Southern DHB Board Meeting

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

06/07/2021 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, 6 July 2021

Recommendation

That the Board receive and note the Interests Registers.

Purpose

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

Changes to Interests Registers over the last month:

- Peter Crampton – Executive of Medical Deans Australia and New Zealand Social Accountability Committee and Board of the National Science Challenge removed, Kiwood Ltd added;
- Lyndell Kelly – New Zealand Brain Tumour Trust added;
- Tuari Potiki – Te Rau Ora Directorship and NEST Board – Need Exchange Services Trust added;
- Andrew Connolly – Currently seconded to Ministry of Health as Acting Chief Medical Officer and Clinical Advisor to the Board, Waikato DHB added;
- Roger Jarrold – Treasury: Health Reform Challenge Panel 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	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	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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 Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil, does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	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		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings Ltd	Corporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	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		

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	
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	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

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
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	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

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
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

Wednesday, 2 June 2021, 9.35 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
	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer *(by Zoom)*
	Mr Rory Dowding	Acting Executive Director Strategy, Primary and Community
	Ms Greer Harper	Principal Advisor to the Chief Executive
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer *(by Zoom until 12.45 pm)*
	Mr Nigel Trainor	Executive Director Finance, Procurement and Facilities
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 KARAKIA AND WELCOME

The Chair welcomed everyone, and the meeting was opened with a karakia by the Chief Māori Health Strategy and Improvement Officer.

2.0 APOLOGIES

There were no apologies.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the Board meeting held on 4 May 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) agreed to check the opening date for the dialysis chairs at Southland Hospital.

6.0 ACTION SHEET

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

Master Site Planning

The CEO advised that a services plan needed to be completed to inform spatial planning. Terms of reference for that had been drafted and could be circulated to Southland Board Members.

Amenable Mortality Rates for Māori

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) reported that the consultants undertaking this work had some capacity issues and encountered challenges locating data, however a report should be ready for the next meeting.

Māori Workforce

The Māori Workforce Strategy was delayed due to the CMHS&IO stepping into the Mental Health and Addiction Services Executive Director role. It was noted that Health Workforce New Zealand was doing some work on this issue.

Quality Dashboard

The Board requested a completion date for the addition of calibration points and staff information to the performance dashboards.

Mental Health

The CMHS&IO reported that he had consolidated a series of reports on Mental Health waiting times, which he would forward to the Chair of the Community and Public Health Advisory Committee.

7.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The Board received a verbal report from Mr Tuari Potiki, Chair of the Community and Public Health Advisory Committee (CPHAC), on the CPHAC meeting held on 1 June 2021, during which he reported that the Committee received updates on:

- Strategy, Primary and Community Directorate activity;
- PHO performance, which showed positive trends, although some targets were not quite being met yet;
- Public Health - what it is and what it does;
- The fluoridation status of community water supplies;
- GP numbers and ratios;
- Māori primary care enrolment.

It was noted that the Committee wished to become proactive on the issue of fluoridation. The CEO reported that after the CPHAC meeting he had been advised by Dr Rob Beaglehole that the Ministry of Health had a fund to support councils to fluoridate their water supplies.

It was resolved:

"That the Chair be instructed to contact the District's mayors regarding the Ministry of Health's drinking water fluoridation subsidy."

L Soper/L Kelly

It was suggested that Dr Beaglehole be invited to attend a CPHAC meeting.

Disability Support Advisory Committee

The Board received a verbal report from Dr Moana Theodore, Disability Support Advisory Committee (DSAC) Chair, on the DSAC meeting held on 1 June 2021, during which she reported that:

- The contributions of Odele Stehlin, previous Iwi Governance Committee representative on the Committee, and Gail Thomson, departing Executive Director Quality and Clinical Governance Solutions, were recognised;
- Positive feedback had been received on the Disability Strategy launch and discussion raised on the impact of the Health reforms, noting that there was to be a separate announcement in respect of disability support services;
- The Committee received a presentation on the new Dunedin Hospital build, including the design progress to date, accessibility issues under consideration, and how these would continue to be prioritised as layouts became more detailed;
- An update was received from the Disability Working Group, chaired by John Marrable;
- The Committee amended its terms of reference, which would be submitted to the next Board meeting for approval.

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee (HAC) meeting held on 3 May 2021 were taken as read and Mrs Jean O'Callaghan, HAC Chair, drew the Board's attention to the following key issues:

- Speeding up the improvement of patient letters by working with the Canterbury DHB;
- The draft strategy for radiology;
- The report on enhanced generalism;

- The update on the deterioration of elective surgery caseweight discharges and the plan to improve that;
- Cancer services, which would be further discussed by the Committee and Board.

The Executive Director Specialist Services agreed to check that the consumer voice and tech gap, particularly for the disabled and elderly communities, had been taken into consideration in improving patient letters and communication.

It was suggested that, along with caseweights, the number of patients be included in Orthopaedic elective surgery reporting.

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

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

- *NZNO Strike* – A lot of effort had gone into planning for the New Zealand Nurses' Organisation (NZNO) strike on Wednesday, 9 June 2021.
- *COVID-19 Vaccination Programme* – Positive feedback had been received from Wellington on the engagement of Kaupapa Māori providers and the equity approach being taken across the Southern District.

  Vaccinations were about two percent ahead of plan and the team were ready to ramp up the volume, including engagement with primary care later in July, as the vaccine supply became more stable.
- *Risk* – The CEO's two greatest areas of concern were cancer and mental health services.

  All immediate practical action possible was being taken to relieve the pressure on the Oncology Service. A five year plan and innovative recruitment advice was needed to attract staff to the service.
- *Care Capacity Demand Management (CCDM)* – The Chief Nursing and Midwifery Officer, Executive Director Specialist Services and Executive Director Finance, Procurement and Facilities had presented him with a joint position on CCDM, which would require significant investment.
- *Aged Residential Care Registered Nurse (RN) Workforce Issues* – The issue or pay parity was a substantive one that needed to be addressed.
- *Southland Emergency Department* – The actual population served by Southland Hospital and the number of presentations versus what they should be needed to be established to determine the appropriate number of treatment spaces for the proposed Southland ED building development. In the interim, additional nursing resources had been put into ED.

  It was expected that the business case would be submitted to the August Board meeting.
- *Finance, Procurement and Information Management (FPIM) System 'Go Live'* – A decision had been made to defer the implementation of FPIM to 1 July 2021, based on surety of continuity of service.

The Board requested:

- An explanation for Mental Health bed days being down for the month and year to date;
- That the Southland ED business case be submitted to the August Board meeting;
- That COVID-19 vaccination numbers be reported by age, ethnicity and gender.

9.0 FINANCE AND PERFORMANCE

Financial Report

In presenting the Financial Report for the period ended 30 April 2021 (tab 8.1) the Executive Director Finance, Procurement and Facilities (EDFP&F) reported that the result was $643k favourable to budget for the month and $13m unfavourable for the year to date. The year-end result was forecast to be a deficit of approximately $15m.

The EDFP&F then highlighted the major budget variances and management responded to questions on the financial results and volumes.

Volumes Report

The volumes graphs (tab 8.2) were noted as an important adjunct to financial reporting.

Quality Dashboard

The Quality Dashboard for May 2021 (tab 8.3) was taken as read.

In response to concerns about the rising number of complaints and the decline in the percentage being resolved, management agreed to report back on the complaints process, the issues worrying patients, and Health Quality and Safety Commission benchmarking data.

Annual Plan Strategic Progress Report

Reports summarising progress towards achieving the strategic intentions in the 2020/21 Annual Plan were circulated with the agenda (tab 8.4) and management responded to questions.

The CEO informed the Board that:

- The Health and Safety Report on the Mental Health Service was due later in the week and would be submitted to the Finance, Audit and Risk Committee;
- The Executive Director Finance, Procurement and Facilities would be leading the Green Healthcare Strategy.

Annual Plan 2020/21 Quarter 3 Progress Report

A summary of Annual Plan reporting to the Ministry of Health for quarter 3 2020/21 was circulated with the agenda (tab 8.5) and noted.

10.0 PRIMARY MATERNITY FACILITIES – CENTRAL OTAGO/WANAKA

Heather LaDell, Director of Midwifery, joined the meeting for this item.

A paper seeking Board approval to progress with a two unit primary maternity facility solution for Central Otago and Wanaka (tab 9) was taken as read. The Acting Executive Director Strategy, Primary and Community and Director of Midwifery outlined the process followed, and consultation undertaken, to arrive at that recommendation, then responded to questions.

Consideration of the commercial aspects of the proposal were held over to the public excluded part of the meeting.

11.0 STRATEGIC REFRESH

The Board received an update from Prof Crampton, Chair of the Steering Group for the Strategic Refresh, during which he advised that the timeline for the project was tight; it was currently at the point of gathering intelligence and data to inform planning.

The CEO informed the Board that the PHO had been invited to join the Steering Group, as one of the critical components of the strategic direction was the determination of localities. Prof Crampton advised that the work programme would also include engagement with the Iwi Governance Committee and the soon to be appointed Māori Health Authority Board.

It was agreed that the Board would receive monthly updates on the Strategic Refresh.

12.0 PATIENT FLOW TASKFORCE

A progress report from the Patient Flow Taskforce was circulated with the agenda (tab 10) and the Board received a presentation (tab 11.2) from the Chief Medical Officer, Chief Allied Health, Scientific and Technical Officer and Chief Nursing and Midwifery Officer summarising what had been achieved, the latest key metrics for patient discharges and patients with a length of stay greater than 21 days, and how they planned to transition the achievements made into operational business as usual.

The Executive Director Specialist Services (EDSS) reported that:

- A texting service was now in place to alert key individuals of hospital status changes;
- The General Manager Operations role was a large one and consideration was being given to ensuring it had a strong focus on patient flow.

Management then responded to questions from members.

During discussion, it was suggested that some Charge Nurses be invited to present to the next Board meeting.

13.0 STERILE SUPPLY SERVICES

The Chief Medical Officer reported that there had been ongoing problems arising from the cramped and unsatisfactory premises Sterile Supply Services operated in. This had resulted in matter that should have been removed being found in surgical trays and he understood that, between 31 March 2020 and 31 January 2021, there had been five occasions when that had been identified at the point of 'knife to skin'. The situation was unsatisfactory, however the matter had been through the sterilisation process, so the risk of infection was small. The proposed new Sterile Supply Unit was expected to eliminate such events but in the meantime the issue was being managed.

The EDSS reported that the detailed design work for the new Sterile Supply Unit (SSU) had been completed and would be brought back to Board, as the cost was about $1m higher than the concept design indicated.

The Board requested a timeline for moving the Oncology offices into the Children's Pavilion and then moving the SSU into the Oncology Building.

14.0 COLONOSCOPY

Mr Andrew Connolly, Chair of the Endoscopy Oversight Group, presented his report on the current state of the Colonoscopy Service (tab 11.1). In addition, Mr Connolly advised the Board that:

- It was essential the DHB was able to train Nurse Endoscopists, Gastroenterology Trainees, and General Surgical Registrars in this service;
- The Service was doing well but took a lot of oversight. Mr Connolly acknowledged the contribution made by Emma Bell, as Project Manager, supported by Patrick Ng, EDSS;
- The Ministry of Health had four colonoscopy categories: symptomatic (divided into urgent and non-urgent), surveillance, and screening. He believed the additional category used by Southern DHB was an ongoing distraction and the cases should be scheduled into the surveillance category;
- There were opportunities to make the system more resilient with a relatively small investment of 0.5 FTE in Invercargill.

Mr Connolly highlighted that the Southern bowel screening programme was one of, if not the, most successful in the country, and the most successful in the world for the indigenous population. He did not believe that screening denied other patients access and had in fact improved access for many people.

Mr Connolly advised that, from analysis of the data now available, it was clear that there had been a significant improvement in access. The timeliness for acceptance was fine and the risk of not being accepted had materially decreased.

The Board thanked Mr Connolly for his report and expressed its gratitude for his tenacity.

It was resolved:

"That the additional category used by Southern DHB for colonoscopy referrals be eliminated."

L Soper/K Crowther

PUBLIC EXCLUDED SESSION

***At 12.45 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.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 3 May 2021 Minutes b) Community & Public Health Advisory Committee ▪ 1 June 2021 Verbal Report c) Iwi Governance Committee ▪ 1 June 2021 Verbal Report d) Hospital Advisory Committee ▪ 3 May 2021 Minutes	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act
CEO's Report - Public Excluded Business	To allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act
Presentation – Oncology	To allow activities to be carried on without prejudice or disadvantage	Sections 9(2)(ba) and 9(2)(j) of the Official Information Act
Primary Maternity Facilities: Central Otago/Wanaka – Financial Assumptions	Commercial sensitivity	Sections 9(2)(i)
Contract Approvals ▪ Rural Hospital Agreements ▪ Off-site Teleradiology Reporting Services Agreement – I-MED NZ Ltd ▪ Outsourced Surgical Services - Southern Cross	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act
Capex – Region Wide Security Upgrade	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act
Digital Indicative Business Case	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act
New Dunedin Hospital	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act
Cyber Security	To prevent use of information for improper gain	Section 9(2)(k) of the Official Information Act
Budget 2021/22	Annual Plan is not public until tabled in Parliament.	Section 9(2)(f) of the Official Information Act

The Chief Māori Health Strategy and Improvement Officer 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 5.00 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 28 June 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	Progress Update in the board agenda attached to the CE report, further refinement date now indicated.	~~August 2021~~ October 2021
Feb 2021	**Master Site Planning** (Minute 9.0)	Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed.	CEO		Sept 2021
April 2021	(Minute 6.0)	Update to be provided in July 2021.	CEO		July 2021
May 2021	(Minute 5.0)	Draft terms of reference to be shared with Southland Board Members.	CEO	Draft ToR circulated to Southland Board members on 3 June.	Completed
April 2021	**Clinical Council** (Minute 10.0)	To provide an update in two months' time.	EDQCGS Deputy CMO	Included in agenda.	Completed
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	Deferred to August following discussion with the Board Chair.	August 2021
Dec 2020	**Māori Workforce** (Public excluded minute 16.0)	Strategy to be developed to grow the SDHB Māori workforce, esp. nursing and allied health, scientific and technical professions.	CN&MO CAHSTO CMHSIO	Paper included in agenda.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
March 2021	(Public excluded minute 15.0)	Board to be provided with staff ethnicity data, if possible by profession, directorate, and recruitment rate.	EDPC&T	Data by service included in HR dashboard. Recruitment data will not be available until the new recruitments system is embedded.	
May 2021	**Quality Dashboard** (Minute 8.0)	Calibration points (expected norms or standards) and an equity lens (Māori, Pacifika, etc) to be added to the quality graphs, along with management or Clinical Council comment.	EDQCGS	Management comments now included where there is a noticeable change in trend or a significant spike or fall in numbers. Calibration points and an equity lens are currently being prioritised, as require IT resource to complete.	
June 2021	(Minute 6.0)	Completion date to be supplied for adding calibration points and staff information to the dashboards.	EDQCGS EDPC&T		October 2021
May 2021	**Mental Health** (Minute 8.0)	CPHAC to be provided with updates on Mental Health and Addiction Services waiting lists.	CMHSIO	Transferred to CPHAC action sheet.	August 2021
June 2021	(Minute 8.0)	Explanation to be provided for Mental Health bed days being down for the month and year to date.	CMHSIO	See attached report.	Complete
June 2021	**Community Dialysis Chairs, Southland** (Minute 5.0)	Board to be advised of opening date.	EDSS	The chairs that have been ordered specifically for the Dialysis patients are en route. These have been air freighted to expedite delivery. The estimated date of arrival is the end of June. Building and Property's work will also be complete by the end of June, however they are awaiting consent from the Invercargill City Council for the plumbing work. We will ask them to follow up with the City Council so that an update can be provided in the Board	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				meeting on the consent as this is now the critical path for project completion.	
June 2021	**Water Fluoridation** (Minute 7.0)	▪ Chair to contact mayors re MoH subsidy for drinking water fluoridation. ▪ Dr Rob Beaglehole to be invited to a CPHAC meeting.	Chair/ CEO EDSP&C	Transferred to CPHAC action sheet. Dr Beaglehole invited to attend 5 August CPHAC meeting.	 Completed
June 2021	**Patient Letters** (Minute 7.0)	Check to be made that the consumer voice and tech gap, particularly for the disabled and elderly communities, are being taken into consideration in improving patient letters and communication.	EDQCGS/ EDSS	The Patient Experience Manager will be involved in the letters process. This should ensure the consumer voice is heard. The technology gap is still to be addressed but most likely will be by the introduction of different communication channels as we move forward with the digital strategy.	Completed
June 2021	**Elective Services** (Minute 7.0)	Both caseweights and number of patients to be quoted when reporting on Orthopaedics.	EDSS	Noted – both volumes and case weighted discharges are now being reported in the HAC report.	Completed
June 2021	**Southland Emergency Department** (Minute 8.0)	Business case to be submitted to August 2021 Board meeting.	EDSS	Working to the August timeline. Benchmarking has been completed, working on concept design and quantity surveyor costs with our Building & Property team.	Completed
June 2021	**COVID-19 Vaccination** (Minute 8.0)	Numbers to be reported by age, ethnicity and gender.	PD DHD	Report appended to CEO Report.	Completed
June 2021	**Patient Complaints** (Minute 9.0)	Report to be provided on the complaints process, including what is being done to address the rise in complaints and decline in percentage resolved, the issues worrying patients, and HQSC benchmarking data.	EDQCGS	Report included in this month's Board papers.	Completed

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
June 2021	**Patient Flow Taskforce** (Minute 12.0)	Charge Nurses to be invited to present to next meeting.	CN&MO	Charge Nurses invited to July Board meeting.	Completed
June 2021	**Sterile Supply Services** (Minute 13.0)	Timeline to be advised for moving the Oncology offices into the Children's Pavilion and then moving SSU into the Oncology Building.	EDSS	The Building and Property team have advised that networking work will be completed in 8 weeks' time and this will enable the oncology team to commence with their move. A paper is included in the Board agenda requesting additional CAPEX which is required for the Sterile Services work.	Completed
June 2021	**Colonoscopy** (Minute 14.0)	Additional category used for colonoscopy referrals to be eliminated.	EDSS	A meeting has been convened with the Clinical Leader, project manager and others and a plan confirmed to systematically remove category 'C' over a three month timeframe.	Completed

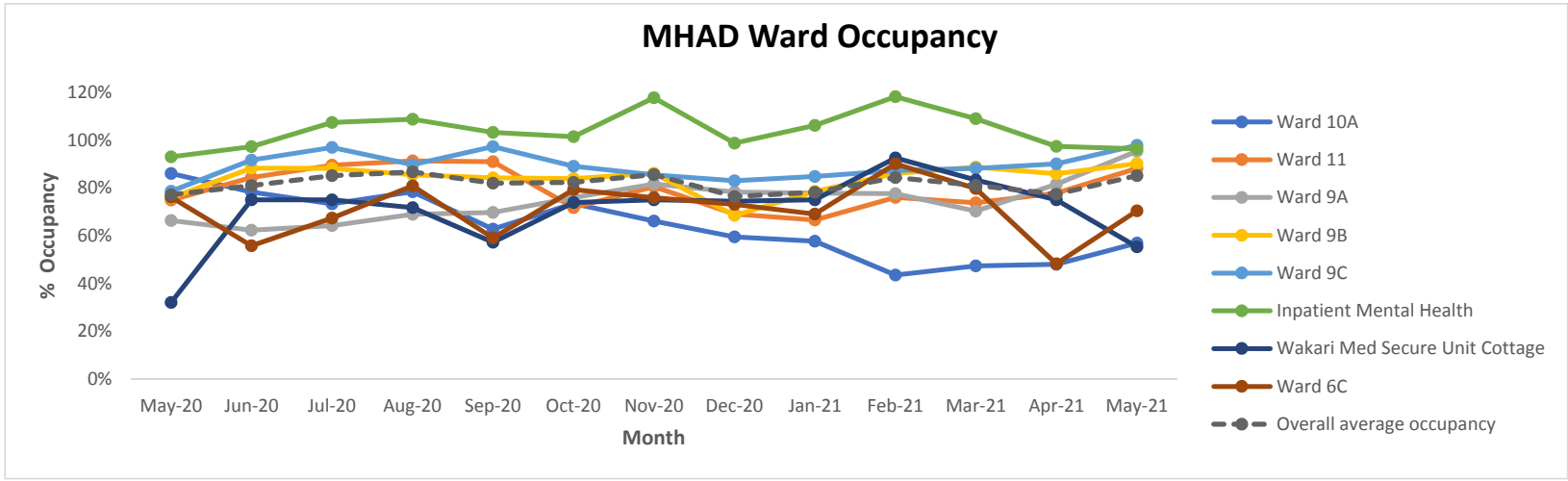
MENTAL HEALTH ADDICTION INTELLECTUAL DISABILITY (MHAID) DIRECTORATE – INPATIENT OCCUPANCY

Overview

- MHAID has eight inpatient wards (92% of the people who have contact with MHAID are not admitted to hospital – they receive interventions from Community based services. MHAID support around 6,300 people at any one time.
- All admissions to Acute Inpatient, Intensive Care and Sub-acute units are acute admissions (approximately 1500 discharges per annum).
- Contemporary best practice is for mental health inpatient occupancy to be 85% to support flow in and out of acute inpatient settings. Bed occupancy is usually higher than this on a daily basis but overall average occupancy for the last 12 months is 81.7%, ranging between 76.4% and 86.7%. This compares with an average overall occupancy of 84.11% for the same period in the 19-20 year.
- Acute inpatient areas have a number of patients who have been requiring a longer length of stay due to their acuity and challenges with the right placement.
- Inpatient Units on the Wakari site have limited ability to flex up.
- The Southland Inpatient Unit flexes up regularly and often sits at 100% occupancy plus.

Strategies in Place to manage demand and support patient flow

- Daily monitoring of bed status and patient flow district wide, identification of potential admissions from crisis teams and community health teams.
- The (Monday to Friday) Rapid Bed Management meeting each morning involving the Wakari site services looking at occupancy, staffing, overtime and Trendcare predictions. The value of this daily meeting has progressively become embedded in the culture of the services.
- Utilisation of limited crisis response NGO beds and other accommodation, for example, motels with support.
- Boarding out to Ashburn Hall to sleep at night if safe and appropriate for the patient presentation.
- MHAID nursing resource team manages flow across the district, out of hours, including directing admissions to the most appropriate inpatient bed
- Establishing systems to ensure initial assessments can be undertaken using AVL technology in rural areas.
- Difficulties remain sourcing the right accommodation for discharge for patients in acute units especially with some of the barriers to discharge such as suitable accommodation and limited options in the community particularly for anyone who has a history of arson.
- MHAID DHB and NGO project working up a model to support this patient group of approximately 14 people is in progress with a draft expected by end of June 2021.



Ward Occupancy

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Bed #	Move to last mth	Move to May-20	Average
Ward 10A	86.0%	78.2%	73.3%	78.4%	62.8%	73.4%	66.1%	59.5%	57.7%	43.6%	47.3%	48.1%	56.9%	12	8.8%	(29.1%)	63.9%
Ward 11	74.9%	84.3%	89.5%	91.3%	90.9%	71.7%	80.5%	69.0%	66.5%	76.0%	73.7%	77.9%	88.1%	16	10.3%	13.2%	79.6%
Ward 9A	66.3%	62.3%	64.2%	69.0%	69.7%	75.9%	81.6%	78.3%	77.8%	77.6%	70.3%	81.5%	95.3%	13	13.8%	29.0%	74.6%
Ward 9B	75.8%	88.2%	88.2%	85.5%	84.2%	83.9%	86.1%	68.5%	78.4%	86.0%	88.7%	85.9%	90.2%	15	4.3%	14.4%	83.8%
Ward 9C	78.6%	91.7%	96.9%	89.7%	97.2%	89.0%	85.5%	83.0%	84.7%	87.2%	88.2%	90.0%	97.8%	16	7.8%	19.2%	89.2%
Inpatient Mental Health	92.9%	97.2%	107.4%	108.7%	103.1%	101.3%	117.6%	98.7%	106.1%	118.2%	108.9%	97.4%	96.3%	16	(1.1%)	3.4%	104.1%
Wakari Med Secure Unit Cottage	32.1%	75.0%	75.0%	71.8%	57.2%	73.9%	75.0%	74.5%	75.0%	92.6%	83.3%	75.0%	55.4%	4	(19.6%)	23.2%	70.4%
Ward 6C	76.1%	55.8%	67.4%	80.8%	59.1%	79.2%	75.9%	73.0%	69.1%	90.1%	79.8%	48.2%	70.3%	12	22.1%	(5.7%)	71.1%
Overall average occupancy	77.1%	80.9%	85.0%	86.7%	81.9%	82.3%	85.5%	76.4%	78.1%	84.4%	81.1%	77.4%	85.1%	104	7.8%	8.1%	81.7%
Information Source:	*Trendcare Reports*																

Daily Bed Utilisation
Dunedin, Invercargill and Wakari Beds
Source Data: Trendcare Ward Activity report
Prepared by Amelia Needs

	Ward 10A			Ward 11			Ward 9A			Ward 9B			Ward 9C			MHU Southland			The Cottage			Ward 6C		
Shift Date	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation	Number of Beds	Number of clients	Bed Utilisation
01/04/2021	12	7	(58%)	16	13	(81%)	13	11	(85%)	15	13	(87%)	16	14	(88%)	16	15	(94%)	4	3	(75%)	12	5	(42%)
02/04/2021	12	6	(50%)	16	14	(88%)	13	11	(85%)	15	14	(93%)	16	16	(100%)	16	15	(94%)	4	3	(75%)	12	6	(50%)
03/04/2021	12	7	(58%)	16	16	(100%)	13	12	(92%)	15	14	(93%)	16	16	(100%)	16	16	(100%)	4	3	(75%)	12	6	(50%)
04/04/2021	12	7	(58%)	16	14	(88%)	13	12	(92%)	15	13	(87%)	16	16	(100%)	16	14	(88%)	4	3	(75%)	12	6	(50%)
05/04/2021	12	6	(50%)	16	12	(75%)	13	12	(92%)	15	10	(67%)	16	16	(100%)	16	14	(88%)	4	3	(75%)	12	7	(58%)
06/04/2021	12	7	(58%)	16	13	(81%)	13	12	(92%)	15	12	(80%)	16	17	(106%)	16	12	(75%)	4	3	(75%)	12	7	(58%)
07/04/2021	12	8	(67%)	16	13	(81%)	13	12	(92%)	15	14	(93%)	16	14	(88%)	16	12	(75%)	4	2	(50%)	12	7	(58%)
08/04/2021	12	8	(67%)	16	14	(88%)	13	12	(92%)	15	11	(73%)	16	16	(100%)	16	12	(75%)	4	2	(50%)	12	6	(50%)
09/04/2021	12	8	(67%)	16	14	(88%)	13	12	(92%)	15	13	(87%)	16	16	(100%)	16	12	(75%)	4	2	(50%)	12	8	(67%)
10/04/2021	12	8	(67%)	16	15	(94%)	13	12	(92%)	15	13	(87%)	16	15	(94%)	16	13	(81%)	4	2	(50%)	12	8	(67%)
11/04/2021	12	7	(58%)	16	13	(81%)	13	12	(92%)	15	13	(87%)	16	14	(88%)	16	14	(88%)	4	2	(50%)	12	8	(67%)
12/04/2021	12	6	(50%)	16	13	(81%)	13	12	(92%)	15	13	(87%)	16	14	(88%)	16	14	(88%)	4	2	(50%)	12	8	(67%)
13/04/2021	12	6	(50%)	16	13	(81%)	13	12	(92%)	15	14	(93%)	16	14	(88%)	16	13	(81%)	4	2	(50%)	12	5	(42%)
14/04/2021	12	5	(42%)	16	13	(81%)	13	13	(100%)	15	14	(93%)	16	12	(75%)	16	16	(100%)	4	2	(50%)	12	5	(42%)
15/04/2021	12	6	(50%)	16	14	(88%)	13	13	(100%)	15	15	(100%)	16	14	(88%)	16	18	(113%)	4	2	(50%)	12	5	(42%)
16/04/2021	12	6	(50%)	16	14	(88%)	13	13	(100%)	15	14	(93%)	16	16	(100%)	16	21	(131%)	4	2	(50%)	12	6	(50%)
17/04/2021	12	7	(58%)	16	13	(81%)	13	13	(100%)	15	12	(80%)	16	16	(100%)	16	17	(106%)	4	2	(50%)	12	8	(67%)
18/04/2021	12	7	(58%)	16	14	(88%)	13	13	(100%)	15	12	(80%)	16	16	(100%)	16	18	(113%)	4	2	(50%)	12	11	(92%)
19/04/2021	12	7	(58%)	16	13	(81%)	13	13	(100%)	15	11	(73%)	16	14	(88%)	16	17	(106%)	4	2	(50%)	12	11	(92%)
20/04/2021	12	7	(58%)	16	14	(88%)	13	13	(100%)	15	13	(87%)	16	15	(94%)	16	16	(100%)	4	2	(50%)	12	10	(83%)
21/04/2021	12	6	(50%)	16	14	(88%)	13	13	(100%)	15	12	(80%)	16	12	(75%)	16	14	(88%)	4	2	(50%)	12	9	(75%)
22/04/2021	12	7	(58%)	16	14	(88%)	13	13	(100%)	15	13	(87%)	16	16	(100%)	16	13	(81%)	4	2	(50%)	12	9	(75%)
23/04/2021	12	7	(58%)	16	16	(100%)	13	13	(100%)	15	15	(100%)	16	16	(100%)	16	14	(88%)	4	2	(50%)	12	10	(83%)
24/04/2021	12	7	(58%)	16	15	(94%)	13	13	(100%)	15	15	(100%)	16	16	(100%)	16	17	(106%)	4	2	(50%)	12	10	(83%)
25/04/2021	12	7	(58%)	16	15	(94%)	13	13	(100%)	15	14	(93%)	16	16	(100%)	16	16	(100%)	4	2	(50%)	12	10	(83%)
26/04/2021	12	7	(58%)	16	13	(81%)	13	13	(100%)	15	13	(87%)	16	15	(94%)	16	14	(88%)	4	2	(50%)	12	11	(92%)
27/04/2021	12	7	(58%)	16	14	(88%)	13	13	(100%)	15	13	(87%)	16	16	(100%)	16	15	(94%)	4	2	(50%)	12	11	(92%)
28/04/2021	12	6	(50%)	16	15	(94%)	13	12	(92%)	15	13	(87%)	16	16	(100%)	16	11	(69%)	4	2	(50%)	12	12	(100%)
29/04/2021	12	7	(58%)	16	15	(94%)	13	12	(92%)	15	12	(80%)	16	14	(88%)	16	11	(69%)	4	2	(50%)	12	12	(100%)
30/04/2021	12	7	(58%)	16	15	(94%)	13	12	(92%)	15	14	(93%)	16	16	(100%)	16	14	(88%)	4	2	(50%)	12	12	(100%)
01/05/2021	12	6	(50%)	16	14	(88%)	13	12	(92%)	15	12	(80%)	16	16	(100%)	16	18	(113%)	4	2	(50%)	12	12	(100%)
Grand Total	**372**	**210**	**(56%)**	**496**	**432**	**(87%)**	**403**	**384**	**(95%)**	**465**	**404**	**(87%)**	**496**	**470**	**(95%)**	**496**	**456**	**(92%)**	**124**	**68**	**(55%)**	**372**	**261**	**(70%)**

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Tuesday, 1 June 2021, commencing at 1.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tuari Potiki	Chair
	Ms Ilka Beekhuis	Deputy Chair
	Mrs Kaye Crowther	
	Dr Doug Hill	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr John Chambers	Board Member
	Ms Lesley Soper	Board Member *(by Zoom)*
	Dr Moana Theodore	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Andrew Swanson-Dobbs	CEO, WellSouth Primary Health Network
	Mr Rory Dowding	Acting Executive Director Strategy, Primary and Community
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer *(by Zoom)*
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The meeting was opened with a karakia. The Chair welcomed everyone, in particular Rory Dowding, who was attending his first meeting as Acting Executive Director Strategy, Primary and Community.

2.0 APOLOGIES

Apologies were received from Prof Peter Crampton, Committee Member, Dr Nigel Millar, Chief Medical Officer, and Mr Andrew Connolly, Board Advisor.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 7 April 2021 be approved and adopted as a correct record."

T Potiki/T King

5.0 REVIEW OF ACTION SHEET

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

- *B4 School Checks Programme and District Oral Health Services* – Substantive updates on these two services, which had been impacted by the COVID-19 response, would be submitted to the August meeting.
- *Breast Feeding* – Information was still being obtained on this issue.
- *Pēhea Tou Kāinga? How is Your Home? Central Otago Housing: The Human Story* – A report on Queenstown Lakes District Housing was included in the agenda (tab 16). Public Health would be bringing a co-ordinated housing report to a future CPHAC meeting.

6.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

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

- *COVID-19 Vaccination Programme* - Staff had been heavily involved in the COVID-19 vaccination programme and had been transitioning back to their substantive roles over the last month. 41,000 vaccinations had been completed to date. A distributed model in primary care, involving GPs and pharmacies, to deliver vaccinations across the district would be implemented as vaccine supplies became available.

  With the Australian border opening, Public Health had been required to stand up another team in Queenstown to operationalise screening protocols.
- *Allied Health* – Physiotherapy staffing at Southland Hospital had reached a critical level. The team were proactively recruiting and trying to make use of private capacity in Southland.
- *Aged Residential Care Nursing Workforce* – The border closure had turned off the supply of Registered Nurses (RNs) for Aged Residential Care, resulting in bed closures in Southland and some people having to be kept in hospital.

Management responded to questions on the timeline for involving GPs in COVID-19 vaccination, physiotherapy staffing and facilities, primary maternity, and the MMR campaign.

The Acting EDSP&C informed the Committee that Public Health would be conducting a stocktake and an assessment of what needed to be done to recover services affected by the COVID-19 response and agreed to report back on whether the NGO sector would be engaged to assist with enhanced youth clinics in schools.

7.0 PHO PERFORMANCE UDPATE

The Committee received an overview of primary care metrics for quarter 3 2020/21 (tab 9)

Corrections:

- Reference to patients who had not had cervical screening in <5 years (page 2 of the report) should read >5 years;

- The percentage of patients who smoke and are seen by a health practitioner in primary care was 9% (not 19%) below target.

The Acting EDSP&C informed the Committee that he was working with the WellSouth CEO and his team to improve the report. It was agreed that national comparisons would be a useful addition to the reporting.

8.0 PRESENTATION – PUBLIC HEALTH

Business as Usual (BAU) Activities of Public Health South

Ms Lynette Finnie, Service Manager, and Dr Susan Jack, Clinical Director, Public Health, joined the meeting and gave a presentation on public health, which included an outline of what it is and how it is delivered, and the social determinants of health (tab 18.1).

Ms Finnie and Dr Jack then responded to questions on system level measures, capacity building, their influence on health determinants, and involvement in the Strategic Refresh.

In thanking Ms Finnie and Dr Jack for their presentation, the Chair acknowledged the need for strong public health initiatives and noted that a new public health entity would be created as part of the Health reforms.

9.0 COMMUNITY WATER SUPPLY FLUORIDATION

The Committee received a report on the fluoridation status of community water supplies in the Southern District and its link to child oral health status (tab 13).

Dr Susan Jack advised that fluoridation was a very effective public health measure.

Members expressed concern that only 58% of Southern DHB's population had access to fluoridated water and the adverse effect of that on child oral health, particularly from an equity perspective.

The Committee:

- Noted that legislation would soon be introduced to mandate the Director General of Health to require community water supplies to be fluoridated;
- Agreed that a letter be written to the Hon Dr Ayesha Verrall, Associate Minister of Health, advising that Southern DHB is willing to step forward to give direction on the fluoridation of drinking water supplies within its district.

Dr Jack and Ms Finnie left the meeting.

10.0 PRESENTATION - PRIMARY CARE IN INVERCARGILL

The Committee received a presentation from Mr Swanson-Dobbs, CEO, WellSouth Primary Health Network, and Helen Telford, Project Manager, on a partnered primary care service in Invercargill (tab 18.2).

Mr Swanson-Dobbs outlined the background leading to the partnership with the local Rūnanga/Rūnaka to open a primary care service in Southland and advised that this model had been developed in consultation with the Southern DHB.

Ms Telford informed the Committee that:

- The model of care aimed to address daytime primary care and after hours primary care issues, noting that it sat within a broader piece of work addressing the flow of patients from the Emergency Department to primary and community services.
- The future direction of travel included medical imaging and diagnostics to undertake ACC accident and medical work, a community health hub model of care and a purpose built facility.
- The original model of care would be refreshed now that Southern DHB's iwi partners had come on board.
- The initial location of the service would be within the WellSouth building but that would not be its long term home.
- GPs were keen to join the after-hours service in a paid capacity.
- The service was expected to produce many benefits and outcomes, including a truly partnered service with Rūnanga/Rūnaka that could be replicated in other parts of New Zealand should it be successful.

Mr Swanson-Dobbs and Ms Telford then responded to questions on clinical leadership, the timeframe for establishing the service, and the cost to patients.

Miss Soper left the meeting at 2.20 pm.

11.0 GENERAL PRACTICE NUMBERS/RATIOS WITHIN THE SOUTHERN DISTRICT

Mr Swanson-Dobbs, CEO, WellSouth Primary Health Network, presented a paper on the General Practice workforce in the Southern District (tab 11).

Dr Hill advised the Committee that Invercargill required more GPs and Dunedin appeared to be borderline. In theory, however, the healthcare home model of care would not be as reliant on GPs.

Mr Swanson-Dobbs and Dr Hill answered questions on the General Practice workforce, ownership, and charges.

12.0 MĀORI ENROLMENT IN THE SOUTHERN DISTRICT

A report on Māori enrolment in the PHO (tab 12) was taken as read and Mr Swanson-Dobbs, CEO, WellSouth Primary Health Network, took questions.

The Committee was informed that the opportunity was being taken to check people's primary care enrolment status during COVID-19 swabbing and vaccination. If they were not enrolled, WellSouth was assisting them to get enrolled.

Following a discussion on data integrity and access to care, it was agreed that this item would be kept on the agenda and the PHO would report enrolment data bi-monthly, so changes could be monitored.

Ms Beekhuis left the meeting at 2.45 pm.

13.0 FINANCE REPORT

A report on Strategy, Primary and Community financial performance to 30 April 2021 (tab 9) was taken as read and the Acting EDSP&C took questions.

14.0 REFERENCE ITEMS

Queenstown Lakes District Housing

The Committee received an update on housing pressures for vulnerable populations in the Queenstown-Lakes District (tab 16).

The Acting EDSP&C informed the Committee that Public Health intended to pull together the various reports on housing within the district and bring back a consolidated report in a few months' time.

Mr Swanson-Dobbs and Ms Telford left the meeting.

PUBLIC EXCLUDED SESSION

***At 2.55 pm it* was *resolved*:**

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

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.

The meeting closed at 3.00 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board

Minutes of the Disability Support Advisory Committee meeting held on Tuesday, 1 June 2021, commencing at 3.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr Moana Theodore	Chair
	Mrs Kaye Crowther	Deputy Chair
	Dr John Chambers	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr Lyndell Kelly	Board Member
	Mr Terry King	Board Member
	Mr Tuari Potiki	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Ms Gail Thomson	Executive Director Quality & Clinical Governance Solutions
	Mr Rory Dowding	Acting Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer *(by Zoom)*
	Dr Nicola Mutch	Executive Director Communications
	Mr John Marrable	Chair, Disability Working Group
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone and the meeting commenced with a round of introductions.

2.0 APOLOGIES

Apologies were received from Mr Kiringāua Cassidy, Prof Peter Crampton, Ms Paula Waby, and Mr Andrew Connolly, Board Advisor.

An apology for an early departure was received from Mr Tuari Potiki.

3.0 COMMITTEE MEMBERSHIP

The Chair reported that there was a vacancy on the Committee, as Odele Stehlin, Iwi Governance Committee (IGC) representative, had stepped down. The contribution made by Ms Stehlin was acknowledged and the Chair advised that she had approached IGC for a replacement.

The Chair also acknowledged the contribution of Ms Gail Thomson during her time as Executive Director, Quality and Clinical Governance Solutions and lead Director for the Disability Support Advisory Committee, in particularly her leadership and support for launching the Disability Strategy.

The Chair reported that the Board had appointed Prof Peter Crampton, Deputy Board Chair, to the Committee.

4.0 DECLARATION OF INTERESTS

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

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

5.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meetings held on 1 February 2021 and 7 April 2021 be approved and adopted as a correct record."

M Theodore/K Crowther

6.0 CHAIRS' UPDATE

Disabled Persons Assembly

The Chair reported that she and the Executive Director Quality and Clinical Governance Solutions had attended the May 2021 meeting of the Disabled Persons Assembly (DPA) to talk about the Disability Strategy and answer questions.

One of the issues raised at the DPA meeting was what impact would the Health reforms have on the Southern Disability Strategy. The Chair:

- Noted that the changes announced by the Minister of Health did not specifically include reforms to the disability support system and there would be a separate announcement later in the year. The Minister did note, however, that treating disability support services solely as a health issue was problematic; and

- Advised that the Southern Disability Strategy 2021 would be important in informing health and disability services moving forward, as it described the vision and priorities of the people of the Southern District.

Mr Hamish Brown, Project Director, Dr John Adams, Chair, Clinical Leadership Group, and Mr Simon Crack, Project Manager, Dunedin Hospital Development and Transformation Support, joined the meeting.

7.0 PAULA'S STORY

It was agreed that a video recording of a patient with lived experience of disability would be played at each future meeting.

The Committee was shown a video recording of Paula Waby's story and experiences with the health system, and what could be improved.

The Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) reported that a Quality and Clinical Governance Hub would be formally launched after the Clinical Council meeting the following week, which would include the Disability Strategy and a section for patient stories.

8.0 NEW DUNEDIN HOSPITAL – HOW ARE THE PINCIPLES OF UNIVERSAL DESIGN BEING IMPLEMENTED?

Mr Hamish Brown, Project Director, Dunedin Hospital Development and Transformation Support, outlined the status of the new Dunedin Hospital project, then presented an update on how accessibility considerations were being incorporated into the new hospital's design, some accessibility challenges and opportunities to be investigated, and the next steps for ensuring accessibility and universal access remain prioritised (tab 10).

During his presentation, Mr Brown advised that:

- At each stage of the design process an accessibility review was undertaken by Jason Strawbridge of Strawbridge Accessibility;
- At the later stages of the design more emphasis would be placed on wayfinding;
- Community Health Council representatives, including disability champions, were involved with the approximately 30 Facilities in Transformation (FiT) groups, which were informing the design.

Dr Adams and Mr Crack reiterated that patient accessibility was front and centre of design, as well as accessible facilities for staff with disabilities.

Dr Adams and Messrs Brown and Crack then responded to questions from members and offered to update the Committee on a regular basis.

It was resolved:

"That the Committee note:

- **The new Dunedin Hospital design progress to date, including accessibility issues under consideration, and**
- **That the project will continue to prioritise accessibility considerations as the design focus on internal layouts becomes more detailed over the coming months."**

Dr Adams and Messrs Brown and Crack left the meeting.

9.0 REVIEW OF ACTION SHEET

The Committee received the action sheet (tab 7) and advice from the Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) that the Annual Plan disability metrics would be reported on when updates were available.

10.0 DISABILITY STRATEGY AND ACTION PLAN IMPLEMENTATION

Disability Working Group Update

Mr John Marrable, Chair of the Disability Working Group (DWG), presented an update on the DWG, its terms of reference, membership, and highlights from its first meeting (tab 9.1), then responded to questions.

The EDQ&CGS informed the Committee that the draft Disability Action Plan table (Appendix 3) set out all the actions from the Disability Strategy and Action Plan. The Executive Director Quality and Clinical Governance Solutions would be the overarching executive sponsor and the business owner to oversee all the actions would be William Robertson, Consumer Experience Manager.

It was resolved:

"That the Committee note the report and the progress made on establishing the Disability Working Group and endorse the Group's updated Terms of Reference."

J Chambers/K Crowther

11.0 SNAPSHOT OF NATIONAL TRAVEL ASSISTANCE FOR THE DISABLED COMMUNITY

The Committee received information on the National Travel Assistance Scheme, in particular as it pertained to consumers with disabilities (tab 11), and the EDQ&CGS responded to questions.

12.0 TERMS OF REFERENCE

The Committee reviewed the revisions to its terms of reference (tab 12).

It was resolved:

"That the Committee confirm the changes to its terms of reference and recommend that they be approved by the Board."

M Theodore/J Chambers

The meeting closed with a karakia at 4.10 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

FOR APPROVAL

Item: Disability Support Advisory Committee Terms of Reference

Meeting of: Board, 6 July 2021

Recommendation

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

Purpose

1. To update the Committee's terms of reference.

Background

2. The Disability Support Advisory Committee has reviewed its terms of reference and at its 1 June 2021 meeting resolved *"That the Committee confirm the changes to its terms of reference and recommend that they be approved by the Board."*

Appendix

1. Disability Support Advisory Committee Terms of Reference with recommended changes tracked.

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)

Terms of Reference

Accountability

The Disability Support Advisory Committee (DSAC) is constituted by section 35, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of DSAC are to give the Board advice on:
   a) The disability support needs of the resident population of the Southern DHB
   b) Priorities for use of the disability support funding provided.

2) The aim of the Committee's advice will be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of disabled people within the Southern DHB's resident population:
   a) the kinds of disability support services the Southern DHB has provided or funded or could provide or fund for disabled people;
   b) all policies the Southern DHB has adopted or could adopt for disabled people.

3) The Committee's advice may not be inconsistent with the New Zealand Disability Strategy.

Responsibilities

The Committee is responsible for:

1) Providing advice to the Board on the accessibility and appropriateness of Southern DHB services, for disabled people and their families/whānau;

~~1)~~2) ~~Providing advice on the overall performance of the~~Assessing the performance of disability support services delivered by or through the Southern DHB against expectations set in the relevant accountability documents, documented standards and legislation;

~~2) Providing advice on strategic issues related to the delivery of disability support services delivered by or through the Southern DHB;~~

3) ~~Focusing on the disability support needs of the population and developing principles on which to determine~~Providing advice to the Board on priorities for using finite disability support funding;

4) Monitoring and supporting the implementation of the Southern DHB Disability Strategy and Action Plan;

~~4)~~5) Monitoring Southern DHB progress against District Annual Plan milestones for Disability;

~~5)~~6) Ensuring that ~~the District Annual Plans (DAPs) of the Southern DHB demonstrate how people with disability will access health services and how the Southern DHB will ensure that the~~ disability support services funded or provided ~~by they the Southern DHBwithin~~by Southern DHB~~'s catchment fund or provide~~ are co-ordinated with the services of other providers to meet the needs of disabled people;

~~8) Assessing the disability support services' performance against expectations set in the relevant accountability documents, documented standards and legislation;~~

~~10)~~7) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

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

The Committee is to comprise a number of Board members as determined by the Board Chair, supplemented with external appointees as required.

Membership will provide for Iwi Governance Committee nominated Māori representation on the Committee, and members with lived disability. The Committee may obtain additional advice as and when required.

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

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda, and it is the responsibility of each member to disclose any new interests which may give rise to a conflict.

Quorum

The quorum of members of a committee is —

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

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

Meetings

Bi-monthly meetings, held separately or collectively with the Community and Public Health Advisory Committee (CPHAC) will be scheduled, however the committee may determine to hold additional meetings if deemed necessary by the Chair, with or without CPHAC, up to a maximum of ten meetings per year.

Review

The Terms of Reference for this Committee shall be reviewed as and when required.

Management Support

The Chief Executive Officer shall ensure adequate provision of management and administrative support to the Committee.

HOSPITAL ADVISORY COMMITTEE MEETING
5 July 2021

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

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 6 July 2021

Recommendation

That the Board:

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

Purpose

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

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

1. Organisational Performance

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

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

Financial performance for the month of May is a deficit of $3.473 million compared to a planned deficit of $1.192 million, and hence an unfavourable result against plan for the month of $2.281 million. Year to date (YTD) financial performance is a $23.184 million deficit against a planned deficit of $7.829 million, resulting in a year to date deficit against plan of $15.355 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 $15.368 million compared to a planned deficit of $6.637 million, so an adverse result of $7.539 million. The result for the month was extremely disappointing and impacted materially by two factors:

- Pharmaceuticals are considerably over budget at $3.686 million adverse to plan (net of unbudgeted revenue and expenditure associated with COVID). Circa $1.5 million is associated with revenue that the Government had previously committed to Pharmac to cover the costs associated with the pandemic which has been unilaterally reduced, and the remainder simply being higher pharmaceutical costs than expected. Pharmac manage the overall budget nationally, but not DHB by DHB, and we have simply picked up more of the new drugs faster than forecast. This is good for patient outcomes, however adverse for us financially.
- Planned care continues to be significantly impacted by resourced bed shortages, while third floor surgical staffing has improved there are issues remaining on fourth floor and in Surgical Southland. The team are attempting to mitigate this, but there are ongoing challenges. On a year to date basis we are $2.806 million behind plan, there will be some cost saving offset particularly in Inter District Flows (IDFs), however there are additional outsourcing costs being incurred. On top of this, there is additional elective initiative funding we have not been able to access (which was not budgeted either as revenue or expenditure) which amounts to a further $1.939 million year to date.
- Workforce expenditure also remains a significant challenge with business as usual (BAU) workforce costs exceeding budget by $5.294 million. Some of these costs are offset by additional revenue however there remains a significant challenge. FTE growth remains very challenging. The table below shows that FTEs have increased by 159.34. The budget increased by 84.26 FTE therefore there has been growth of 75.08 FTE over and above that budgeted. Most of this is in nursing, midwifery and allied health.

	May 2020/21 YTD	**2019/20 Full Year**	**Variance**	**Percentage**
Senior Medical	305.23	295.16	10.07	3.4
RMOs	345.23	335.66	9.57	2.9
Nursing and Midwifery	1,883.18	1,811.83	71.35	3.9
Allied Health Scientific and Technical	728.32	685.71	42.61	6.2
Support	101.65	96.32	5.33	5.5
Management and Admin	738.52	718.11	20.41	2.8
Total	*4,102.13*	*3,942.79*	*159.34*	*4.0*

SMO FTEs in 2019/20 have been amended to recognise reclassification of additional hours into FTE in 2020/21. All categories have had any covid related FTE removed for comparison

From a volumes perspective, comparison to 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 251 or 4.9% for the month compared to the plan, and up 1,129 or 2.17% year to date. On a year to date basis medical is 1.111 or 5.88% ahead of plan, maternity 485 or 10.03%, but surgery was 468 or 1.17% behind plan. There was a continued deterioration in surgical activity in the month, although significantly lower than prior months.
- Raw discharges are up 68 or 1.29% for the month against plan, and up 2,242 or 4.16% year to date. It should be noted the disparity between raw discharges being up and case weights being down is largely attributable to the mix of planned care with orthopaedics impacted more significantly than other services, and orthopaedics have a much higher case weight per discharge due to the complexity of the major joint work.
- Mental Health bed days are 642 or 19.54% below planned levels for the month and 7,470 or 21.04% below plan year to date. It should be noted that the plan of 35,510 beds is based on 100% occupancy of the 106 beds. At 28,040 this represents an average occupancy of 79%.

The Performance Dashboard update has been included as a separate attachment to this report, 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 Need to ensure that there 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	Delegations of authority policy, internal audit work programme, external audit. All reporting through the Finance, Audit and Risk Committee	Improvement through upgrading financial system will assist in more effective management of risk

3. New Zealand Nurses Organisation (NZNO) Industrial Action

Strike action was undertaken by NZNO members on Wednesday 9 June 2021 from 11:00am to 7:00pm. Contingency planning was undertaken in the lead-up to the strike, including provision for life preserving services. Our hospitals were busy, but services coped well and disruption was minimised as much as possible.

The NZNO is currently surveying members regarding options on future industrial action in advance of further balloting if bargaining is not successful.

4. Staffing Shortages

Nursing recruitment continues to be a significant challenge, we have vacancies in a number of areas in particular Surgical Ward in Southland, fourth floor Surgical in Dunedin, and in Mental Health, all of which is having a significant impact. In Surgical this is resulting in bed closures which has a direct knock on effect to planned care delivery. While every effort is being made to minimise cancellations patient and staff safety must prevail.

A significant impact on recruitment is the continued closure of the borders because even though our priority is on recruiting New Zealand trained nursing, overseas trained nursing staff remain a key source for nursing across the district. This is particularly true for Aged Residential Care (ARC) which is being hit both by this closure as well as the fact that the ongoing pay parity gap between remuneration rates paid in this sector compared to the DHB multi-employer collective agreement (MECA) rates means that they are losing staff to District Health Boards while at the same time not having the normal pipeline available to them. While pay parity will not increase the overall number of nurses it would at least level the playing field and remove the incentive of moving for higher remuneration reasons. This issue has been escalated to Ministerial level and we await the whole of public sector response signalled in the letter of expectations. There are however beds being closed in the ARC sector which does have an impact on our ability to discharge patients into care.

5. Southland Site Planning

As noted at the last Board Meeting, we are working with Sapere to put us in a position of being able to do a robust Master Site Planning Exercise for Southland Hospital. This work has a number of components to it with a number of stages.

The first is understanding the need and this includes:

- Population, health and social assessment
- Identify the health needs
- Clinical demand assessment
- Future clinical demand projections and supply modelling
- Service opportunities and directions.

Once this has been completed then we will have a picture of where we need to take the services and the scale of future demands, which can then be utilised to look at the Southland site and do a longer term plan for the utilisation of the site.

This is going to take some time to complete, so concurrent with this we are identifying the short term tactical moves we can undertake to relieve some of the burden on the site. This includes:

- Upgrading the Emergency Department to be fit for purpose for the volumes we should be seeing in Southland (not to be confused with the volumes that are currently presenting)

- Working with the Primary Health Organisation to enhance Primary Care, and in particular support the development of a Community Health Hub in Invercargill which has an emphasis on Urgent Care, very low cost access (VLCA) general practice, and access to appropriate diagnostics
- Expanding the theatre environment with the additional theatre funded by the Government and associated work
- Commissioning of the 12 unresourced beds within the Assessment, Treatment and Rehabilitation (AT&R) Unit.

Once these tactical improvements have been made, we would expect that we would be able to take further steps being informed by the Master Site Planning work which would have been completed.

6. Southern Locality Discussions

As part of the Health Reforms the intention to establish locality networks serving populations of approximately 50,000 to 100,000 people have been signalled. The intention for these localities is to support the commissioning of services to meet the needs of the communities they are a part of. At this stage, we do not have policy advice on exactly what these localities will be (i.e. are they are collective of providers from within the locality, are they community stakeholders etc) and as such any work being undertaken must be seen as preparatory work. It has however been signalled that there will be a call for proposals in due course for circa six proof of concept pilots covering 250,000 population.

Given that Southern is unique in terms of being the largest geographical District in the country and has a high percentage of its population in rural setting, it makes sense that we support the concept of a proof of concept in our region being focussed on rurality. WellSouth Primary Health Network had already initiated conversations with the rural hospital trusts and as such the DHB has joined in on this journey. The intention is to have a symposium where we bring a wide variety of stakeholders and interested parties together to work up what the locality may look like. The intention is to align this work with the strategic refresh work already underway.

Iwi have however recently been clear that they are not ready to have these locality discussions at this stage and had concerns that no formal relationships were in place with the rural hospitals prior to this discussion. This opportunity is critical in a quickly unfolding landscape of health reforms and it is clear that partnerships with Iwi will be a critical part of the preferred models moving into the future. We are intending on continuing the work, however Iwi being an active part of this work will be an essential component and as such this will need to be resolved urgently.

7. Cancer Services

Good progress is being made in terms of actions to address the waiting list and resourcing issues identified in the Cancer Services. Detail of the plans and actions were set out in the Hospital Advisory Committee papers so is not repeated here. Critical to the long term resolution of the challenges is securing the appropriate long term resources identified. Weekly reporting on progress is being undertaken.

8. COVID-19 Vaccination Programme Update

The COVID Vaccine Dashboard is attached as Appendix 1.

This week beginning 31 May Southern DHB reached a milestone of 43,873 vaccinations. The large majority (65.4%) of these were completed in the large DHB run clinics in Dunedin and Invercargill. Increasing numbers (34.6%) are being undertaken by primary care into rural

areas. We have begun a soft launch into tier 3 as we are restricted by the Ministry of Health from publicly advertising to tier 3 to align with the national messaging. Communications have commenced in partnership with WellSouth via text message to patients over 65 years.

We have gone live with ServiceNow and Homecare Medical Limited (HML) to book all appointments from 17 May forwards. All sites are onboard with Service Now, except Gore Health Centre, who are trialling their own Patient Management System. HML are still providing an option for those who do not have internet access.

Mental Health Residential Services

All mental health residential services in the Southern district have been contacted regarding their residents' eligibility to attend vaccinations at the clinics in either Dunedin or Invercargill. An alternate delivery model will be used for residences where the Meridian or Victoria Room locations are not suitable.

Disability Residential Support Services

Of the almost 1,000 Disability Residential Support Services recipients in the Southern district most are living in a residential facility. Their providers have all been contacted and a mixed delivery model will be used to suit each provider, including vaccination clinics at tailored community-based locations. The vaccine delivery will be supported by general practitioners (GPs), pharmacies and flying squads.

Aged Residential Care (ARC)

As at the end of May, aged residential care residents at 14 of our 65 facilities are fully COVID-19 vaccinated (22%), and another 18 (28%) have had first doses. Invercargill, Dunedin and Central/Lakes facilities will all be fully vaccinated by the end of June. WellSouth is organising the COVID-19 vaccinations in the rural areas with the Waitaki, Southland, Gore and Clutha facilities lagging, but aiming for first doses during June. All staff have had the vaccine made available to them.

COVID-19 Vaccination Programme Rollout – Equity, Māori and Pacific Populations

The Associate Māori Health Strategy & Improvement Officer – Secondary/Tertiary is leading the operational COVID-19 vaccination programme rollout alongside the COVID-19 Vaccination Taskforce Group.

The Māori Health Leadership Team has been tasked with providing an Equity Plan to the Ministry of Health which will include a detailed action plan for the vaccination rollout. The COVID-19 vaccination programme requirement is very prescriptive due to vaccine distribution factors and other operational aspects.

The Ministry of Health has allocated tranche one Māori Preparedness funding of $39 million to ensure Māori communities and providers are prepared for the roll out of the COVID-19 programme. They identified four southern Māori health providers with existing vaccinator capabilities allocating them $490k, based on a population formula.

Tranche two COVID-19 support funding will be available for Māori health providers to provide support, health promotion and education, transport, IT capacity for booking appointments and whatever is required to promote the uptake of the COVID-19 vaccination programme. COVID-19 Māori Communication Funding has been applied for by our Māori health providers through Te Putahitanga pending decision outcome.

Pacific Provider Development Scheme Funding will be available to the three identified Pacific providers in the Southern district. These providers are Pacific Trust Otago, Pacific Island Advisory & Cultural Trust and Oamaru Pacific Community Group. At this stage, they are waiting to hear when this funding will be available.

A series of Māori and Pacific roadshows providing information and education on the vaccines are underway. These hui have been well attended and have included the Medical Officer of Health and Southern Community Laboratories (SCL) supporting with the latest information on the vaccine and our strategy on rolling out the vaccination programme.

The Service Delivery model, Service Now has been redesigned to address barriers of access (0800 line wait times, inability to access online) with the inclusion of drop in clinics giving more opportunities for vaccination progress.

COVID-19 Vaccination Workforce

Recruitment for the Invercargill Medium Clinic is on hold until a decision is made on moving to a two-shift model. The Dunedin Large Clinic also has sufficient resource with the Otago Polytechnic students able to fill in both clinical and non-clinical gaps. Work is underway collecting data to confirm assumptions on availability, absenteeism, and turnover rates which will enable us to anticipate ongoing recruitment needs before short staffing occurs. The COVID Vaccination (COVAX) Workforce Team has relocated out of the Senior Leadership Team/Executive Leadership Team meeting room into the Meridian Mall office space.

9. COVID-19 Monitoring and Resurgence Work

Queenstown Airport

The health response at Queenstown airport continues to take up a large proportion of the regulatory and protection team's work. The health team at the airport are now working mostly independently, which has meant Public Health staff no longer have to be there to meet each flight. A total of eighteen staff members have been trained, including five nurses, three operational border leads and ten health support workers. At this stage, the flights still consist of up to four flights per day, seven days a week. There has been a great uptake of COVID-19 vaccinations for all airport stakeholders.

A scenario-based document with flow charts is in draft form to support the team at the airport and the on-call Medical Officer of Health. This document has been created outlines

scenario specific roles and responsibilities with associated actions, as well as all contact information. The Ministry of Health Infection, Prevention and Control (IPC) guidance and operations framework continues to be adapted at a national level to support our health team. Emerging issues continue to arise at the border and the Ministry of Health have improved the way that they communicate these issues to the Public Health units.

Processes are in place to swab symptomatic passengers who arrive from quarantine free flights. Queenstown Airport Corporation are trialling a thermal scanner so 100% of incoming passengers can be temperature checked. The thermal scanner detects anyone walking past the camera and will check their temperature and alarm if the temperature limit is exceeded. This scanner will be monitored on a laptop so that anyone who has a high temperature will be assessed. This should hopefully decrease the number of staff needed per shift once it is up and running.

Dunedin Airport

Health Protection staff continue to plan for the Dunedin airport opening for quarantine free travel. At this stage the flights are not expected until later in the year. The ill traveller protocol has been updated so that there is one protocol that can be utilised for both Queenstown and Dunedin airports. This protocol is for a passenger that is identified with a potential quarantinable illness onboard an international plane.

Maritime Border

Maritime activity continues to take up a large proportion of health protection work, particularly for the staff that are on-call. The team is currently working on a protocol so that each person involved in a certain situation will know what their roles and responsibilities are. This will be supported by actions and contact details (similar to what is being developed for the airport).

Contract Tracing

Preparation is underway for the new release of the National Contact Tracing Solution (NCTS) in July. This system is currently undergoing a major revamp which will help streamline the system and provide additional logic. There are eight new components that we will need to upskill contact tracing staff on. A plan is being developed for training all Public Health staff in the new system and provide ongoing support to the team so that everyone is highly skilled and competent in using the system. Alongside this planning is underway for how we will also train the wider pool of surge staff.

A superuser from each of our offices is being supported to attend a face-to-face training day in Wellington in June. This is a two-day training course that will upskill our users in the new system and allow them to bring back the training knowledge to share with our team. Following on from this there is a week of remote sessions that staff can join, and we will also be hosting trainers from the NCTS project team in one or two of our offices to provide further support with running training sessions for our Public Health staff.

Twenty-one staff have volunteered to be part of a 'Day 1' surge workforce. This group may be required to assist with any contact tracing requirements if there is an outbreak anywhere in the country on the day or shortly after the new release goes live. These staff will be prioritised for training from mid-June to make sure that they are all competent with the system in time for the release date.

Ongoing training will need to be implemented to make sure staff are provided with the opportunities to maintain their skills in the system. This will most likely include scenarios that we will work through with small groups of people. This training will need to fit in alongside our team's normal work.

Māori Health Providers

Further hui have been held with Māori health providers across the district. Kōrero, including listening to their experiences during the first wave of COVID-19, the impact that it has had

on the services they deliver to their communities and the work they found themselves supporting during this time. The kōrero outlined how we can work together if we were to have a COVID-19 outbreak that impacted the communities they look after and how we would support each other to make sure people's welfare is being looked after and ensure they feel appropriately supported throughout the contact tracing process.

Swabbing – May 2021

There have been 4,659 assessments undertaken through this period including 570 at the maritime ports.

- 4,543 Simple assessments
- 69 Virtual assessments
- 0 Full assessments
- 47 No assessment undertaken.

10. Allied Health

Southland physiotherapy continues to have vacancies that are currently impacting on service delivery and staff wellbeing, especially for the inpatient team. Two rehabilitation assistants have been put in place, however, the situation is perilous with one physiotherapist going on maternity leave, with a second to go on maternity leave in June.

Staff from Dunedin continue to support their colleagues in Invercargill with a rotational roster with a senior physiotherapist travelling to Invercargill for three or five days each week. This interim solution has been extended to July, but it should be noted this is now impacting on the Dunedin teams.

There has also been a series of meetings to look at options to improve retention and recruitment, especially at Southland Hospital, where this has been a longstanding issue. The team has work closely with recruitment on both local and overseas campaigns. There has been increased interest from overseas and a number of interviews have been conducted. Offers with a relocation package are being made to three people. There has been no interest from across NZ, with other DHBs also experiencing similar physiotherapist challenges. There are currently over 60 physiotherapist jobs being advertised by DHBs.

11. Primary Maternity Facilities

The Wanaka Maternal and Child Hub is up and running. Lead Maternity Carers (LMCs) are using it for their consultations with women antenatally, post-natally and there has already been one precipitous birth on site. The final refurbishments have yet to be completed, but the lead maternity carers (LMCs) are working around this to provide a service at a central location for women and their infants.

Significant progress has been made in processes to support the seamless transition of Charlotte Jean Maternity Hospital to a Southern DHB run facility by 1 July 2021. The name of the service will be changed at the request of the Trustees of Charlotte Jean Maternity Hospital. It will be known from 1 July 2021 as Central Otago Maternity Hospital (COMH). It will be operating from the same site in Ventry Street, Alexandra. The COMH will be staffed Monday to Sunday, 0800hrs to 2000hrs, with on-call overnight. It is hoped the increased certainty in hours on offer, will attract more midwives to the service. The current staffing is predominantly registered nurses who work under the oversight of the registered midwives in the maternity setting.

The Maternity Options paper for Wanaka and Central Otago was updated with greater financial detail. This paper was submitted to the Board at the June meeting. Their

endorsement means we can proceed with the Request for Proposal process and also advance the Business Case for the Ministry of Health Capital Investment Committee.

A new Project Manager for Primary Maternity has been appointed and will commence work in early July.

12. Annual Plan 2021/22

On 24 May, the Ministry of Health provided feedback on the updated sections provided for the Annual Plan in May, for the following areas.

Actions to improve sustainability

- Southern DHB quantified the financial impacts of the actions identified as requested.

FTE

- An update to the FTE content in the service change section of the Annual Plan was provided to include a narrative explaining the drivers of FTE movements.

Financial information

- Financial information was not required in the last draft. Financial information is still outstanding and will be included in the final draft submitted to the Ministry.

Production plan

- Southern DHB submitted an updated production plan with the last draft of the Annual Plan.

Annual Plan updates

The Ministry provided new guidance for a number of areas, including immunisation, maternity care, environmental sustainability and health workforce. The Ministry has required additions in relation to work health and safety, service change, and commitment to the COVID-19 vaccination programme. A statement is required that out year planning be robust and supports system sustainability throughout the system change programme. Subject matter expects are providing additional content as required.

The full final draft plan will be submitted on 2 July. It is expected that this draft is as comprehensive and completed as possible. The Ministry will provide feedback on the final draft of the Annual Plan on 16 July. DHBs are expected to work towards Board approval processes from mid-July. The final annual plan will therefore be submitted to the August Board meeting.

The timeframe for the completion of the Annual Plan is as per the table below:

Activity	Date
Final draft plans and templates due to the Ministry for review and feedback	2 July
DHB Board signed SPE to be published on DHB websites	Before 30 June
Ministry provides feedback on final draft plans	16 July
Ministry approval of SLM Plan	31 July
DHB Board approved plans put forward for Ministerial approval	From mid July
2020/21 SPEs tabled with 2020/21 Annual Reports	December

13. Service Planning

The planning sessions previously established with Finance and also with Māori Health have been suspended as staff were prioritised turned to COVID vaccination. These will be re-established over the next month, in preparation for 2022/2023 planning guidance and facilitation for the services.

At the Clinical Directors annual meeting in Balclutha (27 May 2021) service planning was discussed; 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 2022/23.

14. Smokefree

As part of our local coalition of Smokefree Murihiku we are supporting Te Ra Auahi Kore Te Ao 2021/World Smokefree Day 2021. Each year there is a focus on the wider work of smokefree in our community and it is celebrated on 31 May annually, but activities occur over the month of May. The theme this year is 'Commit to Quit' which means drawing a line in the sand and committing yourself to being smokefree.

In each community our staff work alongside others to highlight aspects of our smokefree/auahi kore work. This includes Smokefree Otago working with school children in Queenstown and Dunedin to draw pictures of what a smokefree environment/beach looks like to them. These pictures will be compiled into a banner and displayed at the Esplanade at St Clair in Dunedin during a cigarette butt clean-up that has been arranged with 'Our Seas Our Future' on Sunday 30 May, and at the lake front in Queenstown. The aim is to get councils to consider making smokefree outdoor spaces (such as beaches) a permanent decision. The banners will also be useful for display at future smokefree activities and events across the region.

15. South Island Māori Health Workforce Project

The Chief Māori Health Strategy & Improvement Officer attended the South Island Māori Health Workforce Project meeting in Christchurch on 17 May, which is part of the South Island Alliance South Island Workforce Development Hub. This project is a collaboration between Te Herenga Hauora (the South Island DHB General Managers Māori) facilitated by the Southland Island Alliance Project Management Office (Workforce Development Hub) and Kōhatu, Centre for Hauora Māori in the University of Otago. Kōhatu is supporting the background, design, implementation and evaluation of a strategy to grow the South Island Māori health workforce and ensure that workforce is well supported and thrives. Learnings from this project will be of direct benefit to the South Island DHBs and learnings from this project will be shared with others nationally. Analysis of New Zealand's registered health workforce shows Māori are currently greatly under-represented in all areas. For example, workforce statistics show Māori comprise around 8% of New Zealand's registered nurses, and even smaller proportions of doctors (3.4%), dentists (3%) and others e.g. physiotherapy (3%), in the context of the Māori population being 14.9% of NZ's population. This project will complement the proposed new role to establish a Māori workforce development specialist position. The research aspects of this project will inform our recruitment and retention strategy in our attempts to increase and retain our Māori health workforce.

16. Māori Community Cancer Hui

The Chief Māori Health Strategy & Improvement Officer has been communication with Te Aho o te Kahu (TAOTK - Cancer Control Agency) since the discussion at a previous Iwi Governance Committee meeting. The new government service that was established last year to provide national leadership for, and oversight of, cancer control in New Zealand. Te Aho o te Kahu have been working with a range of partners across the cancer continuum (incudes health prevention and promotion services including healthcare community, secondary and tertiary providers) to prevent as many cancers as possible, ensure early detection and diagnosis and provide high quality treatment and care. This year Te Aho o Te Kahu will be holding three Māori Community Cancer Hui in Te Waipounamu (Christchurch, Invercargill and Nelson/Marlborough) in June. The tentative date for the Murihiku/Invercargill hui which is scheduled for Wednesday 15 June, with the view to holding the hui at Murihiku Marae.

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.

17. Māori and Pacific Data Review

The Executive Director Specialist Services escalated to the Hospital Advisory Committee some observations specific to first specials appointments (FSAs). 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 and Children Services 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 Surgical 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 & 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 the HAC committee.

18. Violence Intervention Programme

The Violence Intervention Programme (VIP) team held a quality improvement planning day at which the team reviewed a number of issues and developed some clear actions to help support quality planning moving forward. This included an increased focus on services outside of the Delphi audit to help inform a whole of district perspective and ensure services have clear feedback loops to inform and include in their own quality improvement. The Delphi tool was introduced to measure health infrastructure indicators that support a consistent and quality response to Intimate Partner Violence and Child Abuse and Neglect.

The team will also develop a greater focus on analysis of Child Protection Alert System data including ethnicity to help inform and develop practice. There will also be an increased presence in the Dunedin maternity ward to assist with improving screening and disclosure rates. There will be further discussion and review of event coding data collection for analysis and quality improvement planning. In relation to this the team have agreed to support a trainee intern project with Liza Edmonds (Paediatrics). The team will have the opportunity to work with a trainee intern who has an interest in child protection and recent project experience on an elective project focused on quality improvement/audit work.

19. Refugee Health

Refugee Quota Programme – Ministry of Business, Innovation and Employment (MBIE)

The refugee resettlement programme has resumed. Currently, there are limited intakes, as the COVID pandemic is being managed. In May, one Afghani resettled in Dunedin.

For the 2021/22 financial year, MBIE anticipates a national quota of refugees to be between 750 and 1,000. The current government's pre-COVID plan was to resettle 1,500 refugees per annum. This remains the ambition, but due to the complexities introduced by the pandemic, quotas are reduced, being dependent on factors such as the vaccine and its availability, delivery and effectiveness.

Refugees arriving in New Zealand will go into Managed Isolation and Quarantine (MIQ). They will observe the same COVID-19 health-related requirements as other arrivals to New Zealand.

- Refugees will arrive in small groups in a staged approach
- Refugees will be matched to the availability of MIQ spaces and confirmation of securing safe international travel and transit arrangements
- Refugees who arrive in New Zealand under the Refugee Quota Programme are granted Permanent Residence status in New Zealand and will not pay MIQ fees
- Refugees will have access to interpreters, health services and mental health support, supplemented with virtual welfare support provided by staff from Te Āhuru Mōwai o Aotearoa (the Māngere Refugee Resettlement Centre)
- Translated MIQ information and settlement resources will be provided.

After the required 14-day stay at MIQ, they will transfer to Te Āhuru Mōwai o Aotearoa (the Māngere Refugee Resettlement Centre). They will not depart Te Āhuru Mōwai O Aotearoa until housing has been secured in their settlement location.

While the plan for 2021-22 remains fluid, the current forecast for the Southern Region is:

- Dunedin – 70 refugees, ethnicities: Afghan and Syrian
- Invercargill – 40 refugees, ethnicity: Colombian.

WellSouth Primary Health Organisation (PHO)

On 26 and 27 May, WellSouth held a conference 'Former Refugee Mental Health and Wellbeing – Working Together, Learning from Each Other'. A brief synopsis follows, while a more thorough discussion will be provided in next month's Quarter 4 report.

26 May: The focus of this day was an overview of refugee resettlement with a specific emphasis on the local context and the factors which support positive resettlement. The three stages of the refugee journey were outlined and discussed.

Content focused on the fundamentals in building relationships with people from refugee backgrounds including how to communicate with interpreters using not only a culturally informed perspective but also blending in the essentials of trauma informed care.

Day 2: This day built on the relational work outlined in Day 1, with more focus on the mental health and wellbeing needs of former refugee populations. The keynote speaker was Dr Shirley Richards, Refugees as Survivors NZ (RASNZ).

20. Rural Health

Lakes District Hospital (LDH)

The winter plan has identified times of the day when the Emergency Department (ED) is vulnerable due to dependence on a single senior medical officer (SMO) in the evening. Options to provide a second doctor are being considered. There is also an opportunity to utilise a Physiotherapist for four hours per day in ED to see appropriate patients who do not require SMO input.

The concern about winter workload is highlighted by the advice from Queenstown airport that 40 flights per day are expected over winter. The ski fields have sold four times more seasons passes than previous years. Our experience is that this translates into more injuries and more presentations to ED. This is exacerbated by the lack of private radiology services in Queenstown in the evening or weekends, so all injured people come to ED. Visitors from across New Zealand also always present to ED, as their expectation is that public services are available, for the public.

Rural Hospitals

A new Heads of Agreement document has been offered to the four Rural Trust Hospitals whose existing contracts were due to expire on 30 June 2021. Negotiation about service schedules is underway.

Key areas of concern are:

- Pay parity
- Pay equity
- Increasing cost of inter hospital transfers
- Cost of Holidays Act remediation
- Impact of population growth
- Impact of service provision when existing providers exit a service due to financial unsustainability.

21. Director of Midwifery resignation

Heather LaDell resigned from her position as Director of Midwifery in May. Heather is leaving us to move to Wellington to pursue new opportunities and we wish her all the best for this new chapter in her life. Heather has made a significant contribution during her tenure at Southern DHB, firstly in her role as the Maternity Quality and Safety Programme (MQSP) Coordinator before moving into the acting and then permanent role as the Director of Midwifery. Heather has been actively involved in leading and supporting midwives across the system through some very challenging times as well as stretching herself to provide considerable involvement in the primary maternity strategy roll out. Heather has demonstrated her wholehearted commitment to improving services for women and babies. Heather's last day of work is Friday 11 June. Recruitment for a replacement is underway.

22. International Year of the Midwife 5 May and International Nurses Day 12 May

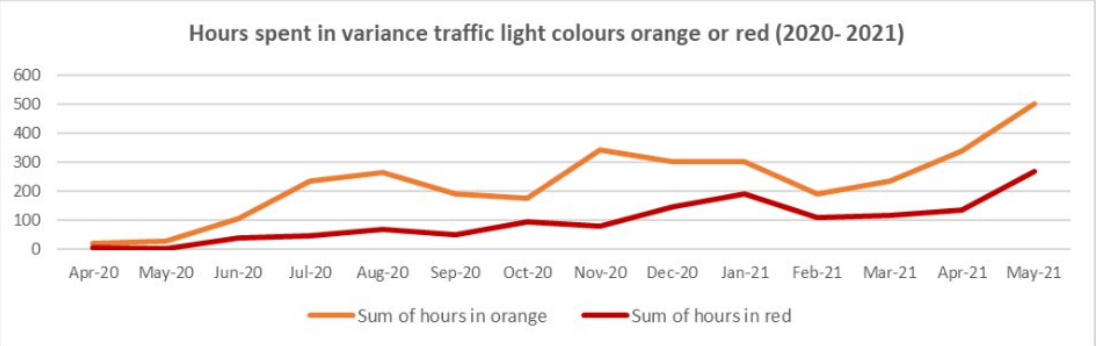
Very successful celebrations were held for both International Day of the Midwife and International Nurses Day held on the 5 and 12 May respectively. Displays in hospital foyers enabled patients and families to leave messages for nurses and these tributes were greatly appreciated. All nursing and midwifery staff were invited to an afternoon celebration hosted by the Otago Polytech School of Nursing, and some were able to attend. Leaders or their representatives of the five partnership institutions (Southern DHB, Southern Institute of Technology, Otago Polytech, University of Otago and WellSouth) shared what International Nurses' Day meant to them and a number of nurses also presented. Unfortunately,

technology let us down and the live Zoom and video recording was not successful. 'Me Time - Tea Time' events took place in a number of services to acknowledge the importance of self-care.

23. Safe Staffing and Care Capacity Demand Management (CCDM)

Southern DHB has completed the data extract process for all 34 wards that are part of the CCDM Programme in determining the FTE calculations for 2021/22. The Chief Nursing and Midwifery Officer, Executive Director Finance, Procurement and Facilities, and Executive Director Specialist Services have agreed at a high level on the recommended investment (at a macro level) and presented this for budget consideration. This involved extracting 12 months of data from TrendCare as per the documented methodology provided by the Safe Staffing Healthy Workplaces Unit (SSHWU) following moderation. As soon the DHB's overall budget is approved, we can confirm the exact investment in FTE and proceed to develop workable rosters at a Local Data Council level. While we await this approval, we are working on a recruitment and retention strategy that considers the impact on the Southern Health system more broadly, particularly changes in skill mix and workforce models of care.

In the meantime, despite significant FTE budget overruns in a number of wards, many due to patient watches, IDF inflows in the neonatal intensive care unit (NICU), and success in recruitment in some areas like the intensive care unit (ICU), Queen Mary maternity, negative shift variances remain consistently at about 25% at a Southern DHB wide view. There are concerning levels of negative shift variances continuing in a number of wards as follows: seventh floor wards between 34-46%, 4A 66%, 4C 44%, Maternity units between 37-53%, NICU 91%, Medical ward 42% and 9B 68%. Areas where staffing has been increased and recruitment has been successful have shown a marked reduction in negative shifts including wards 8Med and 3Surg. Multiple patient watches in 8Med have been able to be resourced from the Resource pool; however, this will show as a significant budget overrun in May.



Considerable concerns exist in being able to fill current RN vacancies let alone any additionally CCDM approved FTE with regulated staff going forward. This is now presenting as a national workforce crisis and is going to require some radical and urgent adjustment to different ways of working with non-regulated staff where that is appropriate and to a level that allows for safe direction and delegation. There will still be the requirement for a significant proportion of registered nurses (RNs) and enrolled nurses (ENs) to be employed and even usual replacement is a challenge. This may mean that there will be delays in recruitment until new graduates are available. The other real concern on our doorstep is the potential for a lot of nurses to move across to Australia (from now) or elsewhere once the boarders are more relaxed. There is a national meeting scheduled for all Chief Nurses/Directors of Nursing in Wellington on 24 June.

24. Staff Engagement Survey

The Staff Engagement Survey results were communicated out to the organisation in May. The organisational development team are working up an action plan that addresses the key organisational focus areas and specific areas of high risk at lower levels within the organisation, for example service areas. In summary:

- Themes of focus areas are:
  - Senior leaders communicating well and living the values
  - How change is managed
  - Addressing performance issues.
- There will be co-ordinated response via three layers of the organisation to the three focus areas above.
  - People Forum (at their next meeting how can this forum assist with actions to support)
  - Tiers 3, 4 and 5 Managers' response to the three themed areas plus additional actions for priority concerns with their services.
- The tool for tracking and reporting should be the tool that we used for the staff engagement survey.

25. Organisational Development

Organisational Development and Team Dynamics Workshops

The organisational development team facilitated further team development workshops during May including Supplies Department, Urology Outpatients (Dunedin) and Lakes District Hospital Leadership Group. Work has begun on reviewing Essential Corporate training expanding on the current portfolio to include a management 101 toolbox. The organisational development team are currently appraising a proposal from the Centre for Creative Leadership which details a modular approach to leadership development and the different leadership challenges experienced at various stages of the leadership pipeline (Leading Self/Others/Functions and so on). In addition, a cost-effective solution is still being sought with the Centre for Creative Leadership for a moderated program on resilience building with further options now being explored.

Other Development Programmes

Further workshops for Change Cycle, Psychological First Aid, a new series of workshops on the 'Accessibility Game' and our LEADS programme happening in June. These initiatives are aligned and in support of our previously established seven staff priorities. The organisational development team are also piloting 'Restorative Practice' workshops next month with a focus on early intervention conflict resolution. The organisational development team have been supporting the School for Change Agents Programme and will be assessing how the learnings can be embedded throughout the organisation. Staff wellbeing continues to be a focus and the organisational development team have been supporting key stakeholders such as the Aukaha Kia Kaha Committee including developing pulse wellbeing surveys for the organisation, trialling wellbeing apps and toolkits and enhancing our current staff benefits. The revision/refresh of the Speak Up program continues with further progression of online learning including modular programme and mobile applications, a speak up share point page and a revision of the speak up supporter role.

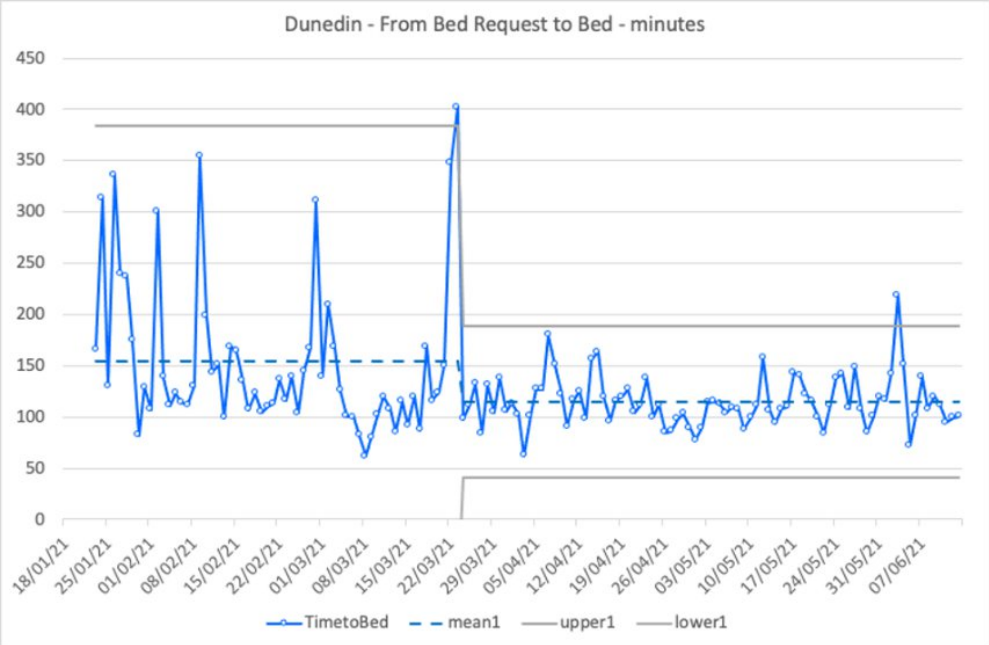
A successful organisational development planning day was held on 25 May which some members of Executive Leadership Team also attended. This was helpful in identifying areas of priority going forward.

26. Patient Flow

Stranded patients

The number and complexity of super-stranded patients remains challenging. Frequent meeting to support the clinical nurse specialist (CNS) working with this group and specific interventions as required.

Time from Bed Request to Bed - Dunedin



This is a chart of the average time each day between request for bed to leaving ED. The control limits are three standard deviations from the mean. Work is underway to render these types of charts as more formal statistical process control charts, but in the interim this model is very similar. There appears to have been progress. The first half of this control chart indicates and 'out of control' status with extreme variability. The second half shows a change. The variability has been reduced and the pattern now represents a controlled process. The mean has shifted down from 151 minutes to 114 minutes. A 'special cause variation' is now visible on 3 June. This was the Thursday before the holiday weekend and before the week of the strike. Now that we have a controlled process it is amenable to a more in-depth process analysis and targeted improvement. Such improvement is much harder, if not impossible, to achieve in an uncontrolled process. 114 minutes (average, with 50% above this) is still an exceedingly long time for a patient to be in ED waiting for a bed. It cannot be determined with certainty which of the bundle of interventions in patient flow has led to this change. It is likely a combination of many things. It is likely that the weekend planning processes play a significant part in combination with improvement in nurse staffing.

Acute Surgery

The directorate team are taking specific actions to improve the access of patients to acute theatre. This is an important strategy that will improve patient outcome and the control of bed occupancy. The latter is likely to improve access for elective surgery. It should be noted that there is no reporting of the number of patients requiring acute surgery who receive their surgery within the clinically appropriate time. This is a serious deficit in operational and clinical monitoring. Work is underway by the directorate team to resolve this. Clinical performance matters such as this should be part of regular reporting to the executive and to HAC (see below for more on this).

Discharge to Aged Residential Care (ARC)

Meetings have been held with local residential care providers to explore the challenges to safe and timely discharge. Access to discharge summaries by clinical staff in ARC and ensuring continuing prescription of medicines have been highlighted as issues that would reduce the barriers to discharge late in the day or at weekends.

HealthOne

It has been reported that a limit has been set by HealthOne (Pegasus) on the number of people in each ARC facility that will be allowed to access Health Connect South (HCS) / HealthOne. We have been pressing for this access for some time (over 12 months) and is very frustrating to have such an external control such as this. A request will be made to the HealthOne team to relax this restriction. If they cannot do this then we will need to seek an alternative. We do have the option of allowing access to HCS directly without HealthOne access. This would be a deviation from previously agreed processes but may be necessary. The utility of HealthOne low for primary HCS users. The data in H1 has not substantively changed since the original inception close to 10 years ago. The most valuable data is that on medicines – GP prescribed and Community Pharmacy dispensed. Community prescribed medicines are now available electronically from the NZ ePrescription Service. A pilot is being run in partnership with Orion health and Canterbury DHB to make these available directly in HCS. Clinicians in Southern DHB are taking part in this. If this is successful it calls into the question the value of continuing to fund HealthOne.

Prescribing Directly in ARC Medicines Systems

An investigation is in progress to develop a pilot that would allow prescribing of medicines in the native system in Residential Care. A community pharmacist has offered to provide training for this, and a working group will work through the issues to assess whether this is possible.

Discharge Summaries

Preparation of discharge summaries appears to a contributor to delays in discharge and overload for resident medical officers (RMOs). This has been revied building on work done in Southland. An outline of the problems has been prepared and will form the core a project to change the process and support technology. This will involve GPs, RMOs, SMOs, AHP, Nursing, Southern DHB IT and Orion Health. The goal is a process that is continuous and not a last-minute rush supported by technology that is easy to use. Also, clarifying the purpose and limiting the content of summaries to the essential.

27. Clinical Leadership

Several Clinical Directors (CDs) have decided not to continue in their positions. This includes the CDs of Rheumatology, ED Southland, Cardiology, Child Health and Neonatology Dunedin, Radiology Southland, Radiation Oncology and Medicine Southland. Most will be replaced shortly, some already completed, but others may take more time. The Medical Directors (MDs) are leading the appointment processes. Most of the potential gaps are in the medicine area.

The CDs workshop in Balclutha was a positive team building event. A need for ongoing development was identified. A draft curriculum has been developed and now we are fitting available opportunities to that model. The agreed starting point was difficult conversations and conflict resolution. There will also be work on service planning to ensure that the clinical leaders are actively engaged and taking some leadership in this.

28. GP SMO Interface Workshop

This workshop was held on 11 May. A very constructive evening workshop facilitated by local GPs, the College and the Chief Medical Officer Office. A positive engagement that led to

several options which are being explored. There was a positive commitment to make change to improve flow for patients particularly when acutely unwell. The DHB Clinical Leaders and GPs found a collective agreement on some of the problems. These are being explored by a small group with the intention to go back to the group with options.

29. Mental Health, Addiction and Intellectual Disability Directorate (MHAID)

Aroha Ki Te Tamariki Trust Mirror Services 30 year Symposium

Mirror Services celebrated 30 years of Transformational Change with 240 people in attendance. The symposium was fully subscribed with many other people keen to attend but not able to due to venue capacity. A smaller group gathered for a evening session. Both sessions had inspirational presentations from a number of individuals and groups with the highlight being the session by Judge Beecroft.

Request for Proposal (RFP) – Community Based Withdrawal Service

The RFP was issued on Friday 9 April with a closing date of 7 May. The RFP is seeking proposals for the provision of a Community Based Withdrawal Service, comprising of 1.6 FTE specialist nurses to cover a geographical area of Invercargill, Southland District and Queenstown Lakes.

By the closing date of 7 May we had received only one proposal for consideration. We decided to extend the closing date out to Friday 21 May. We have subsequently received a further proposal for consideration.

An Evaluation Panel has been established comprising of an Alcohol and Other Drug (AoD) clinician, Maori Health advisor, consumer advisor, senior management and a procurement specialist. The Panel is scheduled to meet in the week commencing Monday 31 May to consider and score the proposals received. The Panel will then make a recommendation to the Project Sponsor (Executive Director Gilbert Taurua) on a preferred proposal (assuming there is one).

The aim is to have a service commissioned by September 2021.

Ombudsman United Nations Optional Protocol to the Convention Against Torture (OPCAT) unannounced visits

Unannounced visits occurred for Wards 6C (Dunedin Hospital) and 10A, and Helensburgh Cottage (both on the Wakari site) during the week 3 to 7 May 2021. A range of information has been sought from both services. Charge Nurse Manager, Murray Gordon has completed compiling the requested information and returning to the OPCAT Team who visited 10A and the Cottage. Preliminary observations were made by the OPCAT Team at the completion of their visit, and a full report will follow in due course.

The OPCAT Team reviewing 6C followed a different process of review, conducting a range of interviews via video link subsequent to their visit. Again, the OPCAT Team provided some initial feedback and have advised that they will provide a provisional report to the facility manager and relevant senior managers toward the end of July.

Collaboration to Transform the way in which Mental Health and Addiction Services are Delivered

The Ministry have commenced the roll out of plans to support the implementation of He Ara Oranga mental health and addiction system transformation. The Ministry have signalled their intention to contract with DHBs to undertake collaborative system design, led by DHBs but engaging all stakeholders. The intention includes funding for DHBs to expand and support the implementation of system changes. The Chief Māori Health Strategy and Improvement Officer and MHAID General Manager met with the Ministry and are awaiting a contract. This initiative will intersect with the Independent Review of the Southern Mental Health and Addiction System currently in progress.

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

The review continues to progress within expected timeframes. Synergia presented their initial findings to the Board meeting in May. Information continued to be requested by Synergia during May and a number of people and groups, for example, families submitted information to Synergia. A draft report is expected to be complete by the end of June.

Psychosocial Mental Wellbeing Recovery

The group made up of Southern DHB, WellSouth, Queenstown Lakes District Council, Central Lakes Family Service and Mana Tahuna continues to meet regularly. Current work plans are focussing on monitoring surge and capacity, delivering workshops to the community, building relationships with the community (Small business, migrant, youth, maternal wellbeing and elderly) and considering communication options. The mental wellbeing navigator is working through an orientation programme, a directory is being developed and funding applications for further workshops have been submitted.

Youth Lived Experience Group

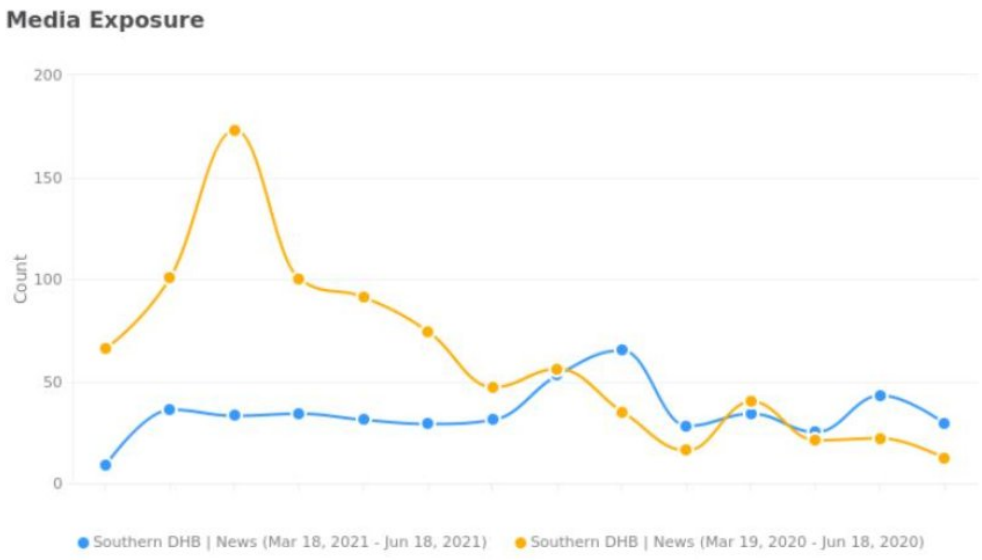
The MHAID Directorate youth advisor has established a Dunedin-based Youth Advisory Group. The group meets monthly and has now met twice. The Terms of Reference (ToR), based on Moving Forward ToR, are still being finalised and the responsible service manager will attend the group in June as part of bedding in the group function and processes.

Peer Support Development in Central Lakes

The Peer group in Wanaka has been successful in obtaining some funding for a trial Peer Support Service which includes individual work, creative arts and ukulele sessions. This has been well received and attended. The Wanaka group connects in through Moving Forward to the local Mental Health and Addiction Local Network Leadership Group. This group have been successful in gaining sponsorship and are setting up as a Charitable Trust so they can expand their reach.

30. Communications

Media volumes are now relatively consistent with 2020, compared to the disparity in previous months due to the COVID outbreak.



Focal areas have included the roll out of the COVID vaccine, including the clinics for Māori and Pasifika, and the impact of the need to manage bookings in line with available supply

of vaccine. The rollout of the COVID vaccine programme remains an intensive area of focus for communications, as we have moved into vaccinating group 3 population. We have been delighted by the community support for the programme, with a promotional video featuring the Highlanders in production, and a clinic walk-through hosted by Dunedin opera star Jonathan Lemalu – please view it here https://youtu.be/Tfypj9VFTts

A possible COVID case in Stewart Island also generated interest and is a reminder of the importance of the vaccination effort.

Other areas of media interest and communications activity have included the nurses strike, the endorsement by the board of a primary birthing unit in Wanaka, questions around sterilisation of equipment, and cancer waiting times.

There has been considerable coverage surrounding the New Dunedin Hospital, including the Detailed Business Case, call for expressions of interest from digital providers, the University's vision for a health precinct and discussions about carparking.

Chris Fleming
Chief Executive Officer

29 June 2021

Appendices

1. COVID Vaccine Dashboard

Patient Analysis

Patients enrolled at a practice within Southern PHO's and eligible for COVID vaccination

Date: 2/26/2021 – 6/16/2021

TLA (Domicile): All

Age Group: All

Ethnicity (Level 2), Su...: All

Gender: All

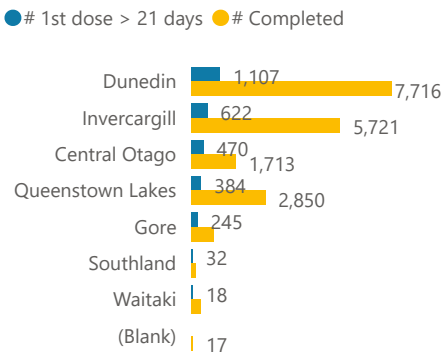
Case Reason: All

Enrolled Practice: All

16 Jun 2021
Latest CIR Data

55,949	37,014	2,878	19,012
Actuals (CIR)	# of Patients	# 1st dose > 21 days	# Completed

1st dose > 21 days and # Completed by TLA



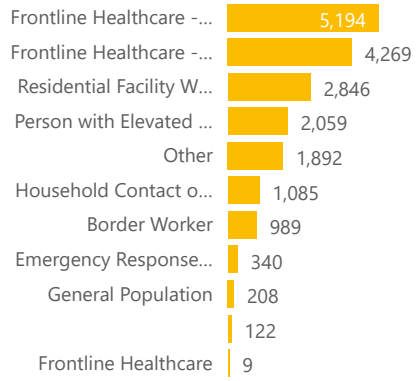
Age Analysis

Age Group	# of Patients (eligible and enrolled)	Actuals (CIR)	% Completed
85	7,411	3,411	12.7%
80-84	8,022	3,104	8.0%
75-79	11,150	4,319	7.1%
70-74	16,011	6,240	7.5%
65-69	18,384	6,622	8.6%
60-64	21,416	5,008	9.8%
55-59	21,664	4,774	9.5%
50-54	21,163	4,304	8.9%
Total	**259,779**	**55,949**	**7.3%**

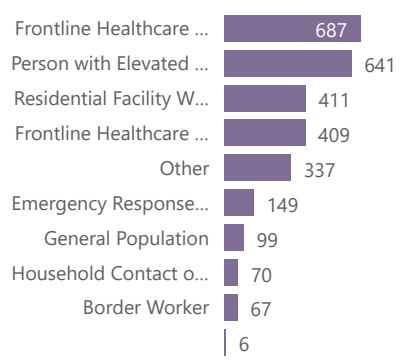
Gender Analysis

Gender	# of Patients (eligible and enrolled)	Actuals (CIR)	% Completed
Female	133,366	36,265	9.8%
Male	126,347	19,676	4.7%
O	5		
Unidentified	61	8	4.9%
Total	**259,779**	**55,949**	**7.3%**

Completed by Case Reason



1st dose > 21 days by Case Reason



Ethnicity Analysis

Ethnicity (Level 2)	# of Patients (eligible and enrolled)	Actuals (CIR)	% Completed
Asian	13,824	3,373	10.4%
European	216,021	48,350	7.4%
Māori	20,479	2,637	4.8%
Middle Eastern/Latin American/African	3,430	594	7.1%
Other Ethnicity	430	105	10.0%
Pacific Peoples	4,927	733	5.8%
Residual Categories	668	157	8.1%
Total	**259,779**	**55,949**	**7.3%**

FOR APPROVAL

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

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

Meeting of: Board, 6 July 2021

Recommendation

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

Purpose

1. **To provide the Board with the financial performance of the DHB for the month and year to date ended 31 May 2021.**

Specific Implications for Consideration

2. **Financial**

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

Next Steps & Action

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

Appendices

Appendix 1 **Financial Report for the Board**

Appendix 1: Financial Report for the Board

Southern DHB Financial Report

Financial Report for:	31 May 2021
Report Prepared by:	Finance
Date:	6 July 2021

Report to Board

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

The net deficit for the month of 31 May 2021 was $3.5m, being $2.3m unfavourable to budget. The result includes Business as Usual net deficit of $1.8m and COVID-19, Holidays Act 2003, New Dunedin Hospital Accelerated Depreciation and Digital Hospital Project Costs net deficit of $0.5m.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 May 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						
99,253	96,321	2,932	F	Government & Crown Agency	1,084,109	1,059,490	24,619	F	1,089,019	1,155,951
1,498	877	621	F	Non-Government & Crown Agency	12,108	9,651	2,457	F	11,047	10,528
100,751	97,198	3,553	F	*Total Revenue*	1,096,217	1,069,141	27,076	F	1,100,066	1,166,479
				EXPENSES						
39,963	37,467	(2,496)	U	Workforce Costs	437,460	421,436	(16,024)	U	484,392	462,125
4,146	3,823	(323)	U	Outsourced Services	42,465	40,393	(2,072)	U	41,837	43,556
9,793	8,272	(1,521)	U	Clinical Supplies	101,758	88,976	(12,782)	U	99,345	96,871
5,621	5,195	(426)	U	Infrastructure & Non-Clinical Supplies	56,148	55,208	(940)	U	63,258	60,354
41,523	40,083	(1,440)	U	Provider Payments	447,787	434,136	(13,651)	U	466,737	474,021
3,178	3,550	372	F	Non-Operating Expenses	33,783	36,821	3,038	F	34,951	40,469
104,224	98,390	(5,834)	U	*Total Expenses*	1,119,401	1,076,970	(42,431)	U	1,190,520	1,177,396
(3,473)	(1,192)	(2,281)	U	**NET SURPLUS / (DEFICIT)**	(23,184)	(7,829)	(15,355)	U	(90,454)	(10,917)

Revenue was $3.6m favourable to budget.

Government Funding included a further reduction of $0.3m related to under-delivery of Planned Care procedures. Offsetting this is unbudgeted revenue for COVID-19 $0.9m Vaccination Programme, $0.6m Surveillance & Testing and $0.5m Incremental Costs, in addition to $0.4m for Mental Health funding.

The revenue for COVID-19 Surveillance & Testing has been recognised to match expenditure. The recognition of $0.6m 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 $0.4m favourable to budget due to two long-stay patients discharged in May. Unfortunately, as one of these patients is not in a position to make payment there is a corresponding increase to the Doubtful Debts provision expense.

Expenses were $5.8m unfavourable to budget.

The Workforce costs were $2.5m unfavourable inclusive of $0.6m additional Holidays Act 2003 provision and $0.7m of Vaccination programme costs.

Nursing personnel were unfavourable $1.7m and 171FTE May ($9.1m and 76FTE unfavourable ytd) due to the following;

- Covid Vaccination Program commenced April with 12FTE increasing to 39FTE in May
- Ordinary time 51.7FTE over budget due primarily to;
    - Unmet savings in the Provider and Mental Health (42 FTE)
    - NICU 3FTE over budget as 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 patient watch hours were recorded as 26 FTE which is partially offset by the HCA budget increase of 13.3 FTE in 2020/21. This is an increase of 8FTE from April. This had a major impact on Medical ward 8A in Dunedin and continued impacts over the Southland Medical and Surgical wards.
    - Other wards were over their budgeted FTE, driven by patient watches, approved CCDM increases.
- Graduate and Post Grad Nursing cost centres were 8FTE over budget for the month however within budget year to date. Recruitment was budgeted February to April however the tail fell in to May. We expect this to be back within budget in June as clinical load sharing ceases and training is complete.
- Statutory FTE was over budget, consistent with prior months with stat days. This did not have an impact on dollars however as April accounts included more of the Mondayised ANZAC day than they should have.
- Other Leave FTE is not as favourable as prior months (2.7FTE verses 7.5FTE). A decision was made to code any sick leave resulting from vaccinations to other leave. The dollars are unfavourable due to the accrual for the Holidays Pay Act correction.
- Sick leave unfavourable by 17.6FTE which is 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 $1.5m unfavourable, reflecting higher Treatment Disposables, Pharmaceuticals expenditure and Other Clinical Costs (including Air Ambulance) which was partially offset by lower Implants & Prostheses costs.

Provider Payments were $1.4m unfavourable, reflecting unbudgeted Mental Health expenditure (offset by additional revenue), higher Community Pharmaceutical expenditure and COVID-19 Surveillance and Testing expenses.

Revenue (Year to Date)

Overall, Revenue is $27.1m favourable to budget year to date.

Government and Crown Agency revenue is $24.6m favourable, including additional funding for COVID-19 $13.0m, Primary Mental Health & Addiction $2.9m and Community Pharmaceuticals $2.5m. These revenue streams have a direct connection to expenditure. The Community Pharmaceutical revenue has been revised down based on Pharmac advice to the Ministry of Health (MoH). The limitation on bed capacity continues to impact on the achievement of Planned Care delivery resulting in a revenue reduction of $2.7m. The Capital Charge funding has been reduced by $1.9m to align with the change in the Treasury rate from 6% to 5%.

Non-Government & Crown Agency revenue is $2.5m favourable to budget. The recognition of the donated clinical equipment and PPE from the Ministry of Health of $3.3m has more than offset the reduced Non Resident revenue of $0.4m.

Expenditure (Year to Date)

Total Expenses year to date is $42.4m unfavourable to budget.

The Workforce costs are $16.0m unfavourable year to date. This includes $6.9m of Holidays Act 2003 liability and $2.7m for COVID plus $1.0m for New Dunedin Hospital which was not budgeted. The $5.3m Business as Usual includes clerical pay equity payments and increased medical workforce costs associated with locum cover, patient watches, reduced annual leave taken, increased overtime and other leave.

Outsourced Clinical Services are $2.3m unfavourable year to date reflecting additional costs incurred for delivery of patient and elective services.

Clinical Supplies are $12.8m 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 Pharms are offset by $2.5m of additional revenue.

Provider Payments are $13.7m unfavourable year to date; comprising payments to NGOs supporting COVID-19 activity, including $8.3m COVID-19 testing in the community, $2.9m for Mental Health & Addiction and $0.9m for Community Pharmaceuticals. The Disability Support payments for Residential Care are $2.2m unfavourable as there has been a higher than expected volume of hospital level care for patients.

Year to Date Results – By Key Drivers

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

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 31 May 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	1,084,109	11,417	1,567	-	-	-	-	1,071,125	1,059,490	11,635	F
Non-Government & Crown Agency	12,108	3,156	-	-	-	-	-	8,952	9,651	(699)	U
Total Revenue	1,096,217	14,573	1,567	-	-	-	-	1,080,077	1,069,141	10,936	F
EXPENSES											
Workforce Costs	437,460	1,628	1,150	6,921	-	900	131	426,730	421,436	(5,294)	U
Outsourced Services	42,465	(3)		-	-	-	-	42,468	40,393	(2,075)	U
Clinical Supplies	101,758	570	8	-	-	-	-	101,180	88,976	(12,204)	U
Infrastructure & Non-Clinical Supplies	56,148	153	260	-	1,852	262	160	53,461	55,208	1,747	F
Provider Payments	447,787	9,815	149	-	-	-	-	437,823	434,136	(3,687)	U
Non-Operating Expenses	33,783	-	-	-	-	-	-	33,783	36,821	3,038	F
Total Expenses	1,119,401	12,163	1,567	6,921	1,852	1,162	291	1,095,445	1,076,970	(18,475)	U
NET SURPLUS / (DEFICIT)	(23,184)	2,410	-	(6,921)	(1,852)	(1,162)	(291)	(15,368)	(7,829)	(7,539)	U

Financial Position Summary

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

Actual 30 Jun 2020 $000		Actual 31 May 2021 $000	Budget 31 May 2021 $000	Actual 30 Apr 2021 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	19,424	7	26,092	7
49,819	Trade & Other Receivables	57,345	54,628	53,238	48,830
6,095	Inventories	6,060	5,105	6,277	5,235
86,925	*Total Current Assets*	82,829	59,740	85,607	54,072
	NON-CURRENT ASSETS				
326,463	Property, Plant & Equipment	326,174	353,476	325,543	355,122
3,307	Intangible Assets	6,138	19,722	6,314	20,149
329,770	*Total Non-Current Assets*	332,312	373,198	331,857	375,271
416,695	**TOTAL ASSETS**	415,141	432,938	417,464	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	14,118	-	16,259
64,666	Payables & Deferred Revenue	70,199	64,971	72,052	64,494
962	Short Term Borrowings	234	955	397	955
88,645	Employee Entitlements	97,899	90,239	95,338	85,533
154,273	*Total Current Liabilities*	168,332	170,284	167,787	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	865	1,025	874	1,018
75,528	Holidays Act 2003	82,017	6,308	81,403	-
19,810	Employee Entitlements	19,810	19,810	19,810	19,810
96,429	*Total Non-Current Liabilities*	102,692	27,143	102,087	20,828
250,702	**TOTAL LIABILITIES**	271,024	197,427	269,874	188,069
165,993	**NET ASSETS**	144,117	235,511	147,590	241,274
	EQUITY				
485,955	Contributed Capital	487,263	522,899	487,265	531,750
108,500	Property Revaluation Reserves	108,500	108,502	108,500	108,502
(428,462)	Accumulated Surplus/(Deficit)	(451,646)	(395,890)	(448,175)	(398,978)
165,993	*Total Equity*	144,117	235,511	147,590	241,274
	Statement of Changes in Equity				
172,410	Opening Balance	165,993	206,398	165,993	206,398
(90,454)	Operating Surplus/(Deficit)	(23,184)	(7,829)	(19,711)	(10,917)
84,744	Crown Capital Contributions	1,308	36,942	1,308	46,500
(707)	Return of Capital	-	-	-	(707)
165,993	Closing Balance	144,117	235,511	147,590	241,274

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 May 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	1,083,197	1,056,397	26,800	1,156,983	1,011,935
Non-Government & Crown Agency Revenue	9,971	9,438	533	10,296	9,862
Interest Received	308	213	95	232	262
Cash was applied to:					
Payments to Suppliers	(660,817)	(627,438)	(33,379)	(675,364)	(619,685)
Payments to Employees	(413,450)	(445,457)	32,007	(499,568)	(392,030)
Capital Charge	(4,124)	(6,263)	2,139	(12,605)	(5,138)
Goods & Services Tax (net)	602	(1,092)	1,694	(486)	3,223
Net Cash Inflow / (Outflow) from Operations	15,687	(14,202)	29,889	(20,512)	8,429
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	6	-	6	-	4
Cash was applied to:					
Capital Expenditure	(27,633)	(67,161)	39,528	(72,294)	(30,292)
Net Cash Inflow / (Outflow) from Investing Activity	(27,627)	(67,161)	39,534	(72,294)	(30,288)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	1,308	36,941	(35,633)	45,763	4,306
Cash was applied to:					
Repayment of Borrowings	(954)	(702)	(252)	(220)	(758)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	354	36,239	(35,885)	45,543	3,548
Total Increase / (Decrease) in Cash	(11,586)	(45,124)	33,538	(47,263)	(18,311)
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	19,425	(14,113)	33,538	(16,252)	(28,199)

Cash flow from Operating Activities is favourable to budget by $29.9 million. Revenue received and Payments to Suppliers are in line with the Statement of Financial Performance. However Payments to Employees is favourable as the budget included payments for the Holidays Act 2003 and the Capital Charge payment is lower than budgeted with the reduction in rate from 6% to 5%.
Cash flow from Investing Activities is favourable to budget by $39.5m. 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 $35.9m. 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 $33.5m.

Capital Expenditure Summary

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

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	7,339	25,129	17,790	U	11,216
Clinical Equipment	13,482	14,506	1,024	U	12,228
Other Equipment	756	869	113	U	386
Information Technology	2,663	9,201	6,538	U	2,908
Motor Vehicles	14	-	(14)	O	3
Software	3,378	17,456	14,078	U	3,551
Total Expenditure	27,632	67,161	39,529	U	30,292

At 31 May 2021, our Financial Position on page 5 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $332.3m, which is $40.9m less than the budget of $373.2m.

Land, Buildings & Plant variance of $17.8m YTD reflects changes to the timing of the following projects Critical Infrastructure Works, the new Sterile Services Facility, the Tenth Operating Theatre/PACU and Southland Chillers for general air-conditioning.

Information Technology and Software variance combined at $20.6m 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 has been cancelled.

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

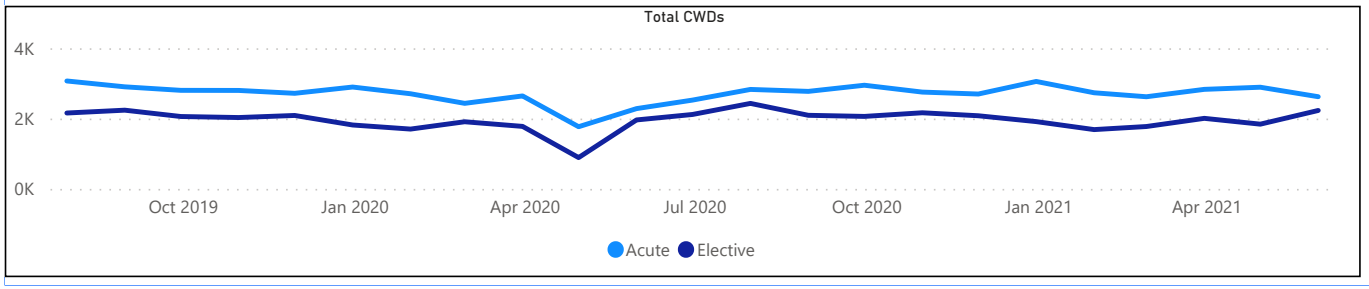
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year On Year YTD Variance
Surgical Caseweights												
Surgical Elective	1,499	1,535	-35	-2	1,319	180	14,334	14,797	-463	-3	13,552	781
Surgical Acute	1,074	1,287	-214	-17	884	190	13,388	13,392	-4	0	12,336	1052
Total	**2,573**	**2,822**	**-249**	**-9**	**2,203**	**370**	**27,721**	**28,189**	**-468**	**-2**	**25,888**	**1833**
Medical Caseweights												
Medical Elective	366	311	54	17	288	77	3,782	3,161	620	20	3,383	399
Medical Acute	1,413	1,507	-94	-6	1,247	166	16,217	15,726	491	3	15,542	674
Total	**1,778**	**1,818**	**-40**	**-2**	**1,535**	**243**	**19,998**	**18,887**	**1,111**	**6**	**18,925**	**1073**
Maternity Caseweights												
Maternity Elective	365	370	-4	-1	353	12	4,168	3,858	310	8	3,695	473
Maternity Acute	135	94	42	45	152	-17	1,152	976	175	18	1,146	5
Total	**501**	**463**	**38**	**8**	**505**	**-5**	**5,320**	**4,835**	**485**	**10**	**4,842**	**478**
Total	**4,852**	**5,103**	**-251**	**-5**	**4,244**	**608**	**53,039**	**51,910**	**1,129**	**2**	**49,654**	**3385**

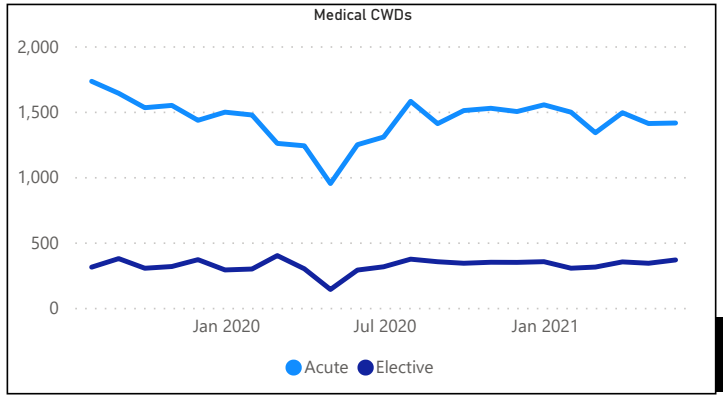
TOTALS

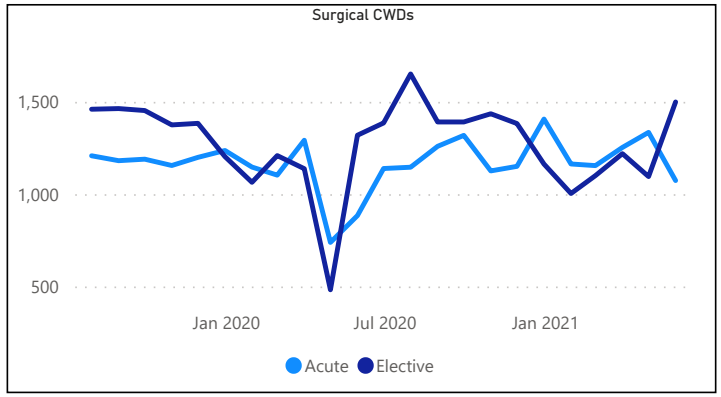
Acute	2,622	2,888	-266	-9	2,283	339	30,756	30,094	662	2	29,024	1732
Elective	2,231	2,216	15	1	1,961	270	22,283	21,816	467	2	20,630	1653
Total	**4,852**	**5,103**	**-251**	**-5**	**4,244**	**608**	**53,039**	**51,910**	**1,129**	**2**	**49,654**	**3385**

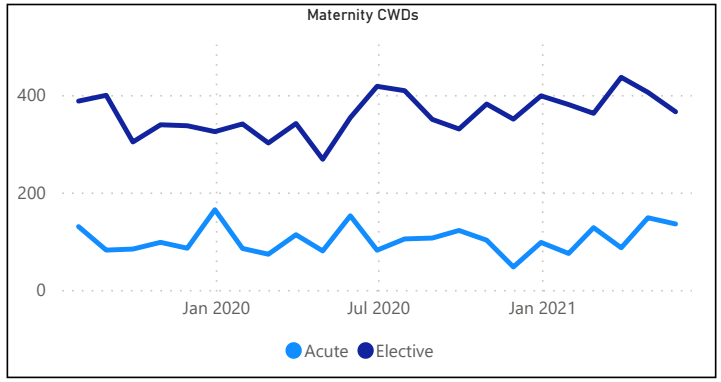
TOTALS excluding Maternity

Acute	2,486	2,794	-308	-11	2,131	355	29,604	29,118	486	2	27,878	1726
Elective	1,865	1,846	19	1	1,608	258	18,115	17,958	157	1	16,935	1180
Total	**4,352**	**4,640**	**-289**	**-6**	**3,739**	**613**	**47,720**	**47,076**	**644**	**1**	**44,813**	**2907**









8.2

SERVICE PROVIDER RAW DISCHARGES

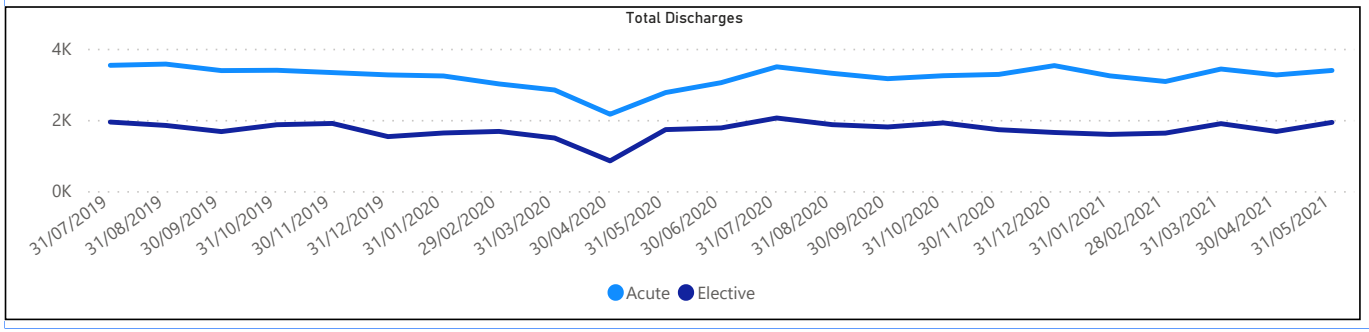
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Surgical Discharges												
Surgical Elective	966	1,075	-109	-10	918	48	9,878	10,370	-492	-5	9,202	676
Surgical Acute	822	834	-12	-1	688	134	9,019	8,674	345	4	8,255	764
Total	**1,788**	**1,909**	**-121**	**-6**	**1,606**	**182**	**18,897**	**19,044**	**-147**	**-1**	**17,457**	**1440**
Medical Discharges												
Medical Elective	433	355	78	22	305	128	4,335	3,663	672	18	3,667	668
Medical Acute	2,469	2,409	60	2	1,980	489	26,388	25,140	1,248	5	25,268	1120
Total	**2,902**	**2,764**	**138**	**5**	**2,285**	**617**	**30,723**	**28,804**	**1,919**	**7**	**28,935**	**1788**
Maternity Discharges												
Maternity Elective	531	495	36	7	504	27	5,510	5,162	348	7	5,253	257
Maternity Acute	98	83	15	17	100	-2	992	871	121	14	961	31
Total	**629**	**578**	**51**	**9**	**604**	**25**	**6,502**	**6,033**	**469**	**8**	**6,214**	**288**
Total	**5,319**	**5,251**	**68**	**1**	**4,495**	**824**	**56,122**	**53,880**	**2,242**	**4**	**52,606**	**3516**

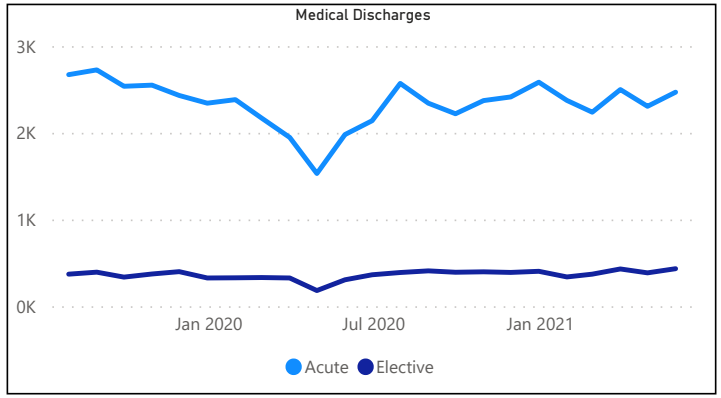
TOTALS

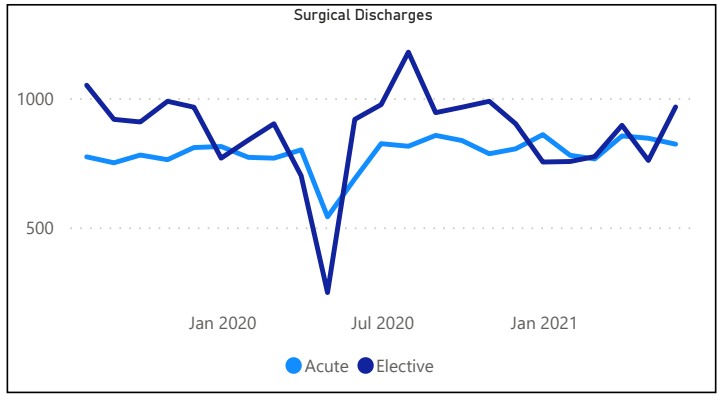
Acute	3,389	3,326	63	2	2,768	621	36,399	34,685	1,714	5	34,484	1915
Elective	1,930	1,925	5	0	1,727	203	19,723	19,195	528	3	18,122	1601
Total	**5,319**	**5,251**	**68**	**1**	**4,495**	**824**	**56,122**	**53,880**	**2,242**	**4**	**52,606**	**3516**

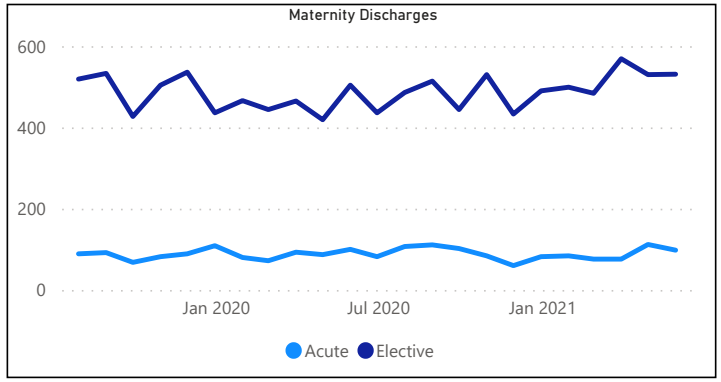
TOTALS excluding Maternity

Acute	3,291	3,243	48	1	2,668	623	35,407	33,814	1,593	5	33,523	1884
Elective	1,399	1,430	-31	-2	1,223	176	14,213	14,033	180	1	12,869	1344
Total	**4,690**	**4,673**	**17**	**0**	**3,891**	**799**	**49,620**	**47,847**	**1,773**	**4**	**46,392**	**3228**



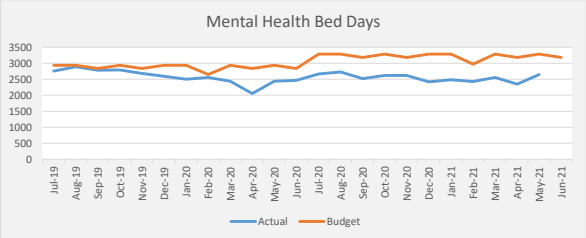




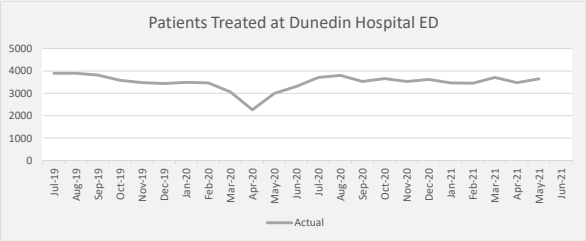


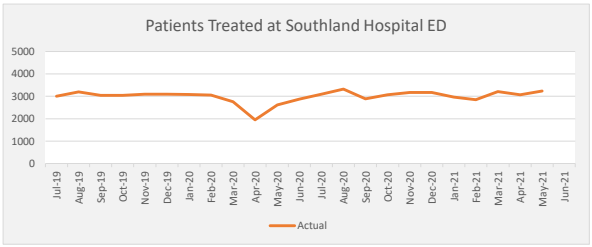
OTHER ACTIVITY

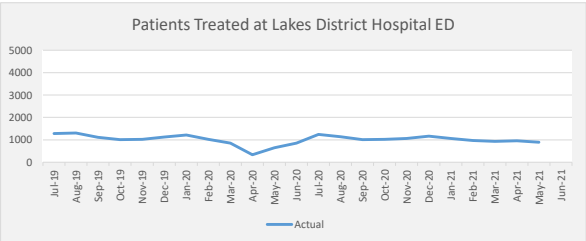
May-21				May-20	YEAR ON YEAR		YTD 2020/2021				YTD May-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,644	3,286	(642)	-20%	2,441	203	Mental Health bed days	28,040	35,510	(7,470)	-21%	28,473	(433)

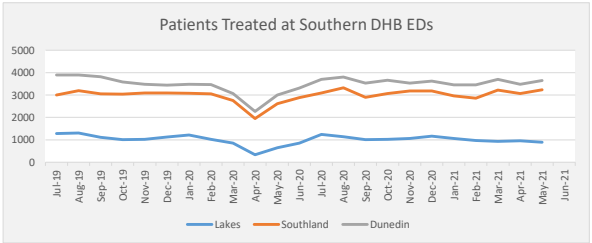


May-21	May-20	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD May-20	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,650	3,000	650	Dunedin	39,597	37,389	2,208
896	642	254	Lakes	11,439	10,894	545
3,231	2,615	616	Southland	34,060	31,928	2,132
7,777	6,257	1,520	**Total ED presentations**	85,096	80,211	4,885









FOR INFORMATION

Item: Quality Dashboard – June 2021

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

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – July 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
   - There is no equity analysis of the metrics currently reported. This will need to be corrected.
4. Other
   - Please note comments in the discussion section

Background

5. The Executive Quality Dashboard was created in 2019. It presents key metrics for the Southern region across the dimensions of effectiveness, patient experience, efficiency, and timeliness. It is intended to highlight clinical quality risks, issues, and performance at a system wide level.
6. The dashboard elements have 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. The last three months have seen highest no of complaints (based on data from last 24 months). Surgical Services and Radiology has seen biggest rise – up from 21 in Jan to 42 in Apr. Communications are the biggest issue – 48% of complaints are made up of poor comms with patient and/or family, attitude and manner of staff or inappropriate comments made by staff. Surgical and treatment delays is a growing issue. The key driver appears to be overworked staff – showing in patient & staff feedback and systems (short shifts, staff absence etc)

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.

11. Restraints appear to have jumped again however a longer view of the data shows that restraints do tend to peak and trough over time. This often due to that fact that one patient can have multiple restraint issues in a particular month.

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

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Appendices

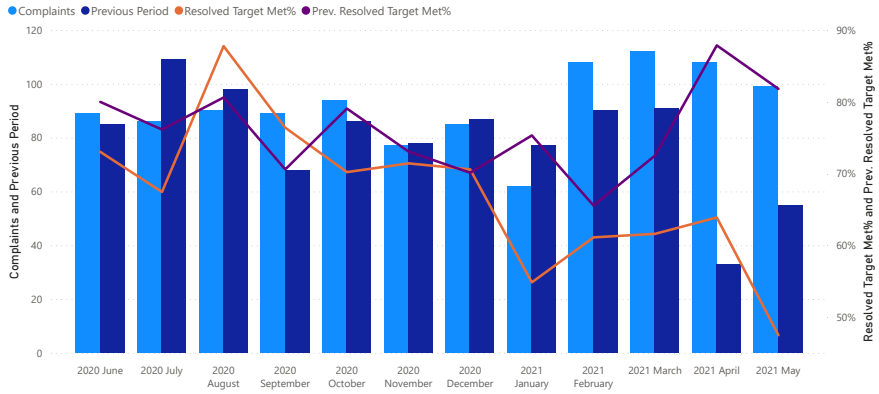
Appendix 1	**Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital**

Executive Dashboard - Patient Experience

(Southern)

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

BY YEAR, MONTH



Safety 1st data.

Complaints

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

Resolutions

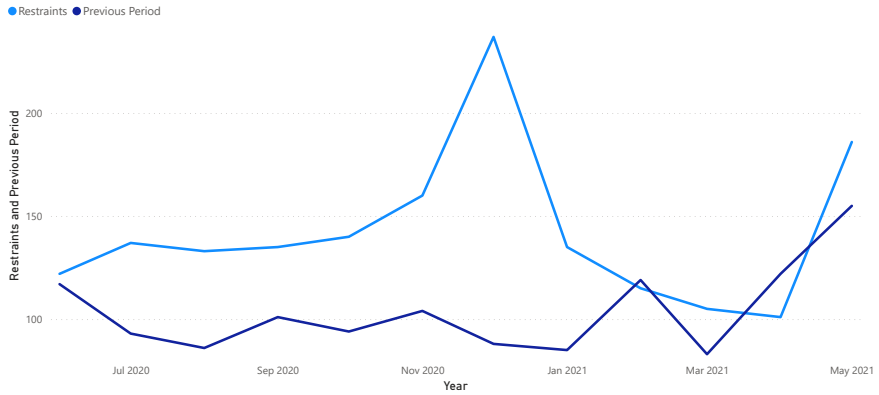
There is a one month (20 working days) time period for complaints to be resolved, or to communicate additional time required to the patient. For that reason the current reporting month will always appear as a lag.

The last three months have seen highest no of complaints – based on data from last 24 months.

- Surgical Services and Radiology has seen biggest rise – up from 21 in Jan to 42 in Apr.
- Communications are the biggest issue – 48% of complaints are made up of poor comms with patient and/or family, attitude and manner of staff or inappropriate comments made by staff
- A growing issue is surgical and treatment delays
- The key driver appears to be overworked staff – showing in patient & staff feedback and systems (short shifts, staff absence etc)

Southern - Restraints, Previous Period

BY YEAR, MONTH



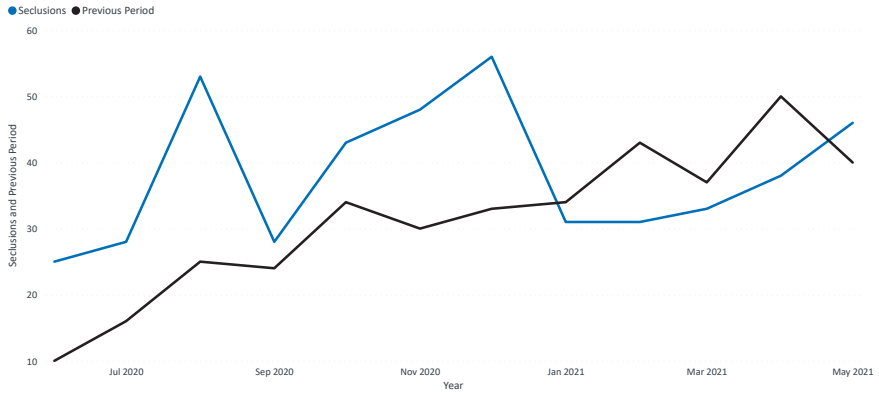
Restraints

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

Restraints appear to have jumped again however a longer view of the data shows that restraints do tend to peak and trough over time. This often due to that fact that one patient can have multiple restraint issues in a particular month

Southern - Seclusions, Previous Period

BY YEAR, MONTH



Seclusions

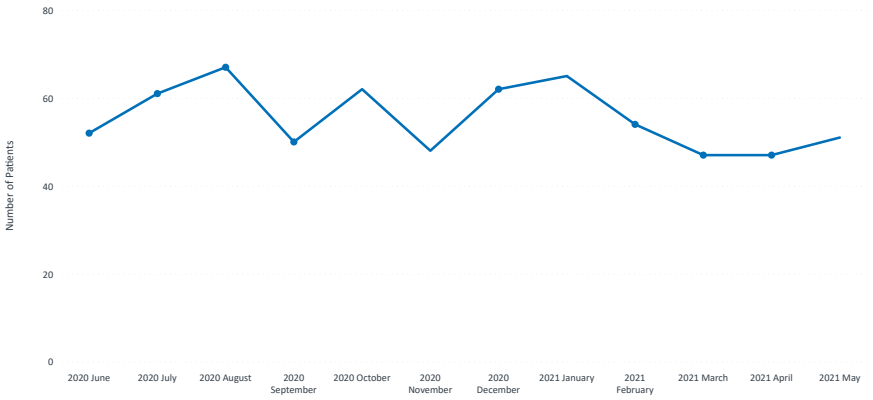
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Southern)

Southern - Deaths

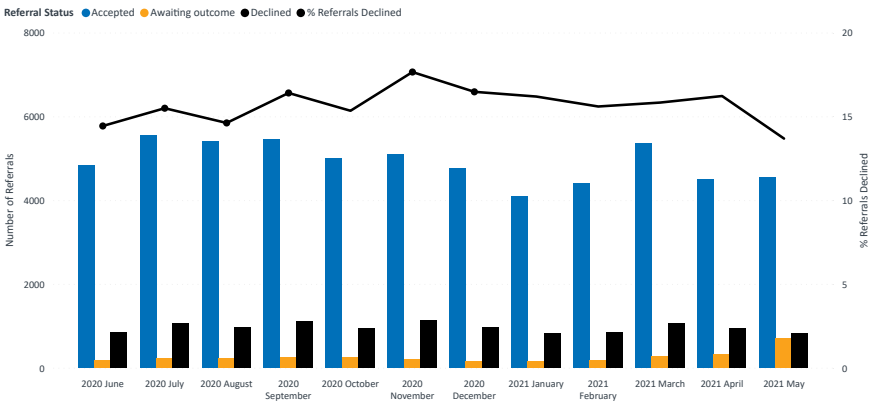
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths

Number of patients deceased by discharge month.

Southern - Referrals Accepted / Awaiting Outcome and Declined

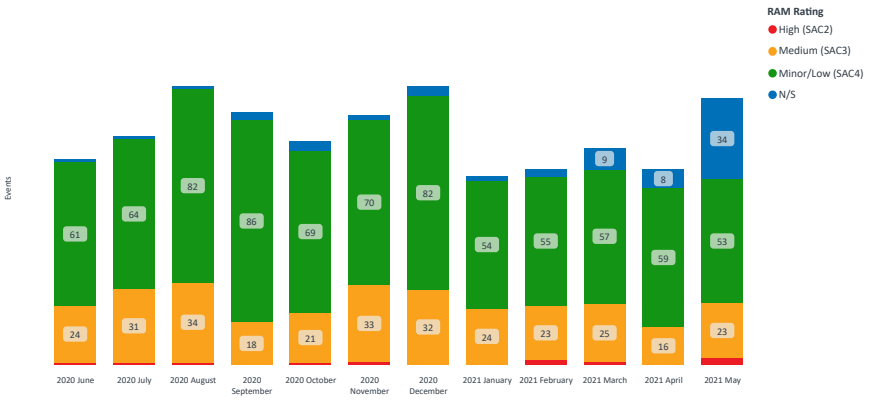


Referrals accepted (authorised), awaiting outcome or declined by month.

% 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).

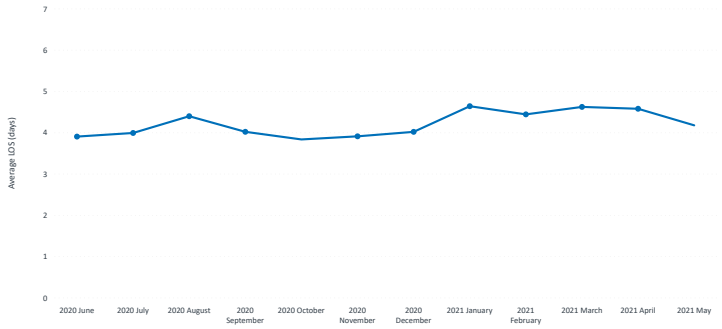
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls forms (visitor falls) which are not associated with clinical practice. These events are not assessed in the same way as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

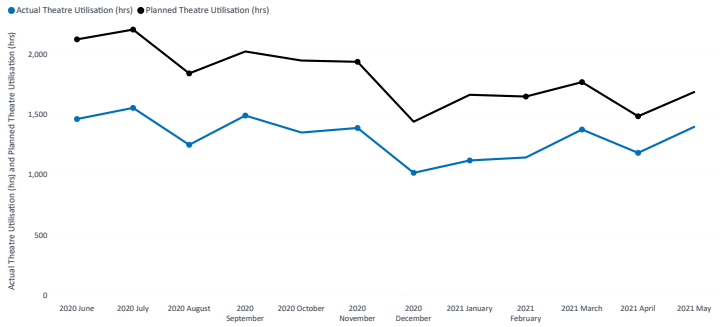


Average Length of stay

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



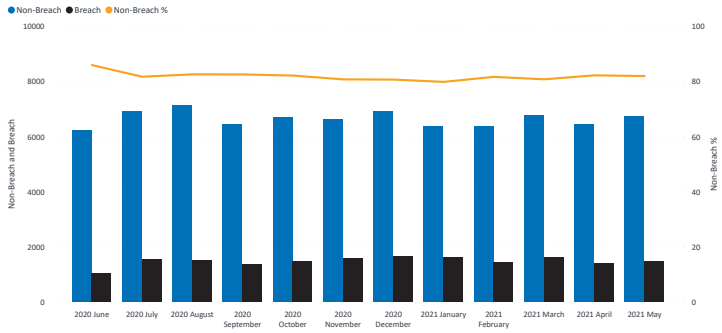
Actual Theatre Utilisation

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

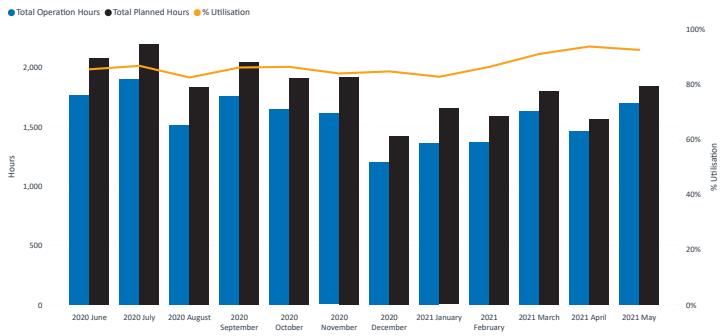
Southern - Monthly 6 Hour %



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 (%)



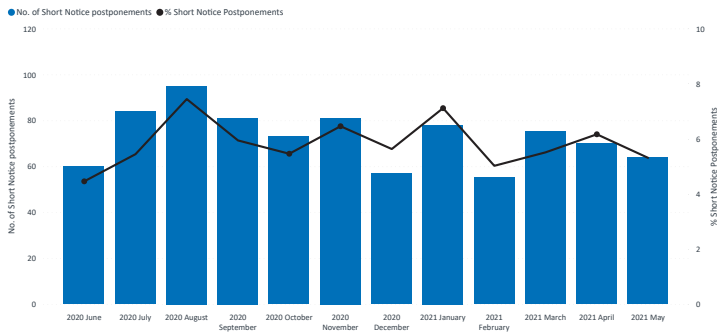
Average Theatre Utilisation (%)

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



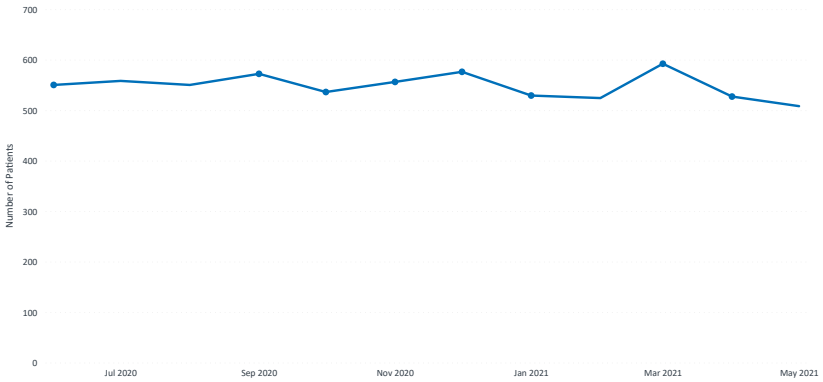
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Southern)

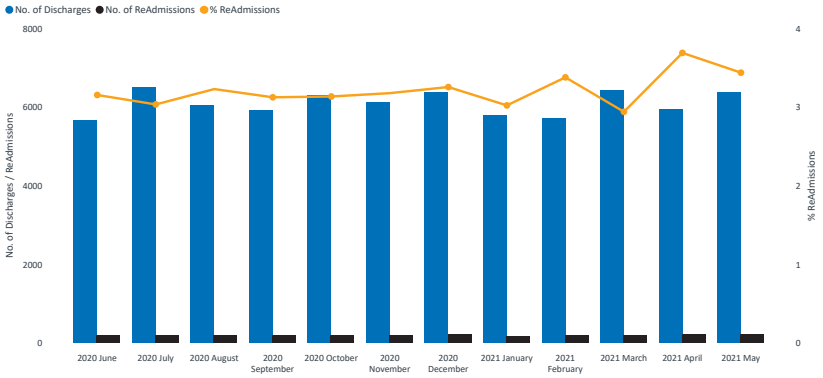
Southern - Number of Patients with LOS > 7 days



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

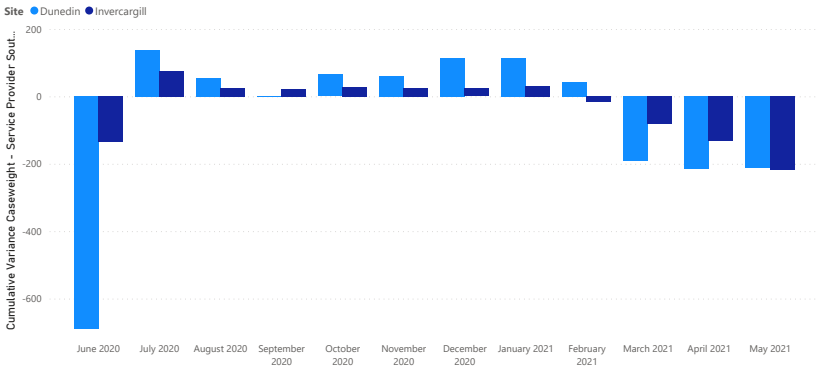


Unplanned Hospital Readmissions within 7 Days

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



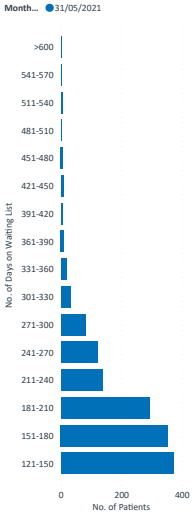
Cumulative Variance Caseweight

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.

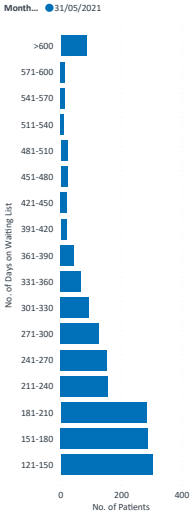
Southern - ESPI 2 Breaches

FOR THE LAST COMPLETED MONTH



Southern - ESPI 5 Breaches

FOR THE LAST COMPLETED MONTH



ESPI 2 and ESPI 5

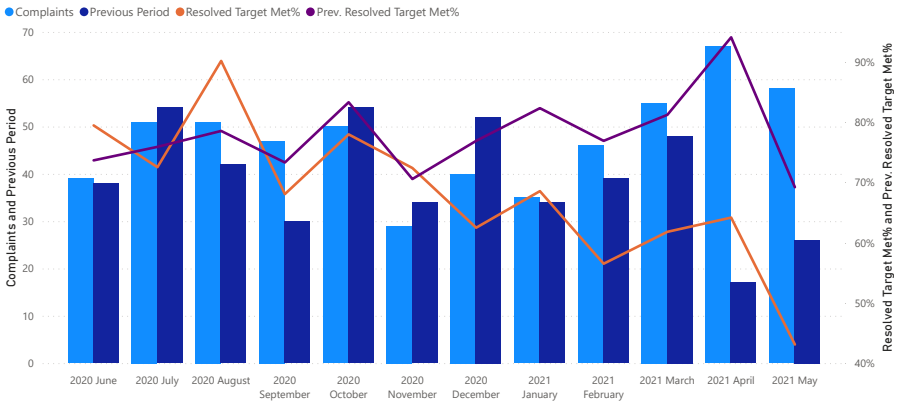
ESPI 2 and ESPI 5 waitlists organised into the given time buckets

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.

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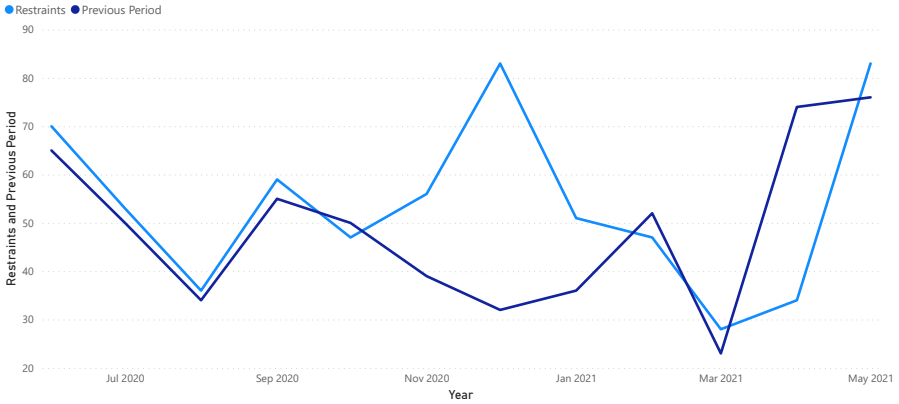
- The key driver appears to be overworked staff – showing in patient & staff feedback and systems (short shifts, staff absence etc)

Dunedin - Restraints and Previous Period

BY YEAR AND MONTH



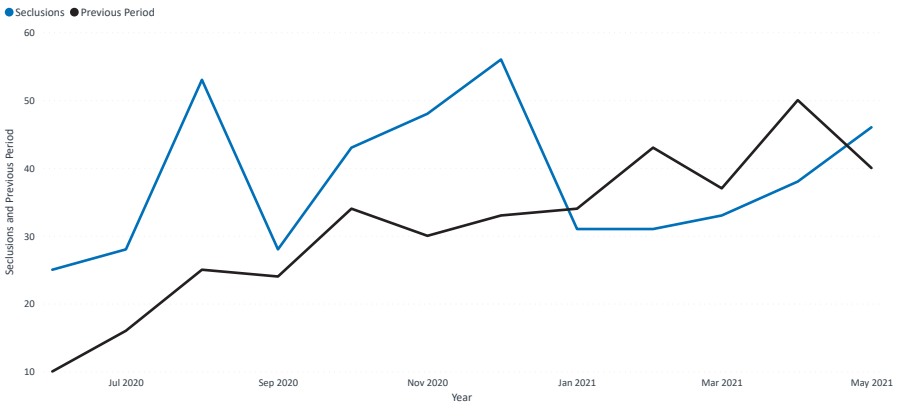
Restraints

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

Restraints appear to have jumped again however a longer view of the data shows that restraints do tend to peak and trough over time. This often due to that fact that one patient can have multiple restraint issues in a particular month

Dunedin - Seclusions and Previous Period

BY YEAR AND MONTH



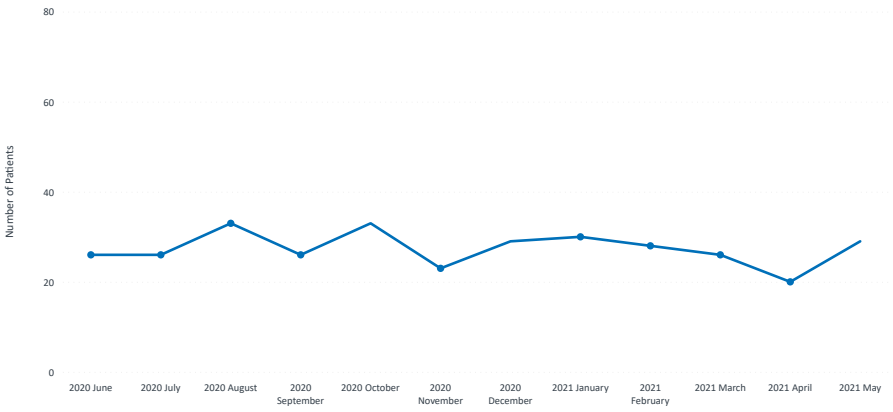
Seclusions

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

Executive Dashboard - Effectiveness

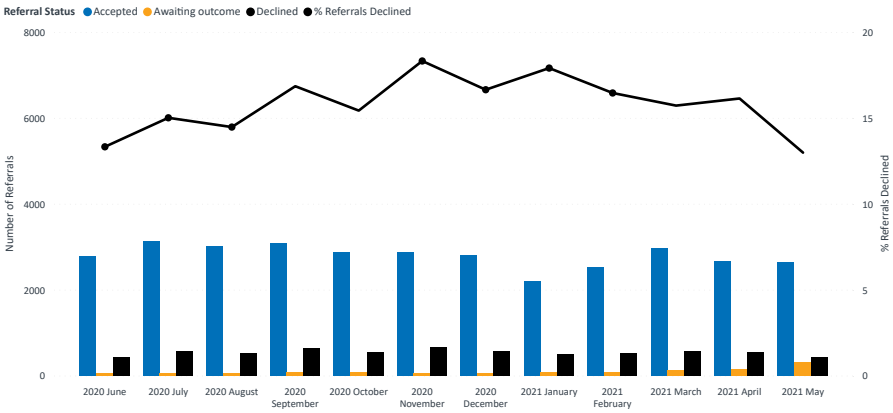
(Dunedin)

Dunedin - Deaths
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



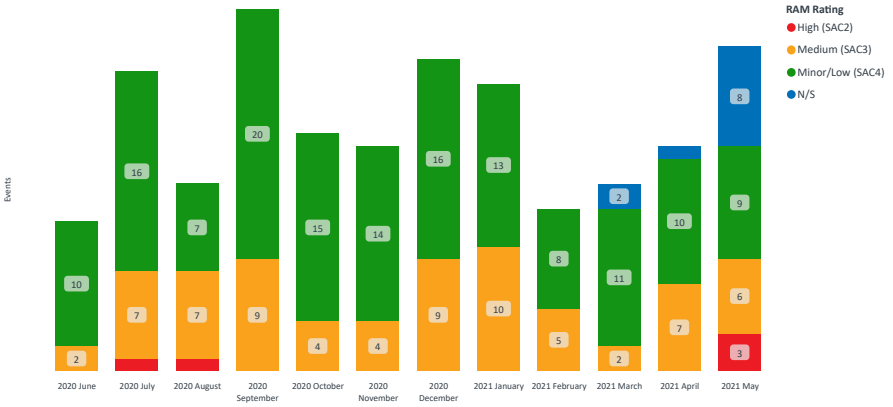
Deaths
Number of patients deceased by discharge month.

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



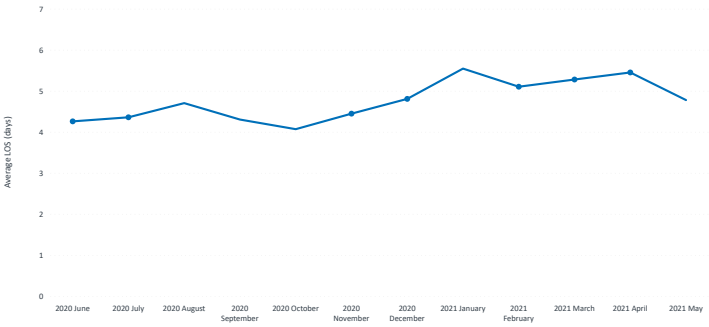
Safety 1st data.
The monthly number of reported staff adverse events
Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

Executive Dashboard - Efficiency

(Dunedin)

Dunedin - Average LOS

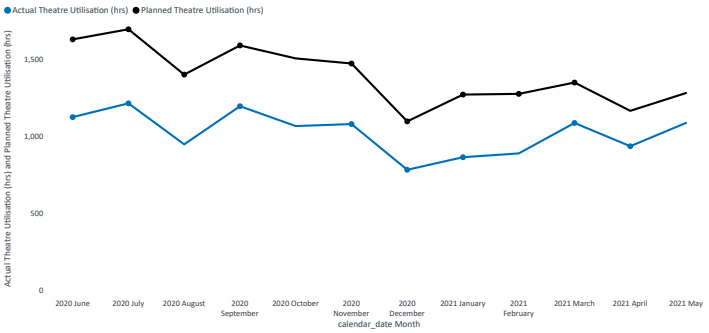
BY DAYS



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
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Anaesthetic Time = Time duration between "Anaesthetic Start Time" and "Patient Ready for Procedure Time"
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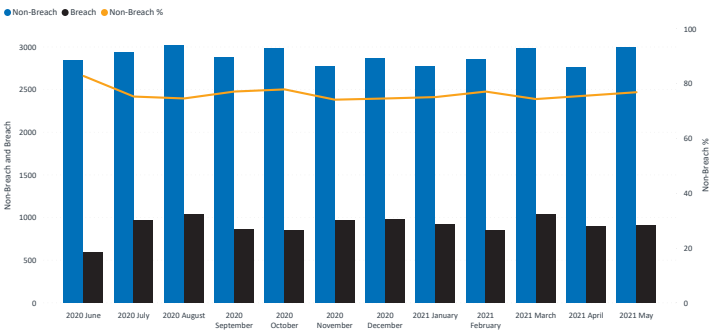
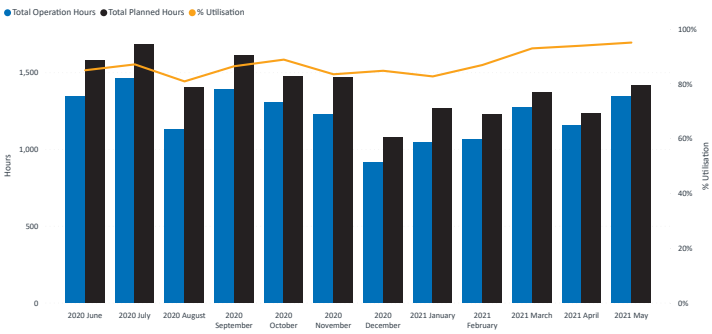
Dunedin - Monthly 6 Hour %



Monthly 6 Hour %

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

Dunedin - Average Theatre Utilisation (%)



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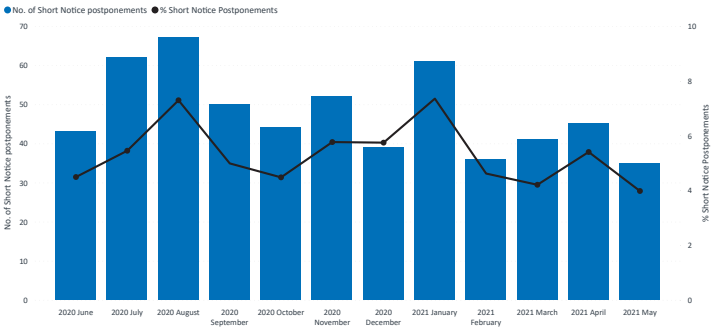
Dunedin - Short Notice Postponements



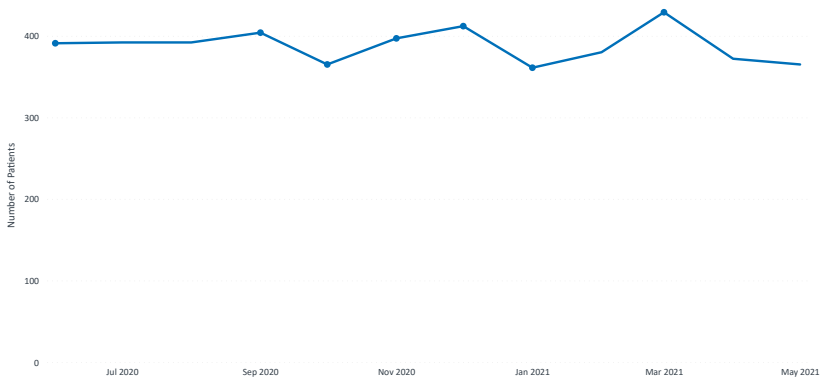
Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure

Executive Dashboard - Timely

(Dunedin)

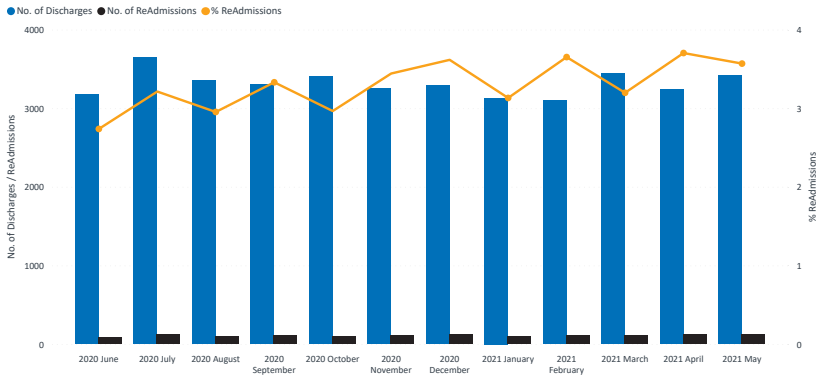
Dunedin - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

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

Dunedin - Unplanned Hospital Readmissions within 7 days

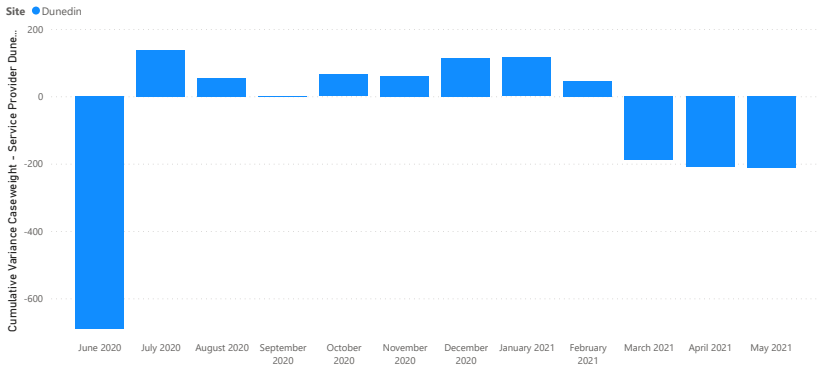


Unplanned Hospital Readmissions within 7 Days

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

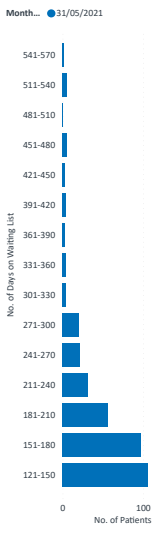


Cumulative Variance Caseweight

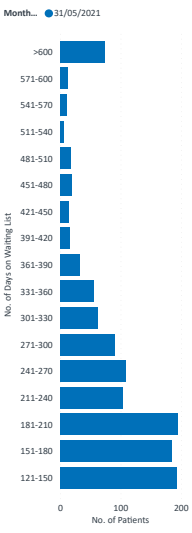
Column chart has cumulative variance case weight for Service provider which compares case weight with production plans based on MoH targets and work done in Southern DHB facilities, the Southern DHB's own population minus outflows plus inflow.

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

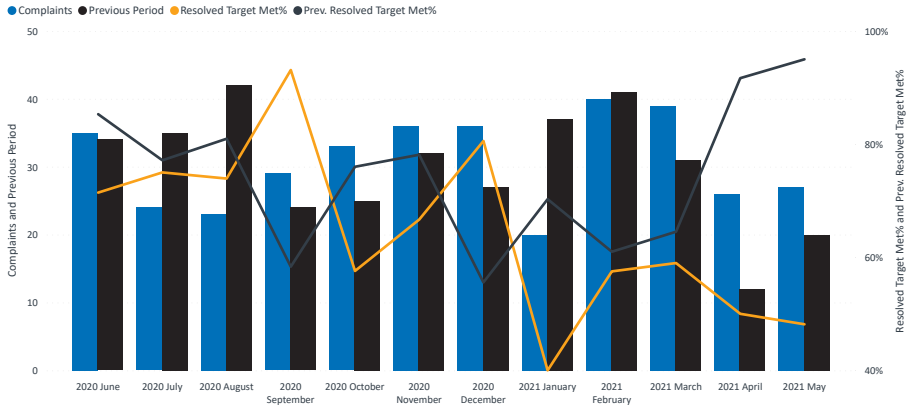
ESPI 2 and ESPI 5 waitlists organised into the given time buckets

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

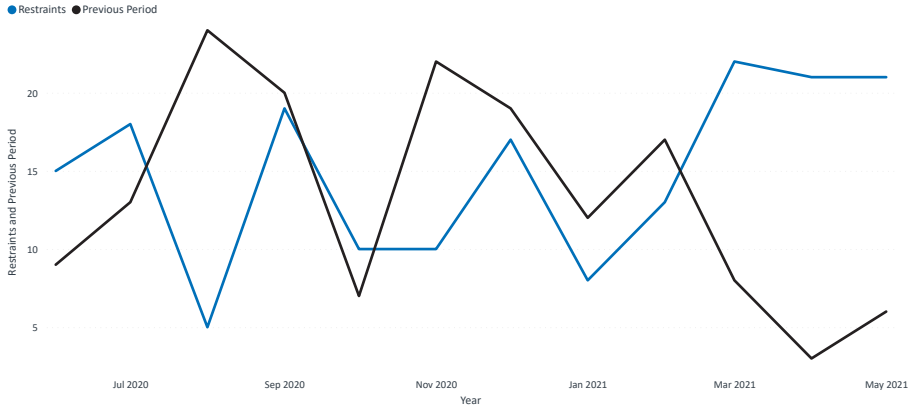
There is a one month (20 working days) time period for complaints to be resolved, or to communicate additional time required to the patient. For that reason the current reporting month will always appear as a lag.

The last three months have seen highest no of complaints – based on data from last 24 months.

- Surgical Services and Radiology has seen biggest rise – up from 21 in Jan to 42 in Apr.
- Communications are the biggest issue – 48% of complaints are made up of poor comms with patient and/or family, attitude and manner of staff or inappropriate comments made by staff
- A growing issue is surgical and treatment delays
- The key driver appears to be overworked staff – showing in patient & staff feedback and systems (short shifts, staff absence etc)

Invercargill - Restraints and Previous Period

BY YEAR AND MONTH



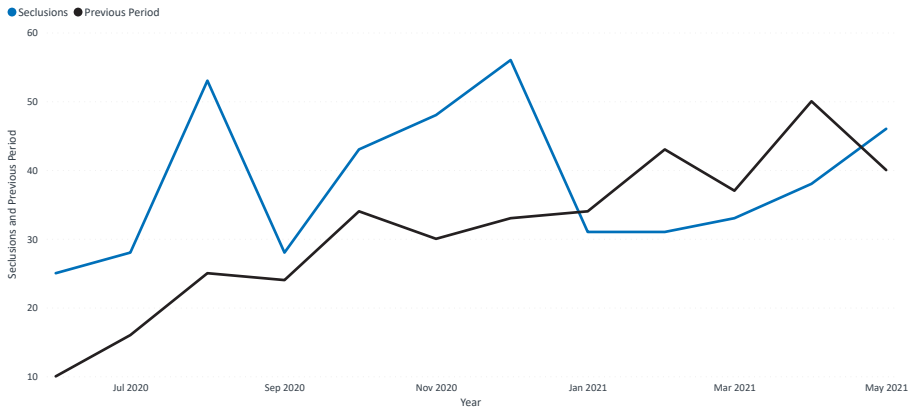
Restraints

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

Restraints appear to have jumped again however a longer view of the data shows that restraints do tend to peak and trough over time. This often due to that fact that one patient can have multiple restraint issues in a particular month

Southern - Seclusions and Previous Period

BY YEAR AND MONTH



Seclusions

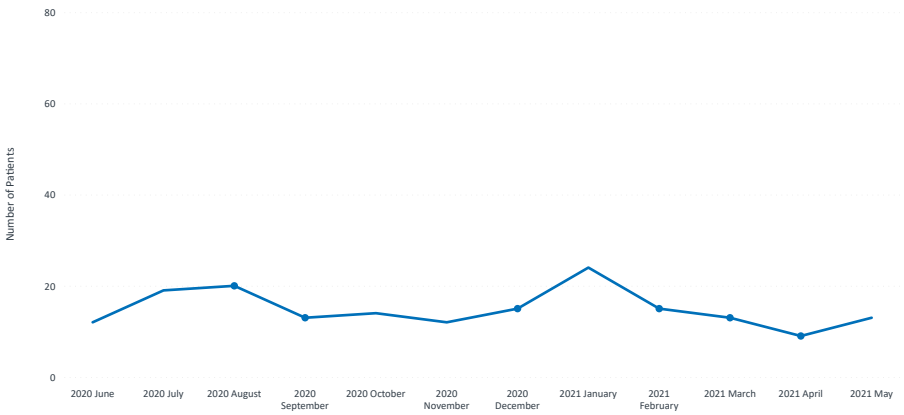
iPM and HCS data. The number of seclusion events per month.

Executive Dashboard - Effectiveness

(Invercargill)

Invercargill - Deaths

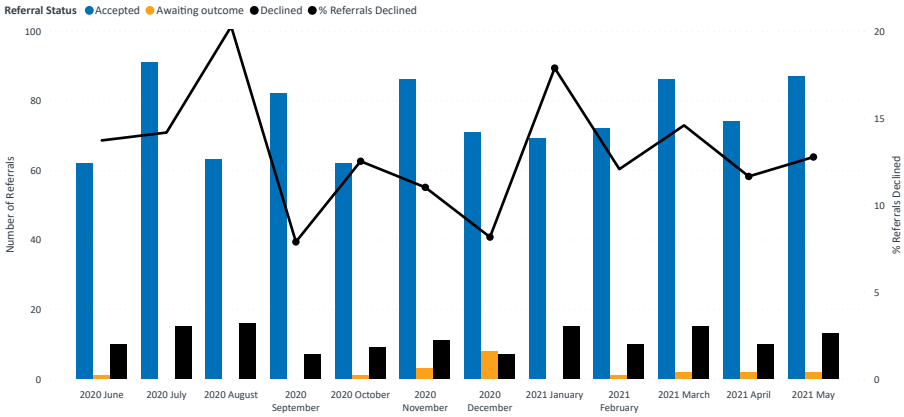
NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths

Number of patients deceased by discharge month.

Invercargill Hospital - Referrals Accepted / Awaiting Outcome and Declined

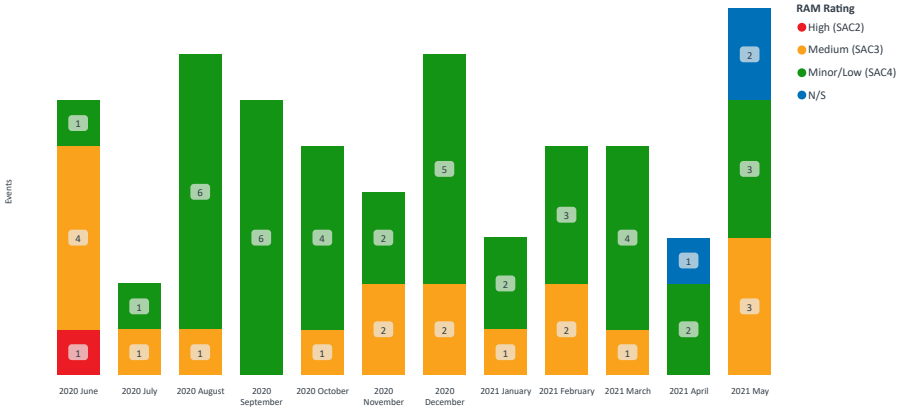


Referrals accepted (authorised), awaiting outcome or declined by month.

% referrals declined

Invercargill - Staff Events

BY RAM RATING, YEAR, MONTH



Safety 1st data.

The monthly number of reported staff adverse events

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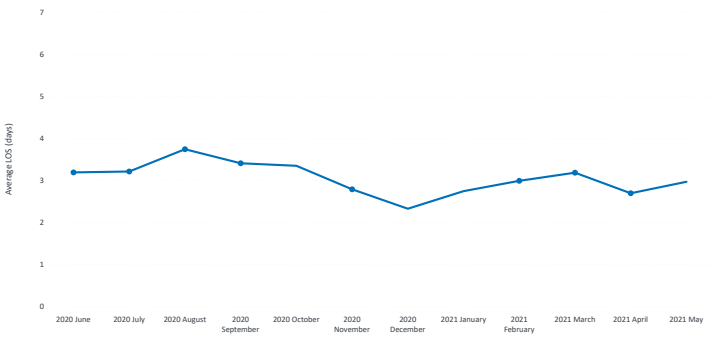
Executive Dashboard - Efficiency

(Invercargill)

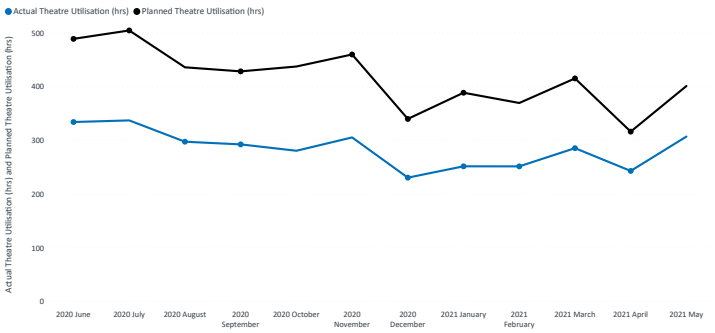
Invercargill - Average LOS (days)



Average Length of stay

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

Invercargill - Planned vs Actual Theatre Utilisation (hrs)



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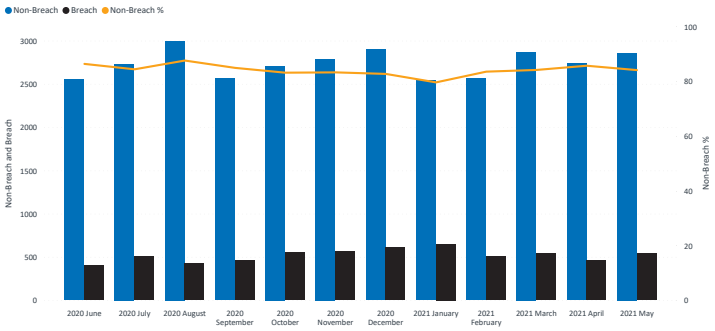
Invercargill - Monthly 6 Hour %



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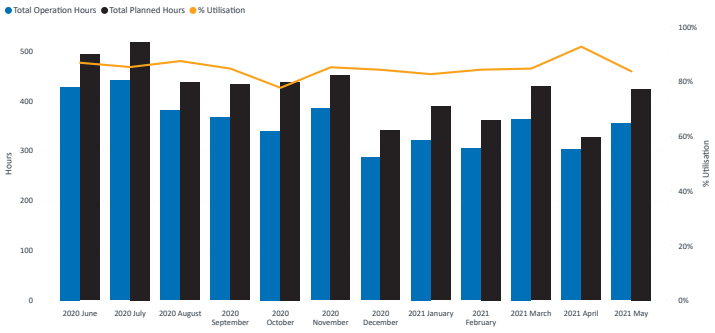

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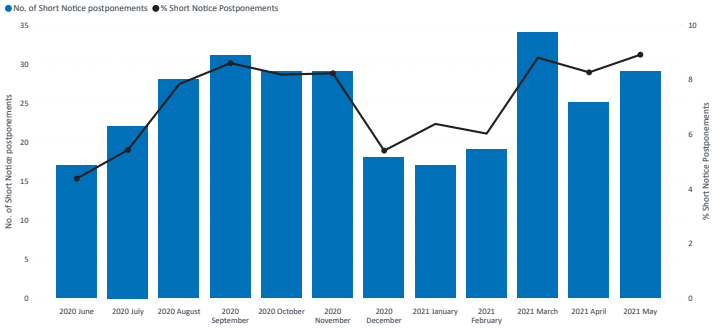
Invercargill - Short Notice Postponements



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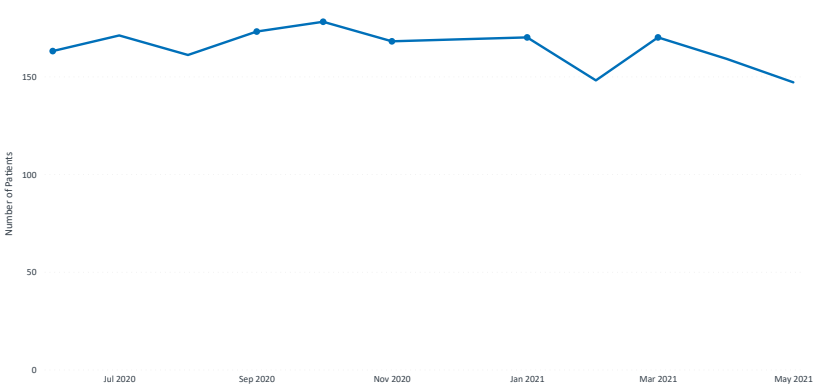
Executive Dashboard - Timely

(Invercargill)

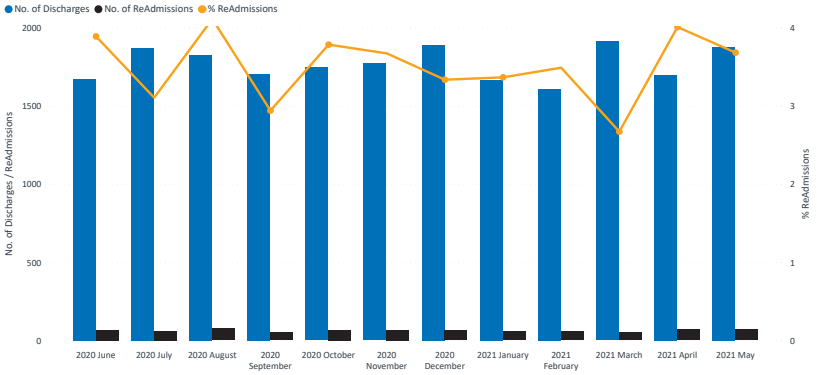
Invercargill - Number of Patients with LOS > 7 days



Number of Patients with LOS > 7 Days

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

Invercargill - Unplanned Hospital Readmissions within 7 days

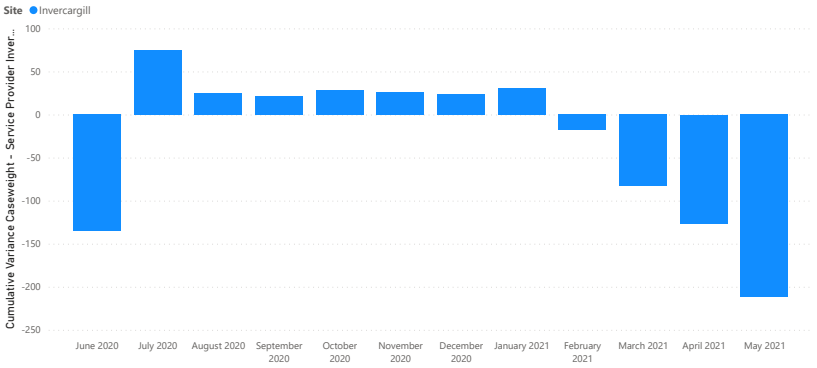


Unplanned Hospital Readmissions within 7 Days

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



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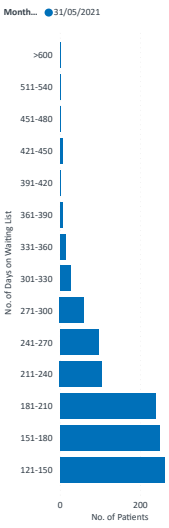
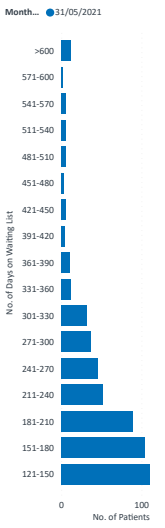


Invercargill - ESPI 5 Breache...



ESPI 2 and ESPI 5

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

FOR INFORMATION

Item: Patient Complaints

Proposed by: Hywel Lloyd, Interim Executive Director, Quality & Clinical Governance Solutions

Meeting of: 6 July 2021

Recommendation

That the Board notes the contents of this report and the concerns raised by consumers through the feedback processes.

Purpose

1. To raise awareness with the Board of the concerns being expressed by consumers about the impact that staffing and resource pressures are having on them.

Specific Implications For Consideration

2. Financial
    -
3. Workforce
    - Excessive workloads are having an adverse effect on staff health and wellbeing.
4. Equity
    - There are issues about equity of access to care, with lengthy waitlists for surgical, particularly orthopaedic procedures.
5. Other
    - Consumers are telling us that the pressures on staff are having an impact on their treatment.

Background

6. SDHB has a well-established process that allows consumers to provide their feedback; comments, compliments and complaints. Consumers are able to provide their feedback in the manner that best meets their needs – orally, by mail or email, or through a web form. Feedback can be provided anonymously if the consumer requests and can, with the agreement of the individual concerned, be raised by a third person.

7. Feedback is entered into the Safety1st system and tasked to the relevant service (or services) for action and for a response.

8. For complaints, the target is to resolve them within 35 days. Over the past 24 months, the average number of days to resolution is 42 days. For complaints closed in May 2021, the average number of days to resolution was 44 days, with 49% resolved within 35 days.

9. The amount of feedback, both compliments and complaints, can vary considerably from month to month. Therefore, care should be taken before drawing conclusions on the basis of one or two month's data. With the establishment of the Consumer Experience Manager and the creation of a feedback team, we are now looking at trends and themes over longer period – from 3 to 24 months or even longer – and using that to ensure that the consumer voice informs change at SDHB.

10. SDHB also participates in the quarterly National Inpatient Survey (NIS). Five hundred SDHB consumers that had been in inpatients between 1 and 14 February 2021 were invited to complete the quarter one National Inpatient Survey: 157 consumers submitted responses. The survey responses for Dunedin and Southland Hospitals is shown in Appendix One.

11. We are also now drawing together feedback from multiple sources, such as the NIS and Safety1st to form a more complete view of what is concerning consumers.

Summary

12. Responses to the National Inpatient Survey (NIS) show that Southern DHB is performing well against other DHBs nationally, with SDHB sitting above the national average in 30 out of 35 of the factors.

13. In the NIS SDHB performs well with inpatients prior to procedures, with patients feeling that they are treated with kindness, respect and understanding, and that they are well informed about their forthcoming procedure.

14. However, SDHB performs less well post-procedure and during discharge, and in the areas of privacy and keeping family/whanau informed.

15. Comments provided in the NIS, as well as both staff feedback and SDHB systems indicate that staff being overworked is a major issue and is having an impact both on staff and on consumers, their whanau and their communities.

16. Both the comments in the survey and SDHB's own consumer feedback point to communications as being an issue, with nearly 50% of consumer feedback issues involving an element around communication.

17. Of growing concern is the feedback from consumers, GPs and staff about the referral times for Orthopaedics and, while SDHB is working hard to catch up on surgical work, it will take time to get the waiting times down.

Discussion

18. 500 SDHB consumers that had been in inpatients between 1 and 14 February 2021 were invited to complete the quarter one National Inpatient Survey: 157 consumers submitted responses. The survey responses for Dunedin and Southland Hospitals is shown in Appendix One.

19. The results for Dunedin and Southland are shown along with the average for Dunedin and Southland combined and with the national average. When compared nationally, SDHB is above the national average in 30 of 35 questions, whereas when looking only at Dunedin and Southland hospitals we are above the national average in 27 question.

20. This is the third set of quarterly results from the current survey provider, IPSOS, and SDHB has seen a significant improvement over that period, going from 10 of 29 question above the national average in August 2020 to where it sits today.

21. If we were to average out the scores from each survey, SDHB had an average score of 80% in August, which has risen to nearly 85% today. Of note are the positive figures around how patients feel they are treated. Also, patients believe that their personal, spiritual and cultural needs are met. When looking at the individual comments provided by consumers, these same themes emerge as positives – the quality of individual care and the dedication and commitment of staff.

22. However, there is room for improvement, with some causes for concern. In many areas there is a disparity between the scores for Southland and for Dunedin. Appendix One highlights areas where there is a variance of more than 10% between the two sites' scores. Across the two sites, two areas of concern stand out: the lack of privacy (only 64.5% of patients felt that they were given enough privacy with talking about their condition or treatment) and communications.

23. The issue around communications also comes through loud and clear in the comments provided by respondents, whether that's with patients and/or their whanau, around the discharge process or between healthcare professionals. In fact, of 174 issues identified in the comments, more than 50% relate to issues of communication.

24. The other issue identified by respondents is the fact that staff are overworked and resources are strained. Looking, again, at the comments, 22 of the respondents refer directly to staff being overworked and another 14 highlighting delays in treatment.

25. While it's hard to draw definitive conclusions from this data, it is fair to say that SDHB and its staff put a huge amount of effort into fixing whatever is wrong with the patient. With finite resources at their disposal clinical managers have to focus those resource and their attention there. Which means that that once the procedure has been completed or the patient is on the mend, there is less of a focus on the patient and patients feel that difference. Patients also feel that their discharge process is being rushed and they are not prepared adequately for going home.

26. The team have correlated the results of the NIS with feedback received from staff, through the voluntary "Pulse Check" survey, and with data from the Care Capacity Demand Management (CCDM) programme, which all suggest that both Dunedin and Southland hospital are understaffed. This is having an impact on the health and wellbeing of staff and it is having an impact on the health and wellbeing of our consumers.

27. Feedback through SDHB's consumer feedback process reflects many of these same themes, with a growing amount of feedback around wait times/treatment delays and around communications: over the past 24 months, 48% of complaints included an issue around communications, whether it was communication with patients and/or whanau, staff attitudes or insufficient information.

28. Again looking at the feedback system, the last quarter was a historic high for complaints, with 237 for the three months, up from 207 in the previous quarter, though May saw a drop in complaints received from 102 and 111 in April and March respectively.

29. The majority of complaints for the last quarter relate to Surgical Service & Radiology, with Orthopaedics being the main area of concern and, within that, care/treatment and access to treatment being the main subjects of complaints. The feedback team has also been recording as "general feedback" referral follow-ups from GPs for orthopaedics and since 1 April, 56 instances of GPs chasing overdue referrals have been recorded.

30. It is appreciated that Surgical Services & Radiology is working hard to identify ways to provide these consumers with treatment and are having some success in reducing the number of referrals. These solutions will not be immediate, which is not the news that our patients want as they await surgery, but it is starting to move in the right direction. The impact on consumers and the wider community, however, are far reaching. This impacts on the physical and mental health and wellbeing of the patient and of their whanau and it has an economic

impact on the community, as previously active and productive people are no longer able to work or contribute as they have done in the past.

31. Both the average number of days to resolve a complaint for May 2021 (44 days) and for the previous 24 months (42 days) also reflect the pressures on staff and their workload. It also reflects SDHB's complaint resolution process, which is focused more on meeting targets for giving the consumer a response, than on agreeing a resolution. The Consumer Experience Manager is assessing the Complaints Process and will be making recommendations for improvements in the near future.

Next Steps & Actions

Review and improve internal response process for feedback & complaints

Understand the themes running through patient experience feedback to ensure these are understood and linked back to the services for improvement work and to highlight potential strategic risk issues.

Appendices

Appendix 1	National Inpatient Survey Results – Comparison between Dunedin and Southland Hospitals
Appendix 2	National Inpatient Survey Results – Comparison of Sites
Appendix 3	Southern DHB Feedback last 24 months

Appendix 1 – National Inpatient Survey Results

#	Question	February 2021				
		Dun/Sth	Dunedin	Southland	Variance	NZ
3.1	Doctors always listened to views and concerns.	83.4%	86.4%	76.2%	10.2%	85.0%
3.2	Nurses always listened to views and concerns.	84.9%	83.5%	88.4%	-4.9%	84.6%
3.3	Other members of health care team always listened to views and concerns.	83.3%	84.5%	80.0%	4.5%	83.2%
4	Always kept informed as much as wanted about treatment and care.	78.2%	81.7%	69.8%	11.9%	75.9%
5	Health care team definitely explained what was going on during stay in an understandable way.	85.9%	89.1%	78.0%	11.1%	83.1%
6	Always involved as much as wanted to be in made decisions about treatment and care.	79.6%	80.2%	78.0%	2.2%	77.8%
7	Not given conflicting information by different doctors or staff involved in care.	73.9%	75.3%	70.3%	5.0%	73.7%
7.b	Was your name pronounced properly by those providing care	90.4%	90.6%	89.7%	0.9%	88.4%
7.c	Did those involved in your care ask you how to say your name if they were uncertain	77.4%	74.5%	84.6%	-10.1%	80.9%
7.d	Did you feel confident to ask any questions you had	90.1%	91.2%	87.5%	3.7%	86.7%
8.1	Definitely treated with kindness and understanding by doctors whilst in hospital.	87.7%	88.9%	84.6%	4.3%	88.1%
8.2	Definitely treated with kindness and understanding by nurses whilst in hospital.	89.9%	89.8%	90.0%	-0.2%	88.6%
8.3	Definitely treated with kindness and understanding by other members of health care team whilst in hospital.	89.0%	90.3%	85.3%	5.0%	88.4%
9.1	Definitely treated with respect by doctors.	95.6%	95.9%	94.9%	1.0%	91.2%
9.2	Definitely treated with respect by nurses.	94.9%	94.8%	95.0%	-0.2%	90.6%
9.3	Definitely treated with respect by other members of health care team.	92.1%	91.4%	93.9%	-2.5%	91.0%
10.1	Definitely trusted and had confidence in the doctors.	89.1%	89.9%	87.2%	2.7%	84.8%
10.2	Definitely trusted and had confidence in the nurses.	87.7%	87.8%	87.5%	0.3%	84.3%
10.3	Definitely trusted and had confidence in the other members of health care team.	86.5%	87.9%	82.9%	5.0%	84.8%
11	Hospital rooms or wards (including bathrooms) were always kept clean.	82.5%	80.4%	87.5%	-7.1%	82.4%
12	Definitely given enough privacy when talking about treatment or condition.	64.5%	64.6%	64.1%	0.5%	75.3%
13	Hospital staff always helped patient to get to the bathroom or to use a bedpan as soon as desired.	86.7%	84.8%	91.7%	-6.9%	81.1%
14.1	Did you feel your cultural needs were met.	94.9%	96.5%	90.9%	5.6%	91.4%
14.2	Did you feel you spiritual needs were met	90.1%	90.6%	88.9%	1.7%	84.9%
14.3	Did you feel your individual needs were met	87.7%	89.1%	84.2%	4.9%	80.7%
16	Hospital staff definitely included patient's family/whānau or someone close to patient in discussions about the care received during visit.	71.0%	72.6%	66.7%	5.9%	76.2%
17	During the hospital visit, patient always received pain relief that met their needs.	82.8%	83.9%	80.0%	3.9%	85.2%
19	Before the operation(s), staff definitely helped patient to understand what would happen and what to expect.	92.3%	95.0%	83.3%	11.7%	89.0%
20	After the operation(s), staff definitely helped patient to understand how it went.	84.8%	86.9%	77.8%	9.1%	81.3%
21	Towards the end of the patient's visit, they were definitely kept informed as much as they wanted about what would happen and what to expect before they could leave the hospital.	72.4%	75.8%	64.1%	11.7%	72.4%
22	Patient definitely had enough information about how to manage their condition or recovery after they left hospital.	70.2%	70.5%	69.4%	1.1%	68.3%
23	Patient was definitely told what the medicine (or prescription for medicine) they left the hospital with was for.	86.8%	85.5%	90.3%	-4.8%	86.8%
24	Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand.	63.6%	67.6%	52.0%	15.6%	63.0%
25	Hospital staff definitely talked with the patient about whether they would have the help they needed when they left the hospital.	64.8%	67.5%	56.0%	11.5%	66.8%
26D	Patient did NOT identify perceived unfair treatment	94.6%	95.5%	90.6%	4.9%	92.5%

Appendix 2 National Inpatient Survey Results – Comparison of Sites

#	Question	February 2021				
		SDHB	Dunedin	Southland	Lakes	NZ
3.1	Doctors always listened to views and concerns.	84.5%	86.4%	76.2%	100.0%	85.0%
3.2	Nurses always listened to views and concerns.	85.9%	83.5%	88.4%	100.0%	84.6%
3.3	Other members of health care team always listened to views and concerns.	84.5%	84.5%	80.0%	100.0%	83.2%
4	Always kept informed as much as wanted about treatment and care.	79.6%	81.7%	69.8%	100.0%	75.9%
5	Health care team definitely explained what was going on during stay in an understandable way.	86.8%	89.1%	78.0%	100.0%	83.1%
6	Always involved as much as wanted to be in made decisions about treatment and care.	80.9%	80.2%	78.0%	100.0%	77.8%
7	Not given conflicting information by different doctors or staff involved in care.	75.5%	75.3%	70.3%	100.0%	73.7%
7.b	Was your name pronounced properly by those providing care	91.0%	90.6%	89.7%	100.0%	88.4%
7.c	Did those involved in your care ask you how to say your name if they were uncertain	78.1%	74.5%	84.6%	85.7%	80.9%
7.d	Did you feel confident to ask any questions you had	90.8%	91.2%	87.5%	100.0%	86.7%
8.1	Definitely treated with kindness and understanding by doctors whilst in hospital.	88.5%	88.9%	84.6%	100.0%	88.1%
8.2	Definitely treated with kindness and understanding by nurses whilst in hospital.	90.5%	89.8%	90.0%	100.0%	88.6%
8.3	Definitely treated with kindness and understanding by other members of health care team whilst in hospital.	89.8%	90.3%	85.3%	100.0%	88.4%
9.1	Definitely treated with respect by doctors.	95.9%	95.9%	94.9%	100.0%	91.2%
9.2	Definitely treated with respect by nurses.	95.2%	94.8%	95.0%	100.0%	90.6%
9.3	Definitely treated with respect by other members of health care team.	92.6%	91.4%	93.9%	100.0%	91.0%
10.1	Definitely trusted and had confidence in the doctors.	89.9%	89.9%	87.2%	100.0%	84.8%
10.2	Definitely trusted and had confidence in the nurses.	88.4%	87.8%	87.5%	100.0%	84.3%
10.3	Definitely trusted and had confidence in the other members of health care team.	87.4%	87.9%	82.9%	100.0%	84.8%
11	Hospital rooms or wards (including bathrooms) were always kept clean.	83.0%	80.4%	87.5%	85.7%	82.4%
12	Definitely given enough privacy when talking about treatment or condition.	66.2%	64.6%	64.1%	85.7%	75.3%
13	Hospital staff always helped patient to get to the bathroom or to use a bedpan as soon as desired.	87.2%	84.8%	91.7%	n/a	81.1%
14.1	Did you feel your cultural needs were met.	95.2%	96.5%	90.9%	n/a	91.4%
14.2	Did you feel you spiritual needs were met	90.4%	90.6%	88.9%	n/a	84.9%
14.3	Did you feel your individual needs were met	88.3%	89.1%	84.2%	100.0%	80.7%
16	Hospital staff definitely included patient's family/whānau or someone close to patient in discussions about the care received during visit.	73.1%	72.6%	66.7%	100.0%	76.2%
17	During the hospital visit, patient always received pain relief that met their needs.	83.7%	83.9%	80.0%	n/a	85.2%
19	Before the operation(s), staff definitely helped patient to understand what would happen and what to expect.	92.7%	95.0%	83.3%	n/a	89.0%
20	After the operation(s), staff definitely helped patient to understand how it went.	85.5%	86.9%	77.8%	n/a	81.3%

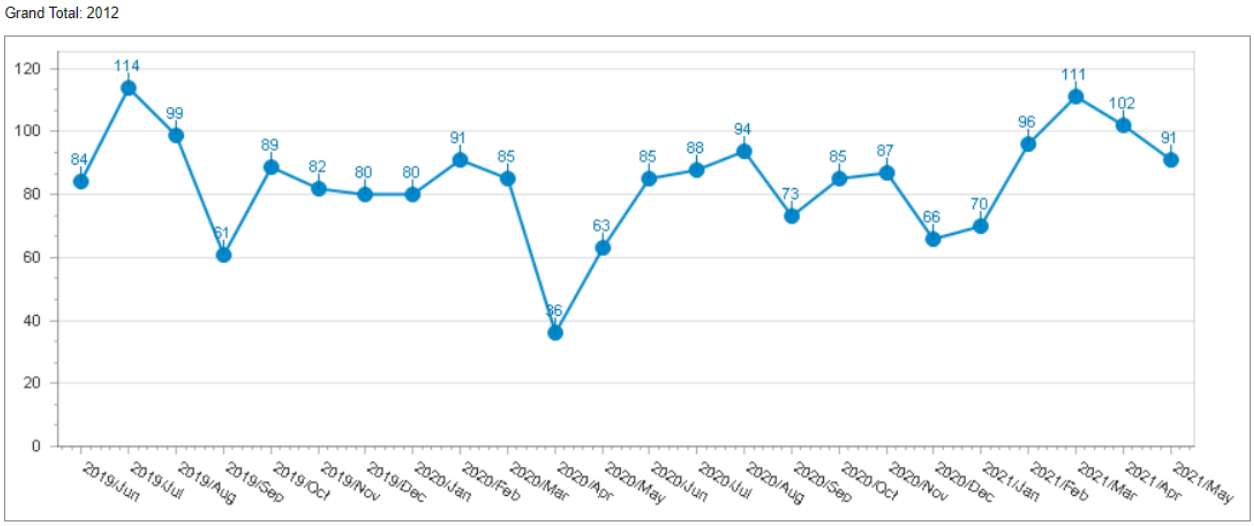
#	Question	February 2021				
		SDHB	Dunedin	Southland	Lakes	NZ
21	Towards the end of the patient's visit, they were definitely kept informed as much as they wanted about what would happen and what to expect before they could leave the hospital.	74.1%	75.8%	64.1%	100.0%	72.4%
22	Patient definitely had enough information about how to manage their condition or recovery after they left hospital.	71.6%	70.5%	69.4%	85.7%	68.3%
23	Patient was definitely told what the medicine (or prescription for medicine) they left the hospital with was for.	86.9%	85.5%	90.3%	n/a	86.8%
24	Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand.	65.7%	67.6%	52.0%	n/a	63.0%
25	Hospital staff definitely talked with the patient about whether they would have the help they needed when they left the hospital.	67.0%	67.5%	56.0%	100.0%	66.8%
26D	Patient did NOT identify perceived unfair treatment	94.6%	95.5%	90.6%	100.0%	92.5%

Key	
Red	Below DHB Avg
Green	Above DHB Avg
	Top 5 Results
	Bottom 5 Results
n/a	Sample Size <5

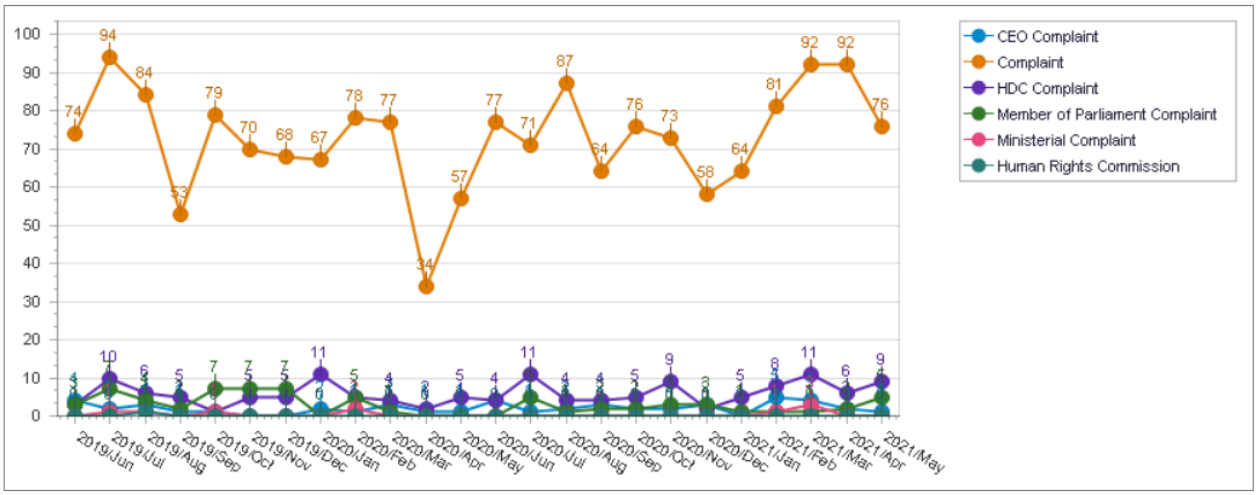
Appendix 3 Southern DHB Feedback last 24 months

Southern DHB Feedback

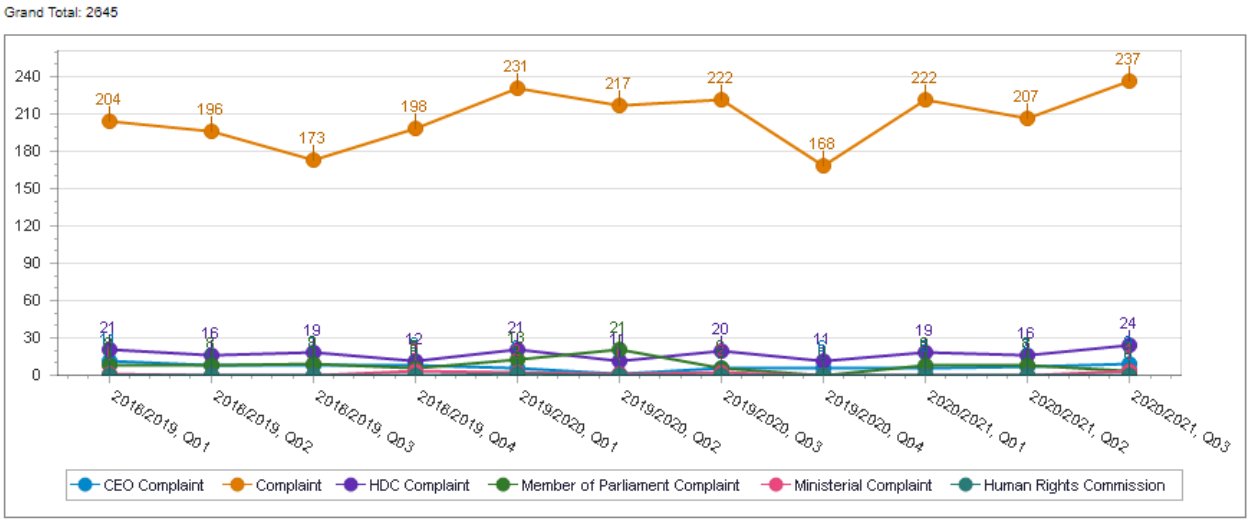
Southern DHB Complaints by month – last 24 months (June 19 – May 2021 inclusive)



Complaints received last 24 months (1 June 19 – 31 May 21 inclusive) by complaint type

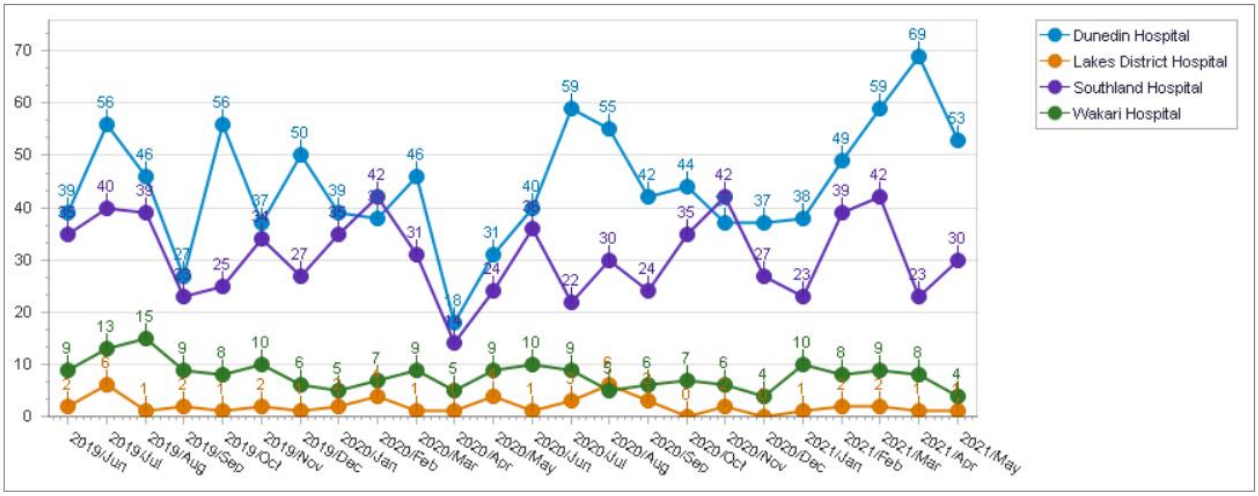


Complaints received quarterly – Q1 2018/19 – Q3 2020/21 – by complaint type



Complaints by site

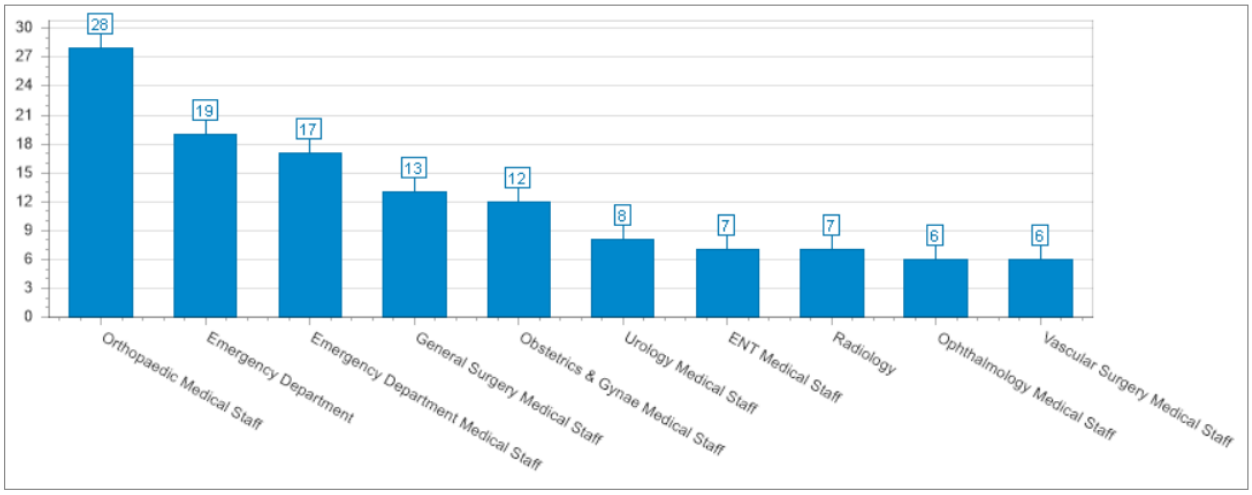
Grand Total: 2047



Note: this includes the 4 main hospital sites only

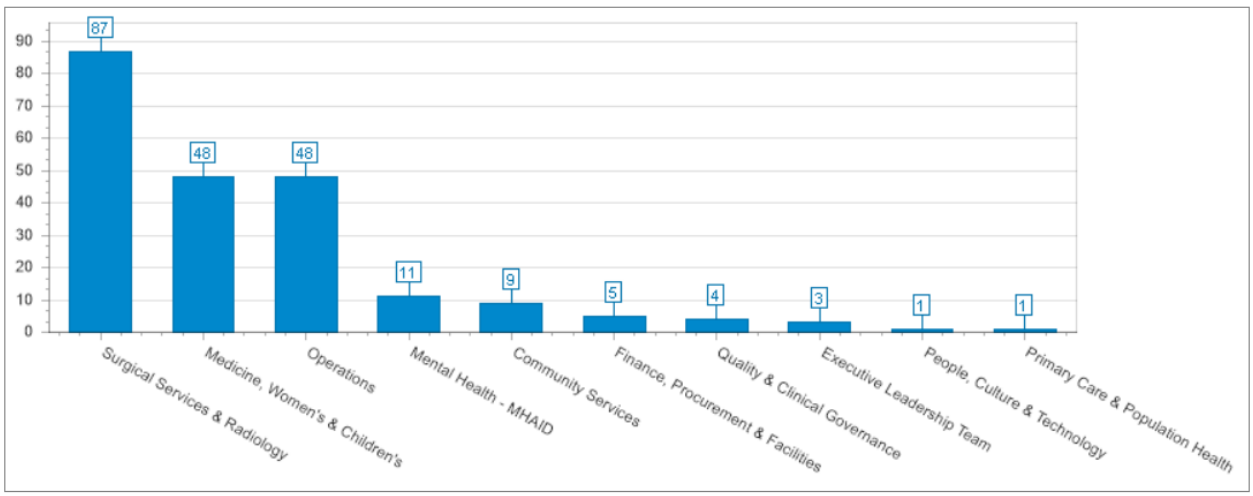
Complaints regarding Dunedin Hospital last 3 months - Top 10 ward/areas

Grand Total: 231

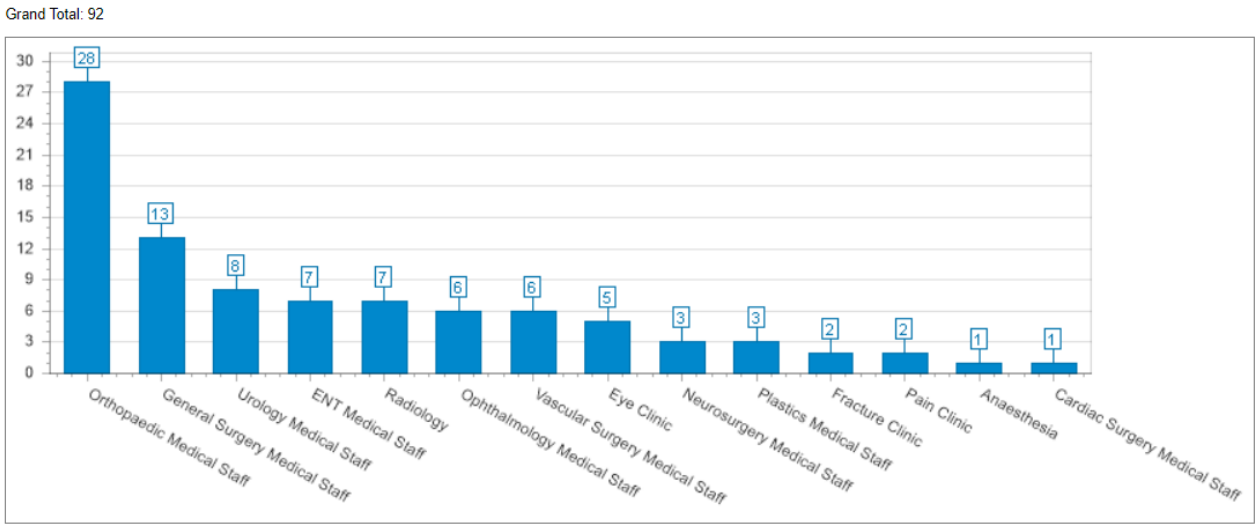


Complaints received regarding Dunedin Hospital in the last 3 months – by Directorate

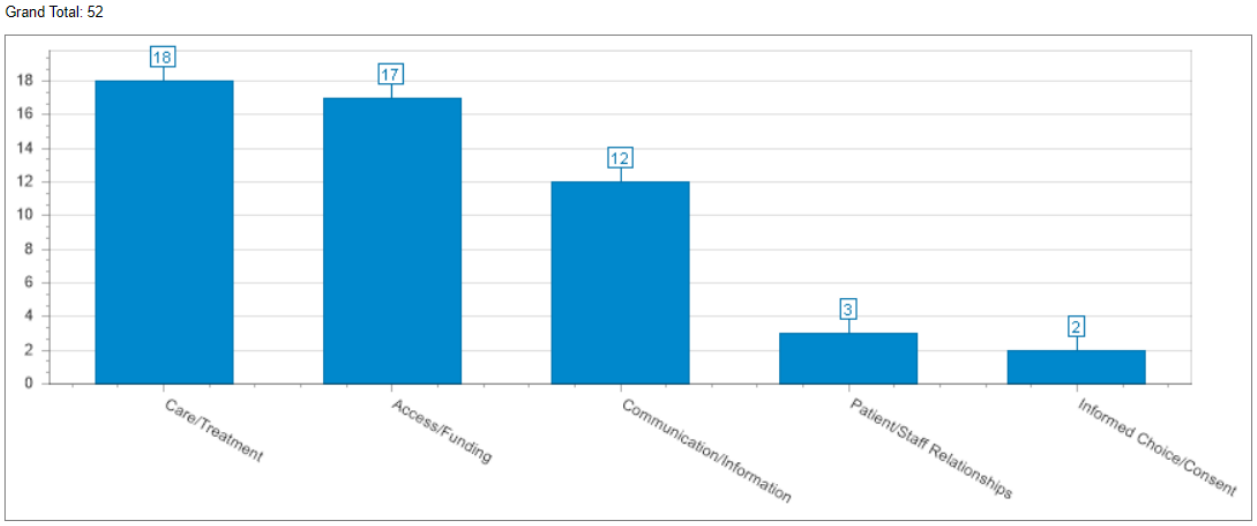
Grand Total: 217



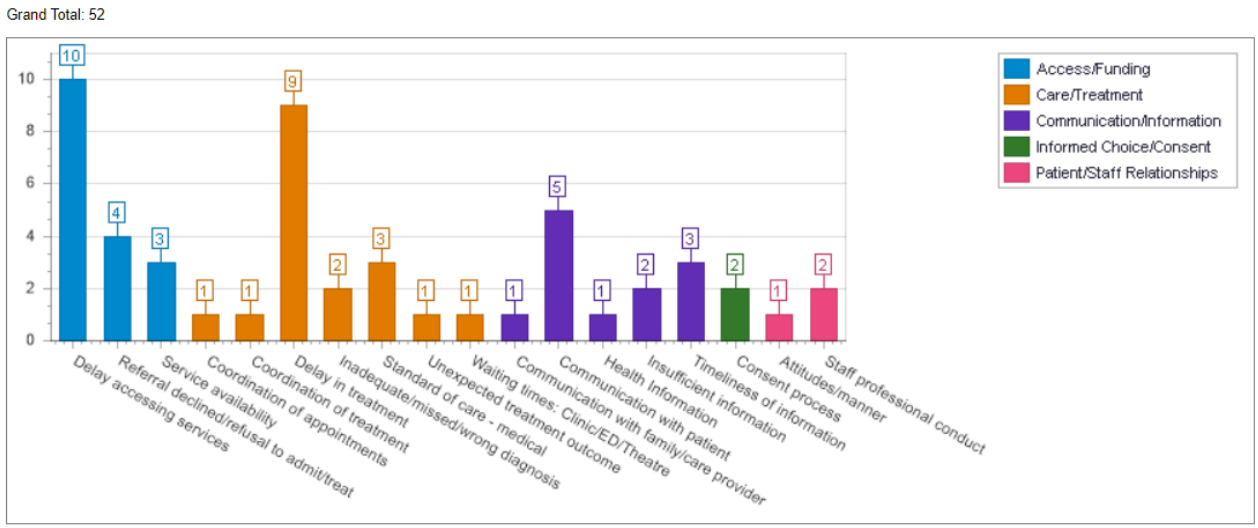
Surgical Services and Radiology complaints received regarding Dunedin Hospital last 3 months – by ward/area



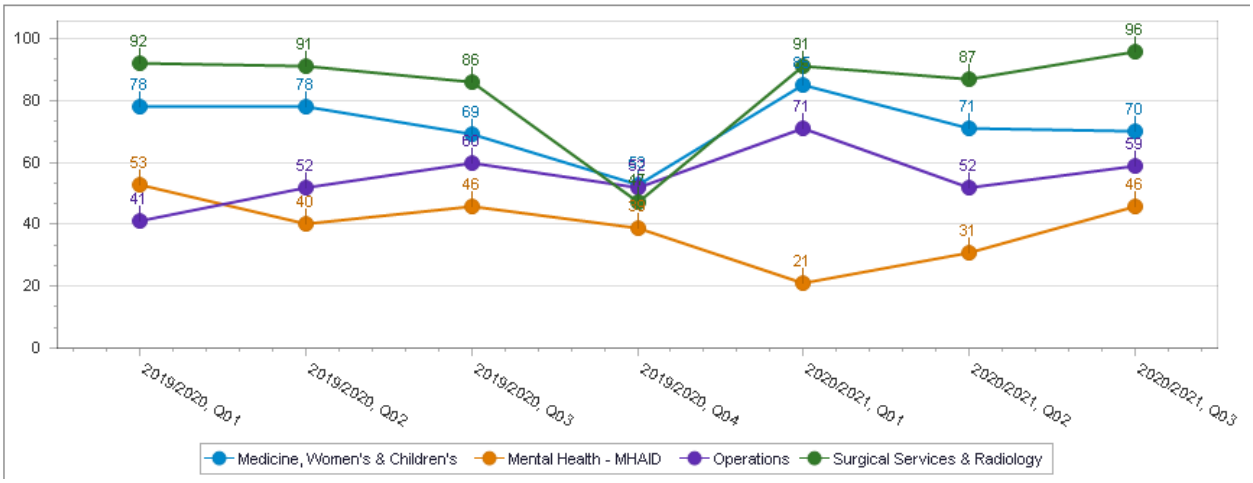
Orthopaedic complaints Dunedin Hospital last 3 months – main categories



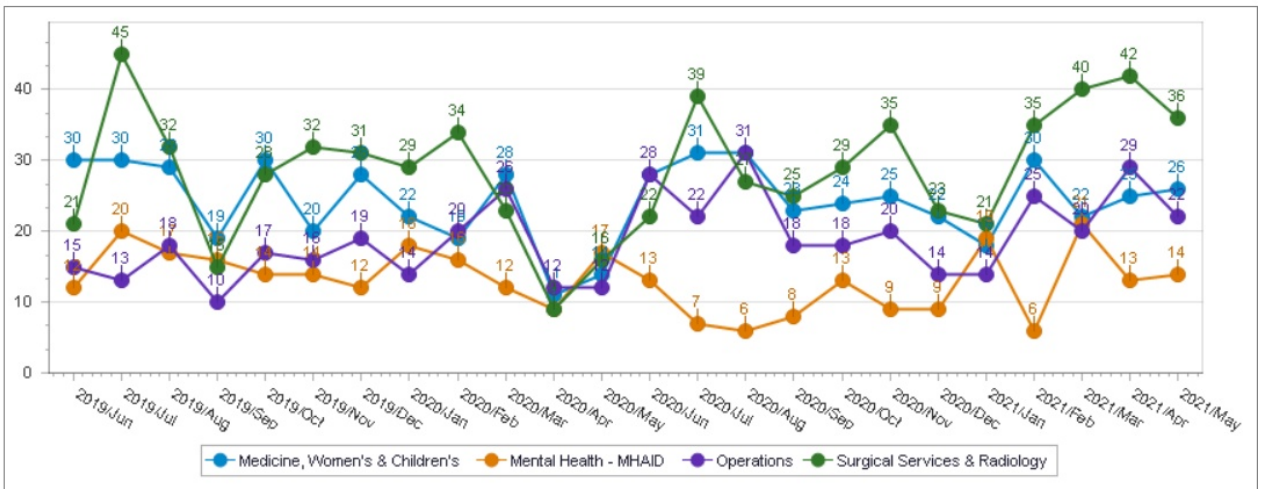
Orthopaedic complaints Dunedin Hospital last 3 months – sub categories



Complaints received quarterly - by Directorate (Top 4)



Complaints received monthly - by Directorate (Top 4)



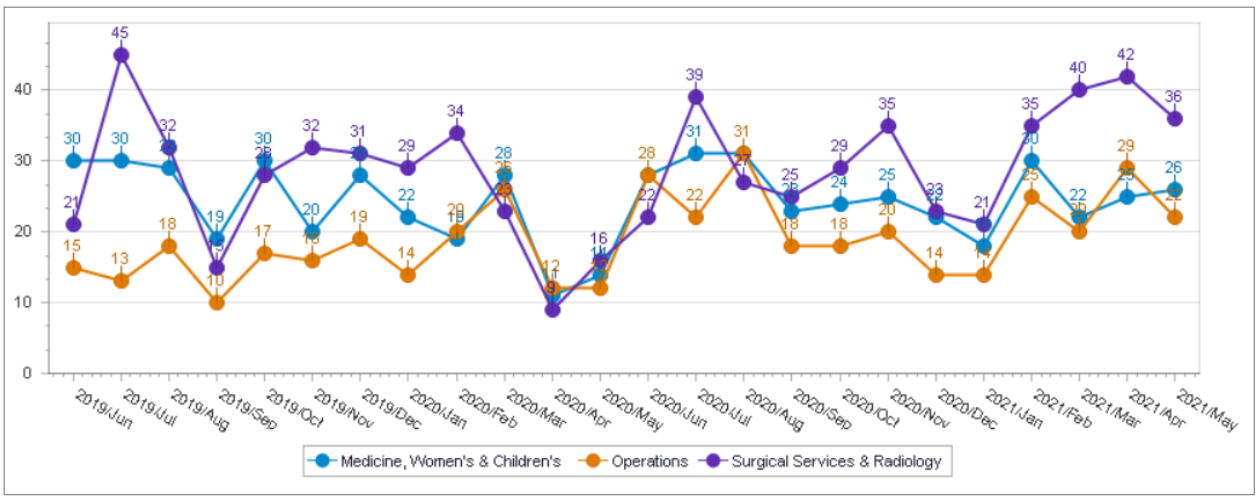
May 2021

Surgical Services and Radiology: 10 complaints regarding Orthopaedics (8 Dunedin, 2 Southland), 6 of these complaints relate to access issues or delays in treatment.

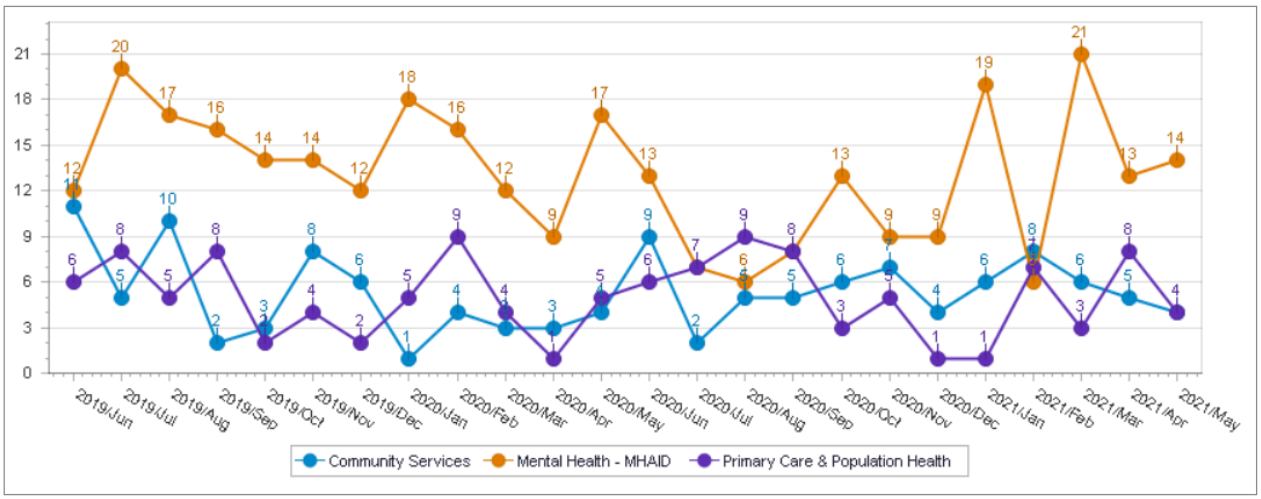
-8 complaints regarding General Surgery (4 Dunedin, 4 Southland) the Dunedin complaints mostly relate to communication/information, other issues are around treatment.

-7 complaints regarding Ophthalmology (6 Dunedin, 1 Southland) these relate to communication, delays in access or treatment.

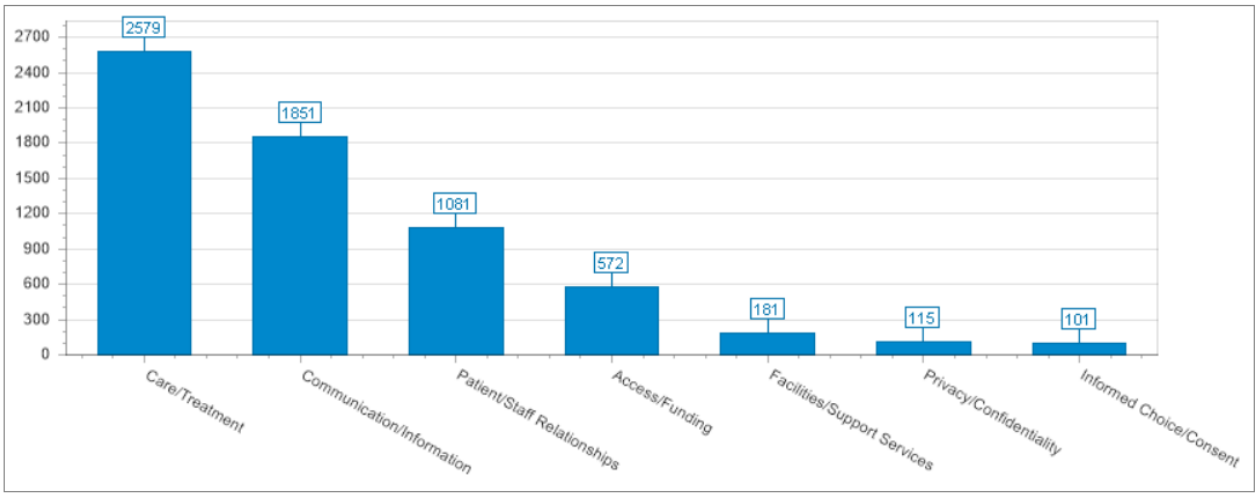
Specialist Services – Complaints by month



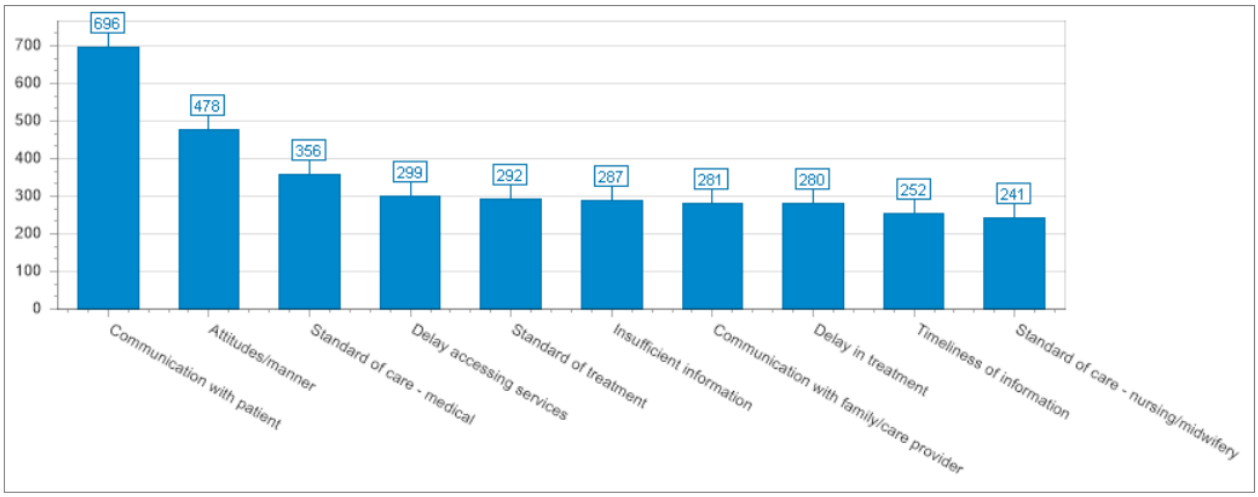
Strategy, Primary and Community – Complaints by month



Southern DHB Complaints Main Categories – Last 24 months



Southern DHB Complaints Sub Categories – Last 24 months

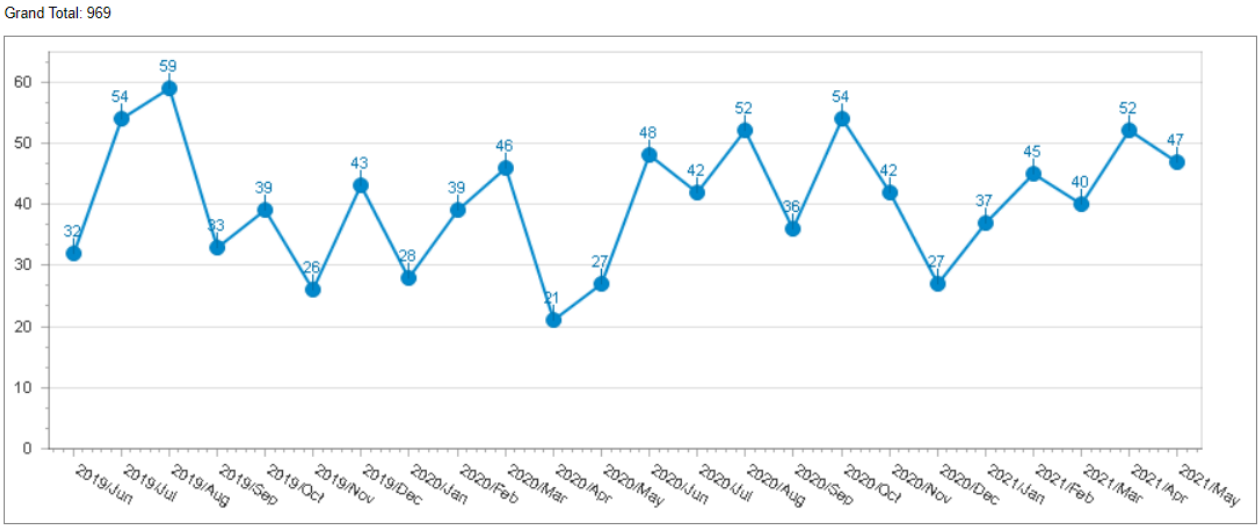


Communication with patient is the top sub category identified in our complaints, followed by Attitudes/manner.

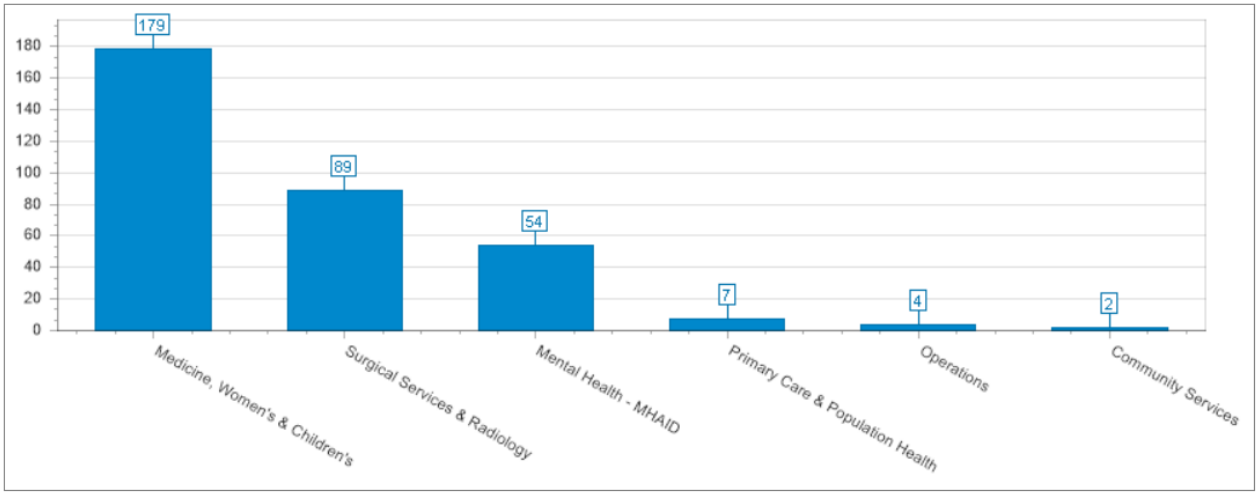
We know communication is a common issue. Below is the number of complaints received by month containing a communication issue of either, communication with patient, communication with family/care provider, attitudes/manner or appropriateness of comments.

There is a total of 969 complaints identifying one of these issues out of a total of 2012. 48% of our complaints received during this period contained at least one of these communication issues.

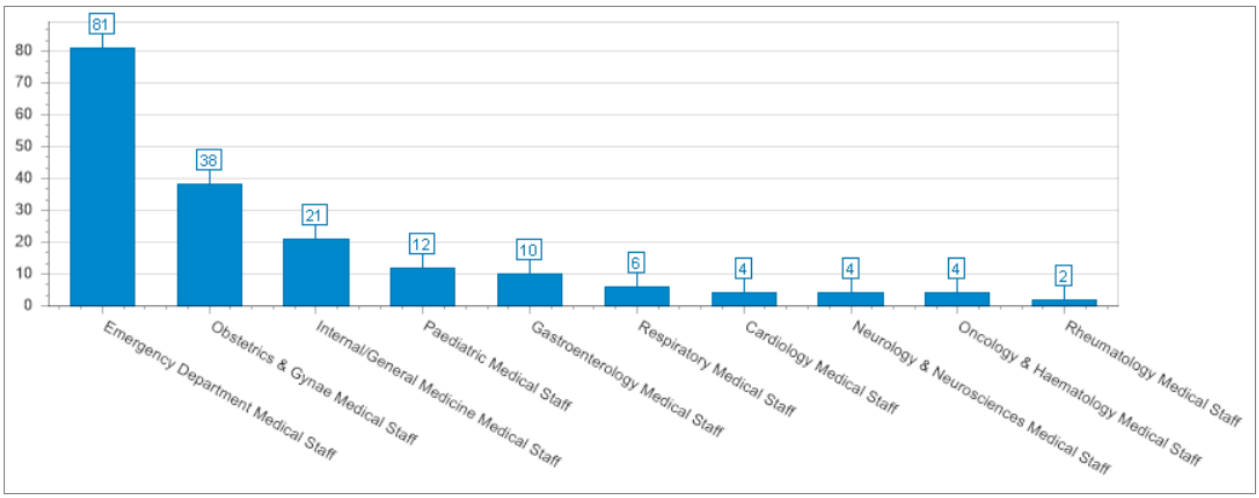
Complaints received by month containing a communication issue



Standard of Care – Medical by Directorate



Standard of Care – Medical Medicine, Women's and Children's Top 10 Ward/Areas



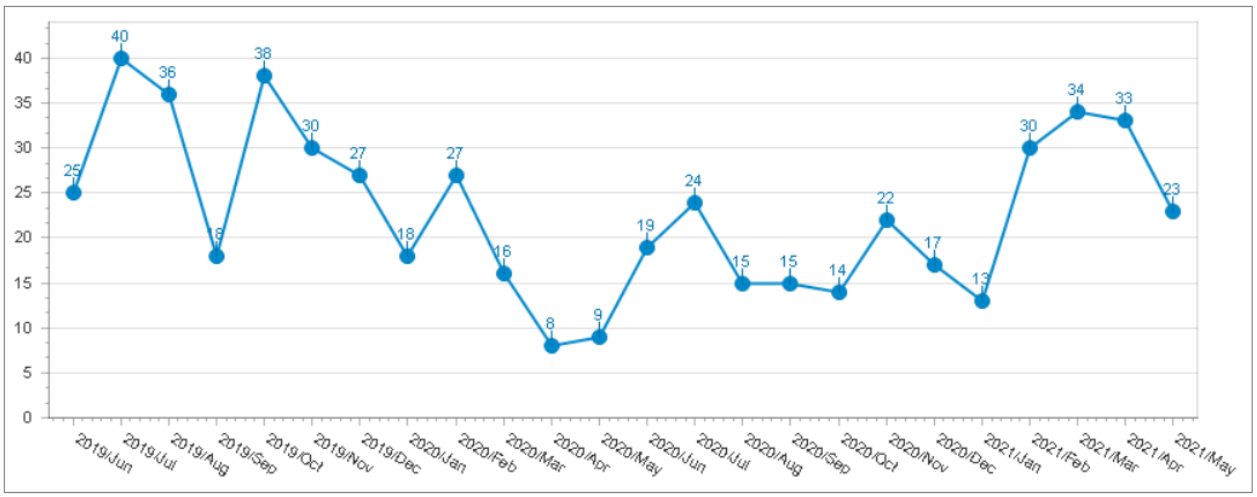
Emergency Department Medical Staff - 47 Dunedin Hospital, 34 Southland Hospital

Complaints regarding Access and Delays in Treatment

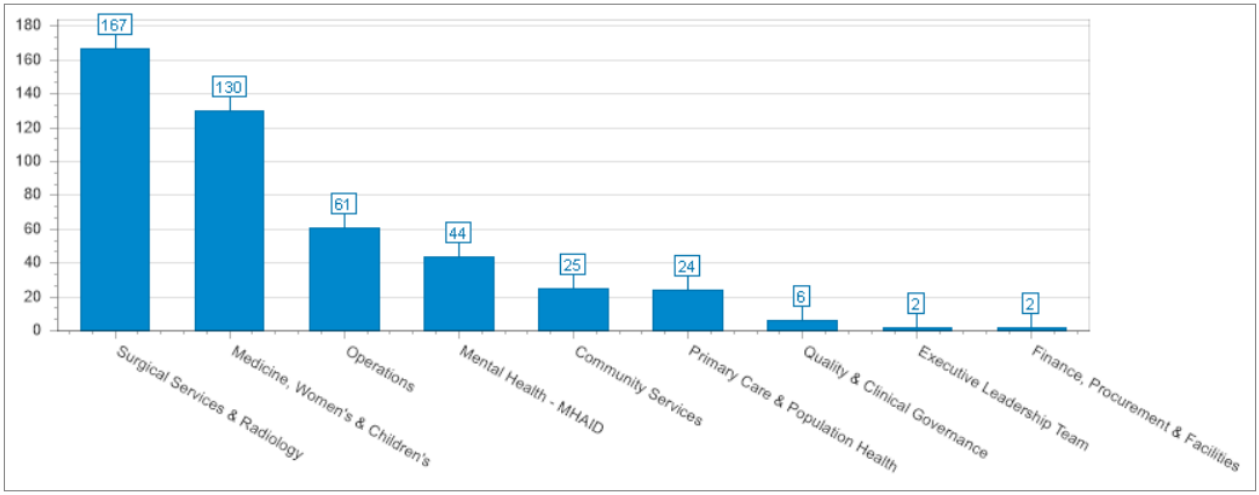
Delay accessing services/service availability/referral declined/delay in treatment

27% of our complaints in the last 24 months identify an access issue or delay in treatment.

Grand Total: 551

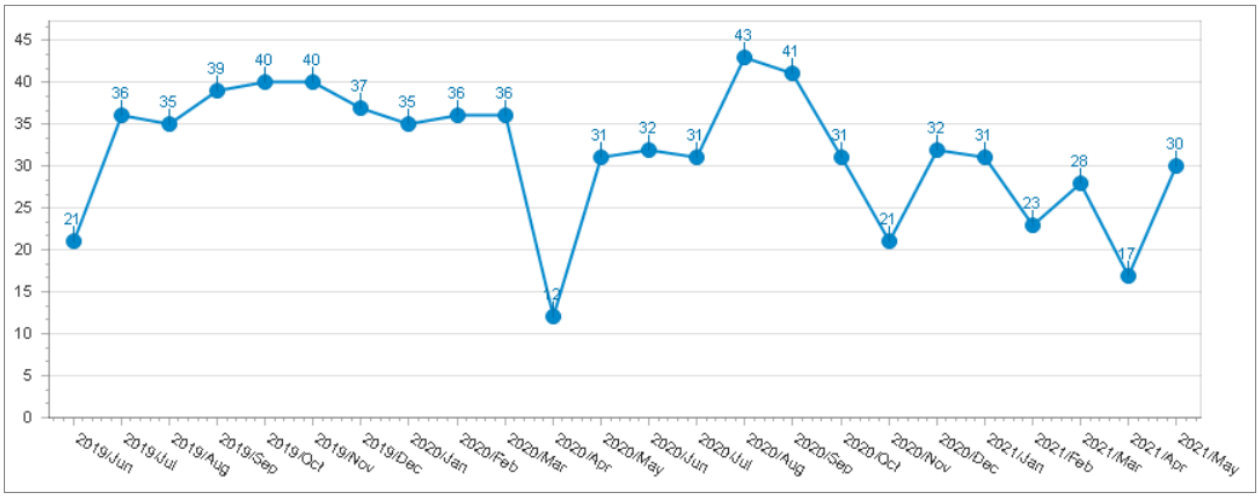


Complaints regarding Insufficient or Timely Information – by Directorate

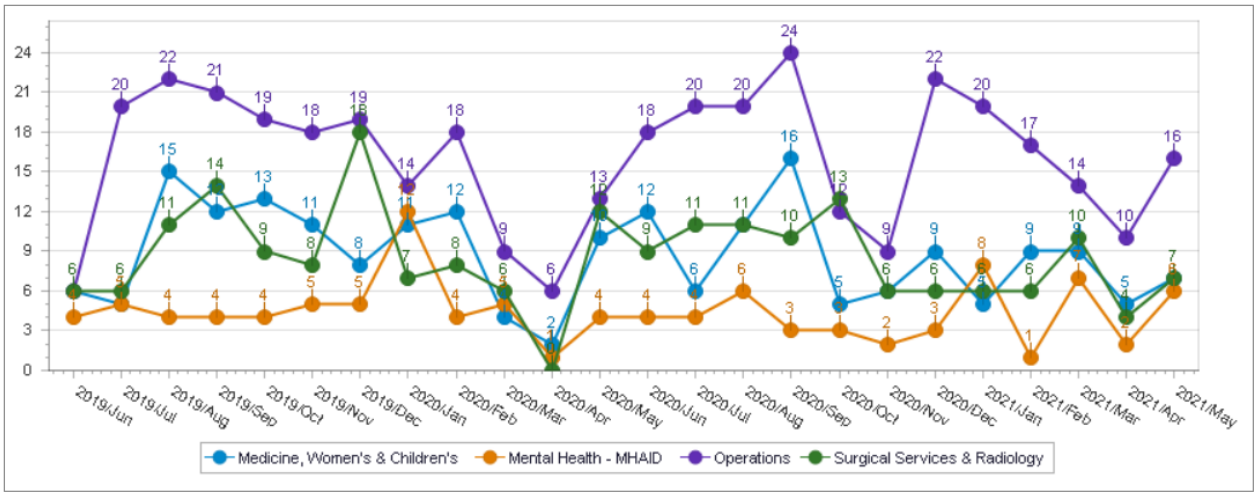


Southern DHB Compliments by month – last 24 months (June 19 – May 2021 inclusive)

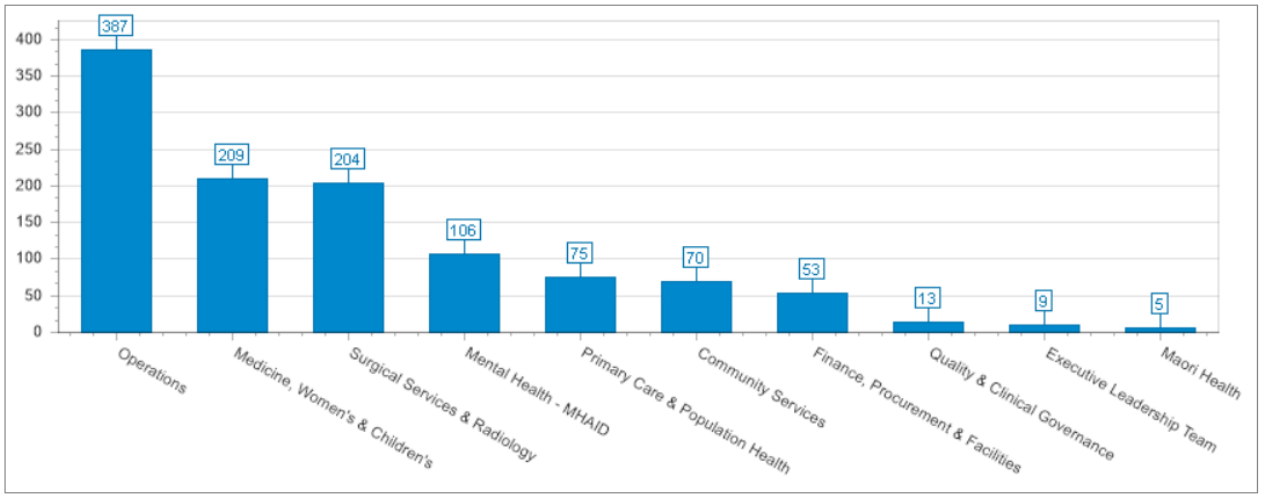
Grand Total: 758



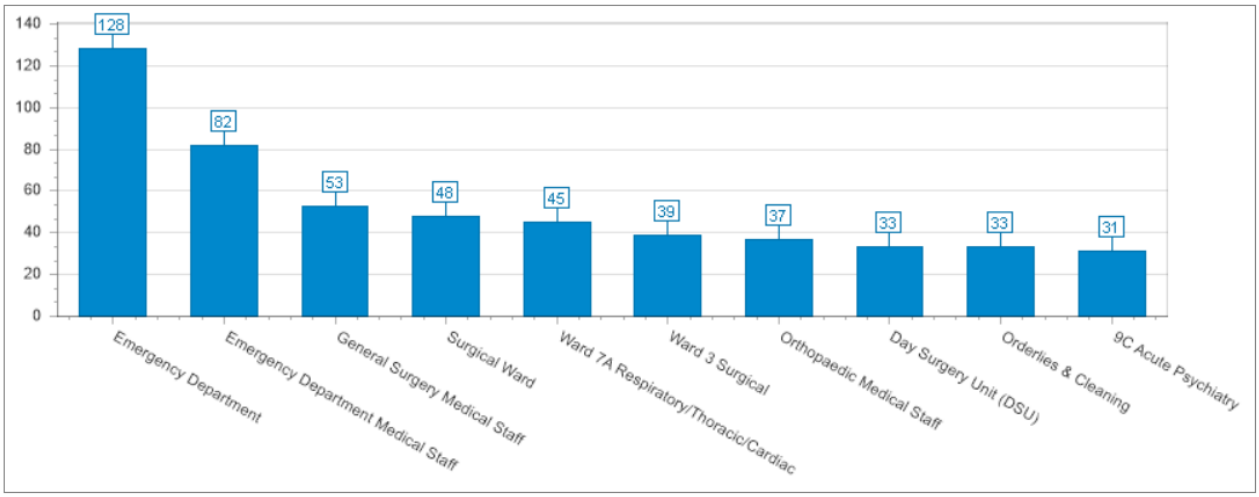
Compliments by Directorate (Top 4)



Compliments by Directorate – Last 24 months



Compliments – Top 10 ward/areas



FOR INFORMATION

Item: Performance Dashboard Development Progress Update 2021

Proposed by: Principal Advisor to CEO

Meeting of: 6 July 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
2. **Workforce**
3. **Equity**

Background

There was an agreed need for a more effective way in which to access performance information relating to our system. Given the evolution of PowerBi in this space, an initiative was started at the end of 2020 to go about building 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 at this point in development.

Next Steps & Actions:

The dashboard build is ongoing.

Appendices

1. **Performance Dashboard Progress Update June 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	Measure (yet to build)
6 Hr Target	Built/Complete	Output per FTE
Resourced Occupancy	Built/In UAT needing sign off	Community Pharms
Physical Occupancy	Built/In UAT	Hospital events as per Escalation Plan
ED Attendances (Rebuild of PoC)	Built/In UAT	High cost Pharms
ESPI 5	Built/In UAT	FSA's
ESPI 2	Built/In UAT	Average length of stay
CCDM Shifts Below Target	In UAT	Worked vs Contracted FTE
CCDM Bed Utilisation	In UAT	Primary Care (Enrolled Pop)
CCDM Care Hours Variance	In UAT	IDF's
CCDM Patient Acuity	In UAT	Mental Health Bed Days
CCDM Variance Indicator Score	In UAT	Follow up metric
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	
FTE (HR Dashboard)	In UAT	

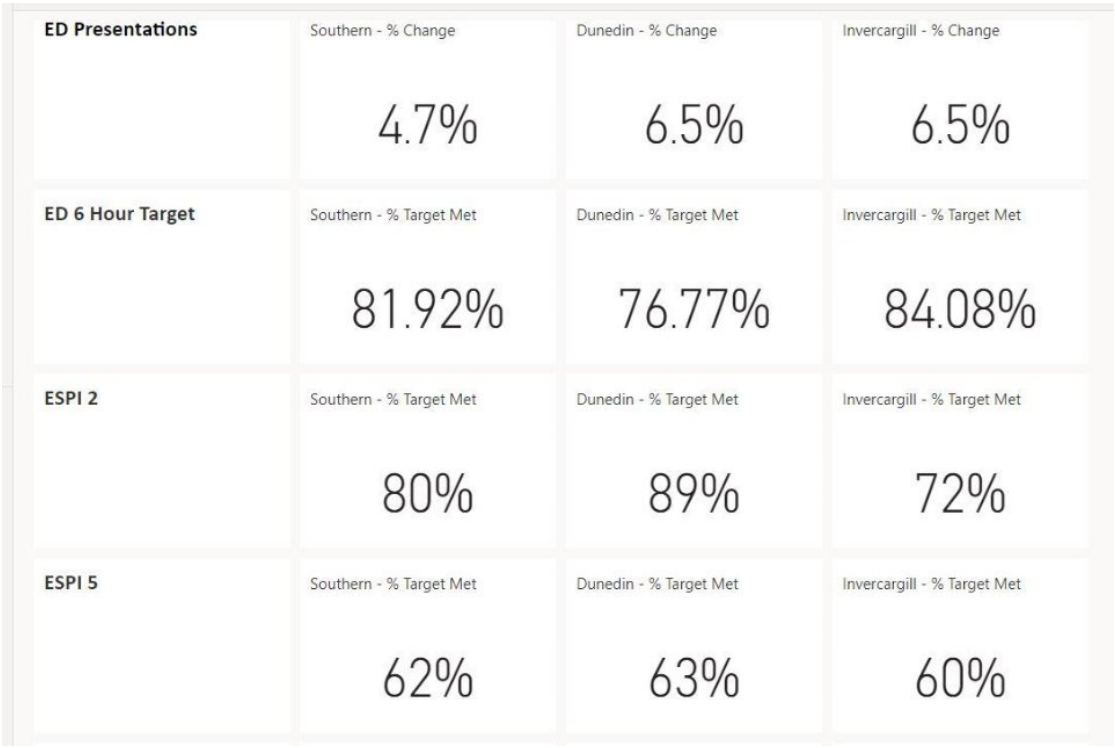
Next Steps:

Once the tiles have been built, they need to go through a sign-off process from staff in our organisation that are the business owners of this information to ensure that the data is being visually represented in an appropriate way, therefore presenting an accurate picture. This same cohort will assist in an ongoing manner to complete the monthly written commentary we are aiming to have embedded accompanying the quantitative measures. This helps make the information more digestible and understandable to dashboard users.

The team have been working through the tiles focussing on the metrics that we already have access too, ones that are more easily surfaced etc. to keep the momentum going as much as possible. There are a few metrics that have not been tackled yet as we know they will be more difficult for various reasons including access to the underlying data set.

Getting sign-off from the business owners has taken longer than anticipated but is being addressed. Currently this group of people is 1-3 people in our organisation so represents a bottleneck.

Figures below: Demo version of dashboard 'home' tile where the user will see a high-level visual of the metrics and some headline indicators. By clicking on any of these tiles, the user will be able to move deeper into the metric and get more detail. *Please note, this is a demo & under construction so the actual measures you see might not be accurate.*



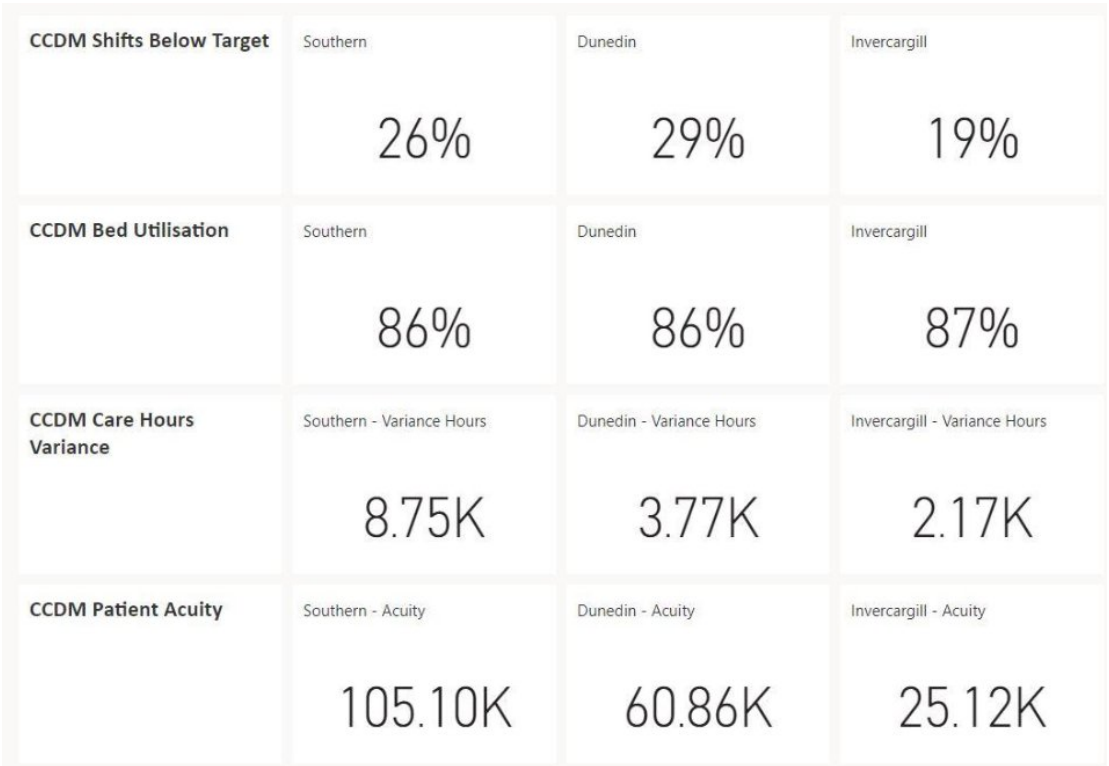
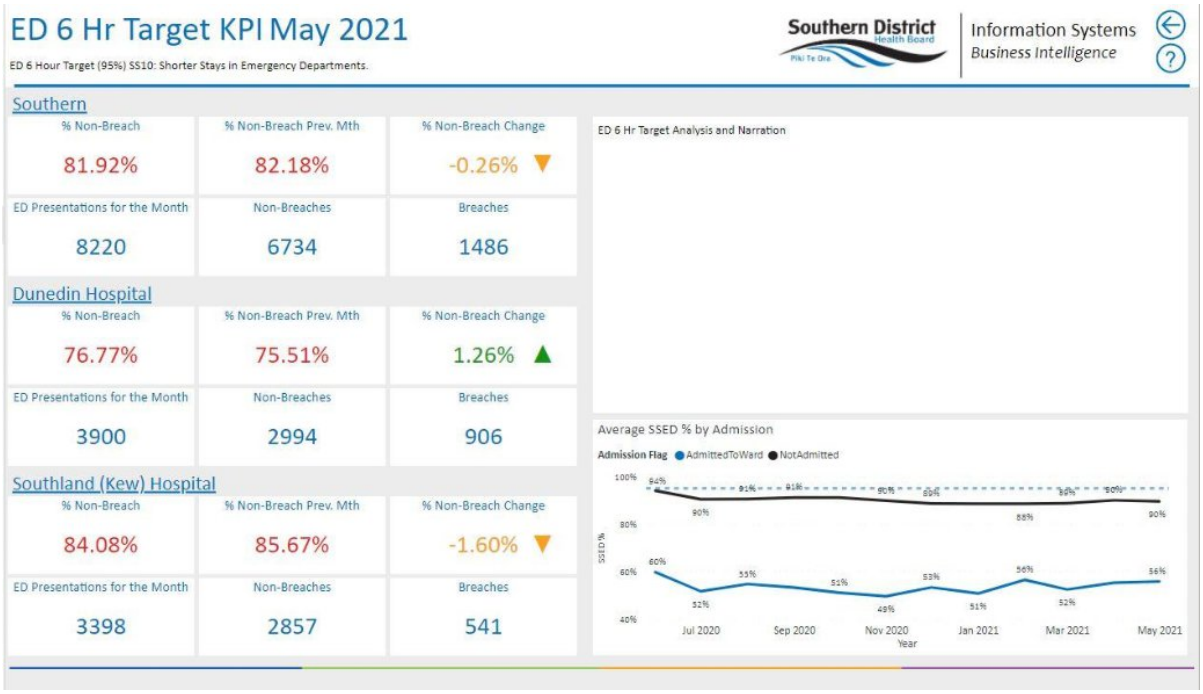


Figure below: Example visual of what the dashboard will present when clicking on the first ED 6 HR Target tile to go deeper into the information. In the empty box on the right will be where the user will be able to read the latest commentary providing context to the quantitative information on the left.

Whilst we are able to have colours and arrows in the deeper level of the dashboard, the higher-level view (in pictures above) is functionality not yet available from Microsoft as it's a relatively immature tool but is an expected update at some point in the future.



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

Specialist Services monthly report for May 2021

Lead Executive: Patrick Ng

EXECUTIVE SUMMARY

- Improving oncology performance, particularly radiation oncology wait list a key focal area.
- Elective surgery on track for June 30th forecast. Impacted by nursing strike, offset with outsourcing.
- Prework is underway on the assumption that a proposal will be requested for a new MRI machine at Dunedin hospital

Performance area	Previous month	Current month	Commentary
Case weights surgery			On track to deliver to April forecast despite unplanned nurse strike (-500 CWD for full year). However, large outsourcing expenditure in June a component of delivering this result.
Discharges			Discharges followed same pattern as CWD delivery. Outsourcing required to achieve + offset nurse strike impact.
ED six-hour target			Benchmarking now supplied and overall case is being written up for Southland. Starting to gain some momentum for MAU in Dunedin. Both initiatives key to long term EDSS improvement.
Cancer target <62 days			62 day performance improved. 53% previous quarter. 76% current quarter. Review completed of reported performance and improvements planned, particularly recruitment of reporting resource to improve use of reason codes in reporting.
FSA (ESPI 2)			Progress in Ortho Dunedin & Gen Surgery. Highest vols in ENT Southland. Successful recruitment but also working on transferring some ENT volumes to Dunedin to address.
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 similar to previous month (i.e. improved from earlier in the year. 2nd machine on track for Aug/Sept. Recruiting for additional shifts noting budgeted in 21/22.
Medical imaging MRI			MRI capacity in Dunedin remains challenging and working on prioritised CAPEX and operating budget to facilitate a 2nd machine. RFP underway for a provider for 2nd machine.
Colonoscopy 14 days			Materially on target despite recent high volumes.
Colonoscopy 42 days			Materially on target despite recent high volumes.
Colonoscopy 84 days			Additional nursing approved in 21/22 and actively being recruited to. Staffing shortage preventing volumes being transferred from Sthld to Dunedin which will speed recovery timeframes.

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.
Financial performance	Focus on achieving elective volumes per the forecast to minimise CWD revenue loss.	Successful with additional outsourcing – will earn more elective revenue but will also see unplanned outsourcing cost.
ICU air handling issues (for stage 2) slow to be addressed	Architects and mechanical engineers verbally agreed that they need to be engaged on developing air handling designs that will meet the specification originally designed to. However, to date the architects have not involved their legal counsel.	Our legal team is writing to the architects and mechanical engineers to advise that they can appoint their own peer reviewer, ours will operate in the background and that they want to engage with their legal counsel.

Generalism

- Recruitment continues with most SMO roles confirmed and a physio role also recruited into.
- Options being worked up by Building and Property to ensure that the de-cant occurs so that the build work for the medical assessment unit can happen as quickly as possible.
- Benefit realisation workshop in July will start to develop unit level measures which can be rolled up into robust reporting which attributes the reduction in sub-specialisation and the future 'pull' into the medical assessment unit combined with more intensive treatment and a shorter length of stay into improved ED performance and reduced overall length of stay for general medicine patients.

Oncology

- Confirmed recruitment campaign providers: building of campaign to attract more staff – underway.
- Proposal from Ernst & Young for the development of a 10 year plan under consideration.
- Confirmed a multi-year outsourced contract for Radiation Oncology treatments via RFP.
- Prioritised oncology roles for next year in partnership with the clinical leaders and will commence recruitment into these roles very soon.
- Commencing work on improving our FCT 62 reporting so that we are using the non-breaching reason codes more consistently with our peers. Recruiting an investigation / assist role for this.
- Supplied all FTE and volumes data to the Cancer Control Agency so that they can benchmark our FTE relative to volumes to the other cancer centres. Collaboration meeting with CDHB planned for the 7th of July.

Gastroenterology

- New reports now in production which split decline reasons by reason code, enabling us to see the raw decline rate and the outright decline rate once re-direction to other interventions is accounted for. Shows circa 18% raw decline rate and a net decline rate of circa 6-8%.
- No referrals now being accepted into category 'C', and the category is systematically being removed as patients currently within the category get their scope over the next 8 weeks. Establishing a KPI to ensure we track it towards closure over the next 8-12 weeks.

SP&C Services monthly report for May 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 31 May, Southern DHB reached a milestone of 43,873 vaccinations. The large majority (65.4%) of these were completed in the large DHB run clinics in Dunedin and Invercargill. Increasing numbers (34.6%) are being undertaken by primary care into rural areas. ▪ Southern DHB and WellSouth has undertaken a co-design process and partnered with four lead Māori providers to lead the rollout for Māori and Pacific Island populations. ▪ The health response at Queenstown airport continues to take up a large proportion of the regulatory and protection team's work. ▪ Maritime activity also continues to take up a large proportion of health protection work. ▪ Preparation is underway for the new release of the National Contact Tracing Solution (NCTS) in July. Further hui have been held with Māori health providers across the district. ▪ There have been 4,659 (COVID swab) assessments in May including 570 at the maritime ports.
Immunisation			▪ Measles Mumps Rubella (MMR) Campaign for 15-30 year olds is on hold within the Southern DHB. However, General Practices and Pharmacies continue to vaccinate. Planning will start in mid-July as to how we restart this programme. ▪ Outreach clinics that were paused due to COVID-19 vaccination programme have returned to capacity.
Maternity			▪ The Wanaka Maternal and Child Hub is up and running. The final refurbishments have yet to be completed, but the LMCs are working around this. ▪ Significant progress has been made to support the seamless transition of Charlotte Jean Maternity Hospital to a Southern DHB run facility by 1 July. The name of the service will be changed to Central Otago Maternity Hospital (COMH). ▪ The Maternity Options paper for Wanaka and Central Otago was updated with greater financial detail. This paper was submitted to the Board at the June meeting. Their endorsement means we can proceed with the Request for Proposal process and also advance the Business Case for the Ministry of Health Capital Investment Committee.

Current Issues	Summary of risk	Mitigation strategies
COVID-19 vaccination programme	Public Health nurse work force has been deployed for vaccination of priority groups in Southern. This means some Business as Usual (BAU) and programme work has stopped.	▪ Employment of a stand-alone workforce has occurred. Some support is still required, in particular in Southland to support clinic staff to develop competencies. ▪ Additional immunisation coordination workforce is still required to support the increasing number of vaccinators in the community undertaking peer assessments. This is underway in the vaccination programme, but will in the short term place strain on the Population Health Immunisation Coordinators.
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

- MoH provided new guidance for a number of areas, including immunisation, maternity care, environmental sustainability and health workforce
- The full final draft plan will be submitted to MoH on 2 July.
- It is expected that this draft is as comprehensive and completed as possible. MoH will provide feedback on the final draft of the Annual Plan on 16 July. DHBs are expected to work towards Board approval processes from mid-July.

Aged Residential Care

- The Registered Nurse (RN) workforce issue in ARC continues to become more challenging, with increasing issues and risks in the system.
- Both our Chief Nursing Officer and Director of Nursing for Strategy, Primary & Community met face to face with the Southland ARC Facility Managers to hear their concerns. Dunedin facilities have requested a similar meeting.
- The system is seeing an escalating reduction in ARC bed capacity due to staffing. This has created significant issues and risks across the system impacting timely discharges, affecting patient flow in hospitals and placing residents at the correct level of care.
- The impact is that facilities are not admitting to beds at all, or only admitting 'non-complex' residents, e.g. those with no behavioural issues, not bariatric, no complex wound or respiratory issues, and no end of life admissions.
- We have reconvened an ARC RN Recruitment & Retention Steering Group to consider suggestions to address the workforce issues.

SP&C Services monthly report for May 2021

Lead Executive: Rory Dowding

EXECUTIVE SUMMARY

Public/Population Health Service

Sexual Health

- The Dunedin Service is operating at 60% of staff capacity due to recruitment, and urgent annual leave. A review of the Southland Sexual Health location needs to occur to ensure that we are clear about what is needed and overall investment required to bring this site to an appropriate standard, as well as determine if there are alternative site options that should be considered.

Drinking water

- Feedback has come from the Ministry and Taumata Arowai that the Water Services Bill may not come into effect until closer to November this year. The impact of this is that Public Health is likely to be continuing to manage drinking water until early 2022.

Hearing and Vision Screening

- Due to a screening breach 150 children screened between 2010-2020 are to be offered a further appointment. This includes 66 children identified who now qualify for the year 7 Ministry of Health screening programme.

Council Long term Planning

- Every three years Councils review their ten year long term expenditure plans. To date five hearings have been completed with the focus being on complementing upstream engagement with council staff (which exists with most councils) and encouraging use of the United Nation's Sustainable Development Goals (SDGs) as a common language between health and councils.
- Local issues are also highlighted using the SDGs as a case study, for example, Smokefree Aotearoa 2025, alcohol harm minimisation, infrastructure, drinking water quality, active transport, food security and air quality.

Community Oral Health Service

- Spacial Equity - Project meeting attended where shortlist of indicators were agreed.
- Arrears have reduced in some areas and overall we are at 25% and trending down. The 4th Chair at Dunedin is starting to make an impact; arrears are building in Wakatipu and Winton

Rural health

Lakes District Hospital

- The winter plan has identified times of the day when the Emergency Department (ED) is vulnerable due to dependence on a single Senior Medical Officer (SMO) in the evening. Options to provide a second doctor are being considered. There is also an opportunity to utilise a Physiotherapist for 4 hours per day in ED to see appropriate patients who do not require SMO input.

Rural hospitals

- A new Heads of Agreement document has been offered to the four Rural Trust Hospitals whose existing contracts were due to expire on 30 June 2021. Negotiation about service schedules is underway. There remain a number of concerns to negotiate, e.g. pay parity, pay equity.

Refugee Quota Programme

- On 26 and 27 May, WellSouth held a conference 'Former Refugee Mental Health and Wellbeing – Working Together, Learning from Each Other'.
- The refugee resettlement programme has resumed. Currently, there are limited intakes, as the COVID pandemic is being managed. In May, one Afghani resettled in Dunedin.
- Refugees arriving in New Zealand will go into Managed Isolation and Quarantine (MIQ). They will observe the same COVID19 health-related requirements as other arrivals to New Zealand.
- While the plan for 2021-22 remains fluid, the current forecast for the Southern district is:
    - Dunedin – 70 refugees, ethnicities: Afghan and Syrian
    - Invercargill – 40 refugees, ethnicity: Colombian.

People and data & digital monthly report for May 2021

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

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

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

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

Immunisation Clinics Workforce

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

Organisational Development

There is a lot of positive work being done across this space including:

- Leadership development – currently appraising a proposal from a partner to work with us on a modular approach to leadership development that focuses on leading self/others and functions.
- Other areas of focus include psychological safety workshops, accessibility dame & the LEADS programme.
- A focus on building our internal change capability is a key strategic area for us as well. This past month has seen the 'School for Change Agents' rollout , as well as change cycle workshops and some further planning around enhancing our use of Prosci.

Proposals for Change

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

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

Green Healthcare Strategy

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

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

People and data & digital monthly report for May 2021

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

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

Digital & Tech Performance Indicators	Previous month	Current month	
My Lab (Physical space developed to assist with Change in technology and behaviours)			Asbuilt RFP closed and are preferred supplier. Funding required for Asbuilt contract from NDH project costs for change. Project on hold until funding can be identified. Mike C meeting with Mike B re funding as part of change management for the NDH.
Digital programme of work			
New Dunedin Hospital (Digital)			Programme Business approved at April board meeting. Now with MoH for DG & CIC approval. Funding approved for T1.1. Paper going to board in June for T2.1 funding. External gateway, technical and independent reviews all now complete, advice taken forward to the detailed business case (DBC). Start-up clinic with Treasury for the DBC was completed on the 29th April.
Digital Strategy Update			SI PIC's project initiated. Currently reviewing Digital team structure to ensure its able to meet the demands of BAU, Projects and NDH development. All projects in the strategy will fall within the detailed business case for the NDH.
South Island PICS			Team currently being recruited, steering group established and project milestones being confirmed.

Current Issues	Update/Achievements	Upcoming key deliverables
Funding for Digital Work plan	Paper being presented to the exec and board in May/June for T1.2	Executive and board approval
Local & Regional Digital Collaboration and Delivery	Meeting with the Chairs and CE's of the South Island re two options for digital services being delivered into the future.	Recommendations are being considered by the DG Digital and Data to ensure alignment with reform principles.
Recruitment of roles (Digital)	It has taken longer than expected to recruit key roles for the T1.1 team who are responsible for developing the detailed business case.	Recruitment for T1.2 will start sooner given lessons learnt from T1.1 recruitment process.

Digital Strategy

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

Finance monthly report for May 2021

Lead Executive: Nigel Trainor

EXECUTIVE SUMMARY

Progress is being made with facility changes to both Dunedin & Invercargill, we are gaining excellent and useful insight into the process.

The financial results for the organisation for May were disappointing, we were over budget in both Personnel and Clinical Supplies, some being offset by revenue and some from a mixture of factors

Budget 2021/22 is processing and must come to a landing soon,. The capital program will be discussed at the next ELT and will come to the Board in August

Key Projects	Previous month	Current month	Commentary
Financial sustainability			While the month of May 21 seen an increase in FTE across a number of areas and being adverse to budget, the Year end is still forecast to be $15m BAU plus additional one offs to finish with a $25m 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.
FPIM: Finance Procurement & Information Systems			FPIM will go live on 1 July and the risk profile is low.
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 feed back with their view on an acceptable bottom line, we are now working through a process to achieve this in the budgets. An update will be verbally reported to the Board

Facilities

- The team are working to a 20-week timeline for the development and delivery of the new CT. This is tracking to time, there are some risks in term of the delivery of the CT, but we are tracking its progress across the world
- The MAU planned for in Dunedin hospital is tracking with the decanting of existing departments plan nearly complete
- The ICU rectification project is being closely monitored with progress being made.
- 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: Strategic Refresh Update June 2021

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

Meeting of: 6 July 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 Strategic Refresh.

Specific Implications For Consideration

2. Workforce

- Engagement with our workforce continues via multiple channels.

3. Equity

- None

Background

4. 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.

Appendices

Synergia Board progress update June 2021

SOUTHERN DHB STRATEGIC REFRESH

June update to the Board

1. KEY POINTS

- The strategy refresh project is proceeding in an environment of some uncertainty and rapid change, with pending health reforms and structural change. The Transition Unit is providing ongoing guidance for the future health system, particularly related to localities.
- 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.
- There is a local process, initiated by the PHO and rural hospitals, to support a broad discussion about establishing localities in the South. There is the possibility of putting up a proposal for one of the Southern localities to be a 'prototype' for how localities could operate. The strategy refresh team will provide information to inform this locally-led process.
- The project is generally on course, with considerable sector engagement completed, and is ongoing. There are some slight delays in data acquisition from the Ministry of Health.
- There has been a delay in the strategy refresh workstream in engaging fully with Māori to explore the opportunities with Māori commissioning, Māori service provision and equity for Māori as part of the strategic refresh process. This is due to Associate Professor Matie Harwood (a part of the Synergia team) being seconded into supporting the establishment of the Māori Health Authority nationally, which has reduced her time availability for this project up until this point. This has been discussed at both the Steering Group and Working Group governance levels for this project.

2. IMPACT OF THE HEALTH REFORMS

With the announcement of the Health NZ structure and timing of the health reforms, the Southern DHB, as an entity, will not exist beyond 1 July 2022. Over the coming year, there will be ongoing guidance from the transition unit and the emerging Health NZ and Māori Health Authority about how the new system will function – which will include hospital services, community services, public health and services for Māori.

Given this situation, the strategy refresh project will not try to provide guidance for the DHB as an entity (as you would with a strategy that is being developed in normal circumstance). Rather it is focusing on guidance for the underpinning aspects of health system performance for the Southern district in the future.

The focus areas include:

1. **Mana whenua partnership**: The establishment of governance and partnership arrangements that give expression to tino rangatiratanga.
2. **Equity:** Focus on a whole-system response that will enable improved outcomes for Māori, and address inequities across population groups, socioeconomic differences and localities.
3. **Localities:** The establishment of effective localities and locality provider networks that deliver improved population health are health care outcomes.
4. **Systems of care:** Guidance for systems/models of care throughout the region that support care closer to home and support the best use of hospital specialist services (a key aim being that in order for the new Dunedin Hospital to be sustainable, there needs to be substantial whole-system efficiencies associated with acute medicine, general medicine, rehabilitation and surgery – and these need to be in place, operational and delivering measurable results before the new hospital opens).

3. NEXT STEPS

The work over the next month will include:

- Ongoing work on the partnership relationship with mana whenua.
- Ongoing engagement with the sector.
- Analysis of population demographic and health data to build a picture of the population, service utilisation and patient journey maps to inform strategic direction.
- Consideration about the framing and communication of this work, in light of the change in focus to supporting the Southern health system to transition in line with the Health and Disability System review.
- Through this, the beginnings of the strategic design to inform the future system will occur.

FOR INFORMATION

Item: Māori Workforce Development

Proposed by: Gilbert Taurua, Chief Māori Health Strategy and Improvement

Meeting of: Southern DHB Board Meeting 06 July 2021

Recommendation

That the Southern DHB Board:

- **Supports the intent to appoint a Senior Manager Workforce Development position that will strengthen the future Māori workforce capacity across our health system;**
- **Notes that it will be the Iwi Governance Committee who will ultimately approve whether this initiative proceeds, in keeping with the intent that IGC will govern the utilisation of investment funds available to enhance Equity Initiatives.**

Purpose

1. To initiate a discussion around Māori health workforce development and to appoint a dedicated role that will enhance our Māori recruitment, employment and retention.

Specific Implications for Consideration

2. Financial
   - There are financial implications with this appointment and could be expended through the 2021-22 increase in equity funding.
3. Quality and Patient Safety
   - Limited impact on quality and patient safety directly, however, over time this would improve responsiveness to Māori patients and their whānau.
4. Operational Efficiency
   - An increase in Māori workforce will have operational implications and efficiency.
5. Workforce
   - This would have a positive flow onto to our Māori workforce while building our workforce capacity and capability.
6. Equity
   - Māori health equity focus to this paper.

Background

7. The Board endorsed this resolution at a recent DHB Board meeting, which has led to the development of this paper and potential proposal to appoint a specialist Māori health workforce position:

   "In recognition of obligations under Treaty of Waitangi and Whakamaua Māori Health Action Plan 2020 – 2025, and acknowledging $800,000 set aside in the 2020/21 Budget for the Māori Health Directorate, the Board approves an increased sum of $1.2million in the 2021/22 Budget as a clear recognition the Māori Health Directorate is under resourced in Otago and Southland".

Appendices

Appendix 1 Māori ELT Workforce Paper

Appendix #1:

Māori Workforce Development Paper

Introduction

If the Southern DHB is serious about increasing our Māori health workforce and leadership across the southern health system, a targeted and resourced approach will be needed. The Board has indicated support to improve our response to increasing our Māori health workforce per a recent resolution that was endorsed.

Increasing the Māori workforce in the health and disability sector is a pathway to improving Māori health and equity across this critical sector. This paper outlines the direction from the government on Māori health workforce development, it provides some South Island DHB Māori workforce data and then provides an overview of current Southern DHB Māori workforce development activity. It concludes with a proposal for the establishment on a Senior Manager Māori Workforce Development based on similar job description that are being established in Mid-Central and Canterbury DHBs.

Central Māori Workforce Policy

There are a number of key Government policy documents on Māori health workforce development and has been supported by the workforce development organisations like Te Rau Ora. These policies provide a platform for our Māori workforce development priorities:

New Zealand Health Strategy:

Enabling Māori to contribute to decision-making on health and disability services and participate in the delivery of those services are pathways to the health system becoming more responsive to people, an action under the People-Powered strategic theme of the New Zealand Health Strategy. This applies particularly to the non-regulated workforces, namely those not regulated under the Health Practitioners Competence Assurance Act (2003).

He Korowai Oranga:

The Māori Health Strategy sets the strategic direction for Māori Health in the health and disability sector. One specific objective is to increase the number, and improve the skills, of the Māori health and disability workforce at all levels.

Raranga Tupuake:

The Māori Health Workforce Development Plan 2006 was a strategic framework that guides the development of the Māori health and disability workforce over the next 10 to 15 years. Two goals identified in the plan are to:

- expand the skill base of the Māori health and disability workforce.
- enable equitable access for Māori to training opportunities.

Whakamaua: Māori Health Action Plan 2020-2025

Whakamaua provides a roadmap of tangible actions that contribute to achieving the vision of pae ora for Māori. It guides the implementation of He Korowai Oranga and bridges a gap between Whakatātaka Tuarua 2006-2911 the Ministry's previous Māori health action plan.

- Te Whainga Tomua 2: Ngā kaiārahi Māori – Māori leadership.
- Te Whainga Tomua 3: Ngā kaimahi o te rāngi Hauora Māori me ngā tānga whaikaha. Māori health and disability workforce.

Southern DHB Workforce Data

This data is provided by the South Island Alliance Programme Office under the South Island Workforce Development Hub and I understand is populated from data and reports submitted from our People Culture and Technology directorate. The Alliance provides regular updates in there 'Te Waipounamu South Island Health Workforce Data' report which is a summary of southern health workforce. While the accuracy is questionable it's the only comparative DHB data I was able to access.

DHB Ethnicity Employee Headcount - Comparison against Proposed Target

DHBs - Sept 2020	Māori Headcount	Total Headcount	Māori in workforce (if = 9.7% total population)	GAP
Canterbury	423	10140	984	561
Nelson Marlborough	170	2622	254	84
South Canterbury	25	791	76	51
Southern	184	4617	448	264
West Coast	44	791	77	33
South Island	846	18961	1839	993

Unknown Employee Ethnicity Data

DHBs - Dec 2020	% Unknown as at March 2015	% Unknown as at June 2019	% unknown at Dec 2020
Canterbury	22.7	15.9	8.1
Nelson Marlborough	15.5	7.3	4.6
South Canterbury	7.8	6.1	4.3
Southern	7.4	5.1	2.8
West Coast	61.7	46.6	17.3
South Island	19.0	12.9	6.6

Southern Workforce Strategy

The Southern Workforce Strategy describes the vision and goals for transforming our workforce, within the context of the overall Southern Health System and goes back to when the DHB was governed by Commissioners. The goal of this Workforce Strategy is to create a sustainable and contemporary workforce by developing workforce capacity and capabilities, as well as improving workplace culture.

The Southern Health Workforce Strategy and Action Plan describes the strategic drivers, objectives, and actions for building a sustainable and contemporary workforce. This Strategy must be viewed as part of the bigger picture of sustainability along with other transformational initiatives carried out by Southern DHB and WellSouth as key partners in the Southern health system. Future development of a Māori workforce ought to be aligned to this Strategy.

Hauora Māori Training Fund

The Southern DHB holds an existing Hauora Māori Training Fund with the Ministry of Health. The purpose of the Hauora Māori Non-Regulated Workforce Training Fund is to provide access to formal accredited training programmes for the non-regulated Māori health and disability workforce. This training supports the non-regulated workforce to develop formal competencies in their current roles and develop their potential to move into other health sectors roles as relevant. Māori whānau who are users of health services benefit from Māori health staff/trainees who complete their programme of study, by having access to a workforce that safely meets their cultural needs. This fund is managed by the Māori health directorate and has supported primarily training like the Tipu Ora Certificate in Whānau Ora.

Māori Cultural Education and Training

The Southern DHB has 1.8 FTE allocated for the purposes of cultural education and training. This training is provided through Learning and Development under People Culture and Technology. Training delivered includes the Treaty of Waitangi, cultural competencies, Māori Health, tikaka and kawa. The educators are involved in many activities and more recently have been delivering training to general practice and the rural hospital.

Discussion have been underway with the Otago Polytechnic to provide a training scheme under the Certificate in Bicultural Competency (Level 4), designed for the upskilling of staff employed by the SDHB and SDHB contracted providers. The proposal has been designed to assist SDHB to build bicultural competency across the organisation, and to enable verification of a minimum standard of practice for all staff. The proposal allows Southern DHB to deliver teaching and assessment in bicultural competency under Otago Polytechnic accreditation.

Kia Ora Hauora

Kia Ora Hauora is a response to the national and international shortage of health sector workers and the demand for more Māori health professionals in the sector. The programme structure comprises of a national coordination centre, which sits with Canterbury District Health Board. There are four regional hubs which are the key mechanisms for delivery of the programme in Northern, Midlands, Central and Southern. The programme promotes health careers to Māori secondary school students. Plans are underway to extend this programme across the Southern health system, which will enable Māori secondary school student opportunities to participate in a Māori health incubator and have exposure to the range of health services across our district including our hospitals. Kia Ora Hauora has a focus on four key target groups:

- Māori who are currently studying at secondary level and whare kura students
- Māori who are studying at tertiary level
- Māori who are in-work and considering a career change, and
- Māori who are in the community, considering a return to the workforce.

TIPU MAHI, South Island Māori Workforce Development Project

This project is a collaboration between Te Herenga Hauora (the South Island DHB GMs Māori) facilitated by SIAPO (Workforce Development Hub) and Kōhatu, Centre for Hauora Māori in the University of Otago. Kōhatu is supporting the background, design, implementation and evaluation of a strategy to grow the South Island Māori health workforce and ensure that workforce is well supported and thrives. Learnings from this project will be of direct benefit to the SI DHBs and learnings from this project will be shared with others nationally. The overall aim is to have the proportion of the South Island health workforce at least mirror the proportion of the South Island Māori population to support equitable health outcomes for the South Island Māori population.

Stage 1 – Background (Review of Evidence, Stocktake, Consultation, Benchmark, Programme and Evaluation Plan)

Aim of Stage 1: To investigate how SI DHBs can deliver 'best practice' in the recruitment, retention and support of the emerging Māori workforce through exploration of the current picture, and review and identification of recognised best practice.

Timeframes: This stage will occur in the first six months of the project.

Stage 2 – Co-design of evidence informed strategy and initiatives

Aim of Stage 2: To draw on knowledge from Stage 1, and to co-design with SI DHBs a strategy and actions to build and support the DHB's Māori workforce.

It is envisaged that this phase will be completed by the end of the first 18 months of the project with outcomes emerging from this stage over the course of 12-18months.

Stage 3 – Implementation and evaluation

Aim of Stage 3: To implement the recommended initiatives, evaluate, quality improvements, write up final report and develop the Toolkit.

We envisage that this project will have an iterative and 'continuous learning' approach, with high levels of communication within and between DHBs, the project team members, project Governance and relevant other stakeholders. Our experience is that responsive and timely communication is a crucial component of success for a project such as this and ensuring there is responsive communication will be an important goal of all phases of the project.

Pro-Equity Māori Recruitment Strategy - Allied Health, Scientific and Technical

The Allied Health, Scientific and Technical directorate have drafted a policy document for recruitment and employment of the Māori allied workforce. The SDHB recruitment guidelines has been developed as an affirmative employment strategy based on the following principles:

- Each DHB will employ a Māori workforce that reflects the Māori population proportionality for their region by 2030 – report annually.
- Each DHB will employ a Māori workforce with occupational groupings that reflect the Māori population proportionality for their region by 2040 – report annually.
- In each DHB 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview - report by October 2019, – report quarterly.

Proposed Senior Manager Māori Workforce Development

The Canterbury DHB are recruiting three new roles in their People and Capability team. Two of these positions are about growing the Māori workforce and the third is about growing diversity in the workforce (including Pasifika, gender and disabilities). The Kaiārahi Matua, Tupu whānake me mana taurite (Workforce Development Lead – Māori and Equity) has responsibilities to lead and implement strategies to attract, onboard, support and grow Māori and tāngata of other diversity and minority groups. That through these roles they will increase cultural competence, equity, awareness, safety and responsiveness across the Canterbury and West Coast DHB. That this position will be permanent full-time position based in Christchurch to lead the delivery of key initiatives and programmes of work, champion inclusive recruitment and workforce development strategies; and help create a more supportive and inclusive workplace.

It is therefore, proposed that ELT discuss this priority and provide direction to the CMHSIO on our commitment to moving our Māori workforce development strategy forward. The following position description has been adapted from the Mid-Central DHB and is provided as a possible solution for ELT consideration. The DHB 2021/22 budget discussions have already identified possible funding to support this position.

FOR INFORMATION

Item: Patient Flow Update Report 21 June 21 2021

Proposed by: Patient Flow Taskforce

Meeting of: Board, 6 July 2021

Recommendation

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

Purpose

To summarise progress of actions of the Patient Flow Taskforce.

Specific Implications for Consideration

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

Background

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

Discussion

Progress in the last month has seen a reset by the taskforce to plan for the next phase. A workshop to plan this with the taskforce has been had and a re-prioritising of focus has occurred.

Next Steps & Actions:

- Two key workshops with the SLT/Ops clinical leadership teams have been scheduled on the Southland & Dunedin sites. The agenda for these is to focus on two main

areas – how to use the metrics and the expectations around driving personal ownership collectively.

Appendices

1. **Patient Flow Taskforce Progress Update**

PATIENT FLOW IMPROVEMENT PROGRAMME

Month #5 Progress Update

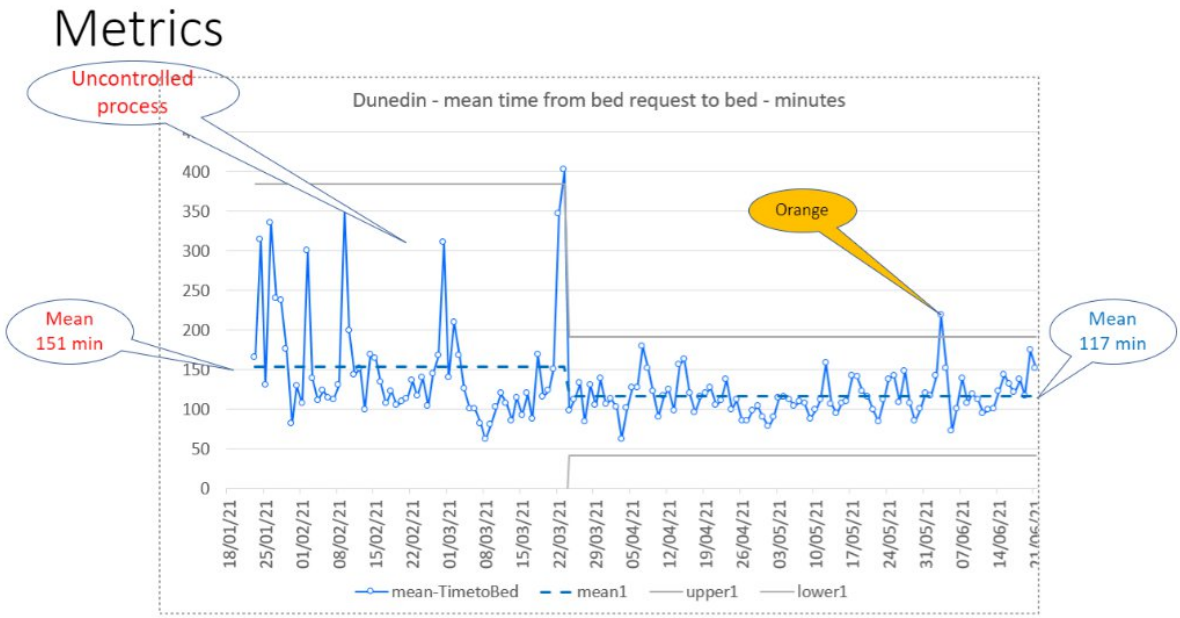
Summary of Patient Flow Taskforce activity to date:

- Comms/Engagement: Ongoing – weekly newsletters to staff outlining feedback, activity and the wins we are seeing in teams. The fortnightly stand-up **is** open to any Executive and Directorate leaders and others to join **and** is ongoing. **Messaging specifically aimed at communicating the reset and continuation of this programme is the next action. The n**ew Exec. Director Clinical Governance & Quality brings fresh leadership to the taskforce which is having a positive effect.

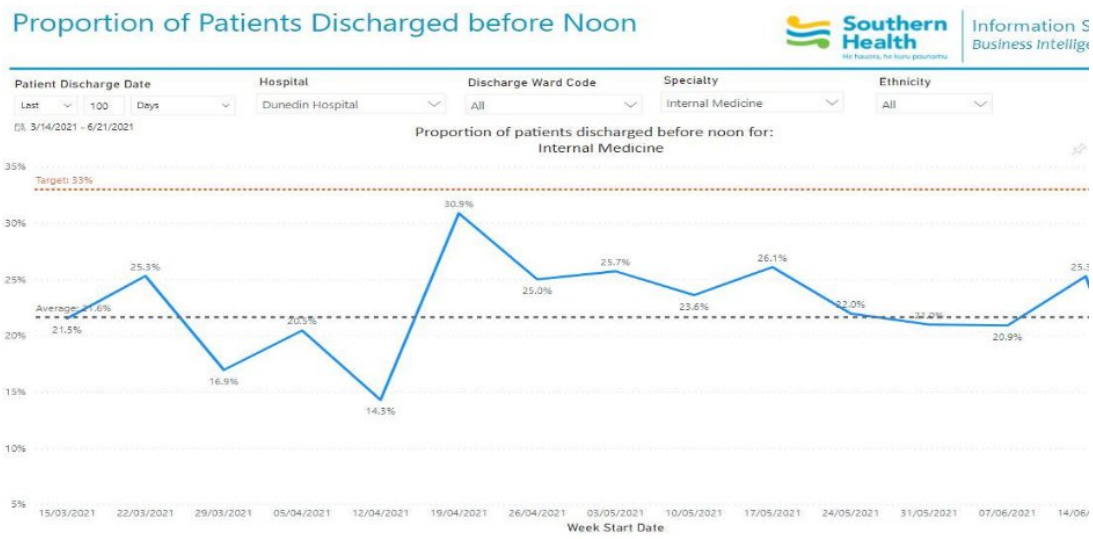
- Wellbeing initiatives are continuing

- Metrics: The run-charts are still in development however within the two SLT workshops planned for the two days post Board meeting, a large focus will be on the metrics, how they can be used and what we expect people to be focussing on **because there is excellent information available now within the patient flow dashboards that needs further socialisation with the teams to maximise the value.**

- On closer analysis of some of the data we can see improvement through a flattening of variation within the measurement of daily average time from bed request to admission into a bed (Dunedin) with a modest reduction of the overall mean from 151 to 117 minutes, as seen in the snapshot below:



Further the Image below is an example of a run-chart style showing Dunedin hospital before noon discharges for Internal Medicine. These are the reports that are still in development.



Significant current workstreams:

- **Establishment of Integrated Operations Centre**: As part of the patient flow work, it is apparent that we need to establish an integrated operations centre at Dunedin Hospital and on a smaller, replicated scale in Invercargill. This would increase operational effectiveness but ensuring information flows are real-time, decreasing the need for multiple meetings that rely on people and paper. This is best demonstrated by seeing this Queensland based example: https://www.youtube.com/watch?v=WBAp81yNTAM Further as part of this work, a visit to ADHB is planned to see their integrated operations centre in late July. Underpinning the physical setup of such a centre also relies on the appropriate operational management framework to ensure there is clear accountabilities and information flows.

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

- **Transitions**: Several meetings have been had with Aged Residential Care (ARC) teams to investigate and trouble-shoot the various issues with transitioning our older patients from hospital care into ARC care. Issues regarding ACC, PPPR processes and pharmaceuticals are all elements that hold up transitions. Further work in these spaces is ongoing.

- **Orthopaedic waitlist (OWL) programme**: Programme completed its initial 6-week phase, and the results were significantly positive.

- **Standard Operating procedures**: Further work in this space is ongoing. The ward processes and expectations manual for nursing has been being circulated and socialised the last fortnight with the Charge Nurse Manager's. It's an evolving manual that is expected to be a live document that gets added too over time.

- **Clinical criteria for Discharge**: Refreshed training and resource pack had been developed and rolled out to clinical teams and ongoing work to increase the use is happening but definitely an area for improvement.

- **Rapid Rounds:** This is ongoing and marked improvements being seen in the process and operating of these. A process of evaluation is planned for this, and a renewed energy focussed on the wards which need extra support.

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

Next Steps:

The key next step is two workshops with the operational leadership teams on both sites in Dunedin and Southland (July 7th & 8th). The two areas for discussion will be around the metrics, how to use this information we now have and the expectations around specific involvement and accountability relating to Patient Flow. Additionally, the focus will be on the three areas: Rapid Rounds, Clinical criteria for discharge and re-invigorating red2green. We will be seeking agreement and commitment from the team around how they will contribute to embedding these standard operating practises.

Risks/dependencies/constraints:

- This is a cycle of continuous improvement, process change, and behaviour change that will be ongoing.
- There is much impending change, perceived or otherwise, occurring in the health sector area currently. This holds risk that teams may experience some of the less desirable outcomes of change and/or engagement in this suffers as a result.
- Potentially more nursing strikes

FOR APPROVAL

Item: 2021/22 Southern District Health Board Statement of Performance Expectations

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

Meeting of: Board, 6 July 2021

Recommendation

That the Board reviews and approves the 2021/22 Southern District Health Board Statement of Performance Expectations.

Purpose

To present the 2021/22 Southern District Health Board Statement of Performance Expectations to the Board for their review and approval.

Specific Implications For Consideration

Financial

- The SPE includes forecast financial statements.

Quality and Patient Safety

- Targets reflect our commitment to improvements in service quality.

Operational Efficiency

- Targets reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

Workforce

- The SPE includes a consolidated statement of our prospective financial performance; this includes projected FTE across the DHB.

Equity

- Targets reflect our commitment to reducing inequities between population groups.

Other

- Not identified

Background

- The SPE is a subset of the DHB Annual Plan and includes output measures and Forecast Financial Statements.

Discussion

Southern DHB is required to upload a signed copy of the Statement of Performance Expectations onto the DHB website by 30 June 2021.

The non-financial information within the draft SPE was reviewed by the Board at the Annual Plan workshop in April.

Further work has been undertaken on the 2021/22 budget to incorporate changes discussed at the last Board meeting. In addition, following a discussion with the Ministry of Health (MoH), and after receiving the planned care funding advice, some additional changes have been made.

This results in a $24.3m deficit, which will be submitted to the MoH in the final draft of the Annual Plan.

Next Steps & Actions

Southern DHB will submit the final draft of the 21/22 Annual Plan to the Ministry of Health on 2 July. MoH will provide feedback on 23 July.

Appendices

Appendix 1 Southern DHB Statement of Performance Expectations 21/22

Southern District Health Board
Piki Te Ora

Statement of Performance Expectations 2021/22

Presented to the House of Representatives pursuant to section 149 (L) of the Crown Entities Act 2004

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OUR VALUES

Kind Manaakitanga

Looking after our people : we respect and support each other. Our hospitality and kindness foster better care.

Open Pono

Being sincere: we listen, hear and communicate openly and honestly and with consideration for others. Treat people how they would like to be treated.

Positive Whaiwhakaaro

Best action: we are thoughtful, bring a positive attitude and are always looking to do things better.

Community Whānaungatanga

As family: we are genuine, nurture and maintain relationships to promote and build on all the strengths in our community.

ANNUAL PLAN DATED

(Issued under Section 38 of the New Zealand Public Health and Disability Act 2000)

OUR VISION

Better health, better lives, whānau ora

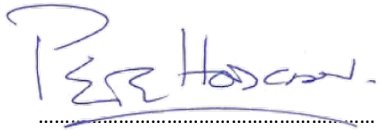
OUR MISSION

We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring.

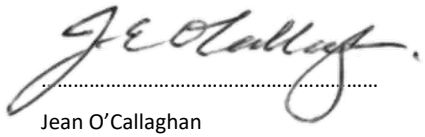
Table of Contents

1.0 Signature Page

This Annual Plan is signed and approved by the Minister of Health, Minister of Finance, the Chair and Chief Executive of the Southern DHB, as required under section 38(3) of the New Zealand Public Health and Disability Act 2000.



Pete Hodgson
Chair
Southern District Health Board
Date: 29 June 2021



Jean O'Callaghan
Board member
Southern District Health Board
Date: 29 June 2021

2.0 Statement of Performance Expectations

This Statement of Performance Expectations sets out the four Output Classes that Southern DHB will deliver in the 2021/22 financial year.

Kev Facts about Southern DHB

Crown Entity (established under *New Zealand Public Health & Disability Act 2000*)

Purpose:

- Improve, promote and protect the health of our population
- Promote the integration of health services across primary and secondary care services
- Seek the optimal arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- Reduce health disparities by improving health outcome for Māori and other population groups
- Manage national strategies and implementation plans
- Develop and implement strategies for the specific health needs of the local population

Vision: *Better Health, Better Lives, Whānau Ora*

Values:

Kind- Manaakitanga
Open –Pono
Positive – Whaiwhakaaro
Community - Whanaungatanga

Governance: Chair Hon. Pete Hodgson

Population: Approximately 353, 100 people live within Southern DHB boundaries.

Southern DHB's Statement of Intent (SOI)[1] provides the basis for our Statement of Performance Expectations (SPE), outlining the strategic directions for the DHB for the next four years, and defining the performance framework and outcomes that we are aiming to achieve

How Will We Demonstrate Success?

The SPE presents a view of the range and performance of services provided for our population across the continuum of care.

As a DHB we aim to make positive changes in the health status of our population over the medium to longer term. As the major funder and provider of health and disability services in the Southern district, the decisions we make about the services to be delivered have a significant impact on our population.

If coordinated and planned well, these will improve the efficiency and effectiveness of the whole Southern health system.

There are two series of measures that we use to evaluate our performance: outcome and impact measures which show the effectiveness over the medium to longer term (3-5 years); and output measures which show performance against planned outputs (what services we have funded and provided in the past year).

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report[2].

[1]Southern DHB's Statement of Intent (SOI) is available on the DHB's website http://www.southerndhb.govt.nz

[2]The Annual Report is tabled in Parliament and will be available on the DHB's website.

CHOOSING MEASURES OF PERFORMANCE

To make all this happen we have to balance our investment so we can deliver services now and into the future. In 2021/22, the Southern DHB plans to spend approximately $1.3 billion in delivering the following four Outputs funded through Vote Health:

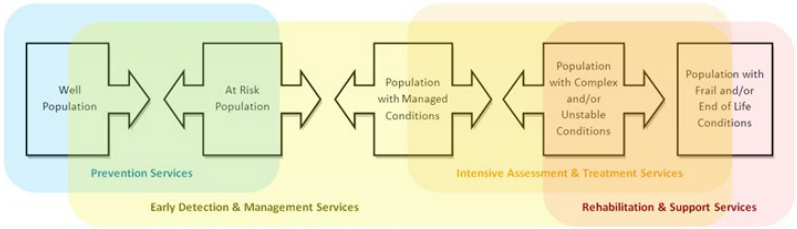
Output 1: Prevention Services;

Output 2: Early Detection and Management Services;

Output 3: Intensive Assessment & Treatment Services; and

Output 4: Rehabilitation & Support Services.

Figure 1: Scope of DHB operations - output classes against the continuum of care



Identifying a set of appropriate measures for each output class can be difficult. We cannot simply measure 'volumes' of service delivered. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. In order to best demonstrate this, we have chosen to present our statement of performance expectations using a mix of measures of Timeliness (T), Volume (V), Coverage (C) and Quality (Q).

Wherever possible, past years' baseline and national results are included to give context in terms of what we are trying to achieve and to support evaluation of our performance over time. Services have also been grouped into one of the four 'output classes' that are a logical fit with the continuum care and are applicable to all DHBs.

SETTING STANDARDS

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Our targets also reflect our commitment to reducing inequities between population groups, and hence some measures appropriately reflect a specific focus on high need groups. Measures that relate to new services have no baseline data.

WHERE DOES THE MONEY GO?

Table 1 overleaf presents a summary of the budgeted financial expectations for 2021/22, by output class.

Table 1: Revenue and expenditure by Output Class 2021/22

REVENUE	Total $'000
Prevention	17,243
Early Detection and Management	246,677
Intensive Assessment & Treatment	791,865
Rehabilitation & Support	186,566
Total Revenue	**1,242,351**

EXPENDITURE	Total $'000
Prevention	17,243
Early Detection and Management	239,881
Intensive Assessment & Treatment	830,861
Rehabilitation & Support	178,673
Total Expenditure	**1,266,658**
Net Surplus / (Deficit) – $' 000	**(24,307)**

Table 2: Revenue and expenditure by Output Class 2019/20 – 2024/25

Revenue & Expenditure by Output Class	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Prevention Services						
Revenue	20,245	18,610	17,243	17,746	18,257	18,783
Expenditure	(20,245)	(18,610)	(17,243)	(17,746)	(18,257)	(18,783)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	221,604	229,251	246,677	252,107	262,963	274,235
Expenditure	(219,815)	(229,707)	(239,881)	(249,132)	(258,694)	(268,597)
Net Result	1,788	(456)	6,796	2,975	4,269	5,638
Intensive Assessment and Treatment						
Revenue	695,300	781,109	791,865	828,225	854,584	881,807
Expenditure	(789,619)	(805,266)	(830,861)	(853,891)	(884,234)	(910,460)
Net Result	(94,319)	(24,157)	(38,996)	(25,666)	(29,650)	(28,653)
Rehabilitation and Support						
Revenue	162,918	167,600	186,566	186,714	192,901	199,296
Expenditure	(160,841)	(168,130)	(178,672)	(183,258)	(187,943)	(192,747)
Net Result	2,077	(530)	7,894	3,456	4,958	6,549
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	1,100,066	1,196,570	1,242,351	1,284,791	1,328,704	1,374,120
Total Expenditure per DHB Consolidated Financials	(1,190,520)	(1,221,713)	(1,266,658)	(1,304,027)	(1,349,127)	(1,390,588)
Net Surplus / (Deficit)	**(90,454)**	**(25,143)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**

NOTE:

Rather than repeating footnotes, the following symbols have been used in the performance tables:

E Some services are demand driven and it is not appropriate to set targets: instead estimated volumes are provided to give context as to the use of resource across our system.

Δ Performance data provided by external parties can be affected by a delay in invoicing and results are subject to change.

❖ Performance data for some programmes relate to the calendar rather than financial year.

✞ System Level Measure.

SUMMARY TABLES: INDICATOR REPORTING PERIODS

Measure	Period value represents
Percentage of children fully immunised at age 8 months	Annual performance
Percentage of children fully immunised at age 2 years	Annual performance
Percentage of eligible girls and boys fully immunised with HPV vaccine	Annual performance
Percentage of people (≥ 65 years) having received a flu vaccination	flu season
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	Q4 value
Infants exclusively or fully breastfeeding at 3 months	Annual performance (calendar year)
Percentage of 4 year old children receiving a B4 School Check	Annual performance
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Annual performance
Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	Previous two years
Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	Previous five years
Percentage of eligible preschoolers enrolled in community oral health services	Annual performance (calendar year)
Percentage of children caries-free at five years of age	Annual performance (calendar year)
Avoidable Hospital Admissions rates for children (0-4 years)	Year to Q3
Number of people receiving a brief intervention from the primary mental health service	Annual performance
Percentage of the population identified with diabetes having good or acceptable glycaemic control	Annual performance
Ratio of repeat pharmacy prescriptions to new prescriptions.	Annual Performance
Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	Annual performance
Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	Annual performance
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	Annual performance

Measure	Period value represents
Percentage of young people (0-19 years) accessing specialist mental health services	Year to Q3
Percentage of adults (20-64 years) accessing specialist mental health services	Year to Q3
Percentage of people who have a transition (discharge) plan	Year to Q3
Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	Year to Q3
People are assessed, treated or discharged from ED in under 6 hours	Annual performance
Number of people presenting at ED	Annual performance
Number of elective surgical service discharges	Annual performance
Percentage of elective and arranged surgery undertaken on a day case basis	Annual performance
Percentage of people receiving their elective and arranged surgery on day of admission	Annual performance
Number of elective surgical services (CWDs) delivered (elective initiative)	Annual performance
Outpatient appointments where the patient was booked but did not attend (DNA) **by ethnicity**	Annual performance
Number of maternity deliveries in Southern DHB facilities	Annual performance (calendar year)
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Annual performance (calendar year)
Proportion of AT&R inpatients discharged to their own home rather than ARC	Annual performance
Percentage of aged care residents who have had an InterRAI assessment within 6 months admission	Annual performance
Percentage of people ≥ 65 years receiving long-term home support who have a Comprehensive Clinical Assessment and an Individual Care Plan	Annual performance
Total number of eligible people aged ≥ 65 years supported by home and community support services	Average annual performance
Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Snapshot reported as at 30 June
People (65+) accessing the community-based falls prevention service	Annual performance
Number of Rest Home Bed Days per capita of the population aged over 65 years	Annual performance

2.1 PREVENTION SERVICES

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

On a continuum of care these services are public wide preventative services.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes, cancer, cardiovascular disease and respiratory disease, which account for a significant number of presentations in primary care and admissions to hospital and specialist services. These diseases are largely preventable.

By improving environments and raising awareness, preventative services support people to make healthier choices – reducing major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. High-needs and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices.

Prevention services are our best opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

HOW WE WILL MEASURE PERFORMANCE OF OUR PREVENTION SERVICES

Output Class: Prevention Services

Sub Output Class	Measure	Notes		Actual 2019/20	Target 2020/21	Target 2021/22
Immunisation Services These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care & allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	Percentage of children fully immunised at age 8 months	C†	Total	95%	>95%	>95%
			Māori	90%		
	Percentage of children fully immunised at age 2 years	C	Total	95%	>95%	>95%
			Māori	96%		
	Percentage of eligible boys and girls fully immunised with HPV vaccine	C	Total	65%	>75%	>75%
			Māori	63%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	54%	>75%	>75%
			Māori	44%		
Health Promotion & Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.	Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	C†	Total	73%	>90%	>90%
			Māori	74%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	64%	>60%	>60%
			Māori	57%		
Population Based Screening These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Percentage of 4 year old children receiving a B4 School Check	C	Total	78%	>90%	>90%
			Quintile 5	74%		
	Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Q†	Total	92%	>95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	66%	>70%	>70%
			Māori	63%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	71%	80%	>80%
			Māori	63%		

2.2 EARLY DETECTION AND MANAGEMENT

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age.

By promoting regular engagement with health and disability services, we support people to maintain good health through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Our vision to better integrate services presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home. Providing flexible and responsive services in the community, without the need for a hospital appointment, better supports people to stay well and manage their condition.

HOW WE WILL MEASURE PERFORMANCE OF OUR EARLY DETECTION AND MANAGEMENT SERVICES

Output Class: Early Detection and Management

Sub Output Class	Measure	Notes		Actual 2019/20	Target 20/21	Target 2021/22
Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination & treatment indicates successful preventative treatment and education.	Percentage of 0-4 enrolled in community oral health services	C ❖	Total	84%	>95%	>95%
			Māori	63%		
	Percentage of children caries-free at five years of age	Q ❖	Total	69%	>70%	>70%
			Māori	56%		
Primary Health Care Services These services are offered in local community settings by general practice teams and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement, accessibility & responsiveness of primary care services.	Avoidable Hospital Admissions[3] rates for children (0-4 years)	Q ✞	Total	5,496	<5,570	<5,570
			Māori	6,685	<5,570	<5,570
	Number of people receiving a brief intervention from the primary mental health service	V	Total	7,025	>7,000	>7,000
	Ratio of repeat pharmacy prescriptions to new prescriptions.		Total	N/A	N/A	<1.0
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[4]	C	Total	54%	>60%	>60%
			Māori	46%		
Community Referred Testing & Diagnostics These are services which a health professional may use to help diagnose a health condition, or as part of treatment. While services are largely demand driven; faster & more direct access aids clinical decision-making, improves referral processes & reduces the wait for treatment.	Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	T	Total	58%	>85%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	44%	>67%	>67%
	Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	T †	Total	65%	>90%	>90%

[3] Avoidable Hospital Admissions are admissions to hospital seen as preventable through appropriate early intervention and therefore provide an indication of access to and effectiveness of primary care, the interface between primary and secondary services. The measure is a national DHB performance indicator (SI1), and is defined as the standardised rate per 100,000. The definition for this measure is being revised nationally and was not available at the time of printing – targets will be confirmed once the definition is set.

[4] An annual HbA1c test of patient's blood glucose levels is seen as a good means of assessing the management of their condition - HbA1c <64mmol/mol reflects an acceptable blood glucose level.

2.3 Intensive Assessment And Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.

Intensive assessment and treatment services include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Why is this Output Class Significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or through corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner of these services, Southern DHB is also committed to providing high quality services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes.

Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

How we will measure performance of our intensive assessment and treatment Services

Output Class: Intensive Assessment and Treatment						
Sub Output Class	Measure	Notes		Actual 2019/20	Target 2020/21	Target 2021/22
Specialist Mental Health These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Percentage of young people (0-19 years) accessing specialist mental health services	C Δ	Total	5.29%	>3.75%	>3.75%
			Māori	6.02%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	4.33%	>3.75%	>3.75%
			Māori	8.96%	>5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	54%	>70%	>70%
	Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	T	< 3 weeks	70%	>80%	>80%
			< 8 weeks	88%	>95%	>95%
Acute Services These are services for illnesses that may have a quick onset, are often of short duration and progress rapidly, for which the need for care is urgent. Hospital-based services include EDs, short-stay acute assessments and intensive care services.	People are assessed, treated or discharged from ED in under 6 hours	T†	Total	81%	>95%	>95%
	Number of people presenting at ED	V	Total	77, 311	< 85,000	< 85,000
Elective Services (Inpatient & Outpatient) These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also nonsurgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).	Number of elective surgical service discharges[5]	V†	Total	11,179	>12,588	12,588
	Percentage of elective and arranged surgery undertaken on a day case basis	Q	Total	57%	>60%	>60%
	Percentage of people receiving their elective and arranged surgery on day of admission	Q	Total	88%	>95%	>95%
	Number of inpatient elective and arranged surgical services (CWDs) delivered)	V	Total	17,292	>18,311	18,464

[5] This measure is based on the MOH Planned Care Initiative, which replaces the Elective Initiative for 2019/20. 2017/18 Actual and Target 2018/19 have been recalculated using the new planned care definition.

Output Class: Intensive Assessment and Treatment (continued)						
Sub Output Class	Measure	Notes		Actual 2019/20	Target 2020/21	Target 2021/22
Maternity Services These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided by a range of health professionals, including midwives, GPs and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Number of maternity deliveries in Southern DHB facilities[6]	V E	Total	3,439	3,400	3,400
			Māori	453	560	560
	Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Q	Total	79.2%	>80%	>80%
Assessment Treatment & Rehabilitation (AT&R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units and outpatient clinics. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.	Proportion of AT&R inpatients discharged to their own home rather than ARC[7]	T	<65 years	N/A	N/A	>85%
			≥65 years	N/A	N/A	>75%

[6] This is a new measure for 21/22
[7] This is a new measure for 21/22

2.4 Rehabilitation & Support

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services.

On a continuum of care these services will provide support for individuals.

Why is this Output Class Significant for the DHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or re-admission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation and the need for more complex intervention.

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering.

How we will measure performance of our Rehabilitation and Support services

Output Class: Rehabilitation and Support					
Sub Output Class	Measure	Notes	Actual 2019/20	Target 2020/21	Target 2021/22
Needs Assessment & Services Coordination Services These are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals.	Percentage of aged care residents who have had an InterRAI[8] assessment within 6 months admission	Q Δ	75%	>95%	>95%
	Percentage of people ≥65 years receiving long-term home support who have a Comprehensive Clinical Assessment & an Individual Care Plan	Q	99%	>95%	>95%
Home and Community Support Services (HCSS) These are services designed to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is indicative of the capacity in the system, and success is measured against delayed entry into residential or hospital services with more people supported to live longer in their own homes.	Total number of eligible people aged over 65 years supported by home and community support services	E	4,474	4,800	4,800
	Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Q Δ	86%	>80%	>80%
Rehabilitation These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupational therapy, treatment of pain or inflammation and retraining to compensate for lost functions.	People (65+) accessing the community-based falls prevention service[9]		N/A	N/A	1,865
Age Related Residential Care These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest-home indefinitely.	Number of Rest Home Bed Days per capita of the population aged over 65 years	V	5.8	<6.11	<6.11

[8] InterRAI is an evidence-based geriatric assessment tool the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.

[9] This is a new measure for 21/22

3.0 Financial Performance

3.1 Forecast Financial Statements

The projected DHB deficit for 2021/22 is $24.3 million. This reflects the ongoing work implementing changes to operating models in the current year and the three out-years.

It has been highlighted over the past few years that the DHB must invest in services and facilities to continue to meet the health demands from the population groups it serves. The investment in the Primary & Community Strategy continues as the catalyst for the fundamental shift in service delivery across the Southern district.

Table 3: DHB Consolidated Prospective Net Results

DHB Consolidated Prospective Net Results	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Governance	(220)	297	0	(1,110)	(1,149)	(1,189)
Funds	5,382	(1,614)	19,617	9,698	13,471	17,463
Provider	(95,616)	(23,826)	(43,924)	(27,824)	(32,745)	(32,741)
Net Surplus / (Deficit)	**(90,454)**	**(25,143)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**

The focus is on valuing patient time as a key driver for change in the DHB. By rethinking the models of care, investing and coordinating the process change across the DHB to drive the pace of change required to take the DHB forward. The budget for 2021/22 continues to reflect the investments on the pathway to a sustainable future across all areas of healthcare delivery.

Key Assumptions

Key assumptions include:

- Successful delivery of the programme of change through service alignment initiatives.
- The improvement of information delivery primarily due to investment in IT systems.
- Achieving elective surgery targets to ensure receipt of the associated revenue.
- Investment in cancer care and diagnostics to reduce patient waiting lists.
- Managing personnel cost growth and the impacts from national collective agreements and workforce retention / recruitment issues.
- Continuing the focus on management of expenditure through regional alignment, national procurement and shared services activity.
- Effective capital expenditure to enhance service delivery and continue on the pathway to robust Asset Management Plan.
- Managing the working capital and cash position to minimise the cost of capital.
- Accelerated depreciation for Dunedin Hospital is recognised and included in the budgeted deficit.
- The liability from the Holidays Act 2003 continues to be accrued, which is included in the budgeted deficit.
- The cost to complete a detailed business case for the digital investment for the new Dunedin hospital is included in the budget and contributes to the deficit.

Significant Assumptions

The DHBs key assumptions relating to the 2021/22 budgeted financial statements are summarised below:

- Funding is based on the Government Allocations under Population Based Funding (PBF). Southern DHB's share of the pool is projected to decrease marginally year on year as shown below.

Table 4: Southern DHB PBF projections

DHB	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Southern	6.77%	6.75%	6.73%	6.70%	6.67%	

- Despite the decreasing share of PBF revenue, Government allocated revenue is forecast to increase.
- The investments include outsourcing to meet capacity constraints, implementing the Primary & Community Strategy Action Plan, increasing ICU capacity, progressively reducing the vacancy factor, resourcing for growth in Lakes region and implementing change management processes with the focus on valuing patient time.
- Demographic driven service growth continues to be projected as follows;

Table 5: Southern DHB demographic driven service growth

DHB	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Southern	2.22%	1.99%	1.85%	1.64%	1.55%	

- Incremental savings and efficiency targets have been built into baseline budgets.

- Costs associated with the activities of New Zealand Health Partnership Ltd (NZHPL) are included.
- Acute demand continues to increase, however the DHB plans to meet the elective targets set.
- The Holidays Act 2003 requirements will be remediated once national decisions have been made on a number of issues. We have included the payment being made in the 2021/22 year and this will require additional funding to support the cashflow.

3.2 Capital Expenditure and Capital Funding

Southern DHB has an on-going need for capital expenditure. Capital Expenditure is shown in Table 6.

Table 6: Planned Capital Expenditure

Planned Capital Expenditure	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Clinical Capital	13,024	13,495	27,945	18,125	12,390	12,865
Building Capital	8,629	4,401	18,997	14,676	13,892	14,110
Strategic Capital	6,698	7,905	18,810	11,627	2,904	3,194
Information Systems Capital	4,279	7,106	13,318	9,664	7,542	7,060
Total capital expenditure budget	**32,630**	**32,907**	**79,070**	**54,092**	**36,728**	**37,229**

The capital investment needs are spread across the DHB with services (demographics), technology, productivity, and quality requirements all driving demand for capital expenditure. The development and refinement of the Asset Management Plan currently in progress is critical for effective assessment of expenditure especially for the Interim Works on the Dunedin Hospital site.

Interim Works

The ICU redevelopment will be completed and fully operational in the 2021/22 year. There are ongoing deferred maintenance projects required to sustain the operational capability of Dunedin Hospital from 2020/21 through to the new Dunedin Hospital. A significant number of projects are included and the final timing of these is to be refined. The most pressing are the new CT & MRI in Dunedin to reduce diagnostic wait times and the development of a MAU in Dunedin hospital to improve bed utilisation. In Southland Hospital the replacement of the CT and potential extension to the ED will be progressed, along with a fifth theatre.

Baseline Clinical Capital

A Contingency fund is included within the baseline investment level to ensure the Southern DHB has the ability to meet expenditure that has arisen through items such as unexpected failures and changes in legislation.

Capital Financing and Debt Facilities

Financing for capital expenditure and the cash requirements for the DHB are shown in Table 7. The key component of financing highlighted is as follows;

- The working cash flow will require careful management. This together with the extensive capital investments required will result in an overdraft facility being utilised. Deficit support will be required when the Holidays Act 2003 liability is to be paid to staff.

Table 7: Planned Capital Financing

Planned Capital Financing	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Deficit Support	80,000	0	0	90,628	0	0
Equity for Capital Projects	4,744	1,309	14,709	9,082	0	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	31,011	14,394	(28,507)	(45,348)	(58,055)	(66,366)

The DHB has the following financing arrangements in place:

Table 8: DHB Financing Arrangements

Facility/Lender	Facility $' 000	Amount Drawn	Due date	Rate
Crown Debt	(0)	(0)	Qrtly instalment	0.00%
Finance Leases	1,091	1,091	Mthly & Qrtly instalment	0.00%
	1,091	1,091		

Asset Valuations and Disposals

Land and buildings are revalued to fair value as determined by an independent registered valuer. The last revaluation was undertaken as at 30 June 2018. The revaluation is undertaken with sufficient regularity to ensure the carrying amount is not materially different to fair value. At each year-end a fair value assessment is undertaken to confirm the carrying amount is not materially different to fair value.

Buildings with known asbestos issues were impaired by $20 million as at 30 June 2017 in accordance with PBE IPSAS 21 – Impairment of Non-Cash Generating Assets. This resulted in a decrease in the carrying cost of the assets as well as a corresponding reduction in the revaluation reserve. As remedial work is undertaken on the buildings, the DHB increases the carrying cost of the asset by the value of the remediation work.

Future valuations of Land and Buildings will be adjusted to include the essential capital maintenance at the Dunedin Hospital site to ensure the buildings are maintained to a minimum standard until the new Dunedin Hospital is operational.

The DHB will ensure that disposal of land or buildings transferred to, or vested in it pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by Minister of Health. The DHB will ensure that the relevant protection mechanisms that address the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act and Ngai Tahu Settlements Act are addressed. Any such disposals are planned in accordance with s42(2) of the NZPHD Act 2000.

Valuation of Land and Buildings at 30 June 2018

Tony Chapman of Colliers Otago undertook a valuation of the Southern DHB land and buildings portfolio at 30 June 2018. As a result a revaluation of $34,570,000 was made to land and buildings at 30 June 2018 based on the existing useful lives. The Minister of Health has announced an intention to build a new Dunedin Public Hospital. The Ministry of Health has commenced work with the concept design being developed, land purchased and demolition on-site in progress.

3.3 Prospective Financial Statements

In accordance with the new Accounting Standards Framework the District Health Board is classified as a Tier 1 Public Sector Public Benefit Entity (PBE).

Table 9: DHB Consolidated Statement of Prospective Financial Performance

DHB Consolidated Statement of Prospective Financial Performance	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Revenue						
PBF Funding Package	945,394	1,029,374	1,071,204	1,108,696	1,147,501	1,187,663
Inter District Revenue	23,648	25,986	27,338	28,344	29,387	30,469
Funder Side Contracts	80,541	84,175	90,254	93,413	96,682	100,066
Provider Misc Revenues	50,483	57,034	53,556	54,338	55,135	55,923
Total Revenues	1,100,066	1,196,569	1,242,352	1,284,791	1,328,705	1,374,121
less Personnel Expenses						
Medical Personnel	(156,219)	(158,537)	(162,040)	(165,803)	(171,605)	(177,612)
Nursing Personnel	(201,693)	(183,051)	(197,346)	(199,377)	(206,355)	(213,578)
Allied Health Personnel	(57,719)	(63,472)	(68,310)	(70,257)	(72,716)	(75,261)
Support Services Personnel	(6,169)	(6,744)	(6,990)	(7,178)	(7,430)	(7,690)
Management/Admin Personnel	(55,633)	(57,859)	(61,503)	(63,123)	(65,333)	(67,619)
Personnel Costs Total	(477,433)	(469,663)	(496,189)	(505,738)	(523,439)	(541,760)
less Non Personnel Expenditure						
Outsourced Services Expenses	(48,797)	(55,084)	(52,426)	(53,998)	(55,618)	(57,287)
Clinical Supplies Expenses	(109,059)	(121,547)	(115,854)	(120,084)	(123,687)	(127,397)
Infrastructure & Non Clinical Supplies Expenses	(88,494)	(88,953)	(94,778)	(101,221)	(107,334)	(108,524)
Total Non-Personnel Expenditure	(246,350)	(265,584)	(263,058)	(275,303)	(286,639)	(293,208)
less Provider Payments						
Personal Health Expenses	(270,490)	(281,133)	(290,255)	(300,415)	(310,929)	(321,811)
Mental Health Expenses	(30,105)	(32,879)	(36,587)	(37,502)	(38,439)	(39,400)
Disability Support Expenses	(154,465)	(161,466)	(171,158)	(175,437)	(179,823)	(184,319)
Public Health Expenses	(10,331)	(9,108)	(6,531)	(6,694)	(6,862)	(7,033)
Maori Health Expenses	(1,344)	(1,880)	(2,881)	(2,938)	(2,997)	(3,057)
Total Provider Payments	(466,736)	(486,466)	(507,412)	(522,986)	(539,050)	(555,620)
Total Expenses	(1,190,519)	(1,221,713)	(1,266,659)	(1,304,027)	(1,349,128)	(1,390,588)
Net Surplus / (Deficit)	**(90,454)**	**(25,143)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**
Supplemental Information						
Depreciation Charges	(25,063)	(30,781)	(33,077)	(41,111)	(41,933)	(42,772)
Interest Costs	(236)	(17)	(50)	(100)	(100)	(100)
Capital Charge	(9,651)	(7,899)	(7,142)	(6,627)	(10,615)	(9,559)
Total IDCC Costs	(34,950)	(38,697)	(40,269)	(47,838)	(52,648)	(52,431)
Medical FTE	613	650	676	676	676	676
Nursing FTE	1,834	1,889	1,953	1,953	1,953	1,953
Allied FTE	709	731	769	769	769	769
Support FTE	99	103	104	104	104	104
Management/Admin FTE	732	745	750	750	750	750
Total FTE	3,987	4,118	4,252	4,252	4,252	4,252

Table 10: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Current Assets:						
Cash & Bank Accounts	31,011	14,394	7	7	7	7
Prepayments	3,635	2,868	2,868	2,923	2,979	3,035
Inventory	6,095	5,235	5,235	5,334	5,435	5,539
Accounts Receivable	46,183	47,149	45,606	46,472	47,355	48,257
Total Current Assets	86,924	69,646	53,716	54,736	55,776	56,838
Current Liabilities:						
Bank overdraft and current debt	(962)	(234)	(28,617)	(45,458)	(58,165)	(66,476)
Creditors provisions and payables	(153,311)	(149,574)	(154,007)	(162,127)	(166,490)	(170,990)
Total Current Liabilities	(154,273)	(149,808)	(182,624)	(207,585)	(224,655)	(237,466)
Net Working Capital	(67,348)	(80,162)	(128,908)	(152,848)	(168,879)	(180,629)
Non Current Assets:						
Land , Buildings, Plant and Equipment	329,770	325,358	371,351	384,332	379,125	373,581
Long Term Investments	0	0	0	0	0	0
Total Non Current Assets	329,770	325,358	371,351	384,332	379,125	373,581
Non Current Liabilities:						
Long Term Debt	(1,091)	(857)	(857)	(761)	(653)	(533)
Other Liabilities	(95,338)	(102,888)	(110,438)	(19,810)	(19,810)	(19,810)
Net Equity	**165,993**	**141,452**	**131,148**	**210,912**	**189,783**	**172,609**

Table 11: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Total Equity at beginning of period	172,410	165,993	141,452	131,147	210,913	189,783
Net Result for the period - Governance	(220)	297	0	(1,110)	(1,149)	(1,189)
Net Result for the period - Funds	5,382	(1,614)	19,617	9,698	13,471	17,463
Net Result for the period - Provider	(95,616)	(23,826)	(43,924)	(27,824)	(32,745)	(32,741)
Revaluation of Fixed Assets	0	0	0	0	0	0
Other movement	0	0	0	0	0	0
Equity Repaid (Revaluation funding)	(707)	(707)	(707)	(707)	(707)	(707)
Equity Injections for Capital	4,744	1,309	14,709	9,082	0	0
Equity Injections for Deficit	80,000	0	0	90,628	0	0
Total Equity at end of Period	**165,993**	**141,452**	**131,147**	**210,913**	**189,783**	**172,609**

Table 12: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	1,097,687	1,195,536	1,239,659	1,283,739	1,327,607	1,373,003
Cash outflows from operating activities	(1,113,027)	(1,178,414)	(1,217,475)	(1,345,459)	(1,302,841)	(1,343,326)
Net cash inflows(outflows) from operating activities	(15,340)	17,122	22,184	(61,720)	24,766	29,677
Investing Cashflows						
Cash inflows from investing activities	312	232	236	238	240	243
Cash outflows from investing activities	(27,344)	(34,323)	(79,070)	(54,092)	(36,726)	(37,229)
Net cash flows from investing activities	(27,033)	(34,091)	(78,834)	(53,854)	(36,486)	(36,986)
Financing Cashflows						
Cash inflows from financing activities	84,744	1,309	14,709	9,081	0	0
Cash outflows from financing activities	(1,473)	(957)	(960)	89,652	(987)	(1,002)
Net cashflows from financing activities	83,271	352	13,749	98,733	(987)	(1,002)
Net increase/(decrease) in cash held	40,899	(16,617)	(42,901)	(16,841)	(12,707)	(8,311)
Add opening balance	(9,888)	31,011	14,394	(28,507)	(45,348)	(58,055)
Closing cash balance	**31,011**	**14,394**	**(28,507)**	**(45,348)**	**(58,055)**	**(66,366)**

FOR APPROVAL/INFORMATION

Item: **Transformational Change Update**

Proposed by: Chief Executive Officer

Meeting of: Board, 6 July 2021

Recommendation

That the Board:

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

Purpose

1. To provide an update on the progress of the Transformation Programme identified in Cabinet Minute [CAB-21-MIN-0124] by way of background information. Further updates will be dashboard based.

2. There is no New Dunedin Hospital (NDH) programme or budget impact from this update

14.1

Background

3. In March 2020 the Southern District Health Board approved a change programme.

4. This update [attached] provided a portfolio-based view of the system changes and workstreams required to meet the investment objectives of the NDH Detailed Business Case and;

    a. Outlined the alignment with the DBC Investment Logic Map

    b. Outlined alignment with early benefits work and outcomes

    c. Identified key workstream (Executive) leads

5. Benefits work was immature in March 2021. Further updates to ESG [June 2021 Appendix] have led to a mature benefits plan aligned with the investment objects and critical workstreams.

6. The impact of the COVID-19 Pandemic on the Southern DHB health system saw a necessity to respond to the pandemic and the challenges that it created. This saw a natural slowing of the change programme, however momentum has now returned.

7. Critical review of this earlier work showed that

    a. Although framed in a portfolio view it was driven from the NDH project .

    b. It lacked alignment with the annual plan as the key accountability document for SDHB.

    c. The "how" or the vehicle to coordinate and deliver the transformation was lacking.

8. Updates since to the Southern District Health Board were template based, however included short-term performance reporting for the Annual Plan with strategic change objectives.

9. An update to the DDG Performance and NDH SRO [December 2020] identified the near-term projects and sort to align these with the strategic goals of the DHB and the Annual Plan.

10. A strategic refresh had been commissioned but was yet to commence that would refocus the SDHB strategic plan from the goals identified in 2016 [Appendix]

Update July 2021

11. Noting the feedback from earlier the work the SDHB Executive Leadership Team (ELT) has approved;

    a. **Approved** the **formation of an Enterprise Programme Management Officer (EPMO)** to provide a view of the programmes/projects of transformation within the Southern DHB system [EPMO scope document] and the alignment with a proven methodology (P3M)

    b. **Agreed** the Governance structure for the transformation programme [Appendix]

    c. **Agreed** to trial a subscription of a SaaS product to assist management of, and report back on the transformation project.

    d. **Agreed** a timeline for EPMO implementation [Appendix]

12. Projects **critical** to deliver near-term goals [Tranche 1] and fundamental system change have been signed off by the SDHB Board and implementation is underway. Reporting templates for the workstreams is attached [appendix] Critical work streams to note are;

    a. Strategic Refresh

    b. ICT Business case (including SIPICS)

    c. Generalism (including MAU)

    d. Primary and Community Workplan

13. Critical risks for the next twelve months include

    a. The health system transformation announced by the Government in April 2021

    b. Changes within the Executive Leadership Team at SDHB and uncertainty in the recruitment environment created by (a).

Next Steps to August

14. Recruitment for the EPMO Portfolio Manager

15. Refinement of Dashboard reporting.

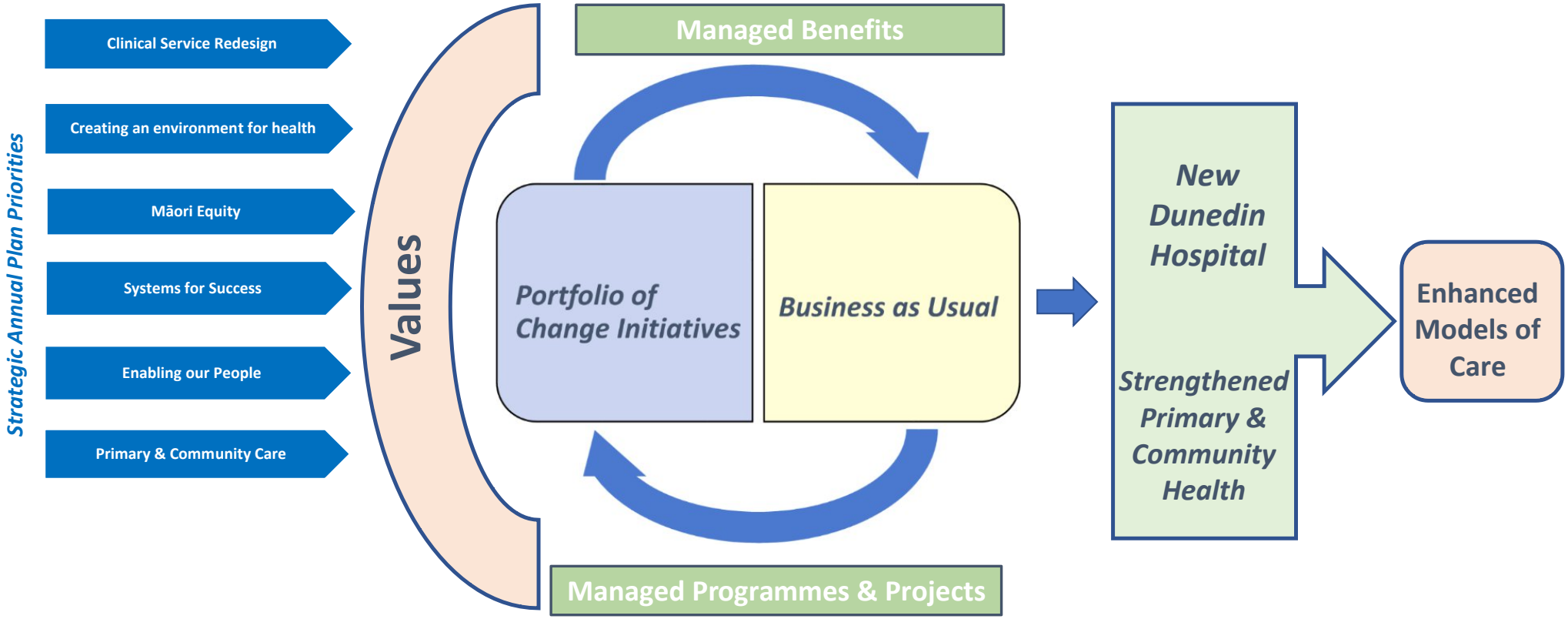
Appendices

1. SDHB Board Change update March 2020
2. Benefits update June 2021
3. Strategic Refresh Scope
4. EPMO Timeline and Governance
5. Reporting dashboard

Strategic Change Portfolio – Progress Update June 2021

Southern Strategic Priorities 2015

- Develop a coherent Southern system of care
- Build the system on a foundation of population health, & primary & community care
- Enhance system capability & capacity
- Live within our means
- Secure sustainable access to specialised services
- Strengthen clinical leadership, engagement & quality improvement



Strategic Change Programme – Progress Update June 2021

Regional Lens & Alignment

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 • Operational Management system implementation • **MAU*** • **Oncology Sustainability Planning *** • **Patient Flow/Implementation of the SAFER Bundle*** • **Hospital escalation plan*** • Discharge documentation re-design	• Operational re-design (Integrated Operations centre) • Generalism	• Implementation of MH review recommendations • Security Review
Build the system on a foundation of population health, & primary & community care	**Creating an environment for health**		• Health Needs Analysis • Primary & Community Work Programme		
	Māori Equity	• Implementing Whakamaua: Māori Health Action Plan	• Equity actions improvement plan		
Secure sustainable access to specialised services 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 • South Island Digital Transformation • Risk Management maturity journey • Production Engineering • Establishment of ePMO & Project Governance Framework	• Clinical Costing System • Right-sizing Southland ED • PICS Implementation • Quality Improvement Framework	• Central Decision Support Model • Performance & Accountability Framework • Sustainability Improvement review recommendations (Singh review)
Enhance system capability & capacity	**Enabling our People**	• 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
Live within our means	**Primary & Community Care**	• Health Care Homes	• Frail elderly pathway • Primary care in Southland	• Maternity Central Otago • Health Hubs Implementation	

(Strategic Refresh Project Underway)

***Shift from last update**

14.1

Strategic Change Portfolio – Progress Update June 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status Current	Previous	Additional Notes
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)					
Strategic Refresh Project	October 30th	Board			MoH data set delay and Maori engagement slowed, being mitigated
MAU	August 2022	EDFPF			De-canting of areas creating slight delay, but overall programme progressing
Oncology Sustainability Planning	Ongoing	EDSS			Multiple workstreams in flight
Discharge Summaries Re-design	December 2021	CMO/EDQCG			
Operational structure re-design	September 2021	CEO/ELT			
Production Engineering	August 31st 2021	EDSS			CSO out to market
Clinical Costing System Implementation plan	October 30th 2021	EDFPF			On track, will be closed RFP process between 2 providers, project plan in production.
Right-sizing Southland ED	30/08/21	EDFPF/EDSS			Work progressing, plan for improvement being validated against data
ePMO & Project Governance framework	October 30th 2021	PACEO			
Quality Improvement Framework	TBC	EDQCG			
Building internal change capability	Ongoing	ELT/EDP&C			
Patient Flow/Implementation of SAFER Bundle	Ongoing	ELT			
Health hubs Implementation	December 2021	EDSPC			Concept designs completed, next stage rollout in progress with chosen partner.
MHAID Review	TBC	CMHS&I			Report to be reviewed & action plan developed
Security Review	Dec 2021	EDFPF			Report has been received, reviewing currently.
MHAID H&S Review	TBC	CMHS&I			Report to be reviewed & action plan developed

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		

Strategic Change Portfolio – Progress Update June 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Notes
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 shortly, 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
Equity Actions Improvement Programme	Ongoing	CMHS&I			As above
Virtual Health	2023 embedded by	EDSS			Needs refocussing as utilisation has dropped again post-covid
FPIM Implementation	1/07/21	EDFPF			Slight deliberate delay decided on by team by 1 month but on track to go live July 1st.
HRIS	Ongoing	EDP&C			Recruitment piece (Success Factors) has been implemented,
Workforce Modelling	Ongoing/No end date	EDP&C			Ongoing piece of work, iterative process
Health Care Homes	2021-22	EDSPC			Third tranche completed in Q4.
Risk Management maturity journey	Ongoing/No end date	EDQCG			Iterative process, initial risk management workshops held
Wellbeing: Aukaha kia kaha programme	Ongoing/No end date	EDP&C			
Health & Safety Workplan	Ongoing/No end date	GM H&S, EDP&C			

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		

14.1

Strategic Change Portfolio – Progress Update June 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Month Status: Prior	Additional Notes
Tranche 2 (Mid -Term Initiatives: 2-6 years)					
Maternity Central Otago	2024	EDSPC			Proceed with RFP and advancing of business case.
Dunedin & Southland Master Site-Planning	TBC	EDFPF			Work progressing in both areas with slight delays
CCDM Implementation	TBC	EDSS & CNMO			$ for full implementation in next financial year, implemented in pockets
Primary Care in Southland	31/12/21	EDSPC & EDSS			Joint work programme with PHO
Generalism	2023/2024	EDSS			Ontrack but dependent on MAU and other projects.
Digital Transformation (detailed business case)	September 2021	EDFPF			
PICS implementation	Q4 2024	EDSS			Programme manager re-assigned COVID programme – July pick up
Central Decision Support Model	N/A	PACEO			Conceptual stage – dependent on sound data warehouse
Implementation of MH review recommendations	TBC	CMHS&I			Recommendations
Key Business as Usual Enablers					
Performance & Accountability Framework	November 2021	ELT			Conceptual stage, planning to begin in near term.
Building our internal change capability	Ongoing	ELT			Planning stages
Develop Service Planning further	Ongoing	ELT			

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		

Structure of the Benefits Realisation Plan

SDHB's Change Management Programme is the key vehicle for realising the system-wide change associated with the New Dunedin Hospital (NDH) Project. Benefits outlined in this document are dependent on the delivery of the solutions/workstreams presented in the Investment Logic Map (see slide 4) and will need to align to the priorities outlined in the Strategic Plan refresh.
SDHB is responsible for developing the Change Management Programme and Benefits Realisation Plan for the NDH project.

Benefit Realisation Plan Heading	Description/Explanation
ID	Reference number
Intermediate Benefit & Owner	Positive improvements resulting from deliverables from outputs. Benefit Owners are ELT members accountable for the realisation of the benefit. SDHB's Clinical Leads will play a key, contributory role across most of the benefit categories.
Key measure(s)	Description about how the benefit will be measured
Baseline Measure (year)	Original data point and year from which progress will be measured. In time, bandwidths (e.g. High, Medium and Low) targets will be introduced. Some measures won't be developed until later in design (e.g. building-specific/"Green Star" measures).
Target	Desired end point for realisation of a benefit
Quantifiable saving ($) and/or improvement	Only initial cost estimates of savings arising from the realisation of benefits have been attempted to date. Costing work continues.
Quantifiable, non-financial benefit	Those benefits that can be quantified, but are difficult to value in monetary terms
Qualitative benefits through delivery of this benefit	Those benefits that cannot be counted, or are too costly or unreliable to count
Realisation Date	Final date by which the benefit will be realised
End Benefit(s)	Contribution to end benefits as determined by the Investment Logic Map (ILM). Most benefits will be dependent on activity across a number of workstreams presented in the ILM.
Workstreams aligned to delivery of this benefit	Those workstreams, which are included in the Change Management Programme, that will help contribute to the realisation of the benefit. In several cases, there is significant overlap. Some rationale for why these projects are included is provided in these sections (in italics). Note that direct attribution to a project is sometimes difficult.
Dependencies, Challenges, notes	Explanatory descriptions to help the reader understand the context for, and description of, each benefit
Reporting frequency	How often ELT will receive a report detailing progress towards the realisation of a benefit (including recommendations for management attention, where necessary)
Rating	PMO's view about trajectory of progress towards realisation of the benefit. Where a rating is Amber or Red, areas for management attention/proposed corrective action will be flagged.

New Dunedin Hospital: Benefits Realisation Plan Update for ELT (1 July 2021 meeting) - WORK IN PROGRESS
NDH-Specific (Stream 1)

Status: On Track | At Risk | Not on Track | Not Started

ID	Intermediate Benefit & Owner	Key measure(s)	Baseline Measure (year)	Target	June 2021 update	Quantifiable saving ($) and/or improvement	Quantifiable, non-financial benefit	Qualitative benefits through delivery of this benefit	Realisation Date	End Benefit(s)	Workstreams aligned to delivery of this benefit	Dependencies, Challenges, notes	Reporting Frequency	Rating	Narrative update *(from Benefit Owner for future updates)*
1.1	**Increased Elective Surgery Rates** **Patrick Ng,** Executive Director, Specialist Services)	1.1.1 Increased number of elective surgical services case-weights (CWDs) delivered	13,112 (2022/23)	2028: 14,650 2033: 16,266 2043: 19,675	Mar 21 YTD: 12,165	• Reduced net occupied bed days for patients waiting for a procedure • Reduced outsourcing of procedures because of capacity issues • Enables more services to be delivered in a given period	• Year on year increase in procedures being undertaken • Reduction in delays in waiting for surgery • Elective Services (Inpatient & Outpatient) - Elective Services Patient Flow Indicators (ESPIs) used to track progress.	• Successful elective surgery outcomes can lead to fewer GP visits and ED presentations and improved quality of life for patients and their whānau • Better adjacencies and appropriate sizing of spaces to optimise clinical work flow • When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own home. It also frees- up hospital resources.	From Outpatients' Opening (>Q1, 2025/26)	• Better Patient Outcomes • Improve Patient Safety • Improved Patient & Staff experience • Increased Productivity • Living within our means	• Production Planning • Planned Care Recovery Programme and other related initiatives • NDH Project (new operating theatres and appropriate recovery spaces etc) • Valuing Patient Time • Seven day hospital programme • Expenditure Improvement Plans • Digital Hospital Programme	Elective Services are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also nonsurgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments). Successful elective surgery can reduce pain and anxiety, restore patient independence, enable them to return to (full time) work and delay the need for people to enter residential care.	Quarterly		
		1.1.2 Number of elective surgical service discharges	11,179 (2019/20)	>12,588 (2020/21)	Mar 21 YTD: Actuals 8457 (Target 8780)	• Enables more services to be delivered in a given period									
		1.1.3 % of elective and arranged surgery undertaken on a day case	57% (2019/20)	>60%	**CY20 39.73%**	• Day cases enable more services to be delivered in a given period • Reduced net occupied bed days									
		1.1.4 % of people receiving their elective and arranged surgery on day of admission	88% (2019/20)	>95%	SDHB FY20: 89.2% Apr 21 YTD: 89.5%	• Enables more services to be delivered in a given period • Reduced net occupied bed days									
		1.1.5 Reduction in outsourced surgery	$8m (2020/21)	$0 (from FY 2029/30)	Apr 21 YTD: $4.6m (FY20 $4.4m)	• Costs incurred for outsourcing lists to private providers (over and above in-house costs for same procedures)									
1.2	**Decreased average length of stay** **Patrick Ng,** Executive Director, Specialist Services)	1.2.1 Reduction in wait times to access diagnostics and imaging	2019/20 data	Rolling average for 2021/22 and 2022/23	Avg Median FYTD May21 CT: 16 days MRI: 51 days US: 32 days	• Increased access to diagnostics (number) in NDH	• Improved quality of life reported/demonstrated through patient satisfaction surveys • Increase in patients receiving non-urgent MRI or CT scan within 6 weeks • Fewer recorded Hospital Acquired Infections (HAIs) • Fewer recorded hospital falls	• Reduced risk of patient harm through hospital-acquired injury or harm • Reduced bed block to help improve flow through hospital • Improve patient flow through better ward design • Value of avoided time in hospital for patients and their whānau • Improvement in Māori health outcomes, as our Māori and Pacific population generally has a higher bed days when compared with non-Māori and Pacific populations	From Inpatients Opening (>Q1, 2029/30	• Better Patient Outcomes • Improve Patient Safety • Improved Patient & Staff experience • Increased Productivity • Living within our means	• Valuing Patient Time • Mental Health and Addictions Improvement Activities • Generalism Work Programme • Seven day hospital programme • Digital Hospital Programme • Bowel Screening and Colonoscopy Wait Times	Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes. Patient satisfaction should be expected to increase, based on metrics associated with complaint rate and resolution. The New Dunedin Digital hospital will enhance patient access to diagnostics, med charts, patient track (observations), assessment and plans (multi disciplinary)	Quarterly		
		1.2.2 Reduced net occupied bed days	Rolling average for 2021/22 and 2022/23	331 Standardised Acute Hospital Bed Days per 1000 Capita (2020/21)	FY20: 39 MarYTD21: 40	• Reduced bed block/improved patient flow by increased day cases and improved elective surgery efficiency									
		1.2.3 Reduced time taken to discharge	2019/20 data (Average Length of Stay (ALOS) (Acute and Elective))	Stay below the MOH target (2.35) for Inpatient Average Length of Stay (ALOS) for acute admissions	ALOS FY20: 4.4 MarYTD21: 4.42	• An increase in the rate of people discharged home from hospital, with appropriate support (fewer bed days) • Increased community capacity for Needs Assessment and Service Coordination services (NASC))									
1.3	**Improved Productivity** **Patrick Ng,** Executive Director, Specialist Services)	1.3.1 Reduced Medical SMO FTE per case weight	2020/21 data	Year-on-year improvement from 2019/20	SMO / CWD FY19: 0.005 FY20: 0.005	• Increase in patient satisfaction metrics due to improved efficiency and productivity (fewer delays) • Lower staff to case weight discharge ratio • Reduction of cancellation on day of surgery • Increase in first case on time starts • Increased theatre utilisation • Reduction of number of cancelled surgical procedures • Forecast reductions in the Average Length of Stay that will allow more service volume to be delivered for fewer resources than would otherwise be the case.	• Increased patient-facing clinical time • % of on-time starts • # of cancelled surgeries due to lack of available beds • Reduced Hospital Acquired Infections (HAI) • Using digital solutions, clinicians identify that they can readily document and access patient medical information (such as identity, reason for admission, medical history and any allergies) on devices connected to a system, instead of using paper files. • Improved digital info to improve outcomes. Digital bedside monitoring devices automatically upload patient vital signs and observations, such as blood pressure, temperature and heart rate, directly to a secure electronic medical record. • Additional ICU beds to help reduce cancelled cardiac surgery	• Improvements to reported patient and staff satisfaction rates through clinicians spending a greater proportion of their time working directly with patients • Reduced risk of patient harm through fewer delays and less time spent in hospital • Avoiding additional costs to address growing demands without improved productivity • Access to real time patient information enables better care and improved workflow	Improvements from Outpatients' Opening (>Q1, 2025/26), key benefits to be realised following Inpatients' opening (>Q1, 2029/30)	• Better Patient Outcomes • Improve Patient Safety • Improved Patient & Staff experience • Increased Productivity • Living within our means	• Generalism (model of admission) • Digital Hospital Programme • Valuing Patient Time (Red to Green initiative) • Production Planning • Seven day hospital programme • Planned care initiatives	Critical dependency on the Digital Hospital Programme to leverage our investment in technology to support clinical decision making and improve the quality of the care we provide. Theatre utilisation, as used here, is the total time the operating theatre is actually occupied by a patient in the OR and the necessary time for changeover (by applying a nominal changeover time) as a percentage of the planned time for elective sessions. Theatre utilisation includes components such as on time starts, accuracy of procedure times when booking/scheduling theatre lists, turn-around time , patients consented in a timely manner, elective surgery cancellations due to acute demand and/or	Quarterly		
		1.3.2 Increased % of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in <4mths	65% (2019/20)	100%	SDHB FY20: ESPI 2: 79.7% ESPI 5: 67.6% Apr 21 YTD: ESPI 2: 80% ESPI 5: 66.9%										
		1.3.3 Reduction in cancelled cardiac surgery	2019/20 instances	Year on year improvement from 2019/20 instances	Apr 21 YTD: 63 cancellations										
1.4	**Improved Patient Flow** **Gail Thompson,** ED Quality and Clinical Governance Solutions; and **Patrick Ng,** Executive Director, Specialist Services)	1.4.1 Time from consult request to bed request to discharge	To follow		FY20: 29.51min March21YTD: 35.73min		• Forecast reductions in the ALOS • Reduction in delays to patient diagnosis, care delivery and discharge (defined by the Red2Green Electronic Whiteboard) • Creation of a single digital workflow from when a patient presents with a clinical condition, with the options for ordering diagnostic tests, receiving prompts and making referrals.	• Improved timeliness of decision making, better flow and improved patient safety delivered through Generalist model • Improvements to reported patient and staff satisfaction rates through clinicians spending a greater proportion of their time working directly with patients and less on inefficient systems	From Outpatients' Opening (>Q1, 2025/26)	• Better Patient Outcomes • Improve Patient Safety • Improved Patient & Staff experience • Increased Productivity • Living within our means	• Generalism • Digital Hospital • Valuing Patient Time (VPT) • Primary Options for Acute Care (POAC) across the district – to increase primary care capacity for urgent need (rather than risk deterioration and presentation in ED). • Seven day hospital programme • Planned Care Initiatives	VPT is about both focusing on removing steps that add time with no value to patients and better managing patient flow to ensure people receive the service they need when they need it. A focus on improving the flow of patients through our hospital will help to reduce duplication of effort and maintain service access while reducing waiting times for treatment.	Quarterly		
		1.4.2 % of daily discharges occurring before noon			FY19: 30.8% FY20: 31.2% YTD21: 31.7%										
		1.4.3 % of inpatients discharged on Saturdays and Sundays			FY19: 17.2% FY20: 17.3% YTD21: 16.9%										
		1.4.4 Number of bed days occupied by super-stranded patients (LOS > 21 days)			YTD21: 13 days										
		1.4.5 Proportion of people in hospital for more than seven days			CY19: 1.68% CY20: 1.76% YTD21: 1.79%										
		1.4.6 Time between inpatient imaging request and imaging report sent to secondary system – weekly and daily			CY19: 11.72% CY20: 11.74% YTD21: 11.95%										
		1.4.7 Number of ED patients left before seen or did not wait			CY20: 36 days YTD21: 14 days										
		1.4.8 Hospital outliers			FY19: 2262 FY20: 2592 YTD21: 2232										
		1.4.9 Hospital readmissions (%age of readmissions within 7 & 28 days)			CY19: 7.7%; 16.4% CY20: 7.7%; 16.0% YTD21: 7.7%; 14.5%										

New Dunedin Hospital: Benefits Realisation Plan Update for ELT (1 July 2021 meeting) - WORK IN PROGRESS
NDH-Specific (Stream 1)

Status: On Track | At Risk | Not on Track | Not Started

ID	Intermediate Benefit & Owner	Key measure(s)	Baseline Measure (year)	Target	June 2021 update	Quantifiable saving ($) and/or improvement	Quantifiable, non-financial benefit	Qualitative benefits through delivery of this benefit	Realisation Date	End Benefit(s)	Workstreams aligned to delivery of this benefit	Dependencies, Challenges, notes	Reporting Frequency	Rating	Narrative update *(from Benefit Owner for future updates)*
		1.4.10 Improved equity performance in Outpatient DNAs			(Totals) Otago 2019 Attended 85%; DNA 13% 2020 Attended 82%; DNA 14%	Further work is ongoing. Additional equity measures will be added as we progress.									
1.5	**Decreased Patient Harm in Hospital** **Gail Thompson,** ED Quality and Clinical Governance Solutions	1.5.1 Reduction in hospital falls	Rolling average for 2021/22 and 2022/23	Year-on-year improvement	# falls FY19: 342 FY20: 315	• 10% reduction in falls - $0.66m (333 incidents pa) • 20% reduction in falls - $1.3m (296 incidents pa) • 30% reduction in falls - $2.0m (259 incidents pa) *Based on average cost per bed day of $1,125*	• Reduced Hospital acquired infections • Reduced bed days (ALOS). (Based on the date of the Fall incident, patients on average will stay an additional 8.4 days post incident. 28% of SDHB's falls patients are noted to have stayed more than 8.4 days after their noted Fall incident).	• Reduced risk of patient harm • Avoiding additional costs to address growing demands without improved productivity • Integrated workflow, enabled by digital technology, helping to release time to care	From Inpatients Opening (>Q1, 2029/30	• Better Patient Outcomes • Improve Patient Safety • Improved Patient & Staff experience • Increased Productivity	• MedChart • Falls assessment/ risk assessment • Digital Hospital programme • Central Line Associated Bacteraemia (CLAB) programme • Valuing Patient Time programme • Nurse Call development • Health Pathways (e.g. psychosis in Children & Youth, nephrology; advice and assessment, Telehealth)	We assume the NDH building design will improve observation opportunities and appropriate flooring will assist mobility and transfer in and out of bed. A 10% decrease in the number of falls incidents and a 10% decrease in the ALOS of a falls patient, over $1.2m of cost savings could be realised. Improved patient mobility will help with reducing the risk of patient deconditioning; keeping independence; and helping to decrease pressure injuries. Improvements in digital technology to assist in reducing medication errors (e.g. MedChart, safe prescribing, workflow) A suite of enhancements will contribute: • improvements to hand hygiene • more toilets (fewer infections, but potentially greater OPEX in cleaning costs) • Appropriate ventilation and pressure systems (positive and negative) • Red and Green streaming/pandemic planning	Bi-annual		
		1.5.2 Reduction in # of hospital acquired pressure injuries	Health Round Table shows a score of 9.9 cases of Pressure Injuries per 10,000 episodes	Reducing instances to meet (or exceed) SDHB's peer group median of 3.2 pressure Injuries per 10,000	TBD	• Reduction in Average Length of Stay due to hospital-acquired pressure injuries									
		1.5.3 Reduction in medication errors	Rolling average for 2021/22 and 2022/23	Year-on-year improvement	TBD	• Reduction in bed nights due to medication errors • Increased automatic dispensing (NDH vs Dunedin Hospital)									
		1.5.4 Reduction in hospital acquired infections	Rolling average for 2021/22 and 2022/23	Year-on-year improvement	# Infections FY19: 84 FY20: 30	• Reduction in bed nights due to hospital acquired infections									
1.6	**Building Performance and Sustainability+** **Nigel Trainor,** ED Finance, Procurement and Facilities + NOTE: Benefits will be worked up through design as the project progresses. Further measures will be added around electricity usage, carbon emissions, EVs etc.	1.6.1 Green Star (5*) accreditation reached	(On opening)	Green Star (5*) accreditation reached in 2028	Development in progress	•Lower operating and maintenance costs • Improvements in productivity, through occupant comfort, lighting, temperature and increased natural ventilation	• Compliance with legislation and alignment with values • Fewer manual-handling workplace injuries (logistics movements related) as AGVs delivering bulk of supplies • Reduction in manual transfers of store trolleys for imprests due to use of AGVs	• Ability to transfer clean and dirty flows on a programmable schedule (outside of core patient hours etc) to reduce disruption and to maximise frequency of movements • Reliable logistics flows will help to underpin MoC enhancements and improve patient flow • Healthier workforce who are more engaged with top of scope activities as bulk of manual handling delivered via AGV • Separate clean and dirty flows and clean and dirty corridors to minimise IPC issues, prevents cross-contamination ,	From Inpatients Opening (>Q1, 2029/30	• Better Patient Outcomes • Increased Productivity • Living within our means	• Robotics/Logistics Management Strategy • Dock management scheduling improvements programme • Digital Hospital programme	• Experience from other Australasian builds shows that AGVs have helped to drive efficiency and productivity improvements. •Reduction in reported manual handling injuries due to use of AGVs taking on bulk of tasks currently delivered via our workforce • Creating a clear workflow between stations (be it an examination room, ward or surgical suite), clean and dirty utility rooms prevents cross-contamination between areas where medical supplies are used. They ensure that utensils will be clean when they enter the point of care, and sanitary when they exit; a process which supports an effective infection control strategy.	Bi-annual		Green Star accreditation process underway. Aiming for 5* accreditation, which will deliver a number of sustainability, operational and performance improvements. Early investigations about "soft landings" framework application, which helps to bridge the often significant gap between predicted and achieved performance in a new building.
		1.6.1 Importance Level 4 (IL4) accreditation reached	(On opening)	IL4 achieved on opening	Development in progress	• Building is able to function immediately following a major event vs current facilities									
		1.6.2 Clean and dirty flow separation	(On opening)	Improvements vs current Dunedin Hospital	Ongoing as part of design	• Fewer recorded cases of cross-contamination									
		1.6.3 Automation (including AGVs) delivered	TBC (AGVs won't be in operation on opening)	Improvements vs current Dunedin Hospital	Awaiting AGV strategy	• Use of robotic technology to distribute meals, linen, supplies and waste (increased productivity and number of movements)									
DISBENEFITS *[note: these are WIP]*															
2	**Cleaning Costs** ED F, P&F	2.1 Increased cleaning costs due to larger floor area and more single-patient ensuites	2027/28 OPEX	Holding cleaning costs from year-on-year increases	N/A	• Increases in cleaning costs incurred due to additional floor area and number of single-patient ensuites	• Patients who need to attend a separate appointment at IPB and/or wait for transport to the acute facility will incur costs to their time • Maintenance of cleaning and buffing machines (not currently required)	• To be determined	From Inpatients Opening (>Q1, 2029/30	• Better Patient Outcomes • Improve Patient Safety • Improved Patient & Staff experience • Increased Productivity	Workforce Strategy and Action Plan Migration and Commissioning Plan	• In the NDH the Oncology/Haematology inpatient Unit will be located with other inpatient units in the IL4 building. The continuation of service delivery from the existing SBCS facilities when acute and inpatient clinical services relocate to the NDH creates challenges in service planning and delivery. • Split sites (OPB and IPB) and increased travel distances between them means some workforce inefficiency will be incurred for Building and Property and other workforce groups.	Bi-annual		Disbenefits will be tracked and reported in the same manner as benefits. Mitigation actions will be determined as we progress. Any disbenefit costs will be subtracted from the benefit cost savings or improvements made elsewhere.
	Workforce duplication or inefficiency due to split sites ED P,C&T	2.2 Workforce inefficiency due to split sites	2027/28 OPEX	Reduction in year-on-year productivity inefficiencies	N/A	• Workforce inefficiencies due to split site and split operating models (i.e. more staff required or staff transferring back and forth) incurs financial costs (TBD)									
	Staff time/maintenance costs increases ED F, P&F	2.3 Maintenance OPEX costs due to split site model	2027/28 OPEX	Reduction in year-on-year productivity inefficiencies	N/A	• OPEX (staff time and transport) increases associated with transfer of maintenance goods back and forth from NDH to BoH workshops for repair and maintenance • OPEX increase due to work previously undertaken in house being contracted elsewhere									

Programme Benefits: Overview.

Benefits monitoring will be a continuous process over the next decade.

SDHB's Programme Director, via PMO, will provide day-to-day management of the Benefits Realisation Plan. Quarterly updates of some indicators will be provided to ELT. Issues that require management attention or direction will be flagged as part of that process.

Given difficulty in attribution, choosing appropriate benefit indicators was not a precise science. Priority was given to those metrics already being reported on across SDHB in order to reduce administrative burden. We acknowledge that a further review and refinement of benefit indicators is required in order to agree those final indicators that will reported to Treasury – for the next decade – as part of our ongoing monitoring.

Issues.

Benefits have been refined, simplified and stratified accordingly to attribution to the project/building (Benefits Stream 1) or to wider, system-wide change (Benefits Stream 2). Some benefits can be attributed to both the facility and the system-wide change.

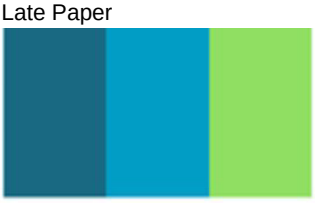
At present, costing of savings arising from the realisation of benefits is in its early stages. More work is required. Figures presented here should be viewed as indicative only, subject to further scrutiny; agreement about attribution; and confirmation that double-counting of a benefit saving has been avoided.

In some instances, proposed benefit measures aren't currently captured in standard reporting. Work to develop such indicators will be required. Duplication of effort will be avoided.

14.1

Benefits Realisation Plan (Stream 1 and 2) -- Data sources, notes, assumptions for benefits

		Indicator	Data Source/notes
NDH-Specific (Stream 1)			
1.1	**Increased Elective Surgery Rates**		
		1.1.1 Number of elective surgical services case-weights (CWDs) delivered	180309 Sapere Modified theatre Forecasts (medium population projections)
		1.1.2 Number of elective surgical service discharges	SDHB's Statement Of Service Performance 2019/20 (p28)
		1.1.3 % of elective and arranged surgery undertaken on a day case	SDHB's Statement Of Service Performance 2019/20 (p28)
		1.1.4 % of people receiving their elective and arranged surgery on day of admission	SDHB's Statement Of Service Performance 2019/20 (p28)
		1.1.5 Reduction in outsourced surgery	2019/20 budget
			https://crollab.moh.govt.nz/LotusQuickr/electiveservices/PageLibraryCC2578BE0004988E1.nsf/h_30DC778E2FA9D778CC257A30000E5130/4D4C227972E47B49CC257A30000EF75C/?OpenDocument
1.2	**Decreased average length of stay**		
		1.2.1 Reduction in wait times to access diagnostics and imaging	SDHB PowerBI Radiology Report - CT, MRI, US wait times
		1.2.2 Reduced net occupied bed days	Acute Hospital Bed Days per Capita "Using Health Resources Effectively" (p12, 2020/21 Annual Plan)
		1.2.3 Reduced time taken to discharge	To follow
1.3	**Improved Productivity**		
		1.3.1 Reduced Medical SMO FTE per case weight	To follow
		1.3.2 % of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in <4mths	SDHB's Annual Reporting (annual)
		1.3.3 Reduction in cancelled cardiac surgery	Dashboard to be developed
1.4	**Improved Patient Flow**		
		1.4.1 % of people presenting at ED who are admitted, discharged or transferred within 6 hours	SDHB's Quality & Clinical Governance Risk Report (monthly)
		1.4.2 Increase in % discharged before noon	SDHB's Quality & Clinical Governance Risk Report (monthly)
		1.4.3 LOS >7 days. Med-Surg& Rehab	SDHB's Quality & Clinical Governance Risk Report (monthly)
			https://app.powerbi.com/groups/me/reports/b9570096-db30-4f6e-a9fa-86857028a7eb/ReportSection2f155a998d8684ca9f59?ctid=45107a8c-6d7c-411e-9a7f-787684a303df
			https://app.powerbi.com/groups/me/reports/7e293da4-8e84-4084-96d5-576e25b97e4c/ReportSection49a79bfac4d070327873?ctid=45107a8c-6d7c-411e-9a7f-787684a303df&OpenAppFromWindowsPCAndTablet=false&openReportSource=ReportInvitation
1.5	**Decreased Patient Harm in Hospital**		SDHB's Quality & Clinical Governance Risk Report (monthly). Total # of bed days stayed after a Fall incident in FY20 was 2,647 bed days. Based on the non resident charge out rate of $1,125 per inpatient bed day (does not include 30% margin typically charged), this is almost $3m in costs.
		1.5.1 Reduction in hospital falls	SDHB's Quality & Clinical Governance Risk Report (monthly)
		1.5.2 Reduction in # of hospital acquired pressure injuries	SDHB's Quality & Clinical Governance Risk Report (monthly)
		1.5.3 Reduction in medication errors	SDHB's Quality & Clinical Governance Risk Report (monthly)
		1.5.4 Reduction in hospital acquired infections	
1.6	**Building Performance and Sustainability**		
		1.6.1 Green Star (5*) accreditation reached	TBC through design
		1.6.2 Clean and dirty flow separation	TBC through design
		1.6.3 Automation (including AGVs) delivered	TBC through design
	DISBENEFITS		
2		2.1 Increased cleaning costs due to larger floor area and more single-patient ensuites	TBC through design
		2.2 Workforce inefficiency due to split sites	TBC through design
		2.3 Maintenance OPEX costs due to split site model	TBC through design



SYNERGIA

SOUTHERN DISTRICT HEALTH BOARD STRATEGIC REFRESH

Draft project plan

4th May 2021

1. INTRODUCTION

Southern DHB is seeking a refresh to its strategic plan, with the development of a strategic pathway to enable an effective response to health needs during the next decade.

Synergia was engaged in early March 2021 to lead a strategic refresh for the Southern district, through a process of consultation and engagement across the region. The work has begun with the establishment of a Steering Group to guide the project.

The recent announcements regarding the health system reforms, following the Health and Disability System Review recommendations have reiterated the need for the strategy refresh process to enable a strategy that is for the Southern Health system rather than solely the DHB.

This document presents a project plan for this work, that will guide the scope and activities of the project through to completion in October 2021.

2. GOVERNANCE, ROLES AND RESPONSIBILITIES

The strategic refresh process has two layers of governance; a Steering Group and a Working Group.

The role of the Steering Group is to give guidance across the duration of the strategy refresh process and support the project team to address any risks that may arise. The Steering Group will review and endorse the final strategy refresh document to be presented to the Southern DHB Board at the close of the project.

Steering Group members are as follows, current to May 2021:

Member	Role
Prof. Peter Crampton (Chair)	Professor of Public Health in Kōhatu, the Centre for Hauora Māori
Chris Flemming (Deputy Chair)	Chief Executive, Southern DHB
Vacant	*Executive Director of Strategy*
Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
Vacant	*Iwi Governance representation*
Dr Nigel Millar	Chief Medical Office
Jason Searle	Community Health Council

The role of the Working Group is to work with the Synergia project team throughout the strategy refresh process to inform and advice on key components of the project. These could include, but are not limited to, local engagement, core strategy design, implementation processes, ensuring Tiriti responsiveness for Māori. The Working Group members are intended to be champions of the strategic refresh beyond the life of the project and become key leaders for implementation.

Working Group members are as follows, current to May 2021:

Member	Role
TBC	

2.1 Māori relationships and engagement

The strategy refresh project will engage with local mana whenua organisations and leaders under the umbrella of the Te Tiriti Crown: Iwi relationship.

Synergia will be guided by these initial Iwi discussions in terms of the process for establishing Māori engagement, partnership and voice throughout the strategy refresh process.

Synergia will be guided by the findings and core principles described in the Waitangi Tribunal Wai 2575 report in terms of addressing structural bias and inequities in the health care system. This forms a critical and necessary foundation for the strategic refresh.

2.2 Synergia project team

The Synergia project team is made up of a multi-disciplinary group of people to support the strategic refresh. The team will lead the facilitation and development of the strategic refresh, while ensuring that it remains a strategy for the Southern health system, by the Southern health system. This will be managed through extensive, wide consultation with the sector, across the region.

Members of the Synergia project team include:

Member	Role
Paul Stephenson (Project Lead)	Director, Synergia
Assoc. Prof. Matire Harwood	Associate, Māori advisor
Dr Felicity Williamson	Public Health Medicine Specialist
Dr Matt Wright	Clinical Lead, Emergency care specialist
Dr Peter Carswell	Organisational Psychologist, implementation science lead
Jess Gasparini (Project Manager)	Consultant
Josie Reynolds	Data Scientist
David Todd	Managing Director, strategy development

3. PROJECT OVERVIEW

The graphic below outlines the overall project plan. Project establishment is occurring during April and May, with the on-site work programme beginning in May and running through to the end of October 2021.

The work programme is made up of four key phases:

1. Project set up and oversight – governance, Te Tiriti engagement, project management, contract management and communications
2. Exploration and understanding of current state
3. Strategic design and key concepts
4. Detail design, confirmation, and communications

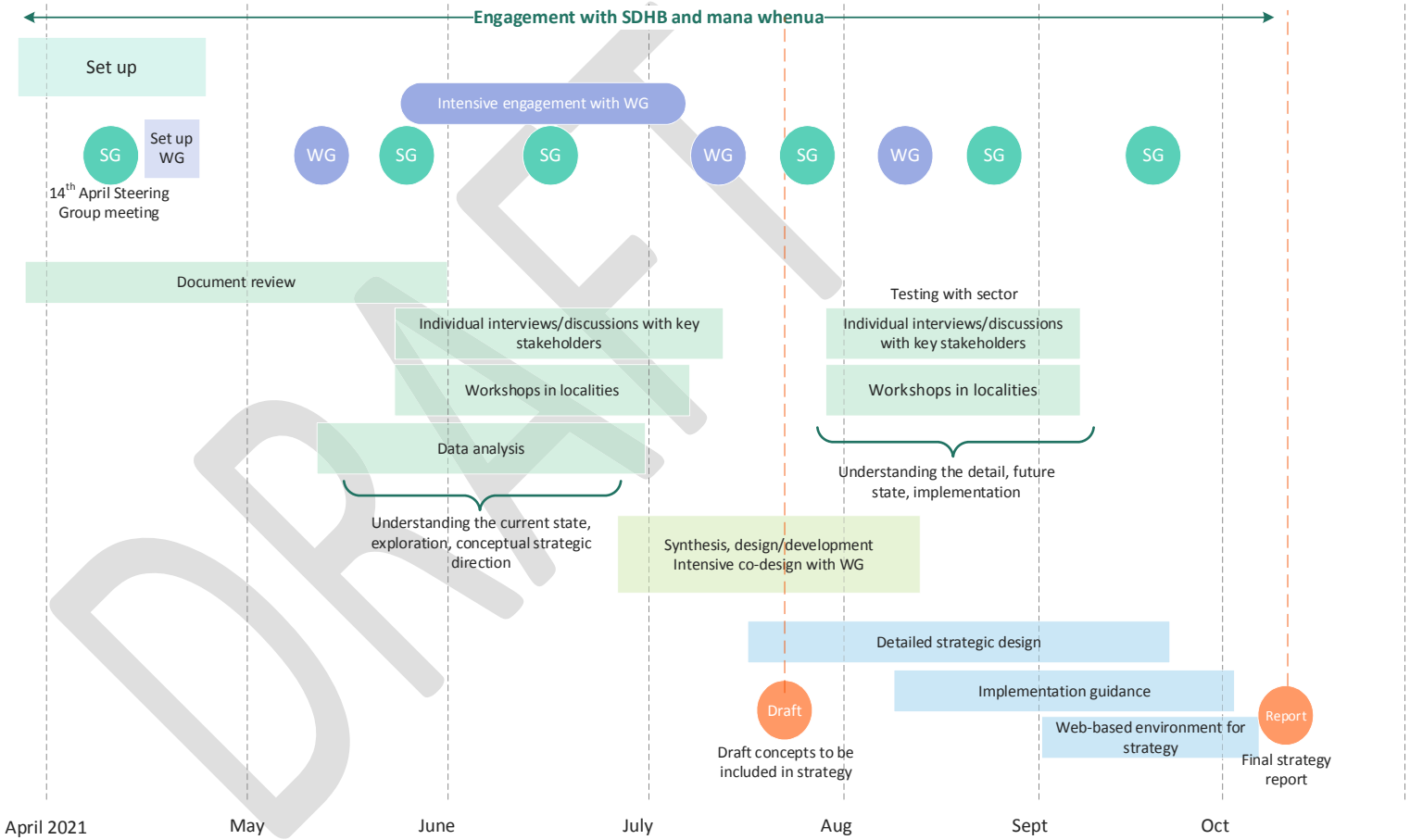
The figure on the following page gives a high level overview as to when activity under these phases is likely to occur.

1. Set up, engagement
- Develop and agree project plan
- Sector comms plan
- Establish SG and WG
- Establish partnerships with mana whenua

2. Understanding, insight and exploration
- Key document and evidence review
- Understanding data
- Explore sector perspectives
- Future exploration, major trends and shifts

3. Analysis, synthesis, design and development
- Synthesis and design workshops
- Understanding of strategic issues

4. Detailed strategic design, implementation
- Detailed strategic design process
- Implementation guidance
- Web-based environment
- Final strategy



4. PROJECT OVERSIGHT

The Synergia project team will support monthly meetings with the Steering Group and the Working Group.

A communications plan will be executed, in collaboration with Southern DHB, to ensure that there are clear key messages with the wider sector about the project and to ensure there is clear understanding about how the strategy refresh fits with the health reforms.

Synergia will provide monthly project update reports for Southern DHB and ensure that any project risk issues are clearly communicated to Southern DHB and the Steering Group in a timely manner.

Working Group activity will be flagged well in advance so that Working Group members are able to manage their time and capacity and are able to support the strategy refresh project.

Engagement and action to address equity and Māori responsiveness will be undertaken with advice and guidance from local Iwi.

5. UNDERSTANDING THE CURRENT STATE

The first phase of the work will involve understanding the current state of the Southern health system. The focus of this section is ensuring that the strategic refresh is built on solid foundations. We will work collaboratively with SDHB to understand the current issues and context that influence strategic direction and design. This process will also facilitate understanding of the strategic drivers within the system, and lead to informing the design of a fit for purpose and high performing Southern health system.

5.1 Initial engagement with mana whenua and non-Ngāi Tahu Māori

As discussed above, it is important that the process begins with identifying the right people to engage with throughout the strategic refresh process. Engagement with Ngāi Tahu and other Māori in the region is paramount to delivering a strategic refresh that is Tiriti responsive and fit for purpose to both achieve Crown obligations and equity. Early relationship building and partnership will take place, leveraging off existing DHB relationships, to understand strategic direction from a Māori perspective.

5.2 Key document and evidence review

This strategy refresh will be strongly influenced by the key direction outlined in the Health and Disability Services Review. Whilst the government may deviate somewhat from the exact recommendation in the review, we believe that the core thinking about issues such as tier 1 and tier 2 services and enablers will remain central to future health system design.

We have begun and will continue to incorporate learnings from current service and enabler strategies, past reviews and future planning documents to help us understand the current Southern health system. This strategic refresh process may be able to leverage off past planning and engagement pieces to build from the strengths and efforts that have already occurred. We want to understand what has been implemented, and in what ways, to be aware of the challenges of implementation, both past and present. We also want to better understand the key strengths in the system that will enable key shifts to occur.

Documents and evidence included in this review are being provided by SDHB, along with a short online scan of relevant documentation to the strategic refresh process.

5.3 Data scan and analysis

To truly understand the current landscape of the Southern health system, we will go through a period of data analysis. There is a wide range of DHB data that is collected and reported in different ways that we will gather and analyse to help us understand current health service provision, use and quality. Potential data sets that may be included are health needs data, system utilisation data, hospital performance and financial data. As a part of this phase, to date we have:

- Reviewed a range of past and present DHB and public reports that outline need, service use and future projections for the Southern region.
- We have made a data request to the Ministry of Health for all major data sets for Southern region for the past 5 years, from 2016 to 2021. We will work with the SDHB data team to explore other data that the DHB currently collects.
- We will also work closely with the patient experience team using any current and experience data or co-design work that has been undertaken.
- To gather an understanding of the full Southern health system, we will explore primary care data collected by the PHO.
- We will be working with the Iwi governance group and kaupapa providers to identify additional data to that might be available through the Ministry of Health or other sources to give insight into how the Southern health system is performing for Māori.

This data will be combined to provide a layered view of the current state of needs, access, utilisation and patient pathways. We will aggregate and analyse this data through a locality lens, in line with the direction outlined in the government health reform updates. We will explore the use of geographic information system (GIS) mapping to provide a visual representation of the current state across localities, which can be layered and stripped back based on different indicators or datasets to form the basis for assessing proposed future service configurations and help to identify future strategic priorities.

5.4 Snapshot of current services

We have developed a 'snapshot tool' that can be filled out by service providers throughout the DHB and the Southern health system to help us better understand service provision, access, strengths and challenges currently facing the system. The tool has been developed by combining and simplifying some of the versions of the Role

Delineation Model used to evaluate health services and using some of the directions outlined in the HDSR of what services should be available to NZ localities.

This tool will be reviewed and tested by the Working Group before being shared, and we will look to engage with key stakeholders prior to opening the survey. We will invite stakeholders involved in service provision through the DHB, working group and PHO networks including selections of:

- Primary care providers including general practice and community services
- Kaupapa Māori providers (invited through Iwi governance and DHB Māori networks)
- Acute care staff and those from regional hospitals
- Ambulance services
- Public and private specialists and providers who work in each area (including those involved in outpatient clinics and telehealth)
- Aged care providers
- Those involved in imaging and laboratory services
- Community and hospital pharmacy

Other specialised roles will be invited to fill out smaller parts of the tool that are relevant to them (e.g. dental).

The tool will support identifying the focus of workshops with localities, and potential participants at these workshops.

5.5 Workshops with localities

Workshops will be primarily to involve service providers in designing what an optimal future health system would look like in Southern DHB. The workshops will support understanding the strategic priorities within the localities as well as the specific challenges the localities are facing. We will be able to unpack the current state of the Southern health system through these workshops, with insights from local service providers as to how the system is functioning for both providers and service users.

We will work with our Working Group to identify potential participants for locality workshops, as well as using other mechanisms such as the snapshot tool and wider communications to the sector.

We are anticipating holding workshops in the following localities, though these will be decided in collaboration with the Working Group:

- Oamaru/Waitake
- Dunedin
- Invercargill
- Lakes District/Central Otago

We anticipate that these workshops will be about three to four hours long, though this will be decided in conjunction with the Working Group using their knowledge of the community and sector as a guide.

We will also be guided by the Māori liaisons for this project (both on the Steering Group and Working Group) on whether specific hui for Māori providers is required to most appropriately gather the views of Māori.

5.6 Key informant interviews

Key informant interviews and focus groups will help the project team to understand the realities of the system and service delivery across the region. Potential participants might include key community and service leaders, organisations, Kaupapa Māori providers, workforce groups, and communities who will have an important perspective on future direction and strategy.

Focus groups may be used for some groups, for example, Pacific communities and people with disabilities, where there are perspectives, we are interested to clearly understand. Focus groups tend to work well where there are groups of people who may have views on similar topics of interest.

5.7 National and international examples

We will review the current literature and examples of service design that are effective in areas with similar population and geographical challenges. We know that there are innovative ways to use technology, networks, data and collaboration to overcome many issues when delivering health services in geographically spread-out populations with uneven population growth. Understanding and learning from what has been done elsewhere may give insight and ideas that could be adapted and build upon for the Southern region.

6. STRATEGIC DESIGN AND KEY CONCEPTS

We will synthesise information from the exploration and understanding phase and use this to inform the strategic design phase. This will be synthesised into concise documentation of key issues and drivers for future strategy.

Where possible data insight will be layered into a GIS platform so that we are able to explore locality information and drivers.

6.1 Working Group co-design

We aim to develop a series of workshops in which we explore the key strategic directions and concepts with the working group in some detail. We imagine that this will include a series of workshops, where there is intensive work between workshops to develop up detail and data.

The intensive design phase is planned to last about six weeks, with the aim of agreeing the key strategic approach – to both system design/direction and implementation by the end of this time.

We anticipate that defining how Southern localities will function in the future under the health reforms will be an important part of the strategic approach, along with improving effective Tier 1 and Tier 2 integration and strengthening of system enablers.

6.2 Te Tiriti based co-design

As discussed earlier, the detail of our approach to engagement and design for services for Māori to address equity will be discussed with iwi partners under the umbrella of the Crow:Iwi Te Tiriti relationship. We are anticipating there will be some form of focused design process that addresses equity and services for Māori. This response may be integrated with the Working Group or may be a separate process – or include elements of both.

6.3 Sector engagement

We are anticipating that the strategy and system design process will be fast moving, with emerging ideas and approaches that we will need to explore and test with various people/organisations in the sector. This is likely to mean we will need to include stakeholder interviews and focus group activity during this time.

7. DETAILED DESIGN, CONFIRMATION AND COMMUNICATION

Following the development of the core strategy and system design work, Synergia will develop the more detailed strategy and implementation approach.

The detailed development will be focused on presenting information and content that is relevant and meaningful to people in the Southern Region. This means we do not intend to provide a traditional 'dense' strategic plan that is often difficult to read and understand. Our aim is to present information a manner that is accessible and actionable for all.

7.1 Test and refine with the sector

We intend to take the core ideas in the emerging strategy to the sector and to explore, test and refine the key ideas with the sector. This will take the form of four workshops, one in each locality previously visited, and also key information interviews. Details of this 'test and refine' process will be discussed with the working group and may be modified closer to the time.

The 'test and refine' process for Māori will be agreed and undertaken in line with the wider process about the Māori engagement and design approach.

The final part of the project is to prepare and present the strategy, system design and implementation guidance within a web-enabled environment, so that information can be made relevant to various audiences.

The strategy communication will identify long term strategies and identify pathways to get there and an approach to implementation. The recommendations will incorporate and reflect the wider health reforms guidance for sector change.

Final sign off will be through the Working Group, Iwi partners and the Steering Group.

8. SCHEDULE OF ACTIVITY

The table below outlines the proposed schedule of activity for this project.

Activity	Date
Planning and scoping • Document review of relevant internal and external documents to understand the current state of the Southern health system • Initial engagement with SDHB and Steering Group • Establish Working Group • Iwi engagement • Delivery of project plan	Friday 7th May
Initial engagement and scoping of current state • Data analysis • Identifying key groups of people to engage with in the sector • Deployment of tool (survey) • Set up engagement sessions • Session with Working Group • Session with Steering Group	Friday 28th May
Workshops in localities • Analysis of tool data to inform workshops • Series of workshops in localities across the region • Engagement with iwi	Friday 25th June
Synthesis and high-level strategic refresh • Synthesis of workshop information • Intensive development period with Working Group to inform high level concepts in the strategic refresh • Identify priority areas • Present high level concepts and priorities to Steering Group and Board (?)	Friday 16th July
Testing of concepts with sector • Workshops with localities to test draft refresh • Additional data collection to inform refinements	Friday 13th August
Detailed design and development of strategic refresh • Including implementation guidance • Refinements of detail included in strategic refresh based off sector engagement • Presentation of detailed strategy to Steering Group and Board	Friday 10th September
Development of web-based environment for strategy • Ensuring accessibility and relevance for all parts of the Southern health system	Friday 24th September
Presentation of final strategy • Present final outputs to Steering Group for endorsement to the Board • Board presentation	Friday 22nd October

9. PROJECT RISKS AND MITIGATIONS

This is a large, complex assignment that relies heavily on engagement with key individuals and groups of people across the region. Key risks are primarily linked to accessing people and information.

Risk	Likelihood	Mitigation
There is confusion and/or distraction resulting from the HDSR and the resulting health system reforms	Medium	This review will be interpreting the reforms and positioning the Southern region as proactive leaders in terms of the key ideas presented in the government response. This will be accompanied by clear communications about the review being for the 'Southern health system'.
The project team are unable to access appropriate people to attend locality workshops	Medium	We will work directly with the Working Group and other staff at SDHB to leverage off existing networks to connect with appropriate people for this phase
Delayed access to data and other information collected by SDHB and the Ministry	Low	We are engaging with key people at SDHB who have influence and lead data collection processes
Limited engagement with mana whenua throughout the detailed design process	Low	Assoc. Prof. Matire Harwood on our team has some historical engagement with the iwi governance group, which we will tap into for this work. We will also work with SDHB to utilise their existing networks into the Runaka in this region.
There is timeline slippage, resulting in workshops and key informant interviews being delayed due to individual's availability	Low	Synergia has a well-developed process of engagement with stakeholders, and expertise in bringing groups of service providers together. We will also work closely with SDHB to schedule workshops and sessions well in advance to ensure availability.

10. SUGGESTED CONTRACT MILESTONES

The table below presents suggested contract milestones, in line with the proposed schedule of activity.

Deliverable	Date	Percentage	Amount
Project plan and engagement • Delivery of draft and final project plan • Development of TOR and initial engagement with Steering Group and Working Group ***Output:*** • *Final project plan* • *Initial meetings with Steering Group and Working Group*	21 May 2021	15%	$36,000
Understanding the current state • Key document and evidence review • Data scan and analysis • Snapshot of current services ***Output*** • *Progress report summarising key insights from documents, evidence and data.* • *Survey dissemination using snapshot tool.*	18 June 2021	10%	$24,000
Workshops, interviews, focus groups • Key data collection points, which may include locality workshops, individual key informant interviews, group interviews and/or focus groups. ***Output*** • *Sector engagement* • *Progress report summarising key insights from initial sector engagement*	9 July 2021	15%	$36,000
Draft strategic refresh • Development of draft concepts to be included in strategy • Co-design workshops with Working Group ***Output*** • *Outline of core concepts to be included in strategic refresh*	30 July 2021	15%	$36,000

Sector engagement and detailed development • Testing core ideas with the sector – key informant interviews, focus groups, workshops if required • Developing the detail of the strategic refresh in collaboration with the Working Group ***Output*** • *Motivated sector* • *Detailed draft strategic refresh*	3 September 2021	20%	$48,000
Development of web-based environment for strategy • Design-focused engagement with Working Group • Technical development of web-based environment ***Output*** • *Interactive online version of the strategy*	1 October 2021	15%	$36,000
Development and presentation of final strategy • Finalise strategy **Output** • *Concise paper version and web-based interactive version*	22 October 2021	10%	$24,000

Governance Structures for ePMO,
enterprise Portfolio Management Office implementation

Delivery vehicle for the SDHB Transformation (Change) Programme

P3O Model

ePMO:
Immediate role recruitment:
Portfolio Manager

Future roles:
Portfolio Benefits Manager, Business case analyst, Quality Assurance Analyst

SDHB Programme & Project Managers

Principal advisor
to CEO/Head of ePMO.

Change Delivery Committee:
Current ELT or sub-set of including Portfolio Manager.
High-level Roles & Responsibilities:

- Monitor progress of the delivery cycle
- Ensure risks & dependencies are effectively managed
- Monitor and approve changes to the benefits forecast based on information provided by ePMO
- Where justified, make recommendations to the IC on initiatives that should be terminated

Investment Committee:
Current SDHB Board or sub-set of including CE, EDFPF & PACEO.
High-level Role & Responsibilities:

- Approve the Portfolio Strategy
- Agree the overall portfolio management processes
- Agree any changes regarding the definition cycle
- Approval of the delivery plan
- Receive investment appraisal & prioritisation reports & decide on the scope & content of the portfolio

High Level Timeline

- Recruit Portfolio Manager to work with P.Advisor in ePMO establishment

- Development of investment & prioritisation criteria/strategic value drivers for the portfolio from which to base ongoing decision-making regarding the transformation portfolio

August 2021	September 21	October 21	November 21	December 21

- Establish supporting governance structures
- Implement Portfolio/Project Management Framework
- Implement cascade software platform to support ongoing change portfolio reporting & accountability

- Onboard additional ePMO roles: Benefits realisation manager & business case analyst

- Implement Portfolio Strategy & delivery plan
- Undertake change initiative (project) audit & build complete view of transformation programme

14.1

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 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.
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.