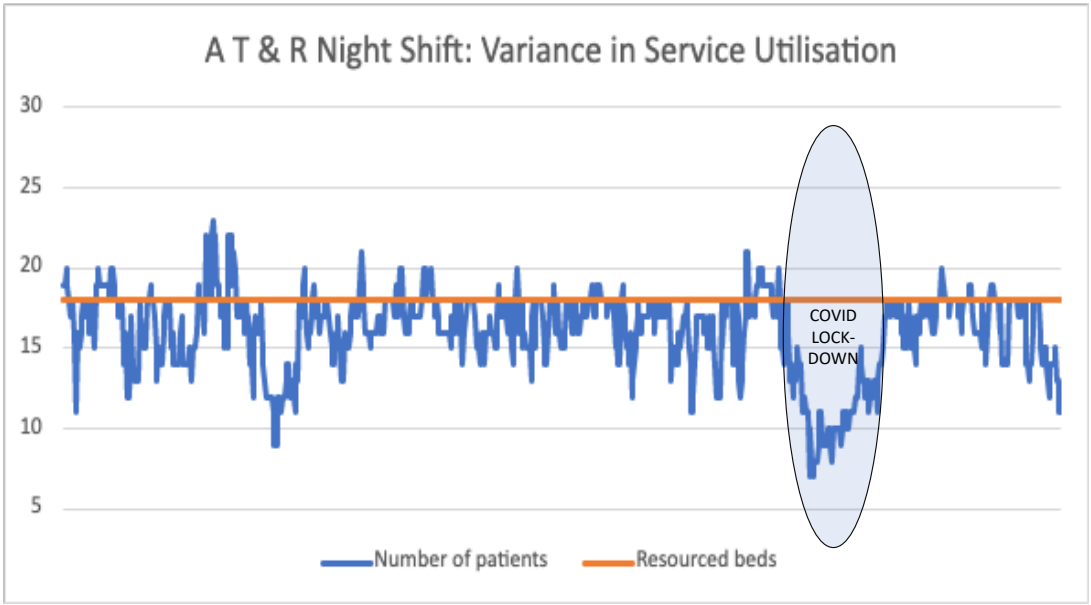
It was noted that the TrendCare system is not adequately capturing the need for patient specials/watches. The actual impact of this on workload is not clear. The level of nursing staff being deployed in and out of the ward is high and not ideal.

Variation in Service Utilisation

Service utilization is a measure of how many patients receive care over a shift and is a more sensitive measure of the nursing requirement for care than bed occupancy. The grey line in the following graphs shows the number of resourced beds and does not capture bed flexing (where bed capacity is increased or decreased based on demand). The 85% occupancy line is not shown for this ward because the low level of churn means that 100% occupancy is the target. The second dip in service utilization relating to the COVID-19 lockdown is an outlier.


AT & R Day Shift: Variance in Service Utilisation
30
25
20
15
10
5
COVID LOCK-DOWN
Number of patients
Resourced beds


AT & R Evening Shift: Variance in Service Utilisation
30
25
20
15
10
5
COVID LOCK-DOWN
Number of patients
Resourced beds



There are two areas of interest for this ward; the degree to which the number of patients exceeds the number of beds (churn), and the shift-to-shift variation. The number of patients is generally above but close to the number of resourced beds. There is significant shift to shift variation in the number of patients receiving care. This relates primarily to variation in occupancy rather than churn.

Medical Ward

The Medical Ward is a thirty-eight-bed ward situated within Southland Hospital primarily providing services to patients requiring inpatient services relating to a range of medical conditions.

Acceptable levels of IRR and patient categorization are being maintained (noting that this information was not provided for all months and all wards). HPPD for the main patient types were not inconsistent with TrendCare benchmarks. The short LOS means that HPPD benchmarks are likely to be at the higher end of the ranges. Evidence provided to the organisation by nursing staff regarding clinical and workplace safety and risk is largely consistent with the TrendCare and IPM data on workforce adequacy and shows workload stress.

The ward averages 274 discharges per month (COVID period excluded). This translates to an average 9 discharges per day and therefore average 9 admissions. The ward profile of high patient churn, high bed occupancy, late discharges (average 82%) and low length of stay has significant implications for nursing workload. With this profile, care needs of patients will be consistently high due to the short

LOS. Nursing time will be being lost to bed management activity. Access block will be experienced due to high 0700 bed occupancy. Late discharges means that more patients are present for more of the shift which adds to workload and that workload will be transferred from the Day to the Evening shift.

Day Shift

A large number of Day shifts are under target staffing. There is some evidence of a seasonal pattern with the winter months likely to be more poorly staffed. There are relatively few Day shifts that exceed the target staffing hours.

Evening Shift

There are relatively few Evening shifts that are under target hours. However, of the shifts that are under target, the degree of deficit is frequently large. There are a relatively large number of Evening shifts above target staffing. However, because there are many below target Day shifts, work will be being transferred to the evening shift that will not be wholly captured in TrendCare. In addition, the late discharge pattern will be transferring work into the Evening shift. High churn will be contributing to workload. TrendCare does not capture this workload well.

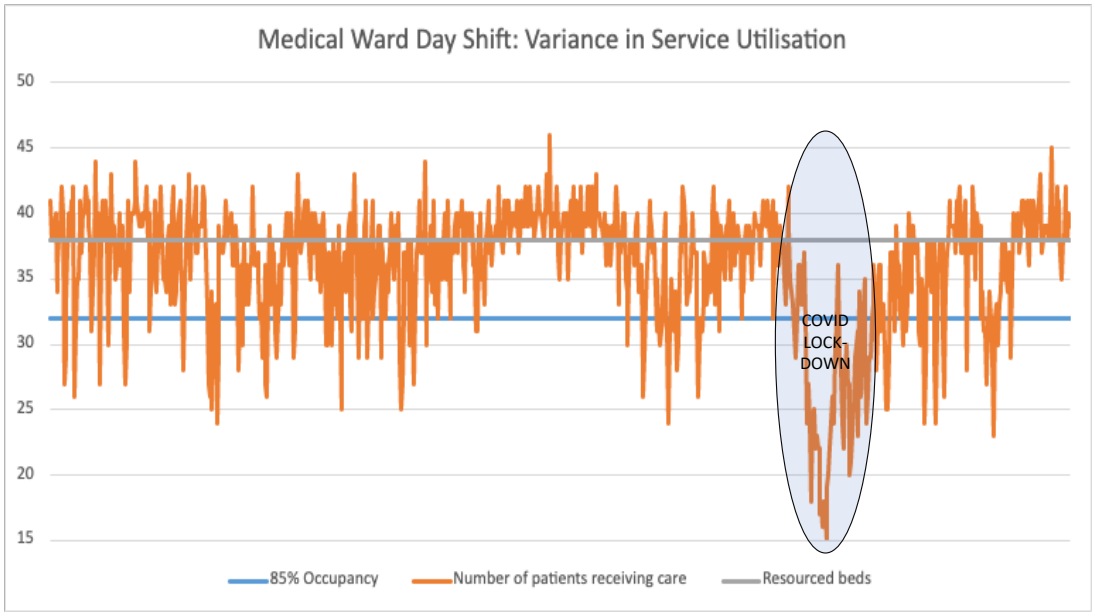
Night Shift

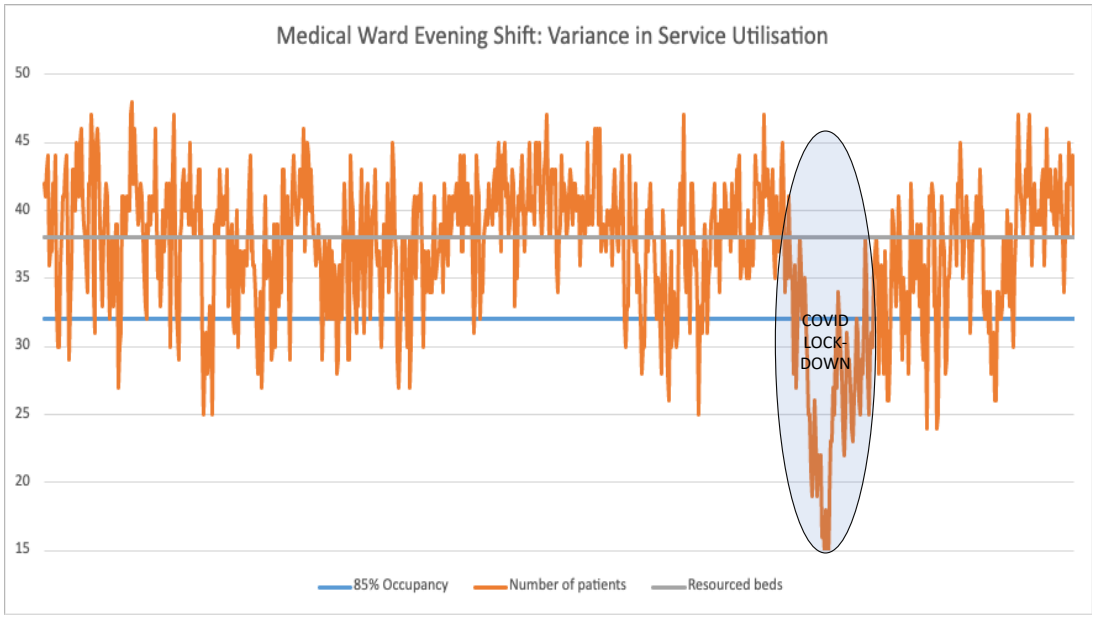
The number of Night shifts below target is relatively low, however the degree of deficit is of concern. Shifts above target staffing are relatively frequent. The relationship with service utilization should be examined to determine if this is associated with shifts with lower utilization/occupancy. In addition, the pattern of workload should be considered, as night shift workload tends to be clustered in the first third and last quarter of the shift meaning that while the hours may look adequate or in excess, there may be maldistribution within the shift. This type of productivity loss is not easily remedied and generally has to be tolerated as a production cost.

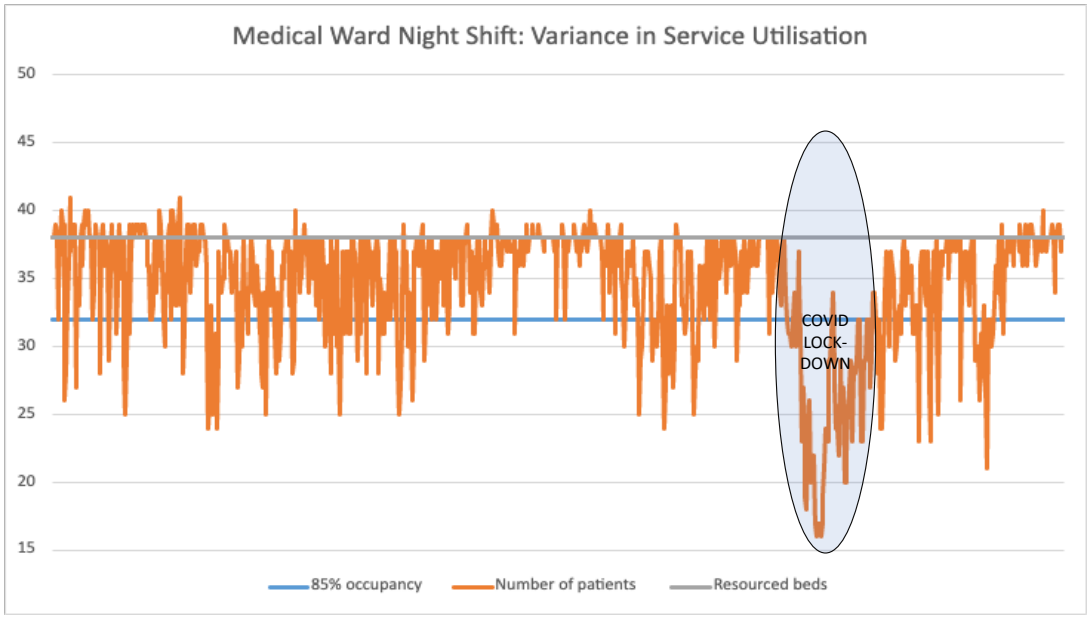
Variance in Service Utilisation

Service utilization is a measure of how many patients receive care over a shift and is a more sensitive measure of the nursing requirement for care than bed occupancy. The grey line on the following graphs shows the number of resourced beds and does not capture bed flexing (where bed capacity is increased or decreased based on demand). The blue line shows what 85% occupancy of the resourced beds would be[4]. The second dip in service utilization relating to the COVID-19 lockdown is an outlier.

[4] 85% bed occupancy is a widely recommended sector standard that allows for functional patient flow in services where patient turnover is high.


Medical Ward Day Shift: Variance in Service Utilisation
50
45
40
35
30
25
20
15
COVID LOCK-DOWN
85% Occupancy
Number of patients receiving care
Resourced beds


Medical Ward Evening Shift: Variance in Service Utilisation
50
45
40
35
30
25
20
15
COVID LOCK-DOWN
85% Occupancy
Number of patients
Resourced beds



13

There are two areas of interest when analysing service utilization for this ward; the degree to which the number of patients exceeds the number of beds (churn), and the shift-to-shift variation. Churn is commonly very high on the Day Shift and the Evening shift with the number of patients using the service exceeding the resourced beds. There is also considerable variability in utilization from shift to shift.

Recommendations

A range of options and strategies that will deliver the largest improvements are suggested for the DHB's consideration. Some of these are known to the organisation and have already been initiated, while others will require new responses. The recommendations are focused on actions that would improve the data, actions that would improve how the system is utilised to achieve its purpose, and actions to improve the integration of CCDM with other operational systems. The recommendations also cover areas of the organisation's operations that are not part of CCDM but which influence its success.

The principal recommendation from the review is that the DHB prioritises treating the elimination of below target shift staffing as a central goal because of the association with patient risk and harm. Other actions can then be oriented around this purpose. This should improve not only the strategic and technical functioning and provide an improved data picture with regard to CCDM and nurse staffing, but will secure enhanced commitment from 'Board to Ward' regarding the imperative to protect patients from exposure to the risks associated with deficient nurse staffing. Shifts above target also merit attention because of the opportunity to redistribute resource more productively and equitably.

1. Resource nurse staffing for every ward using the CCDM methodology with a particular focus on;
    1.1. Ensuring that the process for arriving at the base FTE is correctly applied including making appropriate provision for non-clinically available nursing hours
    1.2. Establish a nursing budget for each ward that matches the base FTE requirement
    1.3. Establishing base rosters that are adequate to cover historical and predicted maximum demand.

Note: The current organisational practice of routinely staffing shifts at less than the predicted requirement (the 30/20/10), is not justifiable. The base roster **may** be set at less than the predicted demand only where a reliable short-notice mobilizable nursing resource is also established.

Rationale: The base roster for a service is based on known patterns of service demand. If there were no workforce or financial constraints, a ward would roster to cover 100% of its predicted upper variation in service demand to ensure patient needs could be met. However, this is not practical or generally warranted because it is likely to result in too many shifts that are over resourced. In preference, the base roster is designed to cover the majority of demand scenarios and is accompanied by a variance response plan where nursing resources are supplied on an 'as needed' basis. There are two important principles to consider when deciding how much resource will be allocated to the base and how much to variation. The first is that because nursing is specialized and because teams that work together regularly perform better, employing nurses to work 'in place' is the first line strategy. The second principle is that relying on variance resourcing is only justifiable if it can be guaranteed to be available.

It is recommended that the DHB follow the SSHW Unit calculation process to individualise the preferred rosters for each ward

2. Take steps to smooth variability in patient demand. The degree of demand variability is at a level where matching nursing resource responsively is extremely difficult. Along with addressing base staffing deficits, addressing this area is the most important action
3. Take steps to integrate operational management of CCDM with operational management of demand with a particular focus on;
   3.1. Matching nursing rosters with predicted demand and scheduling electives
   3.2. Matching nursing resources to demand in the 72 hours leading up to each shift
4. Take steps to improve the ability to reliably respond to on-the-day variation in demand including;
   4.1. Increasing the nursing resource able to be reliably mobilised at short-notice through the establishment of an enhanced centrally operated nursing resource unit (on both sites). The caveat for this recommendation is that it is neither practical nor desirable to create a predominantly 'flexi' nursing workforce. Teams that work together frequently and have a degree of specialisation are preferred.
   4.2. Ensure that appropriate IT is being used to maximise 'capacity at a glance' capability
   4.3. Ensure that the central operations unit is functioning to maximum effectiveness with a multi-disciplinary and 'whole of organisation' focus
   4.4. Base the assessment of how much demand capacity exists on available nursing hours and skill-mix rather than bed availability

Note: Based on the three wards reviewed, it appears that on some shifts there is pressure on wards to care for more patients than there are available nursing hours. This is likely due to the organisation equating empty beds with nursing capacity. The result is that over the course of the shift, there is a high level of patient churn as multiple patients move in and out of beds. This causes significant non-productive work for nursing and reduces the time available for patient care. It is safest and most productive to re-calibrate the available base ward capacity to match the available nursing resource. This means that on different shifts/days the physical bed availability would vary. Patients should not simply be admitted to beds because they are unoccupied. Acknowledging that this approach is already used by the DHB, the number of under target shifts suggests underutilisation of this strategy.

4.5. Consider short-term reductions in deferrable patient services when patient safety cannot be assured

Note: Deferring patient services is an unpalatable option that should only be considered where patient safety cannot be assured due to staffing levels. It is however, occasionally necessary on the basis that patients have the reasonable expectation of not being avoidably harmed in the course of their care. The review was made aware of instances of patients being unable to receive fundamental aspects of care over multiple consecutive shifts that exposed them to risk and harm.

5. Revise how data and metrics used to assess the adequacy of nurse staffing and for diagnosing issues are collected, presented and reported including;

5.1. Linking diagnostic, explanatory and performance metrics to the level of the individual shift

Note: The way that the CDS is currently presented is providing important information but in a form that makes interpretation difficult. CCDM is based on delivering staffing to each shift. Therefore shift staffing is the primary outcome of interest. Aggregating shift-level data to a 24-hour period obscures important information about the individual shift.

5.2. Report shifts under target (>8.5% deficit in clinically required hours) as clinical events that require causal analysis

5.3. Report shifts over target (>8 clinically available hours in surplus) with accompanying causal analysis

5.4. Record and report all requests for specials and watches and whether requests were met or not[5]

[5] TrendCare does not allow hours to be captured where a special or watch is requested but not provided. This means that the true need for specials/watches is not able to be tracked. In addition, it was reported that often when additional resourcing for a special or watch cannot be provided, HCA resources from the available staffing are used which removes up to eight and a half hours of time from other duties.

5.5. Maximise the use of the VRM scoring tool. Variance Indicator Scoring (VIS) uses a group of proxy metrics to detect workload stress. Currently, these metrics are under-utilised as a longitudinal data source on service performance.

-Update to using the most up to date VRM scoring tool provided by the SSHW Unit. The most up to date tool has updated the weightings for each item.

-Undertake VRM scoring at the beginning of the shift and within the shift if there is a significant change (rather than scoring every two hours)

-Introduce end of shift reporting using VRM scoring. Retain these data and include in the data dashboard

-monitor and report on the amount of discretionary time being invested (missed breaks and overtime (paid or unpaid)

5.6. Ensure all staffing-related incidents and risk reported in any form are included in the data dashboard and resolution is formally recorded

5.7. Streamline how staffing-related incidents and risks are reported to improve data capture.

5.8. Resolve any questions of irregularity/inconsistency in TrendCare data through investigation and/or audit. Data entry should not be changed by anyone other than the nurse who originally entered the data

5.9. Request DHB-wide benchmarking data from the SSHW Unit

5.10. Include reporting of shifts under target at a more granular level in Board reports

6. Ensure that responsibilities and accountabilities are clear and unconflicted throughout the CCDM decision-making cycle including;

6.1. Separating line responsibility for the nursing resource from line responsibility for meeting demand targets. Ideally, responsibility for the nursing workforce, (numbers, skill-mix, and professional standards) should have a direct accountability line to the CNMO. Accountability for the achievement of patient volumes should be separate and operational.

6.2. Require sign-off of rosters by the Directors of Nursing and Midwifery (or their delegate)

Note: It was reported that rosters are frequently confirmed with multiple gaps. This guarantees that there will be shifts that are under target based on predicted demand. Director of Nursing or CNMO oversight of rosters adds a layer of senior accountability and will encourage 'whole of organisation' problem solving. Where rosters are not able to be filled, discussion needs to take place with staff responsible for scheduling demand to ensure that the organisation is not 'planning to fail'. Reconciliation of demand and nursing capacity needs to take place before the day of care because options become increasingly limited.

6.3. Require data capture on all requests for staffing support including whether the request was fully, partly or not met

6.4. Invest in the CNMO (or designate) the authority to make beds unavailable where demand exceeds nursing capacity to deliver safe care (over and above the authority of the Ops team)

6.5. Uphold and report on the use by Registered Nurses of Clause 6 of the Safe Staffing and Healthy Workplaces Committee of Inquiry (Appendix 1a Nursing and Midwifery MECA) where workloads are deemed to exceed the limits of safety

7. Ensure adequate workforce supply through;

7.1. Employing short-term strategies to increase the nursing resource, for example increasing new graduate recruitment and considering short-term increases in existing staff hours

7.2. Ensure HR processes for recruitment are stream-lined and consider strategies such as centralising recruitment and advance recruitment (beginning recruitment in anticipation of vacancies)

7.3. Consider making a joint DHB/NZNO approach to government where identified staffing deficits cannot be addressed within current funding and/or through system innovation/operational improvement

Appendix A: Review Scope

SOUTHERN DHB CCDM DIAGNOSTIC

Background

The majority of patients receive nursing care and nurses make up the largest single occupational group in NZ DHBs. Consequently, organisations need to establish the time the nursing team requires to perform their work on each shift. The goal of organisations is to provide neither too little nor too much time. An excess of time squanders a precious resource that once used cannot be reinvested. Conversely, having too little time results in nurses experiencing time pressure that may compromise job performance. Finding the balance matters because DHBs have finite resources that must be optimally invested, and because when nurses are not able to perform their jobs completely and to an appropriate standard, this has been associated with negative impacts on patients' experience of nursing care, nurses' experience of work, and on organisational outcomes.

The SDHB utilizes the CCDM programme as the primary vehicle for establishing the shape, size and distribution of the nursing workforce. Data from TrendCare and the inpatient management system are used to forecast, recruit and deploy the nursing resource. The Chief Nursing and Midwifery Officer has identified the need to review how well this approach to nursing workforce management is meeting the needs of patients, nurses, and the organization, to identify successes that can be scaled up, areas requiring attention, and opportunities for improvement.

Purpose

The purpose of the CCDM diagnostic is to provide Southern DHB with a high-level picture of how CCDM is being implemented, with a specific focus on veracity, fidelity, and resilience;

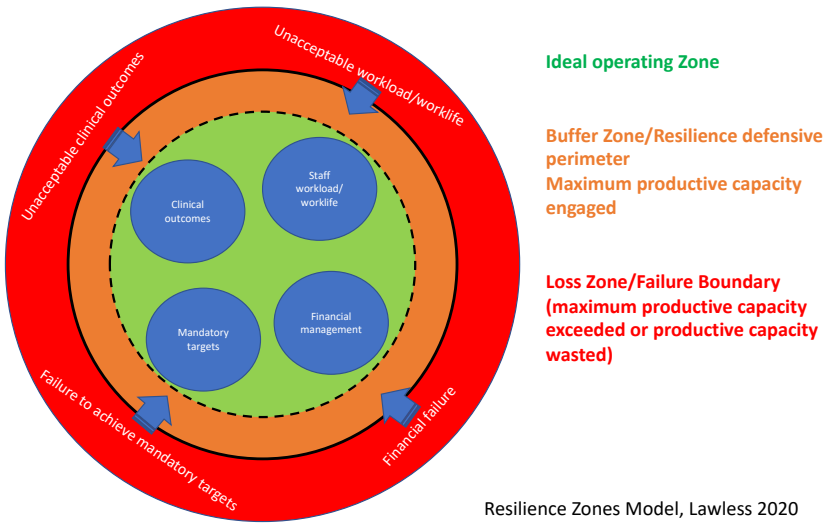
1. Support reality reporting (veracity) – how well can the data be relied upon for decision-making?
    1.1. The quality of data that informs forecasting and resource provision (long, mid and short range)
    1.2. Reconciling "bird's eye" and "worm's eye" views
    1.3. The validity of the underpinning algorithms
    1.4. The appropriateness, monitoring and utilisation of success metrics
    1.5. How the data is being used in decision-making

2. Investigate intervention fidelity – Is what is required being provided in the staffing base & at the shift-level, in regard to HPPD match, appropriate skill-mix, and within-shift distribution of personnel to match the demand pattern?
   2.1. The achievement of a demand/capacity match
   2.2. Responsiveness to predictable variation in demand/capacity
   2.3. Responsiveness to unpredictable variation in demand/capacity
3. Report on organisational resilience
4. Provide recommendations to the DHB regarding opportunities for investigation, development and improvement

Scope & approach

The scope of the diagnostic will be relatively high-level in order to generate useful, timely findings that the DHB can use to consider change and improvement and which may, if desired, lead to a deeper diagnostic dive. The diagnostic will be based on the Resilience Zones model (Lawless 2020, adapted from Cook & Rasmussen 2005) and the Medical Research Council framework (2014) for the evaluation of complex interventions.

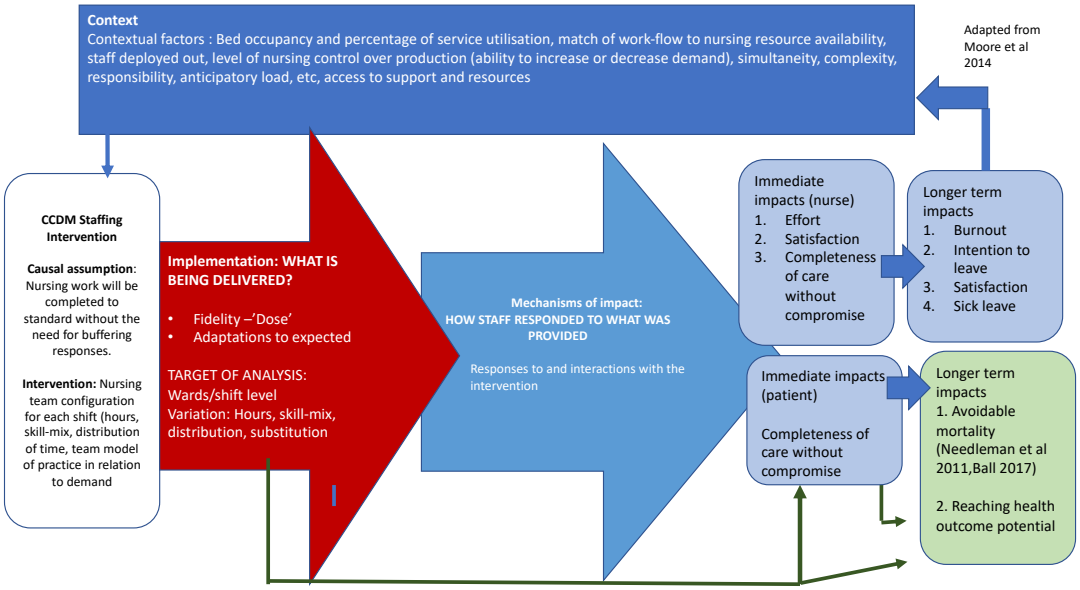
The Resilience Zones model is adapted from Cook and Rasmussen's Dynamic Safety Model (2004). It is predicated on the theory that healthcare organisations operate within failure boundaries for four operating domains; unacceptable clinical outcomes, unacceptable staff workload, financial failure, and failure to meet mandated targets.



Resilience Zones Model, Lawless 2020

To avoid a drift into failure, organisations must know at all times where each domain is located (the operating point) in relation to each failure boundary maintain, and manage a buffer between ideal operating conditions and failure. The four domains operate in competition with each other in a form of dynamic equilibrium. A 'push' away from one failure boundary will result in movement of other domains in the direction of failure. This diagnostic will focus primarily on identifying the operating point of wards in relation to the workload domain and the impact this has on the clinical performance domain.

CCDM is a complex intervention that is based on the causal assumption that if the nursing team configuration for each shift matches the demand on nursing services, nursing work will be able to perform effectively and will achieve the required outcomes. The Medical Research Council (MRC) framework for the evaluation of complex interventions is a method of capturing whether an intervention is being delivered as intended (fidelity), how the organisation interacts with the intervention, and whether the intervention is achieving as intended. The goal is to "understand *how* implementation is achieved" (Moore et al 2014 p223) and to advance understanding on how replication might be possible.



The primary unit of analysis will be the ward and shift level because an assessment of whether nurse staffing is safe and effective cannot be based on averaging achievement. This is because patient risk or benefit is attached to each shift on which care is received. Research provides evidence that the number of sub-optimal/time deficient shifts a patient is exposed to correlates with increased inpatient

mortality (Kuntz et al 2015; Needleman et al 2011). A patient experiencing 100% optimally staffed shifts has a different risk/benefit exposure to a patient experiencing a mix of optimal and sub-optimally staffed shifts.

As well as mapping how well the nurse staffing intervention is resulting in optimally staffed shifts, the diagnostic will attempt to drill backwards from the shift-level to understand what organizational socio-technical systems and/or actions are contributing to any variation observed between the staffing intervention as planned and as implemented. It is emphasised that this will be a limited piece of work that is likely to generate as many questions as answers. However, it is recommended as the appropriate starting point because "without a clear picture of what intervention components [are being] implemented, it is impossible to conclude whether limited effects [or failure to achieve expected outcomes] arise from flaws in the design of the intervention, or failure to implement it fully" (Moore et al, 2011 p223).

The diagnostic will primarily use existing data sources. A limited number of interviews will be conducted to inform the process. Time will be required from relevant SDHB personnel to provide the data for review. A written report of findings will be provided as well as the opportunity to meet with DHB leads to discuss the findings.

Because of the limited scope, the diagnostic review will not provide a comprehensive 'end-to-end' analysis of the CCDM programme as it has been implemented in SDHB. Nor will it definitively answer the question of whether nurse staffing levels are 'right' or 'wrong'. The value of the approach is that it will;

- Identify the degree to which the currently available data is supporting the DHB to assess the efficacy of nurse staffing
- Identify how CCDM is being actually being used to support the DHB's staffing strategy/commitments by identifying gaps between what is intended and what is happening
- Potentially identify areas for further refinement of Southern DHB's CCDM implementation
- Provide a platform for a deeper analysis that may result in securing additional benefits for the DHB, nurses and stakeholders

Jane Lawless
23 October 2020

Bibliography

Cook, R., & Rasmussen, J. (2005). "Going solid": a model of system dynamics and consequences for patient safety. *Qual Saf Health Care, 14*(2), 130-134. doi:10.1136/qshc.2003.009530

Kuntz, L., Mennicken, R., & Scholtes, S. (2015). Stress on the Ward: Evidence of Safety Tipping Points in Hospitals. *Management Science*.

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., . . . Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *BMJ, 350*, h1258. doi:10.1136/bmj.h1258

Needleman, J., Buerhaus, P., Pankratz, V. S., Leibson, C. L., Stevens, S. R., & Harris, M. (2011). Nurse Staffing and Inpatient Hospital Mortality. *New England Journal of Medicine, 364*(11), 1037-1045.

Southland Site – An overview of the stages of activity

Introduction:

Southland Hospital was redeveloped in 2004. A lot has changed since the "new" hospital opened, and there are presently several challenges associated with the facilities which are impacting on the operational effectiveness of the site and the ability to ensure effective patient flow.

There are some immediate actions which need to be taken, but we also need to have a longer-term vision of where Southland Hospital as a facility needs to go. Unlike Dunedin Hospital which is very land-locked, Southland Hospital has the advantage that there is plenty of land which should enable a robust long-term plan which allows short- and medium-term tactical facility solutions to be developed while at the same time having the foresight to understand the longer-term options when a major redevelopment / rebuild will become necessary.

Many hospitals have historically made fundamental mistakes. An obvious mistake made in Dunedin was the disposal of the old Nursing Homes to the University. Had this not occurred the redevelopment of Dunedin may well look quite different to what is occurring. Other hospitals put short term tactical buildings in places that make sense in the short term but completely disrupt the ability to have considered longer term redevelopment solutions which minimise disruptions.

It is vital that for Southland we take three stages:

1) Immediate actions which need to be committed this year
2) Longer term service planning and strategic site planning to set the blueprint for the future
3) Medium term actions which will be further tactical solutions which are developed on the Southland Hospital site which are carried out in a manner consistent with the longer-term vision for the Southland Hospital site. This could involve building activity as well as potentially using the site for other uses that are complementary to hospital activities.

It is important that we tackle these stages in the order above (noting that stage 2 will be occurring concurrently as stage 1 is implemented).

Stage 1 – Immediate Action Implementation in 2021/22):

Activity	Date
Ed Facility Improvement: Modifications to the Emergency Department to provide appropriate flows within the department, the privacy and space expected of contemporary facilities, sized for the volume of patients expected and actually presenting on balance. • Benchmarking exercise to validate the drafted plans • Business case to Board for Approval	Business case – August 2021
ED Queue Software Solution • Proposal to go through normal ELT/Board approval process in progress	ELT August 5th 2021
Establishment of new after-hour primary care service – clinic operational	September 30th, 2021,
Fifth Theatre: Expansion of theatre capacity	In planning

Expansion of inpatient capacity: Commissioning and resourcing of the beds that have not been resourced historically.	Underway

Stage 2 Long Term Action Plan – 2030 – 2040 vision*:*

There are two components of this stage:

- **Detailed Service Planning**

  Development of a detailed services plan of the Southland region including population growth projections and future required service delivery volumes and models. This will examine the Southland region's population, demographics and changes, trends over time and the adjoining catchments of Queenstown Lakes and central Otago given the impact those wider catchments have on Southland. A specific deliverable will be a projected capacity forecast based on identified health needs of the region, any efficiency assumptions identified and based on standardised (and agreed) methodologies (i.e., Health Infrastructure Unit NZ standards).

  Engagement with Sapere Research Group has occurred and an initial planning/scoping meeting with their team and our team has been scheduled.

  This piece of work will also draw on the Health Needs Analysis work being undertaken in the Strategy, Primary & Community Directorate currently.

- **Detailed Southland Hospital Master Site Plan**

  Development of a detailed Southland Master Site Plan which will use the analysis developed in stage 2 above to inform comprehensive plan that provides a vision for what the Southland facilities will need to work towards for the community of Southland. It will provide a framework for all future development.

  A tendering process will be undertaken to choose the appropriate partner to assist us with a Master Site plan development.

Stage 3 Medium Term Action Plan – 2022 – 2030

With the longer-term plan clarified medium-term planning will then be carried out to identify further tactical solutions that can be implemented. This may include facility reconfiguration or expansion but done in a manner which does not compromise the ability to be able to seamlessly support a major redevelopment when the facilities are at this stage.

This may include further capacity in theatres, beds, outpatients etc. It is important that this is carried out in a manner that is supportive of the longer-term plans. The detailed service planning undertaken in stage 2 will be the catalyst to support the medium-term tactical solutions.

FOR APPROVAL

Item: **Dunedin Physiotherapy Pool**

Proposed by: Nigel Trainor, Executive Director Corporate Services

Meeting of: SDHB Board, 3 August 2021

Recommendation

That the Board receive the report.

Specific Implications for Consideration

1. Financial
    - Financial implications on both CAPEX and OPEX.
2. Quality and Patient Safety
    - Health and Disability prevention and improvements for clients that use the Physio Pool.
3. Operational Efficiency
    - Nil
4. Workforce
    - Nil
5. Equity
    - Pool is accessed by a number of different groups from the community, with people who live with a disability making up a significant number of the users.
6. Other
    - Nil

Background

7. The Dunedin Physio Pool is located in a building that is connected but separate to the Fraser Building in Dunedin. The pool and building are both of a similar vintage having been built in the 1940's. In the 1980's the then Otago Health Board made the decision to close the Physio Pool and this led to the establishment of the Otago Therapeutic Pool Trust (the Trust) whom now utilise the pool under a memorandum of agreement (MOU) with the SDHB.

8. The trust currently pays SDHB $142,000 p.a. under the MOU to gain access and utilisation of the pool, $100,000 of this charge is set to cover operational costs incurred by SDHB in running the pool, while the other $42,000 seems to be a historical charge. The Trust has a number of different groups using the pool with approx. 33,000 attendances per year, refer appendix 2.

9. SDHB also uses the pool 2 mornings a week for rehab work with patients, with up to 40 people attending each morning session.

10. SDHB have made the decision when considering the new Dunedin Hospital to not include a Physio Poll in any of the facilities

11. Currently the pool is out of commission due to the breakdown of a water plate heat exchange, this part broke about 2.5 years ago and a second-hand unit was sourced from Wakari hospital. The replacement of this part must be custom made and can only be sourced from Europe which will have a significant lead in time of at least 6 months or longer. This has created a cash flow issue for the Trust as they are not receiving any revenue to cover the costs of the SDHB MOU costs and the wages for their employed life guards.

12. While the pool is out of commission, there is also a significant list of issues with the pool with the entire infrastructure in very poor condition and to keep the pool operating will require approx. $1.3m spent on it in the next few years. This is a cash that the SDHB do not have at their disposal, however the Trust could raise the funds if they had a long-term lease on the pool. These issues are discussed below.

Discussion

13. Short term: The Physio pool infrastructure is very old technology dating back to the 1940's and is failing in many areas. Currently the water plate heat exchange failed, this led to a flood as the sump pump also failed at the same time, on inspection the steam coil has also failed. This failure also took out some of the electrical wiring. To fix this situation the heat exchange will need to be custom build and imported from Europe, the Steam Coil will also need to be custom build. The estimate to fix the current broken infrastructure is approx. $50,000.

14. Even with the above fixed, there is a long list of issues that require fixing and these amount to $1.3m to $1.5m over the short to medium term. The list is attached as appendix 1. The risk is that the current issues are fixed which may place pressure on the other parts of the mechanics and they too are very likely to fail. On top of this the roof leaks and needs replacing, the concrete walls will not hold paint due to the lime levels and will need to be resealed to maintain their integrity. The changing rooms are also sub-standard and require a complete refurbishment. The tiles on the floor of the pool are cracked with other tiles lifting, theses will also need to be replace. Effectively this pool is at the end of its life and any money spent on the pool will fix the current issues, but a clear strategy on the provision of appropriate facilities in Dunedin is required before too much is sunk into this outdated facility.

15. The Trust is in a difficult financial position at the moment and have asked to be relived of the charges while the pool is out of commission, this has been agreed to by SDHB. However the Trust has also asked to be relived of $100k of the $142k permanently, before this is agreed to a full costing of the operations of the pool will be completed.

16. Long Term: the New Dunedin Hospital does not have provision for a Physio Pool and the Trust have asked what the future direction is for a Therapeutic Pool in Dunedin. I have been advised that previous discussion held between the DCC, SDHB and the Trust concluded with the need to look at one of the existing public pools to be enhanced to include a heated therapeutic pool. This would be either the Moana Pool, or the fact that a new facility is presently being developed in Mosgiel. These discussions do not seem to have come to any conclusion.

17. It is clear that the existing pool does have a limited life, the infrastructure of the pool is old technology, the energy source for the pool will ultimately be closed down and the area that the Fraser Building and Physio Pool Building occupy will also ultimately change. The Trust have stated that they are not wedded to the existing pool, if a modern new pool was built somewhere in Dunedin then they would fully support this happening.

18. The options for the Physio pool are limited and these are: 1. the pool is closed due to the cost to repair and the state of the infrastructure. 2. SDHB repairs the current issues with the pool while it undertakes the site master plan. This will buy time to establish if the current land on which the pool is required for other building and activities related to health. 3. Encourage the Trust to commence a plan to relocate to an alternative site.

19. Option 1, this is not the time to close the pool until the Trust has made some decision on the future location of the pool

20. Option 2, the expenditure of $50k will buy the Trust time while the SDHB completes the site master plan. This will determine the use of the current pool location, if the plan is to utilise this location for other health services then the pool will close, on the other hand if the land on which the pool is not required for other health services, then a long term lease to the trust may be feasible.

21. Option 3 the Trust should commence this planning now as a new modern pool co-located with another public pool. This is now becoming common for new pool facilities to include a therapeutic pool. Such pools are no longer part of a hospital but are community based.

Next Steps & Actions

1. Agreed to the relief of charges to the Trust while the pool is out of commission.
2. Complete the repairs to the infrastructure at a cost of $50,000.
3. Confirm cost to SDHB of running the pool and negotiate an appropriate rate with the Trust.

Appendices

Appendix 1	List of issues with the pool
Appendix 2	Paper from Mark Shirley – Trustee Otago Therapeutic Pool Trust

Appendix 1

Immediate & Forecasted work required for the Physio Pool. Estimated cost only.

Priority	Current Issues	Longevity of fix	Estimated cost
1	Pool water plate heat exchanger needs replacing.	5 - 10 Years	$15,000.00
2	New Pool chlorine cylinders auto shutoff valves.	10 Years	$20,000.00
3	Pool ventilation heating system – Steam coil needs replacing	5 - 10 Years	$40,000.00
4	Renew Pool Roof.	15 Years	$150,000.00
5	Replacing Pool tiles	15 Years	$150,000.00
5	Repair/Replace concrete under the pool tiles - upon lifting current tiles the damaged concrete will be revealed	15 Years	$100,000
5	Replace sparge pipe done at the same time as pool tiles	15 Years	$30,000.00
6	Balance tank replaster inside	15 years	$10,000
6	Replace Pool Balance tank scupper pipes	5 years	$5,000
6	Replace Balance tank pool drain valve	10 Years	$10,000
6	Balance tank waste drain valve	10 Years	$5,000
6	Replace cold water main, valve and backflow preveter to Balance tank	10 Years	$10,000
7	Replace pool hoist & lifting beam & chair - chair needs replaced $8k, hoist and beam need checked first by expert	15 Years	$80,000
7	Upgrade of the changing rooms	10 Years	$150,000.00
7	New floor drains in changing rooms done at same time as changing rooms	15 years	$20,000.00
8	Replace 7 no. Pool water sand filters	15 Years	$140,000
8	Replace 1 no. Pool Water circulating pump	5 -8 years	$10,000
9	Replace 1 no. Ventilation ducts sump pump	8 Years	$2,000
10	Replace pool water plastic flow and return pipes from heating plant to pool with stainless steel	15 Years	$30,000
11	New pool handrail shallow end and 2 new handrails deep end	15 Years	$20,000
12	New pool water bicarbonate of soda dosing pump next year	5 Years	$2,000
13	Replace steam and condensate mains from number 2 plant room headers to pool plant room	10 Years	$20,000
		Total	**$1,019,000**
Next 2 - 5 Years			
	Replace supply and extract fans	15 Years	$50,000
	Exterior Painting - next 2-5 years	20 Years	$25,000
	New chlorine auto dosing system next 5 years	10 Years	$15,000
	Replacement chlorine cylinders shelter next 5 years	15 Years	$10,000
	Interior painting - next 5-10 years	15 Years	$40,000
	Air handlers supply & return, filter bank, external louvres next 5-10 years	15 Years	$100,000
	Replacement Chlorinator, venturi & strainer next 5-10 years	10 Years	$5,000

	Replacement chlorine cylinder auto changeover system next 5-10 years	10 Years	$10,000
	New steam to LPHW heating water system to replace current ventilation steam coil and pool water heat exchanger	20 Years	$200,000
		Total	**$380,000**
Next 5 - 10 Years			
	Pool interior Lighting	15 Years	$20,000
	Exterior entrance ramp	15 Years	$10,000
	Steel frame windows replace with double glazing	20 Years	$100,000
		Total	**$130,000**
		Total	**$1,529,000.00**

Appendix 2

Physio Pool

The **Physio Pool** is one of the largest warm water swimming pools in New Zealand and Dunedin's only therapeutic swimming pool.

The key features are:

- water temperature is around 35 degrees,
- wheelchair accessibility,
- hoist,
- graduated depth,
- private and spacious changing rooms and
- proximity to Dunedin Hospital.

The benefits of warm water exercise are tremendous and have an extremely positive impact on the quality of life for all abilities and ages.

Key Benefits of Otago's Therapeutic Physio Pool

- The water reduces or eliminates gravity enabling people to **achieve mobility that they could not on land**. This means people are able to mobilise earlier post orthopaedic surgery and those with neurological injury or disease are able to achieve cardiovascular exercise. People are able to gradually return to exercise in a safe and supportive manner while the pressure of the water reduces swelling in vascular conditions.
- The warmth and buoyancy of warm water makes it a safe, ideal environment for **relieving arthritis pain and stiffness**.
- The pressure of the water on the body's surface helps to **decrease swelling and improve joint position awareness**.
- The warmth of the water assists in **relaxing muscles and improving circulation**.
- Water supports joints to **encourage free movement**, and also acts as resistance to **help build muscle strength, flexibility and stamina**, no matter what one's current level of fitness is.
- Aquatic activities can be **enjoyed by people of all** ages, degrees of fitness, and functional ability.

The non-threatening and quiet environment is ideal for people with disabilities to pursue their rehabilitation and wellbeing. The changing facilities are located a few steps from the pool, making for very easy access, while the warm water temperature provides an opportunity to exercise without getting cold, a necessity for some of the pool users.

The Physio Pool is open to the public. It is a key Dunedin health and recreational facility and an important part of the rehabilitation facilities that are required in the Otago area.

User Demographics

With around 33,000 attendances per year, over 90% of these users of the Physio Pool are over 65 years or have a diagnosed injury or illness, and often co-morbidities, including:

- Cardiovascular disease
- Orthopaedic injury or illness
- Neurological injury or illness
- Paediatric health issues
- Pain or movement disorders
- Mental health conditions
- Significant mobility issues.

These users are unable to access the facilities at other community pools due to a number of barriers including:

- Access to the water
- Access to the facility
- Water and air temperatures in other pools are too cold for individuals with limited mobility.

The Physio Pool is the only opportunity that these users have to exercise and meet the World Health Organisations recommendation of cardiovascular and resistance based activity or exercise. It is therefore a key determinant of helping these individuals self-manage their conditions and prevent them from needing additional primary or secondary care.

Besides hospital patients, private physio patients and individual attendees who rehab, exercise, swim or aqua-jog there are user groups such as:

- Aqua-fitness group
- Special Olympics - swimming group for the intellectually disabled
- Two learn to swim classes
- Muslim women swimming group
- Phoenix Club
- Vera Hayward Clinic, Dunedin Hospital
- Physiotherapy outpatients, Dunedin Hospital.

These groups would find it difficult to use an alternative pool.

Mark Shirley

Trustee

Otago Therapeutic Pool Trust

14 July 2021

FOR INFORMATION

Item: **Amenable Mortality**

Proposed by: Gilbert Taurua, Chief Māori Health Strategy & Improvement Officer

Meeting of: Southern DHB Board, 3 August 2021

Recommendation

That the Southern DHB Board accepts this paper.

Purpose

1. The purpose of this paper is to provide the Board with an understanding of Māori Amenable Mortality defined as premature deaths that could have potentially been avoided given effective and timely health care. That is early deaths from causes (disease and injury) for which effective health care interventions exist and are accessible to our population.

Specific Implications for Consideration

2. Financial

    - Potential solutions to reducing Amenable Mortality would have financial implications.

3. Quality and Patient Safety

    - Amenable Mortality has quality and patient safety implications and ought to be reflected in regular reporting to the Board.

4. Operational Efficiency

    - Amenable Mortality reflects operational related effectiveness and the overall performance of the Southern DHB.

5. Workforce

    - Amenable Mortality has associated workforce related issues and challenges.

6. Equity

    - This paper highlights Māori health equity and inequality related evidence.

Background

7. This paper requested by the Board provides an overview of our Māori and non-Māori Amenable Mortality rates which varies across ethnic and socioeconomic groups. This paper highlights clear equity related gaps across our district and provides the Board with an opportunity to support targeted interventions that will improve the life expectancy for our Māori population.

Discussion

8. This paper provides an updated analysis of this districts Amenable Mortality rates and provides a series of recommendations for the Board's consideration.

Next Steps & Actions

Follow up actions noted by the Board will be actioned and reported back in September 2021.

Appendices

Appendix 1	Māori Amenable Mortality Paper
Appendix 2	List of amenable mortality groups and conditions with ICD10 codes

Appendix 1: Māori Amenable Mortality

Introduction

The purpose of this paper is to provide the Southern DHB an overview of our amenable mortality rates for Māori. Life expectancy is one of the most widely used measures in demographic and health analysis in New Zealand. Equity in health outcomes has long been a goal in New Zealand and is measured mainly in terms of the reduction or elimination of health inequalities between Māori and Pacific. Life expectancy and amenable mortality differentials are a frequently cited inequity and are persistent within the Māori and Pacific populations when compared to non-Māori and non-Pacific populations. Risk factors common to several chronic conditions such as diabetes, cardiovascular disease, cancer, respiratory disease, or vascular dementia, include smoking, alcohol and drug use, nutrition, body size, and physical activity impact on amenable mortality. Improvements in these indicators require public health and intersectoral action to support healthy environments and living conditions for Māori communities, as well as primary care interventions designed for individuals and whānau.

Amenable Mortality Definition

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75). The list of conditions that define avoidable mortality is based on expert review on causes that potentially could have been avoided given knowledge of casual pathways, the determinants of health and therapeutic technologies at the time of death.

Amenable mortality is made up of two overarching categories: amenable mortality and preventable mortality. Amenable mortality includes causes of death that could have potentially been avoided by means of access to high-quality and timely medical interventions. Preventable mortality is broader and includes deaths which could have been avoided through addressing the wider upstream determinants of health, such as individual-level health risk factors, socioeconomic status and environmental factors.

Amenable mortality is a useful screen of health system performance and can serve to identify potential areas of concern for more detailed investigation. It is recommended that we firstly look at the amenable mortality measure as a whole, then drill down to super category level, and finally to specific condition level as outlined in Appendix 2.

The data for amenable mortality is produced from the Mortality Data Collection. The Mortality Data Collection uses information from a variety of organisations to collect and code causes of death for every death in New Zealand. It takes several years for some coronial cases to return verdicts. Given the significant impact these cases can have on some causes of death the Ministry of Health is often unable to release provisional cause of death information for up to five years.

Māori Amenable Mortality and Life Expectancy

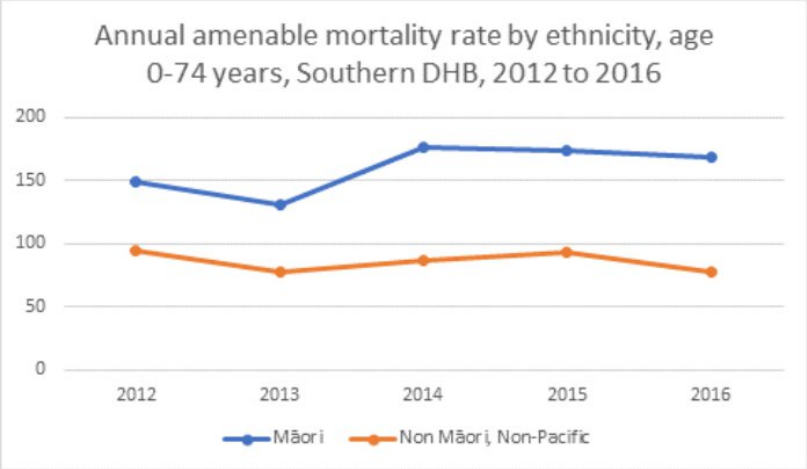
In 2012–14, life expectancy differentials were 6.8 years in Māori females and 7.3 years in Māori males. Within the Pacific population, the differential was 5.2 years in females and 5.8 years in males. While the life expectancy gap between Māori and non-Māori have decreased since 1900, a widening occurred in the 1980s and 1990s. This widening has partly been attributed to the economic structural reforms that occurred during this period. These reforms had a larger impact on Māori than other ethnic groups. The underlying factors contributing to ethnic health inequities, particularly life expectancy, are multifaceted and complex. This is particularly so when the experiences and pathways leading to inequity are likely unique for both the Māori and Pacific populations.

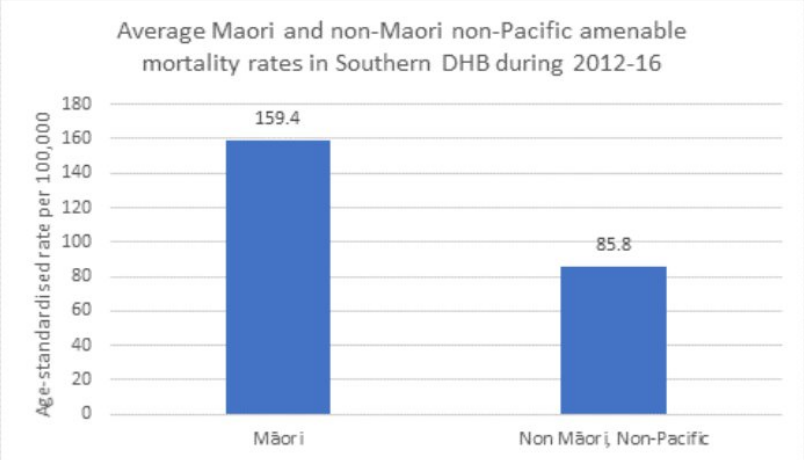
Many of the drivers are related to the unequal distribution of the determinants of health. For example, the unequal distribution and access to resources such as income, education and employment, factors which often compound one another. These factors also pattern exposures to other risk factors such as tobacco use, poor nutrition, overcrowding and poor-quality housing, and drug and alcohol use.

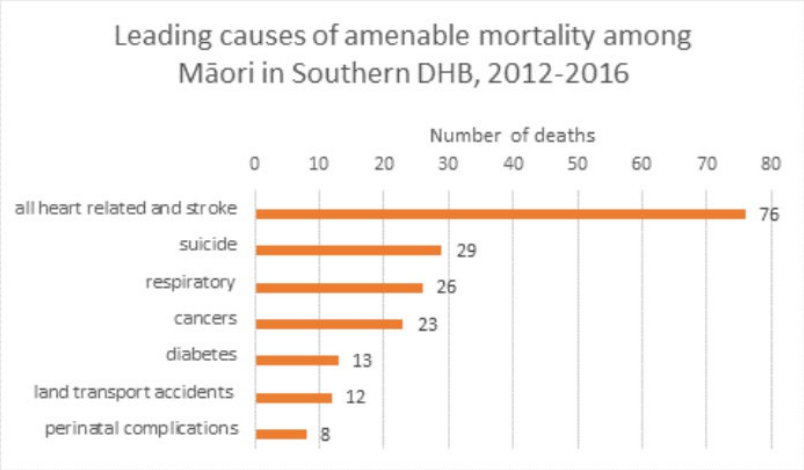
This inequitable distribution of determinants of health, particularly for Māori, is rooted in structural hierarchies that are associated with colonisation. This is not unique to New Zealand. In countries with a colonial past, indigenous populations frequently will have poorer health, even once socioeconomic factors are controlled for. Furthermore, access to the determinants of health and the associated ethnic inequities in health outcomes can arise from processes related to racism, as one's social environment and where people are placed in the social hierarchy can shape health. The contribution of racism, particularly institutional racism, to health inequities is increasingly being recognised in New Zealand. It not only drives ethnic inequities in poverty, but also compounds the already significant negative effects of poverty (M Walsh and C Grey, NZMJ, 29 March 2019, Vol 132 No 1492.).

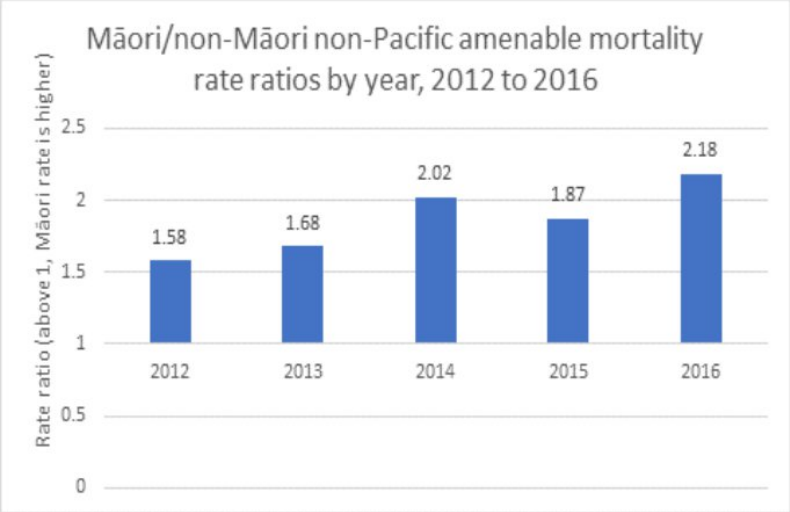
Southern DHB Amenable Mortality

This series of amenable mortality data provides a snapshot into the Māori health inequality across our district to 2016. Quantifying, understanding and monitoring health inequities are important if we are to address both the underlying and presenting health issues for this population.

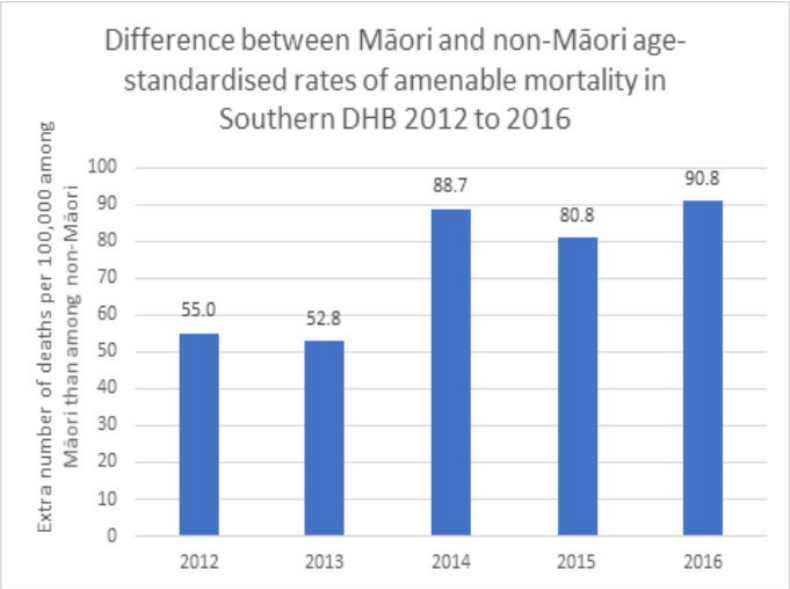



Average Maori and non-Maori non-Pacific amenable mortality rates in Southern DHB during 2012-16
Age-standardised rate per 100,000
180
160
140
120
100
80
60
40
20
0
159.4
85.8
Māori
Non Māori, Non-Pacific


Leading causes of amenable mortality among Māori in Southern DHB, 2012-2016
Number of deaths
0
10
20
30
40
50
60
70
80
all heart related and stroke
76
suicide
29
respiratory
26
cancers
23
diabetes
13
land transport accidents
12
perinatal complications
8


Māori/non-Māori non-Pacific amenable mortality rate ratios by year, 2012 to 2016
Rate ratio (above 1, Māori rate is higher)
2.5
2
1.5
1
0.5
0
1.58
1.68
2.02
1.87
2.18
2012
2013
2014
2015
2016

16



Discussion

The gap in Māori and non-Māori amenable mortality rates has increased over the last 30 years. In 2016, the Māori rate of amenable mortality (159 per 100,000) was over twice the non-Māori rate (86 per 100,000 for non-Māori), compared to being one-and-a-half times as high in 2012 (or 86% higher averaged over the whole period).

The growing gap is unacceptable and more work needs to be done urgently across the system to better understand these findings.

In the Southern Region, heart disease (including coronary, valvular, hypertensive) and stroke were the leading cause over the period 2012-16. This was followed by suicide 2nd then respiratory disease 3rd (mostly COPD, but some asthma), cancers 4th (prostate, breast, with some stomach, rectal and melanoma), diabetes 5th, land transport accidents 6th, and perinatal complications as 7th cause of amenable mortality for the Southern district.

A wide range of health services are involved in reducing amenable mortality rates. The MoH lists the following key contributory measures as areas DHBs can focus on to improve their performance on

- Cancer screening coverage and treatment timeliness
- Cardiovascular risk management
- Other chronic disorder management (COPD, diabetes)
- Injury prevention
- Mental health services (self-harm)

Smoking cessation services.

Key Recommendations

1. The SDHB Board acknowledges that the difference in amenable mortality between Māori and non-Māori is inequitable, being unjust, unfair and in breach of te Tiriti o Waitangi; and commits to addressing amenable mortality, especially for Māori.

2. That a commitment is made to the regular collection, analysis and reviewing of amenable mortality data in ways that will influence decision making.

3. A plan is developed to make changes to DHB delivered services that could decrease amenable mortality rates and influencing current partnerships with other organisations. This may require additional resource to be available for services specifically designed with and for Māori to identify and respond to amenable conditions (e.g. cancer screening and cardiology services) as well as wider links to address social determinants of health and primary care.

4. Signaling to the Strategy Refresh process that amenable mortality is a priority to address through the current locality and models of care work.

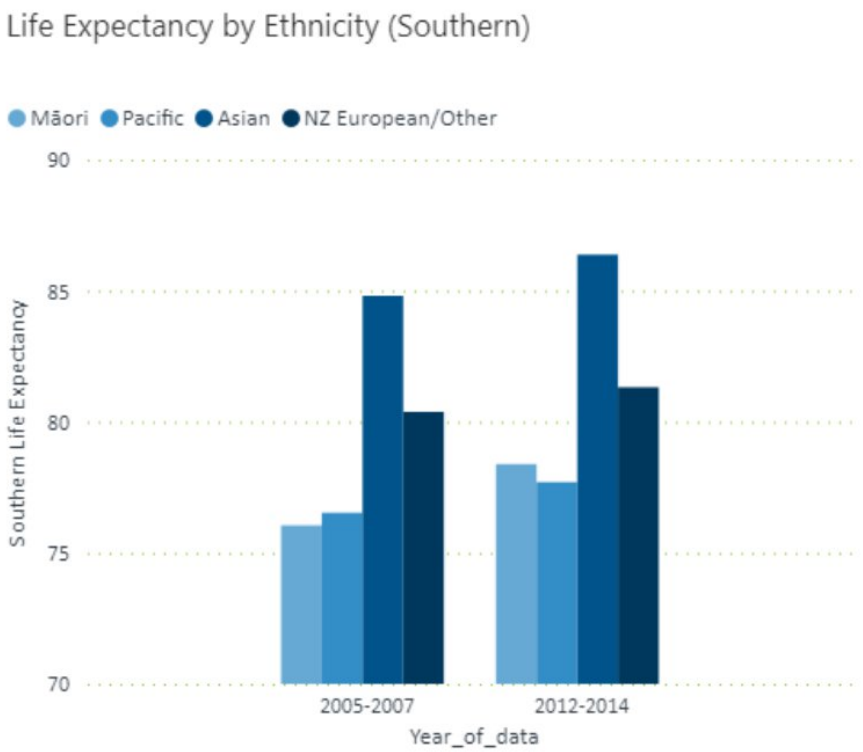
5. To implement recommendations from the recent Mental Health Review to address suicide.

6. A commitment to strengthening population health influence in the Southern Region and ensuring that population health expertise is resourced sufficiently and at the right levels – governance, management and operations. Although Population health interventions aren't included in the amenable mortality definitions, these interventions will affect amenable mortality rates.

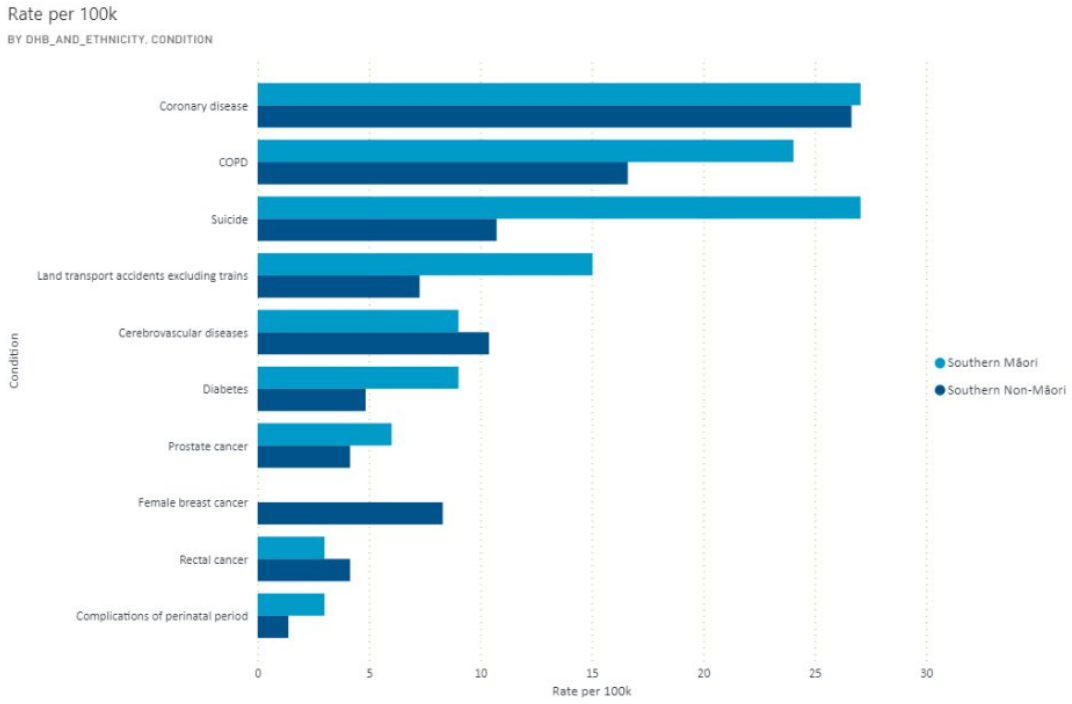
Appendix 2: List of amenable mortality groups and conditions with ICD10 codes

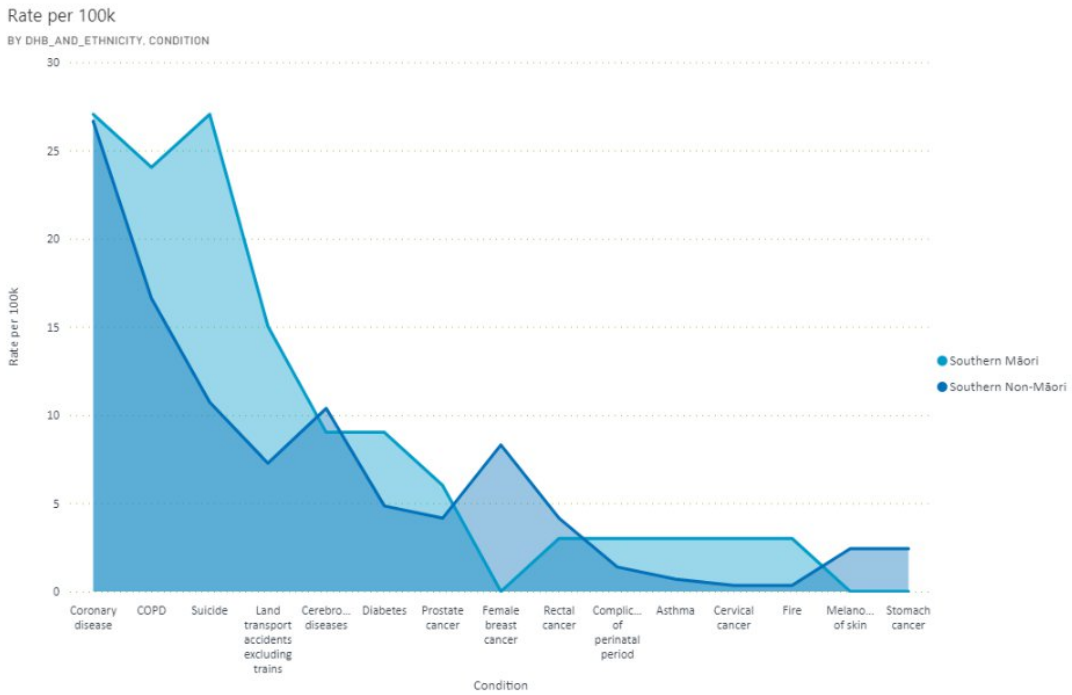
Group	Condition	ICD-10-AM-II	Notes
Infections	Pulmonary tuberculosis	A15-A16	
	Meningococcal disease	A39	
	Pneumococcal disease	A40.3, G00.1, J13	
	HIV/AIDS	B20-B24	
Cancers	Stomach cancer	C16	
	Rectal cancer	C19-C21	
	Bone and cartilage cancer	C40-C41	
	Melanoma of skin	C43	
	Female breast cancer	C50	Females only
	Cervical cancer	C53	
	Prostate cancer	C61	
	Testis cancer	C62	
	Thyroid cancer	C73	
	Hodgkin lymphoma	C81	
	Acute lymphoblastic leukaemia	C91.0	Ages 0-44
Maternal and infant	Complications of pregnancy	O00-O96, O98-O99	
	Complications of perinatal period	P01-P03, P05-P94	
	Cardiac septal defect	Q21	
Chronic disorders	Diabetes	E10-E14	
	Valvular heart disease	I01, I05-I09, I33-I37	
	Hypertensive diseases	I10-I13	
	Coronary disease	I20-I25	
	Pulmonary embolism	I26	
	Heart failure	I50	
	Cerebrovascular diseases	I60-I69	
	COPD	J40-J44	
	Asthma	J45-J46	
	Peptic ulcer disease	K25-K27	
	Cholelithiasis	K80	
	Renal failure	N17-N19	

Injuries	Land transport accidents excluding trains	V01-V04, V06-V14, V16-V24, V26-V34, V36-V44, V46-V54, V56-V64, V66-V74, V76-V79, V80.0-V80.5, V80.7-V80.9, V82-V86, V87.0-V87.5, V87.7-V87.9, V88.0-V88.5, V88.7-V88.9, V89, V98-V99	Include V00 if using ICD-10-AM-VI
	Accidental falls on same level	W00-W08, W18	
	Fire	X00-X09	
	Suicide	X60-X84	
	Treatment injury	Y60-Y82	



16


Rate per 100k
BY DHB_AND_ETHNICITY, CONDITION
Coronary disease
COPD
Suicide
Land transport accidents excluding trains
Cerebrovascular diseases
Diabetes
Prostate cancer
Female breast cancer
Rectal cancer
Complications of perinatal period
Condition
0
5
10
15
20
25
30
Rate per 100k
Southern Māori
Southern Non-Māori


Rate per 100k
BY DHB_AND_ETHNICITY, CONDITION
30
25
20
15
10
5
0
Rate per 100k
Coronary disease
COPD
Suicide
Land transport accidents excluding trains
Cerebro... diseases
Diabetes
Prostate cancer
Female breast cancer
Rectal cancer
Complic... of perinatal period
Asthma
Cervical cancer
Fire
Melano... of skin
Stomach cancer
Condition
Southern Māori
Southern Non-Māori

FOR APPROVAL

Item: **Policies**

Proposed by: Finance, Audit and Risk Committee

Meeting of: Board, 3 August 2021

Recommendation

That the Board approve the attached policies:

1. **Contract Management Policy**
2. **Capital Asset Management Policy**
3. **Procurement and Purchasing Policy**
4. **Internal Audit and NGO Audit Policy**
5. **Sensitive Expenditure Policy**

Background

1. The Finance, Audit and Risk (FAR) Committee reviewed the attached policies at its 5 July 2021 meeting. The changes requested by the Committee have been made.

Appendices

Tab 16.1 Contract Management Policy
Tab 16.2 Capital Asset Management Policy
Tab 16.3 Procurement and Purchasing Policy
Tab 16.4 Internal Audit and NGO Audit Policy
Tab 16.5 Sensitive Expenditure Policy

17

100202

Contract Management Policy (District)

The purpose of this policy is to establish a Southern DHB-wide structure for managing contracts and other legally binding documents.

Policy Applies to

This is a Southern DHB-wide policy and applies to all Southern DHB (Southern DHB) employees wo are involved in the contracting process. It covers all types of contracts, with the exception of employment contracts.

Policy Summary

The policy aims to ensure:

- A standard approach and framework is adopted across Southern DHB in the management of contracts;
- Southern DHB enters into and manages contracts in a manner which facilitates Southern DHB business and minimises risk;
- Southern DHB staff understand Southern DHB's responsibilities under a contract and are adequately skilled and trained to do so;
- The achievement of quality performance and value for money in line with expectations;
- Maximised supplier and industry engagement so that a competitive and willing market exists to support Southern DHB; and
- Southern DHB receives the benefit of the contract.

17.1

Definitions

Contract	Any agreement that commits Southern DHB in legal or financial terms. This includes, but is not limited to, the following: • Leases. • Joint venture agreements. • Agreements for purchase of goods or services. • Agreements for sale of goods or services. • Memorandum of Understanding (MoU). Tender submissions which, when accepted, will constitute a contract.
Contract Owner	The manager to whose budget and/or area of responsibility the contract relates and who has the authority to contract on the DHB's behalf. The contract owner is responsible for the management of the contract.

Contracts Database / Contract Register	The centralised database containing details of all Southern DHB provider contracts.
Contracts Administrator	The Southern DHB staff member(s) responsible for maintaining and updating the provider arm contracts database. (Sector Operations is the agent administrator for the Funder Arm).
Contract Management Plan	A written document outlining the high level requirements, deliverables, performance measures, and actions required for the successful delivery of the contract.
Sector Operations	Department of the MoH who provide agreement administration, entitlement management, registration management, claims and invoice processing, customer enquiry and payment processing services for the Funders.
Other Party	The other party (or parties) to the contract.

Contracting Principles

The following principles must be applied to all aspects of the contracting process:

- Southern DHB has a public law obligation to act in a fair and reasonable manner in its dealings with other parties;
- Southern DHB will be, and will be seen to be, impartial in its decision-making;
- Southern DHB will endeavour to obtain the best value for money over the life of the contract, taking into consideration factors such as price, quality, reliability, delivery, maintenance, technological change, service levels, health and safety issues, and environmental issues;
- Southern DHB's Procurement and Purchasing Policy (District) (11400) and processes and Tendering Policy (District) (25011) will provide for open and effective competition between potential suppliers;
- Southern DHB will act with honesty, integrity and transparency in its dealings with other parties, while protecting commercially sensitive information;
- Southern DHB will comply with all relevant legislation;
- Southern DHB will provide for key performance indicators and deliverables across the life of all significant contracts and effective mechanisms to enforce adherence to pre-agreed acceptable levels of performance;
- Southern DHB will regularly monitor and report on the delivery of all key performance aspects of awarded contracts over the life of the contract using suitably qualified and independent staff.

Conflicts of Interest

- The management of real and perceived conflicts of interest is vital to good procurement, contracting and contract management. The provisions of Southern DHB's Conflict of Interest (District) (27894) and Procurement and Purchasing (District) (11400) policies will apply. For the sake of further clarity: staff involved in the negotiation, preparation, review or signing of contracts must declare all possible real or perceived conflicts of interest;
- The determination of how to manage the real or perceived conflicts rests with the manager two up from the staff member. Where the CEO is involved with the contract negotiation and has a conflict of interest, the escalation would be one up to the ~~Commissioner~~SDHB Board Chair;
- Management of real and perceived conflicts will range from additional documented precautions, to prohibiting the staff member from being involved in the negotiation, preparation, review, signing and monitoring of contracts.

Contract Negotiation

1. Staff involved in negotiating contracts must have an appropriate knowledge of relevant legislation, and must comply with Southern DHB policy, procedure and guidelines in respect of the contracting process.
2. The contract owner must consult internally with relevant parties before proceeding with contract negotiations.
3. The contract owner must keep a complete record of all contract negotiations and related correspondence and ensure this is either
   a. stored in the electronic Contracts Register, or
   b. stored in the excel brief if a funder contract.

Contract Preparation

1. Staff involved in contract preparation must have an appropriate knowledge of relevant legislation, and must comply with Southern DHB policy, procedure and guidelines in respect of the contracting process.
2. All contracts entered into by Southern DHB must be in writing.
3. Contracts involving the procurement of goods or services must comply with the Southern DHB Procurement and Purchasing Policy (District) (11400).
4. All contracts must contain details as specified in the Contract Management Guidelines (District) (100203).
5. Where contracts are prepared by Southern DHB, they should use either:
   a. Sector operations for the creation and administration of funding agreements; or
   b. A standard Southern DHB contract template whenever possible. If no standard template exists, the contract owner should seek assistance from the DHB's corporate solicitor to draft a contract.

Contract Review

1. All contracts in excess of the contract owner's delegated authority must be reviewed on a one-up basis as per the Delegations of Authority Policy (District) (21584).
2. All significant contracts should be reviewed by the in-house corporate solicitor, prior to commitment and execution.

Signing Contracts

1. All contracts must be signed by a Southern DHB staff member with appropriate delegated authority. No other staff members are authorised to sign contracts on Southern DHB's behalf.
2. The DHB will not sign all contracts, as certain entities are approved to contract on the DHB's behalf, such as:
   a. Pharmac; and
   b. Ministry of Business, Innovation and Employment (MBIE).

Contracts Administration

1. Southern DHB's Finance Department will maintain a central electronic database of all provider contracts to which this policy applies. Funder contracts are held by sector operations.
2. The contracts administrator is responsible for the administration of contracts in accordance with the Contract Management Guidelines (District) (100203).
3. The core document that records internal approvals is the Contract Approval Form (CAF) (District) (45387). A copy of this is stored in the contract's register along with the contract and other associated documentation.

Contract Management

The contract owner is responsible for the ongoing management of the contract in accordance with Contract Management Guidelines (District) (100203).

Preparation

a. Southern DHB will include measurable, relevant and robust key performance indicators and deliverables across the life of all significant contracts.
b. Southern DHB will be alert to provisions in contracts which enable the delivery to be contractually acceptable but nevertheless unsafe or unsuitable for the DHB.

Negotiation

c. Southern DHB will ensure that each contract has effective and robust mechanisms to enforce adherence to the pre-agreed acceptable levels of performance.

Monitoring

a. Southern DHB will regularly monitor and report on the delivery of the key performance aspects of awarded contracts over the life of the contract, via the contract owner.
b. Southern DHB will use suitably qualified and independent staff to monitor the delivery of the quality and quantum aspects of the contract.

Escalation

a. Southern DHB staff will have in place mechanisms to escalate, report and resolve contract delivery failures.

Associated Documents:

- Contract Management Guidelines (District) (100203)
- Contract Management Approval Form (District) (45387)
- Delegations of Authority Policy (District) (21584)
- Procurement and Purchasing Policy (District) (11400)
- Tendering Policy (District) (25011)
- Sensitive Expenditure Policy (District) (48567)

100202

References:

- Commerce Act 1986
- Consumer Guarantees Act 1993
- Contracts (Privity) Act 1982
- Contract Enforcement Act 1956
- Contractual Remedies Act 1979
- Copyright Act 1994
- Fair Trading Act 1986
- Illegal Contracts Act 1970
- Māori Language Act 1987
- Minors' Contracts Act 1969
- Contractual Mistakes Act 1977
- Official Information Act 1982
- Privacy Act 1993
- Public Records Act 2005
- Sale of Goods Act 1908
- Government Rules of Sourcing
- Contract & Relationship Management – A Guide for Government Agencies
- National Service Framework Library

14479

Capital Asset Financial Management Policy (District)

Overview

Capital asset financial management is concerned with the effective planning, acquisition, accounting for and disposal of property, plant and equipment. This policy covers the recognition for accounting purposes of assets and capital expenditure.

Purpose

The purpose of this policy is to define the rules the principles for the recognition of capital expenditure. It explains the rules established to ensure compliance with legislation (in terms of accounting recognition), audit and financial management requirements for assets and capital expenditure.

This policy also covers leased assets such as computer equipment and large items of clinical equipment. The method of financing assets does not exclude them from this policy and processes. The definition of an asset remains regardless of the chosen method of financing, i.e. leasing.

Nothing in this policy should be seen to override the expectations of the Procurement and Purchasing Policy (District) (11400), the Tendering Policy (District) (25011) or the Clinical Product or Device Management Policy (District) (16111).

Scope

This policy applies to the recognition and management of capital expenditure for all employees of Southern District Health Board (Southern DHB), including temporary employees and contractors to the DHB. It also applies to any person who is involved in the operation of Southern DHB, including joint appointments, volunteers and those people with honorary or unpaid staff status.

For the purposes of this policy the definition of board members includes the commissioner and deputy commissioners.

17.2

Policy Statement

Southern DHB undertakes to ensure that financial resources are utilised in a way that:

- Maximises achievement of the DHB's stated objectives in the various planning documents adopted by the board of Southern DHB; and
- Sustains and then improves the quality of the current asset base; and
- Maximises the efficiency and capability of the current asset base; and
- Accounts for capital assets in a way that satisfies all legislative and audit requirements, in accordance with the accounting standards.

Definitions

a) Initial Cost: Includes the asset's purchase price (GST exclusive) plus any costs directly attributable to bringing the asset to the location and condition necessary for it to be capable of operating in the manner intended. Directly attributable costs could include, but are not limited to,

- site preparation costs,
- initial delivery and handling costs,
- installation and assembly costs,
- asset testing costs, and
- professional fees (engineers, architects etc).

Initial cost does not include expenditure such as;

- feasibility costs,
- costs of advertising,
- conducting business and administration (e.g. staff training) and other general overheads, or
- cost of relocating or reorganising.

b) Capital Budget: Is the annual amount allocated for capital expenditure approved by the board as part of annual plan (AP) process.

c) Capital Plan: Is the list of capital items comprising of four parts (see below) compiled each year by Finance during the annual planning cycle. Departments will be requested to submit a list of items they believe will require capital expenditure. This list/request will cover a three-year period. Reference will also be made to the Fixed Asset Register to determine items that are reaching the end of their useful lives and cross-referenced to the request list to assist its compilation.
The four types of assets making up the capital plan are;

- Replacement items - portion of the capital expenditure budget to replace ageing equipment for the whole organisation.
- New assets - portion of the capital expenditure budget for assets identified for new services, service growth or expansion or new needs and technologies.
- Buildings - portion of the capital expenditure required on building projects.
- Contingency Fund - portion of the capital expenditure budget by service group to be held in reserve for assets that have an unexpected breakage or for items that were not specifically planned for when the capital budget was set.

d) Useful Life: Is defined as the period over which an asset is expected to be available for use. It is determined in relation to an entire asset category but may be assessed at an individual asset level. The useful life should be determined after considering the following factors; expected usage, physical wear and tear, technical or commercial obsolescence, legal or other limits.

e) Fair Value: Is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction. Where there is no market-based evidence of fair value (because of the specialised nature of the asset) depreciated replacement cost may be used.

f) Repairs and Maintenance: Include costs incurred in the day-to-day servicing of an asset, including labour, consumables, and the cost of small parts.

g) Carrying Value: The amount that the asset is included on the statement of financial position of the customer. Typically this will be the initial cost or revaluation less accumulated depreciation and accumulated impairment losses.

h) Cost Model: Initial cost or revaluation less accumulated depreciation and any accumulated impairment losses.

i) Revaluation Model: Where the fair value of an asset can be reliably measured, the asset may be carried at a revalued amount, being its fair value at the date of revaluation, less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations shall be made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the balance sheet date. All revaluations must be performed by an independent registered valuer; or where the customer

has on its staff a person sufficiently experienced to conduct a valuation, by that person, so long as the valuation has been subject to review by an independent registered valuer.

j) Recoverable Amount: Is the higher of its fair value less costs to sell and its value in use. Generally the "value in use" amount is the present value of future cash flow projections. However the most appropriate valuation methodology to determine "value in use" can vary depending on the asset and the particular circumstances for which the asset has been acquired.

k) Regional Product Governance Committee (RPC): Is a group that oversees the evaluation and approval of capital, clinical and non-clinical products for the DHB.

l) Depreciable Amount: Is the initial cost or revalued cost less the residual value.

Policy

1. Capital Budget Process and Approval

The capital expenditure budget is approved by the board as part of the annual plan process.

Generally, the budgeted amount set for capital expenditure (including assets leased by way of a finance lease) is aligned to annual depreciation charges for each class of asset, i.e. clinical equipment, information systems, buildings, etc.

The capital expenditure budget is set at a high level and approved by the board, with the underlying capital plan (see below) requiring management and prioritisation by the executive within approved budget limits.

Prioritisation should follow a hierarchy of:

- Safety to patients
- Risk mitigation
- Occupational health and safety issues
- Regulatory requirement
- Core service within agreed framework aligned to service plans and asset management plans
- Demographic need
- Improved quality or outcomes focused

2. Capital Plan Process and Approval

Each year a capital plan will be formulated.

The Finance Department (managed by the senior business analyst) will coordinate the preparation of the capital list. Directorates will input capital requirements into the capital expenditure system on the intranet covering the next three-year period to form the draft capital list. Finance will review the Fixed Asset Register and send a list to directorates of assets that are approaching the end of their useful lives to assist with input into the capital list. If available, reference will also be made to the DHB's Asset Management Plan.

The plan will be divided into four categories:

1. Replacement Items
2. Upgrade of Existing Assets
3. New Assets
4. Contingency Fund

The list will be prepared under the above categories and by asset type and service group area.

When it is compiled, the Executive team will then meet to prioritise and manage the list within the annual capital budget allocation approved by the board.

The draft and final capital plans will be available online to the Procurement Team and the Building and Property Team.

- The role of the Procurement Team is to identify procurement opportunities. The departmental request will include identifying the likely quarter of the year when the asset will be required. This provides greater opportunity for procurement.
- The role of the Building and Property Team will be to provide estimates for any building work included in the capital plan. They will also review the capital plan to ensure Directorates have considered the cost of any building work associated with the purchase of clinical equipment.

Once the list is finalised and approved, the Annual Capital Plan will be available via the electronic capital system on the Intranet (Pulse) for departmental reference.

Once the list is approved, capital expenditure items can be requested by departments using the electronic capital system, and approval given by those holding delegated authority in line with the Delegation of Authority Policy (District) (21584).

3. Financial Monitoring of Capital Plan

A monthly report of capital expenditure will be prepared by Finance and reported to the Finance Audit and Risk Committee and/or board, as required.

The report will identify assets by type and service group. It will include the annual budget, the value of assets committed and the value of purchases, with remaining expenditure forecast for the year. The asset will be recorded as 'committed' when approved and the purchase order is placed. It will be recorded as 'purchased' when the invoice has been received.

4. Capital Expenditure Funding

a) Upon approval of the annual capital expenditure plan by the board, capital expenditure will be available for staff to request release of funds against that capital expenditure plan.

b) All capital expenditure applications must be made via the electronic Capital Expenditure (Capex) system. Items are work flowed to ensure Procurement, IT and Finance have the opportunity to review the requested item. Requested items are then work flowed to the appropriate approvers. Once approved either Building & Property, IT or Purchasing raises the purchase order (depending on asset type) and the item is set up in the Oracle Financial Asset System.

   i. Where an item exceeds $100,000, a full business case must be completed. A copy of the final business case and relevant quotes should be attached within the capex system.

   ii. Where an item is less than $100,000 then the capital expenditure justification within the capex system needs to be fully completed along with relevant quotes.

   ~~iii. Any item over $500,000 must be approved by the Regional Capital Group.~~

   ~~iv.~~iii. Any capital expenditure or project items that require ministerial approval (e.g. equity support) must go through the National Capital Committee process. This will be coordinated by the CEO's office.

   The Procurement Department must be involved at an early stage in preparation and costing of the business case in conjunction with departmental business analysts.

c) Substitutions within the capital expenditure budget are allowed, subject to:

i. Justification on why the item was not included in the capital expenditure plan and why the item being substituted is no longer required; and

ii. All substitutions require the approval of the chief executive to the level delegated by the Board. Substitutions exceeding the amount delegated to the chief executive must be approved by the board. In the absence of the CEO, dual approval of the CFO and COO is required.

d) The chief executive will hold a capital expenditure contingency budget. Where a request for release of funds from the contingency budget, there should be:

i. A review of the approved capital expenditure plan to determine if any substitution can be made; and

ii. A justification of why the capital asset was not allowed for in the capital expenditure plan. It is expected that items where the contingency budget is released will be items that could not have been foreseen at the time the capital expenditure budgets were set.

5. Capitalisation Criteria

a) An asset is classed as a fixed asset and required to be recorded on the fixed asset register when it meets all of the following criteria:

i. The GST-exclusive initial cost of the asset meets or exceeds the capitalisation threshold: Initial cost price is greater than $2,000 (GST exclusive) ; and

ii. The asset has an estimated useful life greater than 1 year; and

iii. The asset has not been purchased with the intention of resale.

Should this guidance be insufficient or if confirmation is required, refer queries to the Finance Department whose staff will advise if the expenditure is capital or should be charged to the operating budget as R&M.

b) The purchase of assets that may be classified as a fixed asset and capitalised includes, at the DHBs discretion, the pooling of assets:

i. Of a similar type such as a “bulk” purchase of ICT equipment; or

ii. Assets that are purchased as part of an approved project such as a major ICT or facilities project.

c) Expenditure may be capitalised if it is expenditure on an existing asset and the expenditure was incurred to improve the asset’s functionality, or extend the useful life, not merely to reinstate its future economic benefits (e.g. repairs and maintenance).

d) Spare parts may be capitalised where they meet the capitalisation threshold and the expected useful life is greater than one year.

e) Expenditure splitting in order to get below the capitalisation threshold is not permitted.

6. Measurement after Recognition: Initial Cost Price

a) Items that meet the capitalisation criteria are recorded on the fixed asset register at the initial cost or as otherwise prescribed within applicable accounting standards (e.g. cash price equivalent if purchased using deferred payment, or the present value for assets acquired through a finance lease arrangement).

b) Donated assets are recorded at the fair (market value) on receipt. The corresponding value is recorded as revenue in the Statement of Service Performance.

c) Assets can be recorded as:

(i) Individual assets; or

(ii) A collection of related items or components that cannot operate in isolation, whose combined initial cost meets the capitalisation threshold; or

(iii) An accessory which is required for permanent attachment to an existing asset. The initial cost of the accessory is to be added to the existing asset if it meets the capitalisation threshold; or

(iv) Pooled assets of a similar type, whose combined initial cost meets the capitalisation threshold. Items whose individual initial cost exceeds the threshold must be separately recorded in the fixed asset register and cannot form part of a pool of assets.

7. Measurement after Recognition: Method of Measurement

a) After initial recognition, the cost model of measurement or the revaluation model as specified in clause b and/or d of this section shall be applied.

b) After an asset is commissioned there will often be subsequent expenditure to maintain, renovate or upgrade the asset. Maintenance expenditure is expensed however significant renovations and upgrades may be added to the value of the asset where:

(i) The renovation or upgrade increases the useful life of the particular asset; and

(ii) The parts of the initial asset replaced in the renovation or upgrade can be identified and are able to be written off on commissioning of the new assets.

c) Revaluations of classes of assets are required to be conducted more frequently, than specified in this Policy, if, at balance date, the fair value of the asset differs materially from the carrying amount. Increases in the value of assets are transferred to the asset revaluation reserve for that class of assets.

A decrease in the value relating to a class of assets is recognised in the Statement of Financial Performance in the period it arises where it exceeds the increase previously recognised in the asset revaluation reserve.

In subsequent periods, any revaluation surplus that reverses previous revaluation deficits is recognised as a credit to expenditure in the Statement of Financial Performance up to its original value.

d) The approved methods of measurement by class of asset are:

The following table provides guidance based on current Crown Accounting Policies (CAP) at the time of writing. This table may vary if the CAP are amended by The Treasury.

Asset Category	Measurement Basis
Land	Valuation (at least 5-yearly)
Buildings	Valuation (at least 5-yearly)
Clinical & other equipment	Cost
ICT	Cost
Motor vehicles	Cost

8. Depreciation

a) Depreciation is charged on fixed assets to allocate the cost of the assets over their estimated useful lives. The depreciation charge for each period is recognised as an operating expense and is charged to the cost centre that holds the asset as identified within the Fixed Asset Register.

b) The depreciation method used reflects the pattern in which the assets future economic benefits are expected to be consumed by the Southern DHB. The method and rates are reviewed annually, by the finance department within the Southern DHB, to ensure they remain appropriate.

c) Assets purchased solely for specific research projects may be depreciated over the life of the project. Where the asset is not depreciated over the life of the project, the cost centre owning the project will bear the residual depreciation. If the asset continues to be used subsequent to the end of the project then the customer must transfer the asset to the appropriate cost centre.

d) Leasehold improvements are depreciated over the shorter of the unexpired period of the lease and the estimated useful life of the assets.

e) Depreciation methods and rates will be set at a default rate specified by the finance department unless the manager responsible for the capital asset specifically requests a variation to the default rate.

9. Impairment of Assets

a) An asset could be considered impaired where its carrying amount exceeds its recoverable amount.

b) Any impairment loss on a non-revalued asset shall be recognised immediately in the Statement of Financial Performance. Any impairment loss on a revalued asset is recognised directly against any revaluation reserve to the extent that the impairment loss does not exceed the amount in the revaluation reserve for that asset. If the impairment loss exceeds the balance in the revaluation reserve then the excess shall be recognised immediately within the statement of financial performance.

c) The finance department will review the carrying amounts of all property, plant and equipment on an annual basis.

10. Disposal of Assets

a) All asset disposals must be in accordance with Southern DHB's Delegations Policy and the Asset Disposal and Write-off Policy (District) (100552).

References:

- Asset Transfer Form (District) (13548)
- Capital Expenditure Request Form (District) (17978)
- Clinical Product or Device Management Policy (District) (16111)
- Delegation of Authority Policy (District) (21584)
- Procurement and Purchasing Policy (District) (11400)
- Tendering Policy (District) (25011)
- Asset Disposal and Write-off Policy (District) (100552)
- Relevant accounting standards

11400

Procurement and Purchasing Policy (District)

This policy sets out the Southern District Health Board's (Southern DHB's) staff obligations when procuring or purchasing goods or services for the organisation.

Policy Applies to

All employees and board members of Southern DHB, including temporary employees and contractors, any person who is involved in the operation of the DHB (e.g. joint appointments, volunteers and those people with honorary or unpaid staff status) must comply with this policy.

Policy Summary

This policy covers procurement and purchasing processes for goods, services and health service contracting within Southern DHB.

It is essential that parties responding to invitations to provide goods and services, interested groups and the public at large, are able to have confidence that the DHB's normal procurement, purchasing, tendering and selection processes have been impartial and fair, with no party being given advantage over another or discriminated against.

Note: This policy is aligned to the 'Government Rules of Sourcing'.

The purpose of this policy is to assist all Southern DHB employees, contractors and board members involved in the procurement process for goods and services to:

- Perform their duties in a way that is ethical, fair, unbiased and not affected by any self-interest or personal gain.
- Ensure that all purchasing is controlled, evaluated and co-ordinated, and that those resources are used in an effective and efficient manner.
- Identify situations where tendering should occur and the processes to be followed.

Definitions

For the purposes of this document, Southern DHB will be referred to as the DHB.

Capital asset items are those that have an expected life of greater than one year and a cost of more than $500 for one item or for a group of items purchased at the same time.

Capital assets have a slightly different approval process - refer to the Capital Expenditure Policy (District) (14479); however, the processes described in that document and the Tendering Policy (District) (25011) apply to capital items.

17.3

Catalogue items are those items entered in the FPIM~~Oracle~~ Financials System electronically and made available via the FPIM~~Oracle~~ Intranet - Procurement (iProc). Catalogue items are pre-approved for use.

It is expected that all items on the catalogue are under contract.

Category Ownership Schedule identifies the categories of goods and services for which DHBs, PHARMAC and service partners (respectively) are responsible for procuring. Staff should check with the Procurement Team prior to undertaking procurement activity.

Conflict of interest refers to a situation in which private interests or personal considerations may affect an employee's judgement and/or ability to act in the best interest of the DHB as is required - refer to the Conflict of Interest [Policy] (District) (27894).

It includes using an employee's position, confidential information or employer's time, material or facilities for private gain or advancement (either directly or indirectly) or the expectation of private gain or advancement. It is also where an employee's position with the organisation may be compromised due to their relationship or position within an external agency or organisation, particularly if the needs of both organisations are conflicting.

A conflict may also occur when an interest benefits any member of the employee's family, friends or business associates (either directly or indirectly).

Contestable process means a market-based process where two or more suppliers are able to competitively bid for goods or services — see the Tendering Policy (District) (25011) for detailed definitions.

Electronic approval hierarchy is an automatic workflow that is initiated with the ordering of the item on the DHB intranet's procurement site and used for invoice approvals. Approval limits are set as per the Delegation of Authority Policy (District) (21584).

New Zealand Health Partnerships Ltd (NZHP)~~health Alliance FPSC Ltd (hA)~~ is the service partner providing procurement services to DHBs.

Internet procurement (IProc) is a module of the FPIM~~Oracle~~ Financials System (FPIM~~Oracle~~) to enable online ordering of goods and services.

Non-catalogue items are those items ordered through internet procurement and are generally items that are not frequently used. These items are sometimes used as alternatives to catalogue items when they are not available. Additional approvals are needed to source non-catalogue items.

A **non-government organisation (NGO)** is an organisation that is independent or outside of the government (either central or local). In relation to this policy, the definition refers to organisations that deliver health services but are not government owned.

An **open competitive process** refers to publishing a contract opportunity on the Government Electronic Tenders Service (GETS) and inviting all interested domestic and overseas suppliers to participate in the procurement.

PHARMAC is the New Zealand government's pharmaceutical management agency that decides, on behalf of district health boards, which medicines and medical devices are procured for use in public hospitals and the community.

Probity is defined as uprightness, honesty, proper and ethical conduct.

Procurement is the acquisition of goods and/or services at the best possible total cost of ownership, in the right quantity and quality, at the right time, in the right place and, generally, via a contract between the buyer and seller.

Purchasing is the placing of the order and receiving of the goods.

Service partners refer to those entities conducting national procurement on behalf of the sector, i.e. currently the NZ Health Pertnerships Ltd~~healthAlliance FPSC (hA)~~ and Ministry of Business Innovation & Employment (MBIE).

Simple procurement may involve nothing more than repeat purchasing.

Expectations

Support Service Function	The Procurement Team supports service delivery by providing guidance and assistance with procurement requirements.

The Procurement Team is also responsible for recommending and (in conjunction with PHARMAC and service partners) developing the procurement/purchasing strategy for the DHB, and ensuring compliance and alignment with public sector procurement activities.

Key Principles

The overriding consideration when procuring products and services will be to ensure the suitability of products, value for money — based on total cost of ownership (TCO) — and quality of service. This will be assured by clear and fair processes and procedures based around the following key principles:

- Acting at all times in the best interest of the DHB subject to due consideration of national procurement initiatives and in accordance with the 'Government Rules of Sourcing'.
- Compliance with this policy and key principles by all employees, contractors, NGOs and suppliers.
- Obtaining the best quality service, technology and price for goods and services procured — based on total cost of ownership (TCO) — which includes monetary cost components, e.g. price, inventory cost, distribution, operating cost (including support and maintenance), and non-monetary cost components (e.g. IT system integration).
- For health service contracting, ensuring equity of access, value for money, service coverage and national service framework requirements are met.
- Acting fairly and transparently.
- Communicating in an open and timely manner.
- Standardisation, where appropriate, to ensure safety and achieve cost benefit.
- Appropriately meeting the clinical and work needs of those who use the goods and services.
- Compliance with relevant statutory, regulatory and other legal requirements during the procurement process. (This includes ensuring all medical devices sourced for the DHB are registered on the Medsafe WAND database.)
- Ensuring that procurement activity is co-ordinated and conducted by the appropriate entity for a particular category.

- The DHB and/ or service partners will prepare and publish an annual procurement plan on GETS in line with the 'Government Rules of Sourcing'.
- The DHB in conjunction with the service providers will prepare a formal sourcing plan for the procurement of all products and/or services valued at over $100,000.
- The DHB is expected to seek peer review and advice from MBIE for significant business cases or procurement plans valued at > $5M.

Business Ethics and Conduct

Southern DHB is committed to the highest level of integrity and ethical standards in everything that we do. As employer and employees we must be fair, impartial, responsible and trustworthy at all times. We must always conduct ourselves in a manner consistent with current ethical, professional, community and organisational standards, and in compliance with all legislation.

Any purchaser on behalf of the DHB is accountable for the use of public monies. All purchasers, therefore, should reflect if their purchase will be value for money and will be used for the purposes for which it was provided.

Avoid Conflicts of Interest

Any staff involved in procurement on behalf of the DHB must disclose in writing any actual or apparent conflicts of interest which may impact on their work performance or may influence their decisions around preferred suppliers - for more information refer to the Delegation of Authority Policy (District) (21584) and Conflict of Interest [Policy] (District) (27894).

Staff must not use their role or position to gain advantage in their private life, for example, by arranging jobs / transfers / benefits for family or friends.

Rules for Gifts, Benefits or Rewards

Staff are not permitted to ask others for any reward other than the remuneration paid by Southern DHB or other legal entitlements received as an employee.

Gifts of money are not to be accepted by individual employees under any circumstances. This is expressly prohibited under the Delegation of Authority Policy (District) (21584).

Entities may gift funds to the DHB by way of donations — refer to Managing Gifts and Sponsorship [Policy] (District) (81062).

No gift, regardless of monetary value, should be accepted if it could potentially cause (or be perceived by others as causing) staff to feel any obligation toward the gift giver. This is particularly relevant for those employed in a current tendering / purchasing process or responsible for monitoring a contract involving the parties that are offering the gift. Whilst being involved in any tender process, accepting a gift of any value is prohibited.

Any gifts or benefits received with a value over $200 must be reported to an employee's manager, who will inform the chief executive officer (CEO). Refer to schedule 1.08 of the Delegation of Authority Policy (District) (21584). Actions the CEO could take (but not limited to), include:

- Decline the gift if a conflict of interest exists.
- Allow the gift to be accepted by the individual employee.
- Donate the gift towards an organisational purpose or other worthwhile cause.

An electronic 'Gift Register' is available via the Intranet (Pulse) for the recording of all gifts, regardless of value.

Legal Considerations

DHBs can be subject to judicial review proceedings, ombudsman investigations and other types of review or legal action. It is important that procurement practices comply with relevant statutory and legal requirements at all times. Failure to adhere to appropriate requirements can have serious financial and reputable consequences for the DHB.

DHBs can act only in accordance with their statutory powers under the New Zealand Public Health and Disability Act 2000 and other enabling legislation. To this end, DHB representatives can only exercise financial delegations and other functions in accordance with its statutory powers, and for the purpose of achieving the respective DHB's goals and policy.

Contractual Term

Each procurement process and resulting contract can vary in its terms depending on the nature of the item, the competitive environment and complexity of the procurement plan.

The DHB will generally look to contract for periods of three years. Contracts may be for longer periods to encourage strong supplier

relationships and where the cost of change is high or significant investment or innovation is expected from the supplier or NGO.

Any contractual term above three years requires specific Southern DHB Board approval regardless of the value of the contract. This will exclude all national contracts as per the Delegation of Authority Policy (District) (21584).

Purchasers should take care when dealing with NGOs and whether they have the legal capacity to contract. The legal form of the NGO may be relevant, e.g. trusts.

Active, inactive or rollover is the practice where the contracting parties continue to operate to the spirit of the contract after the contract expiry date. This practice should be avoided. If required, a new contract based on an expiring contract, can be renegotiated with new contract expiry dates.

This is different from a contract that has allowed for a further term based on variables, such as performance. For example, a contract that has a two-year plus extension of two years if the expected performance has been achieved. This is often described as 'a right of renewal clause'.

Fraud or Misconduct

Any suspected fraud or misconduct in relation to procurement processes should be fully investigated and dealt with in accordance with the Fraud Policy (District) (25546) and the Code of Conduct and Integrity (District) (18679).

Non-compliance with Requirements

Failure to follow relevant policies and requirements for procurement practice may constitute a breach of the DHB's Code of Conduct and Integrity Policy and/or Disciplinary Policy (District) (55569).

All employees, under the Delegation of Authority Policy (21584), have a responsibility to use that authority in alignment with this policy.

Departments must not prepare, design or otherwise structure or divide any stage of the process so as to avoid application of policy requirements.

Use of a third party as an agent or consultant to advise on, arrange, or manage a procurement process does not remove from individuals or departments the obligation to comply with these policy requirements, where applicable.

Complaints	Any serious or unresolved complaints about procurement practices should be referred to the appropriate DHB Executive Team representative.
Training and Competencies	Staff involved in procurement activities should have the necessary competencies and receive appropriate training, and be aware of their obligations and responsibilities under DHB procurement policies and the 'Government Rules of Sourcing'.
Market Considerations	When undertaking procurement activities, regard must be given to the impact any decisions may have on the marketplace. Consideration should be given to potential issues of market competition (e.g. Commerce Act 1986 requirements) as well as the need to ensure supplier/NGO sustainability and longer-term choice of options within the market.
Supplier Relationships	For key suppliers, structured business reviews will be facilitated by the Procurement Team and, where appropriate, in conjunction with PHARMAC or the relevant service partner with the participation of DHB business owners at an appropriate frequency. Ongoing contract management is an important part of the contract life cycle and is essential in ensuring ongoing quality of services and productive working relationships. For NGO health service contracts, the business relationship is maintained by the Planning & Funding Department.
Non-discrimination	All suppliers must be given equal opportunity and equitable treatment on the basis of their financial, technical, or commercial capability.
Environmental Responsibility	For all purchases, the environmental impact must be considered. This includes cost and toxicity of disposal, increase to waste product and impact of products on the environment. The DHB will seek to minimise its 'carbon footprint' where practical and possible.
Whole of Life	Any purchase that is made will have ongoing impacts and cost to the organisation. A key principle of this policy is the total cost of ownership; supporting this is the principle of whole of life. This means giving due consideration to ongoing operational costs associated with the contract and the requirement for ongoing monitoring and review of performance against contracts.

Safety Requirements	The DHB must ensure that all of the goods and/or services that it procures meet all relevant safety requirements and regulatory standards for sale and use in New Zealand. The DHB must record evidence of compliance with all relevant safety requirements and regulatory standards for each good and/or service that it procures.
National Procurement	Southern DHB is committed to working collaboratively throughout the DHB and with service partners, PHARMAC and other DHBs in order to improve procurement outcomes. Wherever possible, national and regional implications should be considered and factored into the procurement approach for each project. Examples of working collaboratively include: ▪ Aggregating volumes/requirements ▪ Aligning to common standards ▪ Aligning with common suppliers and supplies ▪ Negotiation of regional/national contracts All national procurement activities must comply with the DHB-specific and regional/national approval processes.
Service Partners and PHARMAC	The DHB will work with the Ministry of Health, Health Benefits Ltd. and other government agencies, such as healthAlliance, PHARMAC and the MBIE Ministry of Economic Development (all-of-government contracts) to deliver value for money to the DHB.
Record Keeping	Full and accurate records should be kept of all aspects of the procurement process, in accordance with the relevant legislation and DHB policy.
Confidentiality of Information	**Maintain confidentiality of information** Treat all information about a person who is receiving, or has received, a public health service with the strictest confidence as required by the Privacy Act 1993 (as amended) and Public Records Act 2005 (as amended). These confidentiality requirements continue to apply to former employees. Only release information about contracts when it is written in the contract, or expressly consented in writing by the supplier to do so.

17.3

Procurement Processes

Departments may order items from the catalogue for values in line with delegation limits.

The processes for procurement described below refer to the Procurement Team activity required to maintain the Oracle catalogue.

Non-catalogue (including capital asset items), services' requests (excluding locums) and health services contracting will need to follow the processes for tendering described below.

When to Tender

The limits below refer to life-of-contract expenditure excluding GST.

A contestable process is required for all goods and service where total external annual costs exceed $10,000 (excluding GST).

Where expenditure is estimated to be equal to or greater than $100,000 ($100,000 per annum for health services), a formal open-sourcing process is required, including publication of the details on the Government Electronic Tenders Service website (see 'References' below).

The process will be supported by the Procurement Team and staff should refer the request to them.

Reference should be made to the Tendering Policy (District) (25011) and if the items are capital assets, reference should be made to the Capital Expenditure Policy (District) (14479) for the required approvals to initiate further procurement action.

Where expenditure is less than $10,000, individuals and departments may raise purchase orders in line with delegation limits, but purchases should adhere to the 'Preferred Suppliers' list where relevant. (The Preferred Suppliers list is on 'Pulse' under Useful Links/Procurement & Supply Chain or contact the clinical product co-ordinators for advice.).

This does not apply to capital asset orders; capital asset items must still follow the capital ordering process specified in the Capital Expenditure Policy (District) (14479).

The Purchasing, Information Systems, and Building & Property Teams are the only ones authorised to generate orders for capital items using the 'Procurement' site on the intranet.

Purchasing

Purchasing Items

All goods purchased for the DHB must have an associated purchase order as per the Delegation of Authority Policy (District) (21584). There will be an increasing requirement for use of purchase orders for services. In some cases where services are arranged, there will be a requirement for a retrospective purchase order to be placed; an example of this is where legal advice is obtained via a phone call.

Goods or services for personal use must not be procured through the DHB.

All goods purchased must be ordered from the internally-approved catalogue, wherever possible using the 'Procurement' site on the intranet. If an item is required that is not in the catalogue, it will be assessed by the Purchasing Team under the following criteria:

- Is there an alternative available in the catalogue?
- Is there approval from the manager with delegated authority?
- Has the product been approved by the clinical product co-ordinators and/or the Product Evaluation Committee?

Purchasing of goods is achieved through the 'Procurement' site on the intranet.

Note: Access will be approved by the budget holder of the relevant area. Access will then be given by the Information Systems Department. The purchasing team leader is responsible for training staff on using the 'Procurement' site on the intranet.

Purchasing Approval

Catalogue Items	This is through the 'Procurement' site with an electronic workflow as per the Delegation of Authority Policy (District) (21584).
Non-catalogue Items	These are initiated with a non-catalogue order entered on the 'Procurement' site. The relevant delegation of authority is assigned.

The order then progresses electronically to the Purchasing Team for final check. All non-catalogue items will be assessed to ensure there is no relevant or acceptable alternative available in the catalogue.

Final decision on a non-catalogue consumable order may be made by the service or general manager.

Capital Asset Items

These are initiated with a non-catalogue order entered on the 'Procurement' site by the Purchasing Team. Information Systems, and Building and Property may raise their own requisition, but the appropriate documentation must be attached for final approval by the Purchasing Team

Departments are not to order capital asset items; these purchase orders are generated by the purchasing teams.

Capital asset items are approved using the workflow and approvals as per the Capital Expenditure Policy (District) (14479).

Receiving Goods

Transactions

As per the 'Delegation of Authority Policy', at least two people must be involved in any transaction. The same person must not perform more than one of these functions:

- Raise a purchase order.
- Receive the goods.
- Authorise the goods for payment.

The current ordering system is automated to the extent that the invoice is automatically paid where the goods receipt record matches the purchase order.

For purchasing, the intention in this clause is that the same person does not have the ability to order an item and confirm receipt without independent verification. The same person should not approve the purchase order and also confirm receipt of the item(s). There will be some practical exceptions to this, predominately where services are ordered.

Items from Onelink and OfficeMax are receipted without checking all items. One random day is selected each week to check two delivery 'rolltainers' (a rolltainer is a container on wheels or rollers) against the delivery docket by the purchasing team leader.

New Suppliers

Procurement

All new suppliers are to be approved by the procurement manager following an internal validation process. This excludes any suppliers that are performing employee duties (i.e. locum medical and allied health staff), which is approved through Human Resources or the Medical Officers' Unit.

An intranet form is available for application for the addition of a new supplier on Oracle.

The Procurement Team will review and complete due diligence before enabling a new supplier.

Catalogued Items

New Items:

Internally-approved Catalogue

Goods that must be on the internally-approved catalogue (excludes capital asset Items)

Goods that will be used on more than a 'one-off' basis must be entered in the catalogue.

Entering new items in the catalogue will be the responsibility of the Procurement Team.

Approval for an item to be in the catalogue will be as follows:

- All clinical products must be approved by the clinical product co-ordinators before being entered in the catalogue.
- All non-clinical items must be approved by the procurement manager before being entered in the catalogue.

Process for new item inclusion on the catalogue as outlined in the Contract Approval Policy (District) (45386).

1. **Department / Supply Team**

   Identifies items as needed and adds to the catalogue. Attached forms are filled out. See the Product Advice Form (District). (17990).

2. **Clinical Product Co-ordinators**

Check if the requested item needs to undergo a product evaluation process.

Endorse the form after the evaluation process has been completed.

3. **Procurement Manager**

   Checks that the item has been reviewed appropriately, that price and terms are agreed, and the item is suitable for adding to the catalogue.

Emergency Procurement

Definition	For clinical or safety reasons, an emergency procurement is defined as occurring when life, property or equipment is immediately at risk or where standards of public health, welfare or safety have to be re-established without delay. In the case of a disaster, normal procurement practices may have to be varied. Poor planning or lack of timeliness in planning is not sufficient reason for varying standard procurement practices.
Action Required	Inside normal 'business' hours, staff are to contact the supply team leaders who can assist in expediting orders. Outside of normal business hours, staff should contact the appropriate site duty manager to get goods/services authorised for purchase. Details of any such orders must be forwarded to 'Purchasing' as soon as the emergency is under control.

Associated Documents:

- Product Advice Form (District) (17990)
- Procurement Sourcing Flowchart (District) (46545)
- Code of Conduct and Integrity (District) (18679)
- Delegation of Authority Policy (District) (21584)
- Conflict of Interest Policy (District) (27894)
- Internal Audit + NGO Auditing Policy (District) (44704)

- Managing Gifts and Sponsorship [Policy] (District) (81062)
- Protected Disclosures / Whistle-blowing Policy (District) (19708)
- Tendering Policy (District) (25011)
- Capital Expenditure Policy (District) (14479)
- Conflict of Interest Policy (District) (27894)
- Sensitive Expenditure Policy (District) (48567)
- Clinical Product and Device Management Policy (District) (16111)
- Contract Approval Policy (District) (45386)
- Pulse (Southern DHB Intranet)

References:

- Office of the Auditor General. 2008. *Procurement Guidance for Public Entities*; http://www.oag.govt.nz/2008/procurement-guide; Controller and Auditor-General. Wellington.
- Ministry of Business, Innovation & Employment (MBIE). 2014. *Government Rules of Sourcing - Rules for planning your procurement, approaching the market and contracting*; 2nd edition; Wellington, Author http://www.business.govt.nz/procurement/pdf-library/agencies/rules-of-sourcing/government-rules-of-sourcing-April-2013.pdf
- MBIE. 2015. *A-Z list of guides, tools and templates* (for agencies); Wellington, Author http://www.business.govt.nz/procurement/for-agencies/guides-and-tools/A-to-Z-guides-tools-templates
- New Zealand Government Electronic Tenders Service (GETS) website; https://www.gets.govt.nz/ExternalIndex.htm

Legislation

- Commerce Act 1986
- New Zealand Public Health and Disability Act 2000
- Privacy Act 1993
- Public Records Act 2005

General Notes

Scope of Practice: Ensure you are fully qualified to perform the role specified in any document.
Deviations: If you need to deviate from any procedure, policy, or guideline, make notes and follow up.
Caution - Printed Copies: Printed copies of this document cannot be relied on after the date at the bottom of the page. Check issue date and version number against the electronic version on MIDAS to ensure that they are current.
Disclaimer: This document meets the Southern District Health Board's specific requirements. The Southern DHB makes no representations as to its suitability for use by others, and accepts no responsibility for the consequences of such use.

11400

Document Data for 11400 V7

44704

Internal Audit + NGO Auditing Policy (District)

This policy sets out the nature, role, responsibility, status, and authority of internal auditing within Southern District Health Board (Southern DHB), and outlines the scope of internal audit work.

Policy Purpose

This policy sets out the nature, role, responsibility, status and authority of internal auditing and NGOs auditing within Southern DHB, and outlines the scope of such work.

Policy Applies to

This policy applies to:

- All employees of Southern DHB, including temporary employees and contractors.
- Any person who is involved in the operation of Southern DHB, including board members, joint appointments with third parties, volunteers and those people with honorary or unpaid staff status.

Definitions

Internal audit function, as set out in the New Zealand Institute of Chartered Accountants (NZICA) International Standards on Auditing, is defined as an appraisal activity established, or provided, as a service to the entity. Its functions include (amongst other things) examining, evaluating, and monitoring the adequacy and effectiveness of internal control.

External auditor refers to the organisation appointed by the Office of the Auditor General to conduct the statutory annual audit of Southern DHB and to provide an opinion on its annual financial statements and statement of service performance contained in the Annual Report.

17.4

Internal auditor refers to the organisation appointed to conduct an internal audit.

Internal audit refers to an instance, or function, of auditing within Southern DHB with respect to its governance, funding administration and provider roles.

NGO auditing refers to audits conducted by external parties on behalf of Southern DHB on non-governmental organisations (NGOs) that are contracted by Southern DHB to provide health-related services. NGOs include trusts and PHOs.

~~Board includes the Commissioner and Deputy Commissioners~~

Central TAS is a shared service agency that provides support for DHB's. District Health Board representatives are involved in governance and decision-making.

The Internal Audit Role

Objectives

The role of internal audit at Southern DHB is to assist the board and senior management to meet their objectives and to discharge their responsibilities, by providing an independent appraisal of the adequacy and effectiveness of the controls set up by management to help run the organisation.

The role includes the identification and recommendation of measures to achieve greater effectiveness, efficiency, and economy, and to remedy practices that expose Southern DHB to risk and vulnerability.

It further assists Southern DHB in accomplishing its objectives by bringing a systematic and disciplined approach to evaluating and improving the effectiveness of Southern DHB's risk management, control, and governance processes.

Accountability

The internal auditor reports to the Finance Audit and Risk Committee (FAR Committee) of the board. Communication and liaison will ordinarily be provided through the chair of the FAR Committee. Internal audit has operational support from the senior management and strategic support from the FAR Committee. Internal audit will have unrestricted, direct access to the chief executive officer (CEO) and FAR Committee.

Appointment

The appointment or removal of the internal auditor will follow a FAR Committee recommendation to the board.

Responsibilities of the FAR Committee

The FAR Committee is responsible for:

- the development, review and modification of internal audit functions, policies and procedures.
- oversight of the internal audit function.
- recommending the budget for internal audit to the board.
- setting the internal audit work plan in conjunction with the internal auditor. The plan shall be informed by the organisational risk assessments of the internal and external auditors and the need to ensure compliance with the policies of Southern DHB and relevant legislation.

- recommending the appointment of the internal auditor to the board. In discharging this responsibility, due regard will be given to ensuring that internal audit personnel are sufficiently skilled and experienced in the health sector.
- Receiving the reports of the Internal Auditor, considering management's recommendations arising from the reports, and monitoring the implementation of agreed recommendations. The decision to set aside any recommendations of the internal auditor rests with the FAR Committee.

The FAR Committee shall meet with the internal auditor independently of management annually.

Responsibilities of Management

The chief financial officer (CFO) is responsible to the CEO, and both officers shall assist the FAR Committee to identify the scope of internal audit work. Both officers shall also recommend action to be taken on the outcome of, or findings from, such work.

Management is responsible for ensuring that the internal audit function has:

- Operational cooperation from staff throughout the organisation.
- Access to staff and systems requested by internal audit.
- Direct access and freedom to report to senior management.
- Unrestricted and independent access to the FAR Committee.

Management must ensure that the capability and capacity exist to implement and monitor internal audit recommendations.

Management is responsible for maintaining internal controls, including setting appropriate policies and monitoring compliance with these, and maintaining proper accounting records and other appropriate management information that ensures effective stewardship of public health funds as required by the New Zealand Public Health and Disability Act 2000, and with reference to the 'Ethics Framework for the State Sector'.

Responsibilities of the Internal Auditor

The internal auditor is responsible for:

- completing an annual organisational risk assessment and discharging the internal audit plan in accordance with the agreed scope of audit fieldwork.
- conducting work in accordance with best practice, and will have regard to relevant standards and requirements of Chartered Accountants Australia New Zealand.
- carrying out the internal audit function in a way that its integrity, objectivity, confidentiality, and competency are not open to question. Standards of professional behaviour are based upon the relevant standards described above, the code of ethics of Chartered Accountants Australia New Zealand, and any relevant standards set by the Institute of Internal Auditors New Zealand (IIANZ).
- making comment and recommendations as to the robustness of the design, installation, and operation of systems and procedures, and comparing with organisational policies and best practice. However, the internal auditor is not responsible for any activities that are audited, nor the design, installation, operation, or control of any procedures or systems.

Scope and Authority of Work

There are no restrictions placed upon the scope of the internal auditor's work. Members of the Internal Audit team engaged on internal audit work are entitled to receive whatever information or explanations they consider necessary to fulfil their responsibilities to the board through their accountability to the FAR Committee. In this regard, the internal auditor may have access to any records, personnel, or physical property of Southern DHB.

The internal auditor will complete the reviews identified and agreed in the annual internal audit work plan. This work plan will set the scope for each review, but will include:

- Reviewing systems established by management to ensure that major risks to the achievement of the organisation's objectives are being appropriately addressed by the controls inherent in these systems.
- Reviewing the reliability and integrity of financial and operating information and the means used to identify, measure, classify, and report such information.
- Assessing compliance with policies, plans, procedures, laws, and regulations that could have a significant impact on operations and reports.

- Reviewing the means of safeguarding assets and, as appropriate, verifying the existence of assets.
- Appraising the economy and efficiency with which resources are employed.
- Reviewing operations or programmes to ascertain whether results are consistent with established objectives and goals, and whether the operations or programmes are being carried out as effectively and efficiently as planned.
- Investigating and reporting on alleged violations of policies and procedures, errors, fraud, or misuse of Southern DHB assets.
- Risk assessment.
- Performing and reporting on follow-up reviews to determine the status of recommendations contained in reports.

To the extent that the internal audit engagement specifies, the internal auditor will provide advice and assistance to Southern DHB when requested, by serving as a consulting resource for:

- The review of policies and procedures, financial and administrative systems, organisational structures, and other related administrative activities.
- The development of control procedures for new or significantly modified divisional or departmental manual and computer-based financial and administrative systems.

Relationship with the External Auditor and other Regulatory Bodies

Where appropriate, the internal auditor will co-ordinate with the external auditors and others as directed by the FAR Committee so that audit duplication is minimised. This will be accomplished by:

- Consideration by the FAR Committee and management of any opportunities for synergies when the internal audit work plan is set.
- Access by the external auditors to the internal audit work plan and the internal auditor's documentation.
- Exchange of management letters, including management feedback.
- Exchange of organisational risk assessments.
- Access to systems documentation.

Southern District Health Board
Piki Te Ora

44704

The NGO Auditing Role

Objectives	The role of NGO auditing is to provide Southern DHB board and management with assurance that NGO-contracted parties meet the required quality and financial-claiming standards as specified in their contracts.
Accountability	The external independent parties used for audits are co-ordinated by, and report to, Southern DHB Planning and Funding function. In turn, this is reported via the CEO to the FAR Committee, which has governance oversight of this function.
Appointment	The appointment of the external parties to conduct NGO audits was determined by health sector structures put in place effective from January 2001 as amended from time to time. Currently, Central TAS conducts quality-based audits on behalf of Southern DHB. The Audit & Compliance Unit (A&C) of the Ministry of Health (MoH) conducts financial-claiming audits on behalf of Southern DHB. The A&C also liaises with DHBs to determine and agree pharmacy audits as part of licensing requirements. Designated audit agencies (DAAs) are designated to audit health care services by the director general of health. DAAs undertake certification and surveillance - unannounced spot audits of age-related residential care services - as part of this function. MedCert undertakes the audits of community Pharmacies.
Responsibilities of the FAR Committee	The FAR Committee is responsible for governance oversight and monitoring of the NGO audit programme. The committee recommends the budget for NGO audit to the board.
Responsibilities of Management	NGO auditing is coordinated by Southern DHB Planning and Funding function via its executive director (EDPF). The EDPF, CFO and CEO shall approve the audit type and providers as part of the annual NGO audit programme, and shall recommend action to be taken on the outcome of, or findings from, such work. Management is responsible for ensuring Southern DHB staff resource and support the NGO auditing programme, as required, and also for ensuring operational cooperation from NGO providers.

Responsibilities of the NGO Auditors	The contracted parties have audit methodologies and standards developed within their own organisational structures, and with reference to professional standards. The contracted audit parties are responsible for ensuring they have sufficient capacity and capability to meet Southern DHB NGO auditing requirements, with Southern DHB recognising any overall resource constraints in managing multiple DHB requirements.
Relationship with Other Regulatory Bodies	Where any certification of accreditation issues arise from NGO audits, the NGO auditors (in consultation with Southern DHB) will liaise with the appropriate regulatory bodies.
Scope and Authority of NGO Audit Work	Quality audits will consider the quality aspects of the service provision in line with the contracted quality standards, certification and accreditation requirements (if appropriate) to ensure that patients and consumers are receiving an appropriate standard of service intervention. Financial claims-based audits will ensure that NGO provider claims meet the required contractual terms and are sufficiently robust to ensure that claims are accurate, timely, and valid. If Southern DHB has concerns about a provider that warrant investigation, it may initiate an unannounced audit in relation to any clinical, social, facilities or financial matter. These audits will be undertaken by Central TAS or A&C. The scope for each type of audit will be specified and agreed at the beginning of each piece of audit fieldwork.

Planning and Reporting

Internal Audit	Internal audit will work with management and the FAR Committee to agree on a three-year internal audit work plan setting out the recommended scope of its work in the period. The work plan should have due regard to the key areas identified within the risk assessment framework, monitoring compliance to policies and procedures associated with the Fraud Policy (District) (25546), and an appropriate level of forensic audit. The annual work plan will be developed with reference to the longer-term specific outlook for internal audit work, be prepared in conjunction with management, and have regard to the business plans, risks, and strategic outlook of the organisation as a whole. The key elements of internal audit reporting will be as follows: • Draft reports will be generated by the internal audit team in the field and discussed with management on site. Reports will be provided to line management within the time frames specified in the internal audit engagement contract.

Generally, this will be within 30 working days of the conclusion of the visit. Reports are to be at their final stage within 60 working days of completion of the fieldwork, subject to the availability of management to provide comments and feedback.

- The completed report on each audit project within the work plan will go to the FAR Committee. Reports will be:
  - Focused.
  - Action-orientated — summarising the issue, the control implication, internal audit's recommendation (with due reference to cost versus benefit), management comments, and the action to be taken to resolve the issue by whom and when.
- In addition to the audit project reports, the internal auditor will report to the FAR Committee against the agreed internal audit programme detailing:
  - Progress against the work plan.
  - Key findings.
  - Any resulting recommendations for the following audit period.
  - The time frame for follow-up of implementation of recommendations from prior reports.

The internal auditor will raise any serious concerns about unresolved issues relating to projects or the management team itself directly with the FAR Committee chair.

The internal auditor will meet with the FAR Committee without management present, at least annually.

The internal audit will formally update the organisational risk assessment annually. The update will be informed by the outcomes of the internal audit plan projects and will focus on the risks identified to the organisation and strategies to mitigate those risks and improve operational effectiveness.

NGO Auditing

The NGO Audit Programme is set annually by Southern DHB.

In setting the annual work plan and selecting contracted providers to audit, a mix of quality and claims (financial) audits are selected with consideration to:

- Whether the provider is claims-based or contracted for outputs.
- The financial value of the contract.
- Complexity of service provision.

- Unusual patterns from data analysis (e.g. high close control pharmacy claims, high PHO enrolments, duplicate PHO enrolments, etc).
- Advice from licensing or regulatory bodies.
- Where issues or concerns are raised (by Southern DHB, public, staff, fraud line, consumers, etc).
- The time between audits and type of audits for particular contracted providers.
- The level of spot audits to be conducted.

Reporting is a standing FAR Committee agenda item and should include:

- Any routine audit that;
  - presents a reputational risk to Southern DHB or
  - cannot be resolved within the usual course of business.
- Any audit that is:
  - out of the ordinary or
  - resulted in recovery of money from a provider, or
  - in which a decision was made to exit a provider, if for example, a provider has not undertaken required corrective actions.

The reporting to the FAR Committee will provide the following information;

- Schedules of current and outstanding quality and claims-based (financial) audits.
- A numeric summary of outstanding audit recommendation.
- Executive summaries of quality audits - provided as part of the report.
- Full audit report which is required for claims-based audits, with recommendations made by management on recoveries.
- Schedules of any significant findings from certification/surveillance and spot audits.

Associated Documents:

- Fraud Policy (District) (25546)
- New Zealand Public Health and Disability Act 2000
- State Services Commission, 'An Ethics Framework for the State Sector' (Occasional Paper No.15. SSC, August 1999)

48567

Sensitive Expenditure Policy (District)

This document aims to outline the limits surrounding Southern District Health Board expenditure of a sensitive nature.

Policy Purpose	To identify clearly the parameters within which Southern District Health Board (Southern DHB) shall incur and authorise expenditure of a sensitive nature.
Policy Applies to	All employees and board members of Southern DHB, including temporary employees and contractors, must comply with this policy. It also applies to any person who is involved in the operation of Southern DHB, including joint appointments, volunteers and those personnel with honorary or unpaid staff status.
Definitions	Sensitive expenditure is expenditure that provides, has the potential to provide, or has the perceived potential to provide a private benefit to an individual staff member that is additional to the business benefit contained in the entity of that expenditure. It also includes expenditure by a public entity that could be considered unusual for the entity's purpose and/or functions. Expenditure in this category has been divided into four categories, as follows: • Entertainment and hospitality related expenditure • Travel and accommodation related expenditure • Staff support and welfare related expenditure • Goods and services related expenditure Conflict of interest refers to a situation in which private interests or personal considerations may affect an employee's judgement and/or ability to act in the best interest of Southern DHB. Controls are the means by which to promote, direct, restrain, govern and check on various activities. Credit card has the normal meaning, but should also be read as applying to vehicle fleet card, purchase cards and equivalent cards use to obtain goods and services before payment is made. ~~Note: For the purposes of this policy the definition of board members includes the commissioner and deputy commissioners.~~ Probity is defined as uprightness, honesty, proper and ethical conduct.

17.5

Levels of Approval as defined in the Delegation of Authority Policy (21584) are as follows:

- L1 – Chief executive officer
- L2 - Chief operating officer/deputy CEO, executive director nursing and midwifery, chief medical officer (CMO), chief financial officer, executive director planning and funding
- L3 - Executive members excluding L2 above / general managers and Senior Management Team (SMT) Team / finance manager / senior business analyst / supply chain manager and facilities & site development manager
- L4 - Service managers, service improvement managers, nurse managers, planning & funding portfolio & contract managers (PCM), medical officers unit team leader, procurement manager
- L5 - Cost centre budget holders, financial accountants (FA)

Expectations

Key Principle

Southern DHB spends public money, and all such spending must meet standards of financial probity that will enable it to withstand Parliamentary and public scrutiny.

Southern DHB provides guidance to staff by way of policies and expects that all expenditure should be subject to proper authorisation and controls, and that no individual should approve their own expenditure.

Standards

Within the principles-based approach, the standards applicable to sensitive expenditure decisions include the following considerations in each decision made. That it:

- Has a justifiable business purpose.
- Preserves impartiality.
- Is made with integrity.
- Is moderate and conservative, having regard to the circumstances surrounding it.
- Is made transparently; and
- Is appropriate in all respects.

As an example, an employee may ask permission to take personal leave in conjunction with business travel. The proposal may raise issues of dominant purpose, impartiality and transparency. Southern DHB, if it were to give approval, would need to be satisfied that the primary purpose of the trip was business-related, there were no additional costs, and the arrangement would not give rise to any perceptions of inappropriateness.

Approval

Approval of sensitive expenditure should be:

- Where it meets the standards described in this policy.
- Given before the expenditure is incurred wherever practical.
- In accordance with delegated authority; and
- Made by the line manager of the staff member who may be perceived to benefit from the expenditure.

Claims

Claims relating to sensitive expenditure are made via the Expense Claim System and must:

- Clearly state the business purpose.
- Be accompanied by original supporting documentation.
- Document the date, amount, and description for items of minor expenditure where receipts are unavailable (under $50).
- Be submitted promptly after the expenditure is incurred.
- Refund of expenses limited to six months from the date of invoice, effective from the 2018/19 financial year.

Credit Card or Charge Card Expenditure

Using credit cards or charge cards is not a type of sensitive expenditure, but is a common method of payment for such expenditure. Refer to the Credit Card Policy (District) (29625).

Any expenditure charged to these cards must be for business use only. No personal purchases are permitted.

Southern District Health Board
Piki Te Ora

48567

Entertainment and Hospitality Expenditure

Entertainment is defined as a business expenditure usually for the purposes of:

- Building relationships
- Representation of the organisation
- Reciprocity of hospitality
- Recognition of significant business achievement

Entertainment / Hospitality

The following are the principles that staff are expected to adhere to:

- Expenditure must be based on a pre-approved budget with a pre-agreed purpose.
- Wherever possible, approval must be gained before the event from the person holding delegated authority. If the person holding delegated authority could be a perceived beneficiary, then the line manager principle for sign-off must apply.
- Where a board member is a beneficiary, approval from the Board chair must be obtained. Expenditure of the board chair must be approved by the chair of the Finance, Audit and Risk Committee.

Expenditure must not be extravagant and must be appropriate for the occasion. Good judgement in line with the principles of this policy is expected to be exercised.

Gifts to External Parties

Southern DHB Koha Policy (24622) applies to all gifts to external parties. See the 'Staff Support and Welfare Section' below for guidance on staff gifts.

Travel and Accommodation Expenditure

Limits and expectations are set out in the Staff Travel Policy (16163) and are aligned with this policy.

Air Points and Other Loyalty Points Programmes

Employees or board members are entitled to receive any air points or other loyalty points earned while travelling. However, any travel booked must be at the best and lowest cost to Southern DHB, ignoring any loyalty programme the employee or board member may be linked to.

	Evidence may have to be provided (where possible) that travel at the best and lowest cost to Southern DHB has been booked, which is why its approved travel supplier (or an equivalent process for making bookings) must be adopted. All travel with the exception of travel funded via CME must be booked through the DHB's approved travel supplier. Where possible SMOs will utilise airpoints programmes that allow additional recognition points for the DHB. Use of air points or loyalty points gathered generally must be applied for personal use only. They may not be used for business purposes and then followed up with a subsequent expense claim for reimbursement. If an employee decides to use personal air/loyalty points for business purposes in order to support an application for a conference, then no reimbursement for the equivalent cost or any other type of reimbursement will be made.
Private Travel Linked with Business Travel	The principles of this policy state that the primary purpose of the trip must be business-related. However, personal travel may be allowed in conjunction with the business trip provided there is no additional cost to Southern DHB. Any additional costs incurred must be reimbursed by the employee. The fact that private travel is planned to occur in conjunction with the business trip must be disclosed pre-approval.
Travelling Spouses, Partners, or Relatives	As a general principle, travel costs of accompanying spouses, partners or other family members are not paid by Southern DHB, In the rare circumstance that involvement of these parties contributes to the business purpose, any spouse/partner related expenditure must be pre-approved by the chief executive officer (CEO).

Staff Support and Welfare Expenditure

Salary Related and Miscellaneous Expenditure	A wide variety of expenditure falls under this category, from club memberships, motor vehicles and telephone reimbursements to professional memberships and papers/periodicals. The following principles apply: ▪ Eligibility to payments of a remunerative nature will be clearly identified within the employee's employment agreement. ▪ Where an item of expenditure is not covered by the staff member's employment agreement, eligibility will be determined on a case-by-case basis. Approval must be obtained and clearly documented before the expenditure is incurred. ▪ Due to the tax implications of the above expenditure, the finance manager must be contacted prior to granting approval of the expenditure to ensure any relevant tax ramifications are addressed appropriately.
Staff Recognition and Team Building	The following principles must be adhered to: ▪ Expenditure must be based on a pre-approved budget with a pre-agreed purpose. ▪ Wherever possible, approval must be gained from the person holding delegated authority before an event takes place. If the person with delegated authority could be a perceived beneficiary, the line manager principle for sign-off must apply. ▪ Based on the line manager principle, where the Executive Team/CEO is involved, the Southern DHB chair must be advised. Expenditure must not be extravagant and must be appropriate for the occasion. Good judgement, in line with the principles of this policy, must be exercised. As a general guide, if meals or functions are involved, $50 per head would be a reasonable figure. Associated accommodation costs should align with the limits outlined in Staff Travel Policy (16163). Any facilities hired for such events are expected to be moderate in nature.

Gifts to Staff	This section of the policy applies to gifts made to Southern DHB employees. The following limits to apply: • Gifts under $~~200~~ 100 require Level 3 approval • Gifts over $100~~200~~ and up to $250~~500~~ require Level 2 approval • Gifts over $250~~500~~ require Level 1 approval Entertainment expenditure as listed in the Delegation of Authority Policy (District) (21584) does not apply to, or include, gifts within the definition of entertainment expenditure. The receiving of gifts is covered in the above-mentioned policy which states that all gifts must be disclosed and approved. An electronic register for workflow approvals is available on the Intranet for this purpose.
Sponsorship of Staff	Staff taking part in an activity that is not part of their work duties, e.g. a sporting event, may be sponsored through the provision of, or payment for, goods and services (e.g. a T-shirt or entry fee). Sponsorship is required to have a justified business purpose, which may include publicity for the event and its objectives, or organisational recognition and development. The cost to Southern DHB should be moderate and conservative. If the event does not have a justified business purpose, then the cost is deemed a gift and has the required approval level specified in this policy. See 'Gifts to Staff' above. Sponsorship of staff is not listed under the entertainment classification in the Delegation of Authority Policy (District) (21584) and requires specific approval as follows: ▪ Sponsorship under $100~~200~~ requires Level 3 approval ▪ Sponsorship over $100~~200~~ requires Level 2 approval ▪ Sponsorship over $250~~500~~ requires Level 1 approval
Ex-Gratia Payments	These types of payment are unusual and require the specific approvals as nominated in the Delegation of Authority Policy (District) (21584).

17.5

Sale of Surplus Assets to Staff

The Delegation of Authority Policy (District) (21584) specifies approval levels of the disposal of assets.

It is expected that asset disposals are fair and transparent and are at market value, particularly if the assets are sold to staff. Where market value is not obtainable, NBV can be used as a proxy for market value if the NBV is under $1,000.

Assets are not to be sold at a discounted rate to staff if a greater value could be realised by an alternative method. If there is any doubt, then any sale to staff should not be authorised.

Other Considerations

Communications Technology

Communications technology, such as cellphones, telephone, e-mail and other access to the Internet is widely used across the organisation. While some level of access of personal use is permissible, excessive use and/or cost are not allowed. Refer to the Code of Conduct and Integrity (District) (18679) for further information.

Where it is economically feasible, costs related to the use of technology owned by staff but used for business purposes should be reimbursed. For guidance, monthly costs per person that exceed $20 should be recoverable.

Private Use of Suppliers

From time to time Southern DHB publishes lists of suppliers from whom staff can obtain a discount on the purchase of goods for private use. The expectation is that such discounts will not influence the organisation's supply source.

The Southern DHB Procurement Team controls which companies are permitted to offer staff discounts. Requests must be referred to the procurement manager for approval.

Staff cannot charge any personal purchases to the Southern DHB's account - they must pay the supplier directly.

48567

CEO & Chair Expenditure

CEO Expenditure	Expenditure incurred by the CEO must follow the standards and principles outlined in this policy and requires approval from the board chair.
Chair's Expenditure	Expenditure incurred by the board chair must follow the standards and principles outlined in this policy and requires approval by the chair of the Audit, Finance and Risk Management Committee. ~~Any reference made to the board or chair in this document is to be equally applied to the commissioner and deputy commissioners.~~

Associated Documents:

- Delegation of Authority Policy (District) (21584)
- Code of Conduct and Integrity (District) (18679)
- Staff Travel Policy (16163)
- Credit Card Policy (District) (29625)
- Expense Claim Form (16951)
- Koha Policy (24622)

References:

- Institute of Internal Auditors NZ Inc. 1996. A Management Guide to Discretionary Expenditure
- State Services Commission. June 2007. Standards of Integrity & Conduct
- Controller and Auditor-General. February 2007. Controlling Sensitive Expenditure: Guidelines for public entities; www.oag.govt.nz/2007/sensitive-expenditure/

17.5

General Notes

Board Report Colonoscopy Services to 30 July 2021

Progress continues in all areas.

- Timeliness to symptomatic colonoscopy remains excellent as does timing for Screening colonoscopy
- Surveillance continues to improve but there are pressures due to nursing shortages which has slowed the trajectory to eliminating overdue cases, however there are no examples of harm.
- Referral tracking to determine ultimate outcome of all referrals continues (complete since April 2021). The decline rate continues to drop.
- The surgeons have unanimous agreement on the role of CT colonography after an acute diagnosis of a common condition called diverticulitis. This should materially decrease some colonoscopy demand.

A significant emphasis in the EOG is now being directed to Training opportunities. We have a risk of the College of Surgeons removing accreditaiotn if General Surgical registrars cannot access opportunities. It is important to note that General Surgeons provide much of the colonoscopy services especially in Provincial New Zealand hospitals, hence why the College is staunch in its view of this issue.

As the Board is aware, I find considerable benefit in examining "failure". In terms of colonoscopy this is especially around those cases waiting outside the MOH timelines. Whilst small, a new issue may be emerging and that is of cases requiring a General Anaesthetic. I have asked the Team to examine this more as if there is a slow, but increasing demand for GA colonoscopy (or heavy sedation) it has implications for resourcing and timetabling, not only in Endoscopy Services, but also in Anaesthesia and Theatres.

We also need to review the letters sent to GPs and patients if we decline a colonoscopy. Our Community representatives on the EOG feel these are inadequate in some circumstances. I understand there is a hospital-wide plan to look at these types of letters across all services.

In terms of the recommendations from various reviews that were accepted by the Board, ten are completed and of the remaining 10, one is no longer relevant (a recommended change process superseded by a better process) and 8 are in progress. A further one of the 20 recommendations is around the post-colonoscopy pathways for colorectal cancer. This is broadly being addressed via the DHB work on cancer services and has not therefore been duplicated by the EOG work. Thus all 18 "live" recommendations are progressing or embedded.

From the perspective of further investment, the Budget for 2021-22 allows for significant expectation of increased capacity that will aid timeliness, volumes, and training. As CT colonography is clarified as a choice, there may be further need for capital investment in another CT scanner but we are not in a position to make firm recommendations as yet.

Andrew Connolly
Independent Chair, EOG

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 ▪ 5 July 2021 Minutes b) Hospital Advisory Committee ▪ 5 July 2021 Minutes c) Disability Support Advisory Committee ▪ 2 August 2021 Verbal Report d) Iwi Governance Committee ▪ 2 August 2021 Verbal Report	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
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.
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.
Draft Annual Plan 2021/22	Plan is subject to Ministerial approval	Section 9(2)(f)(ii) of the Official Information Act.
Draft South Island Regional Health Plan 2021/22	Plan is subject to Ministerial approval	Section 9(2)(f)(ii) of the Official Information Act.
Capital Plan 2021/22	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 Approvals ▪ Replacement Navigation System for Neurosurgery Procedures	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.
Contract Approvals ▪ Strategy, Primary and Community	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.

*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.