Southern District Health Board Review

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Photo source: Southern DHB website

Executive Summary

Southern District Health Board (SDHB) provides secondary and some tertiary health services to a community of approximately 350,000 over a large geographical area. The DHB was amalgamated in 2010 in anticipation of reducing administrative and overhead costs and ensuring that Southland hospital and Dunedin hospital could work clinically together, strengthening clinical governance and patient access. However, there was no financial support provided at the time to ensure true integration and as such there are several systems between the two hospitals that have remained separate including the patient administration system. This lack of integration has hindered the true spirit of the merger and today, for the most part the two hospitals work as independent entities, with some cross over with some specialities, mainly driven by resource constraints.

The DHB has maintained a deficit financial position for many years and at times has struggled to maintain appropriate clinical and operational oversight resulting in events of lost accreditation in radiology and ICU and non-compliance with ESPI targets and staff dissatisfaction.

Healthy organisations have good governance and accountability frameworks embedded in all aspects and at all levels of the organisation. Operational variation within an organisation is the single biggest driver for cost over runs and inefficient practices. Where practical, standardisation is the preferred model. To enable standardisation of performance, an organisation needs to be transparent in its direction, clear in communication and have an executive and management team that follows through on achieving the strategic outcomes by adjusting the operational response to refine to the changing conditions it faces. The organisation needs to be agile and allow flex within the various levels of management to manoeuvre and adjust seamlessly to the changing needs of the business on a daily basis whilst still directing it toward the strategic goals. It should have a high trust environment overlaid with a strong performance and accountability framework and be driven by data.

SDHB operates in a low trust environment, with low levels of delegation, poor transparency and the science of data lost within the crisis environment it finds itself often in, where data is not embraced to identify opportunities and improvement beyond the short term fix. There is poor staff morale and confusion around direction, a high clinical/corporate divide and too much variation in clinical and operational practice. The positives for SDHB are that it has a committed workforce, the people within the district intend to stay within the district, having established families in the region, they are not looking elsewhere. Overall, whilst the temperature of the organisation is currently despondent, it will not take much to turn this around providing theexecutives and managers are willing to engage actively and genuinely with staff, and this means holding people to account – clinicians and non clinicians alike.

The DHB currently operates in a permanent crisis mode, it lurches from one issue to the other on a day to day basis, causing confusion and duplication of effort. The reasons for this, is simply due to an absence of an effective accountability and performance framework. There is a lot of effort going into the day to day operations of the business, however, the effort discharged is greater because of the crisis nature of managing the organisation and executives not necessarily aligned to each other and the overall reason why the DHB exists. It is hard to seebeyond the issues of the day and create a sense of direction and calm when “fires burn in all directions”. However, for SDHB to get through this period, it will need to reflect on its priorities, its performance and whether it can do better. This is a confronting exercise and reviews such as this one, are often received defensively andeffort is placed into disputing observations, findings and recommendations. It is important, that whilst the Board, executive or management may disagree with some, or all of the statements made in this report, that they use it to reflect and to have an honest conversation amongst themselves upon some of the themes raised by staff and, through the reviewers observation and review.

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Background

The DHB has maintained a deficit financial position (forecasted $15m deficit for the 20/21 FY) and at times has struggled to maintain appropriate clinical and operational oversight resulting in events of lost accreditation in radiology and ICU and non-compliance with ESPI targets and staff dissatisfaction.

The CEO of SDHB and the Ministry of Health engaged S2P Consulting Ltd to review resources within the organisation to determine whether resources are adequately allocated within the DHB and identify areas where improvement can be made without compromising clinical safety and outcomes.

Scope of Project

Phase one of the review was to perform a high-level review of the two campuses with a particular focus on the provider arm to understand the underlying issues financially, clinically, and culturally that sit with the SDHB and recommend where appropriate actions that could be undertaken to rectify these deficiencies. It is anticipated that following this first phase, the SDHB will then move into phase two of determining areas of priority and further development that it wishes to pursue based on the findings of phase one. This engagement excludes any work associated with phase two.

The review was conducted in 16 days through interviews with staff both in a clinical and non-clinical setting. A large data request was made, with the majority received over the period of the review. The absence of an analyst in this review has meant not all data has been vigorously analysed but there has been adequate review performed to form opinions. It is suggested that for phase two, a dedicated analyst be assigned to the approved work to ensure greater analysis occurs and the right solution implemented.

Timeframe and Resources

The review was conducted on site over a 5-week period, noting considerable interruptions due to the high level of public holidays and school holidays that occurred in April, resulting in not all DHB personnel being available when required due to leave commitments and as such not all clinicians that were initially identified were engaged due to the timeframes. Administrative support was provided to assist with the collation of the data requests and setting up of meeting times, and an expression of thanks to Joanne Fannin is offered for providing this invaluable support.

Findings and Recommendations

We acknowledge and thank all participants that provided input into this review. The openness of the staff at the health board was most appreciated and the collective desire to look toward solutions to improve the DHB was atestament to the many teams to their commitment towards a cohesive and sustainable health organisation and system.

On 21 April 2021, Government announced that there would be major health reforms undertaken over the next two years, namely, removing the 20 DHB model and moving to a regionalisation and national health model. It is anticipated that these changes will take effect 1 July 2022 and as such a few areas around vulnerable and specialised services are no longer considered as areas to advance with as they will be captured with the national reforms. There remains a 12-month period between the current system and the transition into the new system and the focus of the executive should be on its people, removing unnecessary bureaucracy, improving local level systems and processes, and improving its governance. The next 12 months will be a test of leadership and management to provide clear direction to staff and assure them that SDHB is prepared to seamlessly move into the new reforms with an engaged workforce. As such the recommendations around these areas are the aspects that this report focuses on.

Executive Level Clinical and Corporate Governance and Leadership

Governance is an essential component of all organisations. It measures the performance of the organisation, mitigates risk, and strategically drives the future. Without effective governance, an organisation will make decisions in isolation of performance and direction, it will fail to deliver quality outcomes and fail to improve. This report focuses on an improved governance and leadership framework which will identify the variation in clinical and operational practice which costs the organisation the most money. Variation is the largest cause of cost in any organisation, it can be easily hidden in large organisations such as SDHB and as such can create surprises in out years by exponentially growing. Many DHBs start off with deficits that sit within the $10m to $20m range but quickly escalate to $50m plus within a year and therefore it is important to embed good governance and leadership over an organisation as quickly as possible.

SDHB has published several strategies which have not yet been fully implemented and are not on the trajectoryto do so. One of the key reasons for this lack of progress has been the absence of an accountability framework and a convoluted structure which has multiple roles accountable for the same outcomes. When everyone is accountable, no one is accountable.

The primary care and community team hold significant operational portfolios with limited operationally experienced managers and executives and whilst these operational areas were not included in the review, conversations with the most senior members of this directorate indicated that little operational and clinical governance occurred in these areas.

There is a disfunction in the relationship between the Primary Health Organisation (PHO) and the DHB with little integration/interaction occurring at multiple levels of either organisation and as a result the closer to home initiatives have not been optimised.

During the review, it was difficult to understand the health needs of the community as no one person was able to articulate the community profile or the DHBs performance against community need and as such it was not possible to ascertain whether the DHB is meeting the health needs of the population other than reviewing standard intervention rates where there was some under and over delivery in some areas. Without understanding the community needs there is a possibility of specialities growing or procedures introduced which over services the population at the expense of the population where the most need is.

The traditional planning and funding function is absent from SDHB and split through the structure allocating responsibility for the community liaison and work with the services within the hospital. This philosophy presumably was embedded to ensure there was “end to end” responsibility for the health issues within the community through to the hospital setting, but the reality is the appointed manager role is reacting to the crisis in front of them, which inevitably is the hospital demand and pressure. Such a methodology would only work if there was depth of skill within the management teams to perform their roles at the highest level, leaving the Executive Director, Specialist Services with the capacity to work more strategically. It is recommended that SDHB refocus on some of the traditional planning and funding aspects that have been absent from day to day business.

There was minimal data differentiated by ethnicity and as such there was no opportunity to understand whether the health needs of Maori and Pacifica were being met adequately. All data should be cut by ethnicity to ensure those who are in the most need is being prioritised for care and to determine whether any unconscious bias exists with treatment of care and access for follow up care.

Siloed Structure

The structure at the executive level splits operational roles and places them into traditionally non-operational functions and the provider arm is split by profession not by service. The organisational design and structure have contributed to the inefficiencies experienced within the organisation, slowed down any progress to improve models of care and adequately plan for anticipated service constraints.

Primary Care, Community, Mental and Allied Health

The traditional planning and funding function would ordinarily sit in this portfolio and as mentioned above, the absence of the functions of this role is contributing to a lack of progress in implementing appropriate strategy with the primary and secondary care sectors. It is suggested this function be returned to this directorate.

Allied Health is a critical operational function and should sit within the provider arm, along with the hospital functions for older persons which should sit within the medical directorate.

Mental Health is a core operational function – the hospital and DHB provided health services in the community requires concentrated clinical and operational oversight and governance and should not form part of this directorate. Ideally it should sit within the provider arm, as mental health should be integrated where possible with physical health but with the current state of the provider arm, it would not be recommended to place this function in the provider arm and as such, for the time being, it would be recommended that the mental health division become a directorate reporting direct to the CEO but with a requirement for all clinical governance to be integrated and follow the provider arm governance framework once implemented.

Human Resource and Data Intelligence

These two functions are mutually exclusive and should be separated, both are specialised and large enough to have an Executive Director overseeing each function.

Both executive roles are, or will, become vacant soon as such it is an ideal time to make these changes without causing disruption to incumbents. With the upcoming changes to the health system as announced by Government in April, there may be a reluctance of people to relocate to Dunedin for what will be considered a one year contract. It is noted that Canterbury DHB are also holding similar level vacancies and as such it may be prudent to combine roles such as the Data and Intelligence portfolio to attract higher calibre individuals who will see the opportunities of contributing on a wider scale.

The Provider Arm

Within the provider arm, most of the nurses' report to an operational GM, the medical and operational accountabilities sit with a different GM and the allied health resources sit outside of the provider arm reporting into the primary care and community directorate. A patient's journey is intended to be a seamless one, where they interact with the entire system at the right time to get their best care, and as such, it seems unusual to have the resources deployed to the patient coming from different areas of responsibility. Service specialities should work together and hold joint accountability and responsibility for the model of care. Under the current structure the model of care is created in silos and in the absence of the other disciplines, resulting in fragmented care, frustration when resources are required but not available and tension between departments. The current structure does not work, 98% of the personnel interviewed within the provider arm, cited the structure as being a significant distractor and an inhibitor to implement any improvements. They stated that there was considerable tension and vetoing of initiatives on any one day making their jobs impossible to execute, with the middle tiers feeling the most vulnerable. The provider arm manages by crisis rather than planning, and the convoluted structure exasperates the chaos with many "hands" on the crisis. Many people stated that most of the crisis were predicable and had been flagged prior to being urgent but because there were so many people who "had to agree to prioritise the response" inevitably nothing happened until it became a crisis.

The structure cannot continue in its current form, it will continue to cause unnecessary stress within the system and burn people out. A structure should be consulted on with the staff that brings the medical, nursing, allied and corporate functions together by service with clear lines of accountability and responsibility.

Accountability and Performance Framework

There is no distinct accountability framework within SDHB. Monthly meetings with managers predominately look at the financial result and ESPI compliance, these are not documented formally, and do not look at key clinical and quality indicators. The structure pushes the "responsibility" of certain indicators to other executives who do not have operational accountability or control. The provider arm must be responsible for not only the financial performance and ESPI compliance, but it must be responsible for the clinical and operational delivery of all services within its remit, the quality and governance of the operation. The current expectation within the organisation is that the three professional leads and the Executive Director, Quality and Governance are responsible for clinical and quality outputs. These roles are support roles to assist the ED specialist services and other ED operational roles, not to take direct accountability for the performance of the provider arm.

The absence of an accountability framework means that when changes are needed to be made, sometimes the responsibility falls to the incorrect role to rectify. An example of this would be the patient flow taskforce work. It became obvious with the bed block and strain on resources that a circuit breaker was required to halt the deteriorating trajectory of timely access for patients. The team have done a commendable job in implementing some good discipline onto the wards, however, the initial phase of this work was done somewhat independent of the operational arm and lead by the professional leads. This has resulted in duplication of processes, frustration in some areas and delayed decision making creating further disruptions. To make any change sustainable, it must be embedded into the day to day running of the operational teams and becomes part of theprocesses. Patient flow is a day-to-day process, it should be part of how the hospitals are run and embedded and overseen by operations, drawing on support from the professional leads to assist in unblocking flow or implementing new clinical/operational models. It should be owned by operations and supported by the professional leads.

There is ad hoc review of quality data and this is dependent on the capability and capacity of the charge nurse managers and service managers. There was little evidence that good clinical governance was embedded in the organisation allowing appropriate review and actions to be taken by people at senior levels of the organisation. This poses some serious clinical risk as some underlying issues may not be detected early enough with interventions delayed.

The SDHB operates predominately in a crisis mode, each day there is something that drives its priorities which may be different from the day before. Operational variation is normal and should have systems and processes behind it to allow a seamless flexing to accommodate this variation, however, at SDHB there is a more notable reaction to variation, with lots of senior resources involved and decisions made from different parts of the management team without fully understanding the implications of the decision, resulting in short term "fixes" that create a chain reaction of crisis the following weeks/months. Health volumes both acute and elective are entirely predictable and the use of the principles behind production planning is essential for any business. The EDSS needs to prioritise the focus on production planning to allow forecasting to occur, predicting bottlenecks and issues in the future and then making decisions that change the trajectory of the direction and allowing for seamless patient flow and maximising the assets such as theatre to operate efficiently.

Implementing an accountability and performance framework within the DHB will draw the key risks of the organisation out early and allow for adequate planning to mitigate the identified risks.

Clinical Governance

Several committees have been set up or are in the process of being set up to oversee clinical governance but based on the review of the minutes of these committees it is clear the maturity and comfort of what the committees are doing still requires direction.

The clinical council has had a change in membership to move the focus from academia to core clinical issues, however, the review of the minutes imply a progressive discovery of what it wishes to focus on and appears to be still haphazard with limited focus on the core issues of the DHB, instead it spreads across all operational aspects of the DHB. The membership spans across the clinical disciplines, but does not include the ED, Specialist Services which, given their accountability is for safe, timely and effective services, it would seem appropriate for them to be a member of the clinical council. Greater discipline is required over the management of the action points with many being still outstanding for up to 8 months.

Some specialities hold multi-disciplinary team meetings around complex patients but often do not include the anaesthetist or a geriatrician where applicable. These two specialised disciplines offer significant insight and solutions to patient issues when engaged appropriately and can bring some balance to the discussion as to whether the proposed clinical intervention will really improve the quality of the patient's life, considering all their morbidities and risk factors.

From the high-level review, there appeared to be little discipline within departments around conducting mortality and morbidity reviews and whilst a policy and process is established within the SDHB the execution of the reviews are not embraced. It is imperative M&M reviews are implemented into departments to provide a safe space for clinicians to learn and provide assurance to the SDHB that clinical practices are at an acceptable standard and safe care is being administered to the community.

There is some review around stranded patients throughout the week, but little action recorded to ensure meaningful changes to their care occur to ensure they can leave hospital. An example of this was a stranded patient report in March that showed a patient who received a surgical repair that should have had a length of stay of 1-2 days and had a post operative complication that would have resulted in up to a 30 day length of stay, however, the patients length of stay was shown as 238 days and that he was clinically unwell and deconditioning. Without looking into this patient's condition, this level of information documented around stranded patients would not account for a 200 plus day stay. There was no action against this patient that assisted him with his care, the issues that he is experiencing, and the specific teams needed to provide action. There was no evidence of his care plan from the past or one going forward. This lack of rigour appeared to be common around most patients with actions simply noted as "team to review". Greater emphasis needs to be placed around long stay patients, multi-disciplinary reviews, and engagement with aged residential care units where applicable. SDHB has a greater number of long stay stranded patients than its peers and focus needs to be placed on these patients with community-based solutions included.

The lack of clinical governance within SDHB is contributing significantly to its crisis state, key risks and issues are not being effectively governed or managed and resources are deployed to areas that "want them" as opposed to where the need is most required. It is good to ensure staff are willing to incorporate and accept the resource, but it is equally important to ensure the resources of the quality improvement teams are deployed to the areas with the greatest deficiencies as opposed to the areas of interest. Influence on where the quality resources are deployed need to be made collectively by the EDSS, the professional leads and the ED Q&CG rather than the ED Q&CG alone. Feedback from the operational and clinical teams is that they do not think there is adequate partnership between the quality and operational teams with all stating that large components of the quality department has become siloed and lacks integration.

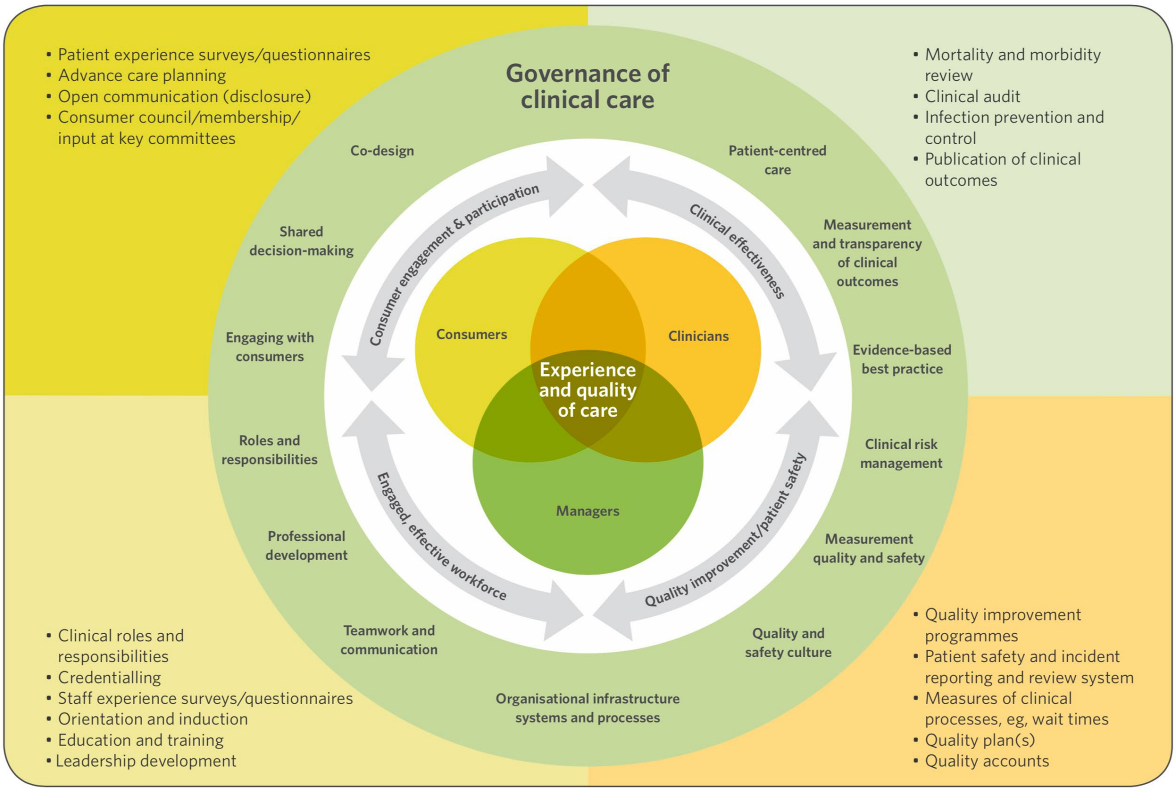
The crisis state costs the organisation significantly in short term thinking, decision making and reduced staff morale. It should not be underestimated how much this will impact the organisations bottom line.

The HQSC guide provides a framework for clinical governance that aligns to these dimensions and the principles that align to good clinical governance, they are:

- consumer/patient engagement and co-design
- open, transparent, and learning culture
- prioritising quality improvement and patient safety
- clinical leadership for quality and safety
- an emphasis on partnerships and involvement of all staff

- effective multidisciplinary teamwork
- measuring clinical processes and outcomes
- use of data to identify variation.
- effective management of clinical risks.

In essence these principles guide the organisation to being an effectively governed and managed organisation. The key risks are identified and mitigated, the areas of innovation and improvement are identified and implemented, and the investment of funds is placed in areas identified with the most strategic value.



Source: NZ Health Quality and Safety Commission in 2017: "Clinical Governance: guidance for health and disability providers".

There needs to be a concentrated effort around improving clinical governance within SDHB and not be driven using a centralist model. It is important that the governance team provide the support to setting up the required frameworks and infrastructure, but ownership must sit with the clinicians and led by the professional leads and the EDSS. The current role out of governance is not embraced by the clinicians or managers interviewed, it appears there is conflict around perceived priorities and collaboration with the services and as a result there is little value being driven from the limited governance implemented. It is imperative clinical governance is rolled out in conjunction with the accountability framework and placed at the appropriate levels within the organisation.

Quality and Risk

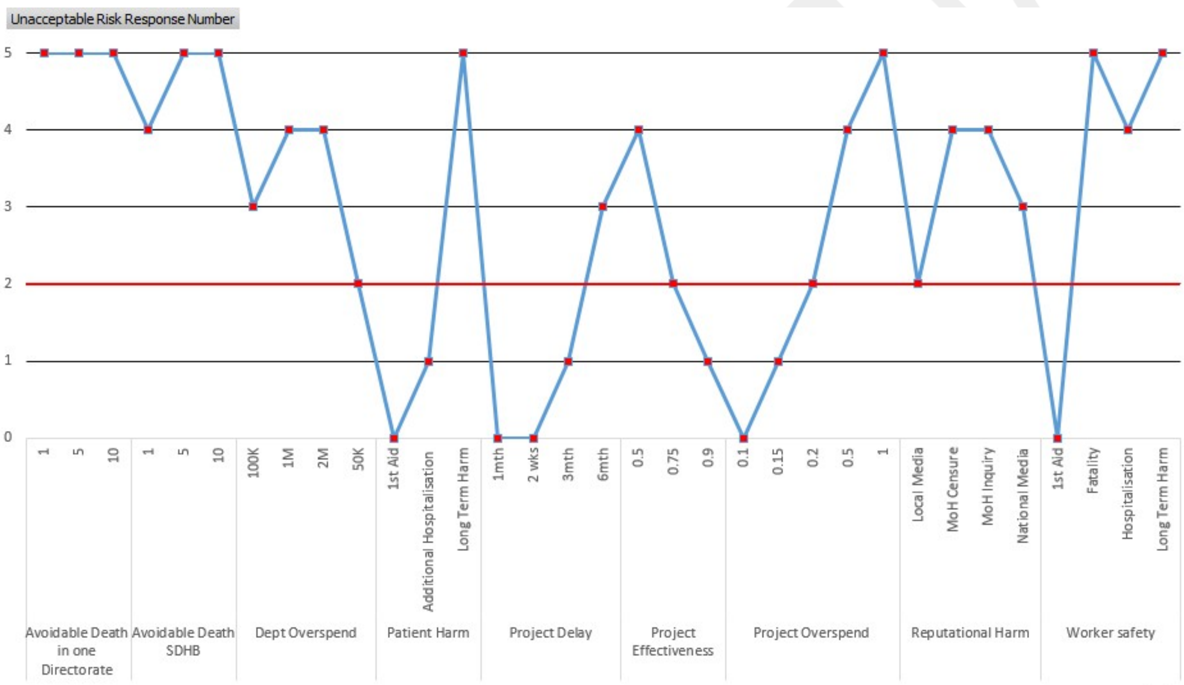
SDHB has a low maturity around risk identification and mitigation. The appointment of the Risk Manager in 2020 has brought some discipline to the methodology and reporting of organisational risks but there is still considerable progress to be made. The current system of risk identification and reporting is paper based and reliant on several individuals to handle the risk forms before they are entered into a spreadsheet. Manual systems mean that there is little assurance that the identified risk will be captured and reviewed by the appropriate risk owner. The Risk Manager advised an electronic system will be rolled out to the organisation by

July 2021 and it is imperative that this deadline is met as it will assist in the rollout of an accountability framework and ensure organisational risks are appropriately captured and mitigated at all levels of the DHB.

At the time of the review, there was selective reporting of high and extreme risks to the relevant governing bodies (Board, FARC, and Clinical Council). The reporting was provided to the relevant committees post discussion at executive level. This means that some risks currently reported as extreme (high probability with catastrophic consequences) are not being escalated to the relevant committee. Good practice governance around risk is that the ELT should be able to mitigate most risks with only few requiring Board intervention andtherefore categorised as “extreme”. At the time of the review the risk register was incomplete with many risks not validated by the risk owner and mitigation not provided, with several extreme and high rated risks not showing any action or mitigation against them. As a matter of priority, the FARC and Clinical Council should receive the unabridged list of high and extreme risks and the extreme risks presented to the Board.

A risk appetite exercise was completed with Clinical Council and the ELT, it was the first time that such an exercise had occurred with the participants and as such there was some uncertainty around how to complete an exercise. The results are demonstrated below.

ELT Risk Appetite



Clinical Council Risk Appetite

The graphs above show that there is a reasonable appetite for projects to go over budget and to not meet their deadline milestones and a high tolerance to not all the intended benefits of the project/investment being met. This is concerning as such complacency means that the effort going into projects that do not return the intended benefits are wasting resource, focus and money. This culture of tolerance appears to be reflected in the frustrations shown within the staff survey where there was almost unanimous feedback that the organisation does not implement change well and does not communicate why changes are being made. If benefit realisation, project discipline or fiscal responsibility are not high focus factors on change implementation, staff will be frustrated and demoralised with the level of effort going into a change with minimal or no perceived benefit. The executive and key governance committees may benefit from risk training and how it applies to the day to day working of the organisation.

It is also concerning that there is some (albeit low) appetite for patient/staff harm. Whilst not always avoidable, the appetite toward any harm should always be zero.

Risk appetite should be driven from the Board down into the organisation and as such a risk appetite workshop should be held during a Board planning day to effectively communicate the risk levels it expects the organisation to follow. This should then flow down into the organisation and processes, systems and accountability should be placed around this.

Financials

The budget setting is performed on a budget-to-budget basis rather than linked to cost drivers and activity. Essentially the prior year budget is the base line with the approved adjustments made throughout the year added on. Based on discussions with the ED SS, the ED Primary Care, Community and Allied Health and the ED of Finance little adjustment is made for escalation or known cost increases that have not gone through an approved business case (e.g., Cost escalations associated to the supply of goods). A budget-to-budget approach can only work if the base budget was correct in the first place, otherwise budgets are set up automatically to fail and thismakes holding people accountable for their budget near impossible and unreasonable. Examples were provided where base FTE was not appropriately translated into financial budget thus meaning the budget was exceeded post the first month of the year. Additionally, the savings plans associated with making the budget are not robust or appropriately managed. In the February Board papers, it was noted that the savings plans were not being achieved see table below.

Feb-21	Full Year Budget $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Full Year Forecast $000s	Traffic Light
Lisa Gestro						
Optimising Pharmaceutical Utilisation	1,300	668	867	(199)	1,300	
Aged Residential Care	1,386	0	924	(924)	0	
Mental Health	3,418	2,256	2,256	0	3,418	
SubTotal	**6,104**	**2,924**	**4,047**	**(1,123)**	**4,718**	
Patrick Ng						
Procurement and Clinical Supplies	1,950	346	939	(592)	979	
SubTotal	**1,950**	**346**	**939**	**(592)**	**979**	
Organisation Wide						
Management of Workforce and Annual Leave	2,500	58	1,667	(1,609)	2,500	
SubTotal	**2,500**	**58**	**1,667**	**(1,609)**	**2,500**	
Total Savings	**10,554**	**3,328**	**6,652**	**(3,324)**	**8,197**	

Capital expenditure has been underspent annually, with reasons for doing so being unknown. Capital expenditure is a relatively easy avenue to drive clinical efficiency, patient flow, comfort, and safety. Investing in the environment also drives an improvement in staff morale which lead to several financial benefits.

During the review there were examples where small amounts of capital would benefit patient flow, make operational efficiencies, and improve morale but required significant business cases and justification, with a core focus on financial return. Whilst financial return should be a key factor in every application, sometimes patientflow and staff morale should weigh more heavily, especially on the smaller level investment requests (<$50k). An example of this is the outpatient configuration at Southland Hospital, where an investment of approximately $50k capital would vastly improve patient flow, patient and staff experience and ensure like services are better co-located for greater synergy. This paper was submitted for approval mid 2020 with no notable feedback provided and remains outstanding. Subsequent requests to move subsets of the outpatient area have been approved (and done so independent of the overarching paper) but done in isolation of the overall footprint which further restricts future flexibility. As a matter of good practice, SDHB should spend the entire capital allocation annually, to ensure assets are being replaced in accordance with their lifecycle.

Monthly reviews should take place on the capital expenditure forecast and adjusted accordingly for projects unlikely to be substantially completed within the financial cycle and capital reallocated to the prioritised capital list and released to ensure adequate replenishment/upkeep of SDHBs assets.

The EDSS holds monthly financial reviews with the various divisions, however, there is no formal accountability framework in place that looks in depth into the financials against volume, quality, risk, and safety. There is no evidence of good corporate or clinical governance embedded within the provider arm. The financial explanations contained in the FARC papers are generic in nature and there is no evidence of in-depth financial analysis or forecasting to understand the trajectory and decisions that must be made because of any deviation of budget. An accountability framework and formal performance monitoring framework should be put in placeas a matter of urgency, with clinician attendance at these meetings.

The costing system was discontinued in SDHB several years ago, in a bid to save costs. As such no costing analysis is being performed. Whilst it would be ideal for a costing system to be invested in, this should not stop the organisation from in-depth financial analysis. SDHB have several analysts employed and many are performing ad hoc reporting, predominately for corporate based requests. There are too many ad hoc and repetitive requests for information and the team should be concentrating on placing 80% of available data in power BI and roll out Power BI to all staff to access and only concentrate their efforts on the complex 20% of data analytics that require specialist analytical expertise. At the time of the review, Power BI was not readily available to clinicians and middle managers and where access was granted, only specific data sets were available. There should be little restriction to accessing data sets via Power BI, with the only restriction being personnel detail.

The delegations of authority levels are low, and there is a perception by staff that almost all things require CEO signoff, resulting in delays in decision making due to the multiple levels the request needs to go through prior to reaching the CEO. The delegations were in place during the tenure of the Commissioners. Such low delegations mean excessive paperwork and justification occurring for some minor investment. During the review, numerous examples were produced that showed extensive delays in approval of feedback from relatively straightforward investment requests which would improve operational efficiency or patient experience. Many staff stated that they often did not receive feedback from their papers and did not know what happened to them. This sometimes forces the staff to "go around the system". By deviating from the system, it means the system does not work. With the introduction of an accountability and performance framework, the delegations should also be increased within the organisation to ensure the people who are responsible for managing the risk have controlover the decision making to mitigate.

A review of several business cases indicates a higher level of optimism around perceived benefits and bed closures attributed to refined models of care, greater productivity/efficiency etc. The generalist business case is a good example of this, where the intention of moving to a generalist model will significantly reduce bed days and potentially attribute to a reduction of overall bed numbers and therefore nursing costs. Whilst these figures are ambitious to realistically achieve them, there would need to be a significant emphasis on the integrated model of care from multiple areas such as ED and medicine. The likelihood of achieving the total benefits notedin the business case are low, at the time of the review, the new MAU area was being planned predominately from a medical model of care and discussion with nursing revealed that it was not actively engaged in this change in model of care. Moving to a generalist model is indeed the best way to go for the medical wards at Dunedin hospital, but to assume this will result in a significant reduction in bed numbers and therefore nursing numbers is an unlikely benefit that will be realised. Furthermore, the concentration of this change whilst significantly impacts on the medical staff, the nursing staff need to be fully engaged in an integrated medical model for any benefits to be realised. There appears to be little or no reporting against key milestones and reported benefits realisations from large projects and this should be incorporated into the FARC papers at least 6 monthly, preferably with a more regular update on progress against reported project milestones. Project management around implementation of key strategic pieces of work needs significant improvement and discipline.

A retrospective look at the business case and intended benefits of the 3 Surg ward, indicates that few of the benefits have been realised, with increasing pressure on beds, regular cancellation of elective cases and preventable serious adverse events have occurred. This ward has a committed Charge Nurse Manager and ACNMs, however, the siloed structure of the provider arm has contributed to tension between the medical and nursing staff on this ward with differing views on the on-ward model of care and management of the patients.

Management of annual leave balances need additional focus, with the staff members holding large balances coming from large teams (nursing, HCA, cleaner, medical in non-vulnerable services, administrators) meaning annual leave should be easier to manage over the year. At the time of the review, 1,055 personnel had leave balances greater than 10 weeks totalling a liability of $30.011m, with 187 holding balances great than 20 weeks and a liability of $8.552m.

The management of the RMOs within SDHB is fragmented with most of the RMOs at the Dunedin Hospital site being rostered and managed by the services. Southland RMOs are rostered by the RMO unit and line managedby the service. A review of overtime paid across the district highlighted several registrars earning over $100k in overtime in the last 12 months, given the already high workload hours contracted and paid within their MECA, additional payments of over $100k indicate some RMOs may be working excessively high hours. The decentralisation of the RMO rosters results in a lack of oversight around the health and wellbeing of registrars and ensuring that the appropriate number of registrars are placed in specific services throughout the year.

A request has been made to obtain all allowances paid to staff that fall outside of the MECA, this information has not yet been received but is in production. Anecdotal evidence suggests there are high allowances being paid to some staff when services were vulnerable, but not adjusted to account for the growth in FTE. A reconciliation of this needs to be completed with a review to engaging with affected staff to normalise pay rates and adjust according to service need.

As identified in the governance section, the discipline of using data to make decisions and identify clinical variation is not apparent within SDHB. There are a number of core metrics that should be implemented as partof the performance framework to identify clinical variation, which inevitably leads to avoidable financial costs. SDHB waiting lists including deferred patients, average length of stay and hospital acquired complications are significantly higher than their peers. This variation needs attention at speciality level, full engagement with clinicians and alternate models of care and pathways should be identified for high-risk patients to avoid HACs orat least minimise their effect where predictable. The data analytics teamwork needs to be prioritised to createthe appropriate performance framework which must be owned by the EDSS and supported by the CMO, DON and DAHT&S.

Hospital Operations

There is a real feel of crisis within the provider arm, strong levels of disengagement and poor morale particularly in Dunedin Hospital. Southland Hospital operates predominately as a standalone hospital and being smaller, has a more cooperative and coordinated feel to it, however, would benefit from a full time on site General Manageras a permanent position that holds joint accountability to the relevant GMs across the service spectrum.

There is evidence of a clinical/corporate divide with the managers within the provider arm only focused on ESPI compliance and financial management, and a notable absence in quality and safety monitoring and forward planning. It appears issues are managed as they arise, as opposed to planned and the day to day running of the operations feel chaotic. It must be noted, however, that the managers within the provider arm are dedicated and want to do the best for the Southern DHB and the community. The chaotic nature of the operations has come from a lack of discipline around ensuring key quality, financial and clinical indicators are being met acrossthe DHB and appropriate planning and communication with the clinical teams.

The structure of the provider arm as mentioned is siloed and contributes significantly to the poor coordination within the organisation. In addition to the siloed nature of the structure, there is inequity around the level of support service managers receive, with some having administrative staff and others do not, particularly at Southland. It is impossible for service managers to be able to manage their divisions effectively without a coordinator assisting them with administrative tasks such as roster and leave management. With the change in structure there needs to be a realignment of functions to ensure that available resourcing should be placed at the correct levels. This should be performed in a cost neutral manner.

The nursing costs within the provider arm are not excessive and appear reasonable. The stress in the system comes from the fragmented structure, the lack of transparency and the competing priorities of each of the professions. There has been notable turnover in some of the higher acuity areas and this will be placing pressure on the charge nurse managers with recruitment of adequately skilled staff. SDHB relies on a large proportion of its nursing workforce from the international market, and the global pandemic and closing of borders has placed additional pressure on this workforce. Once a more cohesive structure is in place allowing cross profession models of care, there needs to be a workforce analysis performed to identify progression pathways for the nursing workforce including greater use of CNS and NP resources in outpatients and the community which may allow greater flow out of the hospital.

The ICU in Dunedin has recently taken responsibility for the HDU as was the intention through the business caseof the newly refurbished area for ICU/HDU. With the non-commissioning of the HDU, the model of care is fragmented and haphazard. The HDU remains an “open HDU” which opens the organisation to a higher clinical risk as often patients can be secondary to those based on the ward. It would be advisable, when ICU/HDU obtain adequate nursing resource, the model for the HDU moves to a “closed HDU” ensuring appropriate patients are being admitted and that discharging out of the HDU occurs in a timely manner which will also assist in the reduction of cancelled planned electives where an HDU bed is required for 24 hours for the patient post operatively.

The provider arm is not meeting its ESPI compliance targets and there are considerable wait times for many specialities not only for first assessments but also follow ups. Whilst a recovery plan has been produced, the strategy doesn't appear aligned to the specialities/staff and not commonly brought into or executed. At the time of the review, there was no recovery plan available to improve cancer treatment times, despite a second CT scanner coming online. Discussions with managers around the planning for recovery once the CT scanner becomes operational was conflicting, with three different responses three layers throughout the hospital and it was clear a documented plan has not been thoroughly communicated or implemented. The FCT target accountability sits with the GM Surgical and Radiology, despite not all cancer treatments being surgical in nature.It would be better owned by the manager who runs the cancer services who liaises with the relevant services to ensure they do their part.

Orthopaedics have a large waiting list for FSA and follow ups and currently struggle to keep up with demand on the acute and elective lists. Discussions with the orthopaedic team, is that they have not filled a complete elective list since December 2020 due to the multiple daily cancellations they are experiencing from the patient flow taskforce actions. This is compounding the elective waiting list issue and has resulted in an almost impossible situation of recovery without significant financial implications.

There are three aspects to the orthopaedic recovery:

1. Allied Health resource should be dedicated to the FSA list, there should be an assessment clinic for all FSA to go through prior to any patient seeing a patient. This will remove the patients who will not benefit from a surgical intervention and place them on a medical/rehab pathway to alleviate/manage/eliminate their pain.
2. Analysis needs to be performed to determine the best days to place additional elective orthopaedic lists in theatre and these lists in the short term take priority over other non-urgent elective lists, along with any additional surgery outsourced to other DHBs or private facilities. The additional in-house electives should be the procedures that attract a short length of stay to ensure rapid turnaround of beds. Additional allied health resource should be prioritised to these patients. temporarily assigned beds would be required to provide certainty of the lists.
3. Specific aged residential care homes to be engaged to provide a "step down" facility for patients to go to for rehab, care, and eventual discharge. This will require a tight partnership between the ARC provider and the DHB to ensure fast access to follow up treatment if required and that appropriate pathways for the patients have been identified and agreed.

The SDHB should liaise with the MOH to see if one-off ring-fenced funding could be accessed for this initiative for a period of 6 months to obtain some control over the wait list for orthopaedic surgery.

The cancellation of elective surgery in December/January and then the subsequent unfilled nursing vacancies that occurred in January/February resulting in bed closures has significantly contributed to the theatre block being currently experienced. SDHB is now in a circular situation, where it cannot accommodate the demand of the backlogged electives, keep pace with the usual monthly elective lists and balance with acutes. This has resulted in daily cancellation of electives; elective lists not being filled as to avoid patients being turned away on the day and poor staff morale. The constant cancelling of electives results in significant disruption for theatre planning for both the theatre and surgical teams but also the anaesthetists who have prepared their patients the day prior, only for them to be cancelled and replaced with acutes. The practice of cancelling electives will always be a reality, but it should not be a daily function. Significant changes in theatre schedules on the day results in theatre down time with equipment being moved, supply chain inefficiencies with bill of materials being produced for planned cases no longer being used and introduces greater clinical risk due to staff preparing for planned cases moving to unplanned cases regularly. Discussions with staff both clinical and non-clinical have indicated a fatigue around this practice and believe it has become an embedded process whereby a meeting is held daily to decide who will be cancelled. This practice should cease, and cancellations should only occur after all avenues are explored days in advance using the principles of production planning and forecasting.

The utilisation of the day procedure theatre in Dunedin is poor and additional effort needs to go into this theatre to ascertain why there are delays and gaps in the utilisation of the theatre during the day.

The ICU model within Southland is vulnerable. There is a single intensivist employed on site and covers the day shift when rostered, alternatively an anaesthetist will cover the shift if the intensivist is on leave or on a rostered day off. The unit is an open unit meaning others can admit into the unit and the medical model is reliant on theprimary treating clinician to maintain oversight and ownership of the patient within the unit with consultation occurring in the more complex patient. Overnight coverage is an on-call arrangement with the anaesthetic team until 11pm and then the medical registrar takes over care. The unit cannot cope with more than 1 ventilated patient and if there is a ventilated patient then the coverage of HDU beds is reduced due to nursing ratios. There are times where weather will prevent any transfer from occurring to Dunedin or Christchurch and the unit will be required to manage these patients until a transfer is possible. The medical model for managing ICU patientsin Southland is lean, the overnight coverage especially post 11pm is not ideal and could present some clinical safety issues with the patient. This model is heavily dependent on nursing staff who also respond to code blue alerts throughout the hospital. Whilst there is a view that complex patients are discussed with Dunedin, there is no formal documented pathway that states when patients should be discussed and potentially cross coveredby the Dunedin ICU whether it be via a roaming video link so that the Dunedin intensivist can see the patient or via telephone coverage for questions. A single intensivist employed within the ICU makes the service very vulnerable, reliant on a single person with the right skill level. There will always be a need for Southland to have an ICU due to the geographic nature of the region, however, it is strongly recommended that the governance and management of the unit be joined with the Dunedin ICU, incorporating treating models that allow appropriate 24/7 cover and management of patients.

There is currently a staffing model for Anaesthetic Technicians (AT) within Southland that essentially has a 24-hour component to cover. The AT works a full day shift and then proceeds to offer an on-call service immediately after the shift. If the AT is called out, they have an automatic stand down period of 9 hours for mandated rest, and their shift must be covered for the following day. If the shift cannot be covered, the planned surgery will need to be cancelled, resulting in theatre teams rostered on not performing surgery. Not withstanding this, having an individual on call following a full day's work and then placed on the roster the following day is not considered to be good rostering practice. Irrespective of whether the individual gets called out, they are still oncall and as such they do not get the same rest pattern those who are not on call, there is always an element of being alert enough to hear the phone and as such they may not be adequately rested to be performing their functions the following days. This staffing model needs to change to ensure adequate rostering of staff to enable them to perform at high levels of alertness.

The Southland emergency department is too small for the number of presentations it has, to allow the efficient flow of patients. Whilst there is a view that the primary care teams need to pick up some of the volume of category 4 and 5, the reality is that there is a limited number of GPs many of whom are getting closer to retirement age. There is no quick fix solution to this problem and whilst the PHO has stated that they will be opening an urgent care centre to capture those unable to enrol with a GP, this will be a user pays facility and the demographic of Southland means there still will be a number of people who will present to the ED. Category 4 and 5 patients do not take up a lot of ED time once presented, but it does compound the waiting time for patients and adds unnecessary work to an already busy ED. This hospital would be an ideal location for an onsite GP service with a common triage point. This model has worked well in other DHBs and hospitals around the world.The emergency department needs additional space, and the most logical place for it to expand into is the fracture clinic behind the ED. With any expansion of space, models of care need to be reviewed and enhanced with the additional space to ensure efficient flow, easier discharge, and access for multi-disciplinary teams to work with the patient. It is recommended that the ED reconfiguration work be supported to planning stages as a priority piece of work and as part of this include innovative models of care based on patient presentation trends, and working with the PHO. The ED would also benefit from point of care testing equipment for blood samples to quicken the pace of diagnosis, evidence suggests that the laboratory is not meeting its KPIs around turnaround times for Southland ED.

Interviews with staff highlighted a concerning level of low staff morale, clinical and non-clinical staff felt a clinical/corporate divide and a frustration around reactive decision making and changing demands and messages. The staff survey echoes this sentiment with a an overwhelming 50% of staff stating that they did notbelieve the organisation implements change effectively, that they do not have input over important decisions, that performance issues are not managed timely or at all, and that they were unaware of the direction of the DHB. These same issues were highlighted to me through the various discussions almost universally on all four points. Low staff morale directly contributes to a poor financial position, staff need to be engaged in a transparent and open way, feel that they are being heard and can contribute to the problems of the organisation. A number of clinicians stated that they feel like they are regarded as the problem and not engaged in the solution. All stated their willingness to engage in the DHBs problems acknowledging there will be decisions that will not go their way, but by being part of the solution they feel they hold some control as to how their work environment will look in the future. Culture comes from the managers and executives of an organisation, and some development work needs to be done with the managers/executives to improve engagement and joint problem solving.

Rural Hospitals

$38m is allocated to the rural hospitals with Lakes being the only facility being run "in house" by the rural and community team. The rural hospitals are provided with an annual price volume schedule but are not held to account against it and it has been a general understanding between the organisations that the rural hospitals would have the freedom to use the funds as they want depending on community need, with any significant variation to be reported in writing back to the DHB. This fundamentally means that the rural hospitals are bulk funded. Whilst each organisation should be agile around meeting the needs of the community there should be clear agreement between the two around what the strategic and operational direction of the facility prior to commencing the new financial year, along with clear KPIs (clinical and non-clinical) and reporting that should be submitted back to the DHB regularly. This ensures that the DHB is discharging its duty to spending public monies wisely, accountability is embedded with the service provider and assurance is obtained on safe clinical practice.The contracts for three of the rural sites are approaching expiry and it is an ideal opportunity to incorporate these disciplines and reporting into the new contract, taking a collaborative approach and linking the entire rural network together.

The Lakes facility is an expensive in house 24/7 model that heavily relies on SMO cover at a premium due to the rurality of the area. There are integrated urgent care centres and a newly built (yet to operationalise) private hospital in the area. Dunstan hospital is in close proximity to the Lakes hospital and consideration should be made to offer a single integrated service for both locations rather than expending funds over two facilities in such close proximity. It would be prudent to explore opportunities of a joint venture or a full outsource of work to these facilities as it would enable a multi-disciplinary model of care (increasing nursing and allied health presence), would enhance the private organisations capability with additional SMO coverage and operate out of a single facility. The current model at Lakes is SMO centric and a good rural model would benefit from having an increased nursing presence such as CNS who can practice at the top of their scope including prescribing rights.

Procurement

There are procurement benefits not being realised and a poor discipline around the SDHB going to the market for price and then not following through on the process in a timely manner. At the time of review there were notable examples of where the lack of follow through and accountability has resulted in the organisation incurring higher than normal expenditure. The largest opportunity being the changeover of a teleradiology provider which would save an annual cost to the DHB of $400k, the procurement outcome was finalised late

2020 but the transition to the new provider has yet to occur because the stakeholders and business owner has not dedicated time to implementation.

There were also examples where the DHB went to the market for price and service and then did not proceed with the change despite savings being available or have notified successful suppliers but not followed through on the execution. Examples of these include record scanning and integration software and Voicera where suppliers had been notified of their successful bid in 2020 but to date nothing has been implemented, with reasons unknown as the paperwork for signoff appears to be “lost” in the system.

If the DHB is approving an RFP to be released, then it should be prepared to proceed with the changes unless the market offers something unattractive. Issuing RFPs and not following through on them, is poor practice, cost supplier’s money in preparing tenders and creates a level of scepticism with suppliers who may not spend as much effort into future tenders or offer their best price. In addition to this, it is a waste of SDHB staff time preparing and evaluating tenders for no reason. Greater discipline is required from the managers to ensure that when their service is going to the market, they are to follow through on the outcomes in a timely manner to maximise outcomes.

It was also noted during the review that there is capex approval for volumetric pumps and associated consumables to replace the end-of-life fleet in 2020 with final product and supplier sign off occurring in October 2020. At the time of the review the pumps have not been replaced as the “approval” to implement is still goingthrough the clinical practice committee, ELT, and the Board. The replacement of volumetric pumps is routine, whilst there will be some technological upgrades to the pumps since the last instalment of the pumps there is little clinical risk around use and the effort should be concentrated on implementation, fleet change out and communication rather than a need for the pumps to be approved by the clinical practice committee (noting that these pumps have already been deemed suitable to use through the procurement process). The only additional signoff for such routine end of life replacement should be a one-page approval from the Board with respect to financial delegation around signing off a contract more than $1m. Had this been done in October 2020 then thefull fleet of pumps would have likely been replaced.

Routine capital replacement of like for like assets should be budgeted for in the annual capital expenditure allocation and procurement should work with the relevant budget holder to procure and implement in a timely manner.

Table of Recommendations

Action Item	Action Required	Action timeframe	Action Owner
1	All Datasets to be distinguished by Ethnicity and action areas of disparity		
2	Realign Executive Portfolios to better focus on the key critical issues of each area. Consider aligning executive portfolios with Canterbury DHB		
3	Design and consult over the realignment of the provider arm structure to improve clinical engagement and integrated models of care Review the quality improvement team work functions and ensure that the resources are deployed to the greatest need for the DHB to enable improved clinical practice, operational efficiencies and financial payback.		
4	Design, implement and embed an accountability and performance framework		
5	Establish a clear clinical governance framework, embed discipline around meeting structure, action follow through and focus		
6	Improve risk identification, rollout the electronic reporting system as a matter of priority, embed a risk culture within the organisation Appropriately report risks to FARC and Board		
7	Board to set the risk appetite for the organisation and executive to roll out to the organisation and embed into process and system		
8	Reconcile budget to activity, identify clinical and cost variation against peer DHBs and assign appropriate costs savings against those areas. Implement formal reporting structures to monitor and manage progress Hold Executives and managers responsible for ensuring the achievement of targeted savings		
10	Implement annual asset replenishment targets, adjust frequently to ensure capital expenditure is spent within the financial year. Streamline and delegate the financial process of approval of capital items <$50k to service level		
11	Partner financial analysts/management accountants with GMs to ensure robust and documented financial analysis occurs		
12	Look to canterbury for their costing system and consider expanding it into Southern to assist in understand cost structures		

13	Focus on placing 80% of most commonly used data sets into Power BI, establish a data dictionary and rollout fully to all clinical leaders and service managers		
14	Review and revise delegations to align with the accountability framework		
15	Implement project discipline, require robust reporting around project milestones, financial performance against activity and benefit realisation		
16	Incorporate the nursing and allied health model of care into the generalism work and roll out an integrated model.		
17	Manage annual leave balances and have them incorporated as core KPI for managers		
18	Centralise the management of the RMO unit		
19	Review all outside of MECA agreements and engage with the relevant services and union to realign pay rates with FTE support		
20	Prioritise data driven work practices, including production planning and forecasting		
21	Establish, communicate and implement recovery plans for FCT and ESPIcompliance along with ensuring the additional CT is fully utilised post commissioning		
22	Implement recovery plan for orthopaedics		
23	Take a reflective look on the work performed on the patient flow taskforce group, embed established procedures into BAU and move to focus on the areas of production planning, community based beds/step down facility, frail pathways and stranded patients		
24	Appoint an HoD for ICU across both Dunedin and Southland and assign responsibility for improving clinical support and governance of both ICU		
25	Revise the AT roster to improve the health and wellbeing of the staff and improve theatre utilisation		
26	Proceed with the planning of an expanded footprint in Southland ED in conjunction with the PHO and GPs around how to improve access outside of the core ED. Planning must include an emphasis on innovative models of care rather than just footprint. Investigate the possibility of an onsite GP service next to the ED with a combined triage and pathways		
27	Create a strategy and implement around a culture of performance and engagement to improve morale		
28	Embed operational, strategic and compliance KPIs in all rural contracts, networking them together where practical		

29	Investigate a combined Lakes/Dunstan/Private provider partnership for the lakes district improving access for the community with refined models of care including increased nursing support		
30	Streamline the procurement approval pathway to ensure timely decision making and implementation.		