Southern DHB Board Meeting

Board Room, Level 2, Main Block,
Wakari Hospital Campus, 371 Taieri Road, Dunedin

05/10/2021 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, 5 October 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 since the last Board meeting: Nil

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 (updated 26.08.2021)	Ex-officio Member, Executive Steering Group, New Dunedin Hospital		
	22.12.2020	Board Member, Otago Innovation Ltd (paid)		
	25.02.2021	Board Member, Quitta Ltd (unpaid)	Nicotine replacement therapy under development.	
Peter Crampton (Deputy Board Chair)	16.04.2021	Employment: Professor, Kōhatu Centre for Hauora Māori, University of Otago (appointed July 2018)		
	16.04.2021	Member, Health Quality and Safety Commission Board (appointed April 2020)		
	16.04.2021	Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)		
	16.04.2021	Honorary Fellow, Royal New Zealand College of General Practitioners		
	16.04.2021	Fellow, New Zealand College of Public Health Medicine		
	16.04.2021	Wife, Alison Douglass, is a member of the Health Practitioners Disciplinary Tribunal		
	25.06.2021	Director and Shareholder, Kiwood Limited	Nil (farm forestry plot).	
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	Member, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company).	
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	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.	
	26.08.2021	Idea Services Board of IHC	Possible conflict with contracts and service delivery models.	
Tuari Potiki	09.12.2019	Employee, University of Otago		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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		
	28.08.2021	Chair, NZ Drug Foundation (3 month appointment)		
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings Ltd	Corporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	~~15.01.2019~~	~~Member, Royal Society Te Apārangi Council~~	Removed 01.07.2021	
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	17.08.2020	Health Research Council Fellow		
Andrew Connolly (Advisor)	21.01.2020 (updated 02.06.2021)	Employee, Counties Manukau DHB. Currently seconded to Ministry of Health as Acting Chief Medical Officer		
	21.01.2020 (updated 02.06.2021)	Clinical Advisor to the Board, Waikato DHB		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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		
	26.08.2021	Advisor to Health Transition Unit on Finance/Procurement		
Benjamin Pearson (Crown Monitor)	21.07.2021	Consultant Paediatrician, South Canterbury DHB		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Hamish BROWN	25.02.2021	Portobello Maintenance Company	Nil, Body Corporate for residential area.
Kaye CHEETHAM		Nil	
Rory DOWDING	18.01.2021	Change Quest Ltd	Stepfather (Ross Hanson) and his trading entity (Change Quest Ltd) are at times employed as a contractor to SDHB HR Directorate
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	~~Director Otākou Health Services Ltd~~	Removed 28.06.2021.
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	28.06.2021	Director, Te Kura Taka Pini Limited	100% owned by Te Rūnanga o Ngai Tahu.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil

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
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017 (updated 26.08.2021)	Ex-officio Member, Executive Steering Group, New Dunedin Hospital	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
Hywel LLOYD	16.06.2021	GP, Mosgiel Health Centre	
	16.0.2021	Wife, Nurse, Paediatric Outpatients	
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
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	

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
	23.07.2020	Wife, Chief Data Architect, Inde Technology	Inde is part of WSP's Digital Health Collective, the consultancy service supporting the NDH Digital Infrastructure and Digital Facility Services
Gilbert TAURUA	05.12.2018	Prostate Cancer Outcomes Registry (New Zealand) - Steering Committee	Nil
	05.04.2019	South Island HepC Steering Group	Nil
	03.05.2019	Member of WellSouth's Senior Management Team	Reports to Chief Executives of SDHB and WellSouth.
	21.12.2020	Te Whare Tukutuku	Te Whare Tukutuku is sponsored by the NZ Drug Foundation and Te Rau Ora. Programme is designed to increase education and awareness on Maori illicit drug use to primary care and in Maori communities funded by MoH Workforce NZ.
Nigel TRAINOR	17.05.2021	Daughter, Sonographer (works part-time for Dunstan Hospital)	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

Minutes of the Southern District Health Board Meeting
Tuesday, 7 September 2021, 9.30 am
By Zoom

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	*(until 3.00 pm)*
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Dr Ben Pearson	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Tanya Basel	Executive Director People and Capability
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Mr Rory Dowding	Acting Executive Director Strategy, Primary and Community
	Dr David Gow	Chair, Clinical Council
	Ms Greer Harper	Principal Advisor to the Chief Executive
	Dr Hywel Lloyd	Interim Executive Director Quality and Clinical Governance Solutions
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer/Acting Executive Director MHAID
	Mr Nigel Trainor	Executive Director Corporate Services
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 KARAKIA AND WELCOME

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

2.0 APOLOGIES

An apology was received from Dr Moana Theodore.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the Board meeting held on 3 August 2021 be approved and adopted as a true and correct record."

L Soper/I Beekhuis

5.0 MATTERS ARISING

Amenable Mortality Rates for Māori

The Board and Hospital Advisory Committee recorded their thanks to management for the paper to be considered later in the meeting and the work they had done on Māori health.

6.0 ACTION SHEET

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

Māori Workforce

The Executive Director People and Culture reported that work had been paused on staff ethnicity data collection due to the COVID lockdown.

ED Pressure

The Executive Director Specialist Services (EDSS) reported that as the 3.7 FTE Senior Medical Officers (SMOs) were hired for the Generalism approach, more effort would be placed on early assessment either in the ED or the existing Medical Assessment Unit (MAU).

Clinical Council

Dr David Gow, recently appointed Chair of the Clinical Council, was welcomed to the meeting and introduced himself.

Mental Health and Addiction Services Wait Times

David Jaggard, Manager, Specialist Addiction Services, joined the meeting for this item.

The Acting Executive Director, Mental Health and Intellectual Disability (MHAID) presented a paper on national and SDHB Mental Health wait times and opioid substitution waiting times (tab 5.1).

Mr Jaggard informed the Board that there was a long waiting list for people to receive opioid substitution, which was mainly methadone but beta-endorphin was also used. The reported average days wait for treatment was 45 days, however people starting treatment were reporting they had been waiting one to two years. The number of referrals received in the agenda papers also appeared to be incorrect.

Management responded to questions on the resourcing of the opioid substitution programme and triaging of clients, and child and youth mental health services.

The Board considered the wait times for opioid substitution treatment were unacceptable and requested management report back to the October 2021 Community and Public Health Advisory Committee meeting with corrected data and advice on how the issue is best addressed, eg through budget reprioritisation, involvement of the PHO, etc.

7.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The minutes of the Community and Public Health Advisory Committee (CPHAC) meeting held on 2 August 2021 (tab 6.1) were taken as read. Mr Tuari Potiki, CPHAC Chair, highlighted the presentation from Dr Rob Beaglehole, National Public Health Advocate for DHB CEs and Chairs, on population health issues, including water fluoridation, and the presentation on the setting up of a Partnered Primary Care Service in Invercargill.

Mr Potiki informed the Board that external support had been brought in to assist with the review of Māori health service provision within the district.

Disability Support Advisory Committee

The minutes of the Disability Support Advisory Committee (DSAC) meeting held on 2 August 2021 were taken as read (tab 6.2).

Mrs Kaye Crowther, DSAC Deputy Chair, highlighted the presentation from Koha Kai and the training and support that community organisation provided for people living with disability.

Hospital Advisory Committee

The Board received a verbal report from Mrs Jean O'Callaghan, Hospital Advisory Committee (HAC) Chair, on the HAC meeting held on 6 September 2021, during which she reported that the Committee:

- Reviewed resourced and physical beds for Dunedin and Southland Hospitals, and Mental Health;
- Received a briefing on the current state of aged residential care, noting the sustained pressure the sector was experiencing with staff shortages;
- Agreed to a service by service approach to improving patient letters;
- Received a detailed recruitment summary and information on immigration challenges;
- Received an update on the Southland Dental Unit's general anaesthetic waiting list;
- Noted improved data was being received on equity;
- Reviewed caseweight performance, ongoing outsourcing, and noted the need to have a good production plan;
- Discussed the differing levels of access to orthopaedic surgery across the district and pressure on ED services.

Management responded to questions on the development of a water only policy and the Dunedin physiotherapy pool.

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer commented on his monthly report (tab 7) as follows.

- *Organisational Performance* – The July 2021 financial result was marginally favourable; understanding productivity continued to be an issue.
- *COVID Management Response* – The CEO was proud of the way staff had stepped up during the move to Alert Level 4. Public Health were assisting Auckland with contact tracing and Dr Susan Jack, Medical Officer of Health, was currently helping in Auckland. The CEO also praised the PHO and Te Kaika for their swabbing and vaccination work.

  Southern DHB had one of the highest COVID vaccination rates per capita in the country but was behind plan, as it had set very ambitious targets.

  The Board congratulated and thanked staff for their work in contact tracing and vaccination, their willingness to work outside the district, and their preparedness to go the extra mile. The Board also acknowledged the PHO, general practices in partnership with WellSouth, Māori and Pasifika health providers, pharmacies, rural hospitals, and all other players in the vaccine rollout to date.
- *Annual Plan 2021/22* – Southern DHB's Annual Plan was amongst the first to be put forward for Ministerial approval.
- *Māori Equity Investment* – A decision had been made to increase the budget for kaupapa Māori services in 2021/22 but the CEO advised that more investment was needed.
- *Industrial Action* – The New Zealand Nurses' Organisation (NZNO) and Midwifery Employee Representation and Advisory Service (MERAS)' notices of industrial action during August had been withdrawn but the situation was still not resolved.
- *Health System Indicators* – The new Health System Indicator Framework (Appendix 2) would be incorporated into SDHB's performance and accountability framework.
- *Leena Singh Report* – Good progress was being made against the recommendations made by Leena Singh. IT's ability to provide information had impeded the development of the accountability framework but this was being addressed.

Management responded to questions on the hospital system's readiness for COVID, progress on the performance and accountability framework, and the appointment of a head of department for intensive care across Dunedin and Southland.

During discussion, the Board:

- Requested that a progress report on the development of the Te Kaika Health and Wellness Hub be submitted to the next meeting;
- Acknowledged the efforts being made to address oncology matters.

9.0 FINANCE AND PERFORMANCE

Financial Report

The Financial Report for the period ended 31 July 2021 (tab 8.1) was taken as read.

The Executive Director Corporate Services (EDCS) advised that the greatest financial risks were pharmaceutical costs and multi-employer collective agreement (MECA) settlements.

Volumes Report

The volumes graphs (tab 8.2) were noted.

The Executive Director Specialist Services (EDSS) informed the Board that a report analysing performance against the previous year's results would be included in next month's papers.

Quality Dashboard

The Interim Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) commented on the Quality Dashboard (tab 8.3) as follows.

- To be useful for quality purposes, the period covered by the dashboard graphs needed to be extended to cover at least two years.
- The number of complaints remained high and related mainly to access to services and communication.
- There had been a slight increase in the number of deaths in hospital, however the base was very low, and it did not appear to be a trend.

In response to questions about short notice surgery postponements, the EDSS advised that if efforts to put additional acute capacity into the system were successful, elective surgery cancellations during peak periods would reduce.

Annual Plan Strategic Progress Report

The Board considered reports summarising progress towards achieving the strategic intentions in the 2020/21 Annual Plan (tab 8.4).

Management reported that:

- The location of the new Central Sterile Supply Department (CSSD) in Dunedin was being reconsidered, as there may be a better solution;
- High level plans for the Central Otago primary birthing unit had been drawn up and would be incorporated into the business case to be sent to the Ministry of Health;
- As requested by Board, comparative annual staff turnover by occupational group as at 30 June 2021 was including in the reporting.

Performance

The Principal Advisor to the CEO presented a progress report on the development of the Performance Dashboard (tab 8.5).

Quarter 4 2020/21 Annual Plan Reporting

The Acting Executive Director Strategy, Primary and Community presented a summary of DHB Annual Plan reporting to the Ministry of Health for quarter 4 2020/21 (tab 8.6), noting that a lot of services had been impacted by the COVID vaccination programme.

Management were asked to check that staff disability awareness training completion rates were being reported to the Disability Support Advisory Committee.

Steve Bayne, Acting General Manager, Adell Cox, Director of Allied Health, Mental Health, Addictions and Intellectual Disability; Peter Cammock and Chris Jansen, Directors, Leadership Lab, joined the meeting for the following two agenda items.

10.0 PSYCHO-SOCIAL SUPPORT IN TE ANAU/MILFORD AND QUEENSTOWN LAKES DISTRICT

The Board received a report (tab 11) and a verbal update from Ms Cox on the activities of the Te Hau Toka Southern Lakes Wellbeing Group.

Ms Cox emphasised the importance of working with the community and reported that the Group was embarking on a co-design process to build sustainability. Five key areas of the community had been identified as being particularly impacted by the effects of COVID-19: business, the migrant community, young people, older people who had been disconnected, and new parents, who had similarly been disconnected from their wider family.

The Acting Executive Director, Mental Health, Addictions and Intellectual Disability (ED MHAID), informed the Board that:

- Ms Cox had been instrumental in the implementation of the project and had shown extraordinary leadership;
- Leadership Lab was supporting some of the co-design aspects of the project.

11.0 MENTAL HEALTH REVIEW IMPLEMENTATION

The Acting Executive Director Mental Health, Addictions and Intellectual Disability (MHAID) Services presented an update on the implementation of the Mental Health and Addiction System Review (tab 12.1), and:

- Recorded an apology from Toni Gutschlag, Service Improvement Manager, who was unable to join the meeting due to another commitment;
- Informed the Board that Louise Travers, General Manager MHAID, had left the organisation for family reasons and acknowledged the contribution she had made to the sector over many years;
- Noted the intention to appoint an executive lead with responsibility for MHAID;
- Reported that the first meeting of the Change Governance Group would be held later in the month under the chairmanship of Dr Clive Bensemann.

Peter Cammock from Leadership Lab, who were providing support with the organisational development programme, introduced himself and his colleague Chris Jansen, then gave a brief overview of their experience.

MHAID staff and the Leadership Lab were thanked for their attendance. It was agreed that the Board would be provided with bi-monthly progress reports.

12.0 PATIENT FLOW TASKFORCE

A progress report from the Patient Flow Taskforce was circulated with the agenda (tab 12.2). The Chief Medical Officer highlighted the key points, then took questions.

13.0 CLINICAL COUNCIL AND QUALITY UPDATE

The Board received a presentation from Dr David Gow, Chair of the Clinical Council, and Dr Hywel Lloyd, Executive Director Quality and Clinical Governance Solutions (EDQ&CGS), on governing for quality (tab 16).

Dr Lloyd covered governing for quality clinical care, the health quality and safety framework, and operationalisation of clinical governance.

Dr Gow outlined his background and clinical governance experience, then gave his perspective on the Clinical Council's roles and responsibilities, noting it was a governance, not an operational group. This included an overview of the Council's subcommittees, and how these could be drawn together to give better outputs, and the wider picture of where the Clinical Council should sit within the organisation.

Dr Gow advised that the Clinical Council needed to be visible, relevant, approachable, culturally aware, accountable, driven, legitimate, responsive, straddle the health disciplines, and be able to identify and nurture partnerships. To achieve this he recommended that the Council's membership and reporting lines be rationalised.

Dr Gow concluded his presentation by stating that currently the quality and safety of a patient's care was dependent on the quality of the practitioners who treated them, not the standards of the organisation in which they were treated. He advised this needed to change.

Drs Gow and Lloyd then responded to members' questions, following which Board members expressed support for the direction they were taking and thanked Drs Gow and Lloyd for their presentation.

14.0 COMMUNITY HEALTH COUNCIL

Ms Karen Browne, Chair of the Community Health Council (CHC), was welcomed to the meeting and presented an update on CHC activities over the last six months (tab 12.4). She also spoke on the following areas, which the CHC felt would benefit from the injection of a consumer perspective:

1. The feedback process for the DHB, and
2. Patient stories, with a view to submitting a draft policy on the consenting process, storage and use of recordings.

Ms Browne also reported that a sub-group was working on a paper for the New Zealand Medical Council, documenting how the Southern Community Health Council began and the processes that had been used to get it where it is today.

Board members and the executive noted the importance of the consumer voice and expressed the view the Southern CHC was an exemplar for the country.

The CHC's input was invited into the work on the rising number of complaints, which was concerning the Board.

15.0 STRATEGIC BRIEFING FOR THE SOUTHERN HEALTH SYSTEM

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

The Deputy Chair reported that it was hoped the first draft of the strategic briefing would be available mid-October.

16.0 STRATEGIC CHANGE PROGRAMME

The CEO presented a progress report on the Strategic Change Programme (tab 10). It was noted that the programme content would continue to be developed and mature as the workstreams that fed into it evolved and the ePMO was recruited to.

17.0 CARE CAPACITY DEMAND MANAGEMENT IMPLEMENTATION

The Chief Nursing and Midwifery Officer (CNMO) presented an update on the implementation of Care Capacity Demand Management (CCDM) and quarterly DHBs' milestones (tab 13), noting that SDHB was at 80% of full implementation as at the end of March 2021.

The CNMO reported that the current focus was on FTE calculations to achieve workable rosters at ward level. Requests for recruitment had been raised for 29 FTE, with 10 FTE being appointed to date.

Management responded to members' questions on the nursing budget, CCDM success measures, staffing mix, and CCDM for midwifery and allied health.

The Board requested that CCDM success measures and gains be included in the next report.

18.0 POLICY APPROVALS

Mr Roger Jarrold, Finance, Audit and Risk (FAR) Committee Chair, reported that the FAR Committee had reviewed the following policies (tab 14) and recommended they be approved by Board subject to the following adjustments:

- Clarification being added on receiving and giving of gifts, with reference to Continuing Medical Education (CME);
- Changing the Treasury section so it is consistent with the Board's Treasury Policy;
- Introductory remarks being added to the Koha Policy.

It was resolved:

"That, subject to the adjustments requested by the Finance, Audit and Risk Committee, the Board approve the following policies:

1. **Delegation of Authority Policy**
2. **Koha Policy."**

P Hodgson/L Soper

19.0 GENERAL

Food Services Contract

In response to a question about the savings achieved from the Food Services Contract, the Executive Director Corporate Services advised that care had to be

taken when making comparisons and advised that the DHB, not the contractor, had driven staff costs.

PUBLIC EXCLUDED SESSION

***At 12.25 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 6 September 2021 Verbal Report b) Hospital Advisory Committee ▪ 6 September 2021 Verbal Report c) Iwi Governance Committee ▪ 2 August 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.
Māori Health	To allow activities (incl staffing) to be carried on without prejudice or disadvantage	Section 9(2)(i) of the Official Information Act.
Capex Approvals Southland ED 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.
Contract Approvals ▪ Strategy, Primary and Community ▪ Regional Intellectual Disability Secure Services ▪ Digital Design and Support for NDH Digital Programme ▪ Philips Healthcare – Service Maintenance ▪ Southern Cross Queenstown – Service Provision	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.

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

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

The meeting closed with a karakia at 3.05 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 28 September 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020 Updated Nov 2020	**Quantitative Performance Dashboard** (Minute 6.0)	Draft quantitative dashboard to be presented to the Board.	CEO	Further refinement date now indicated and work is progressing.	~~August 2021~~ October 2021
July 2021	(Minute 8.0)	If possible, national benchmarking to be included in reporting.	PACEO	National benchmarking can be included. The Team are exploring which datasets are available and would be appropriate to include (Health Round Table or Health, Quality Safety Commission data for instance).	
Feb 2021	**Southland Site Planning** (Minute 9.0)	Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed.	CEO	Will not be completed by September. Target date will be discussed and agreed with Sapere.	~~Sept 2021~~ December 2021
March 2021	**Māori Workforce** (Public excluded minute 15.0)	Board to be provided with staff ethnicity data, if possible by profession, directorate, and recruitment rate.	EDP&C	Errors on the HR Dashboard has resulted in a review of the configuration of the dashboard. Work is in progress.	
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 EDP&C	Errors on the HR Dashboard has resulted in a review of the configuration of the dashboard. Work is in progress.	October 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2021	(Minute 9.0)	Period covered by dashboard graphs to be extended.	EDQ&CGS		
August 2021	**People and Capability** (Minute 8.0)	▪ Comparative data from other DHBs on staff churn and vacancy rate to be provided. ▪ Paper and presentation on the Health workforce to go to the next Board meeting.	EDP&C EDP&C	Comparative data is released by TAS on a quarterly basis. Awaiting updated information for last quarter of FY21. CEO proposed that this be delayed due to COVID-19 response.	October 2021 November 2021
August 2021	**Strategic Progress Report – Finance** (Minute 8.0)	Where possible, timelines to be added to the Facilities box.	EDCS/ PACEO	Completed	November 2021
August 2021	**Policies** (Minute 17.0)	One page summary of the important policies to be published for Board members' reference.	EDCS	Yet to be actioned. Full policies available in Diligent Resource Centre.	January 2022
Sept 2021	**Opioid Substitution Treatment Waiting Times** (Minute 6.0)	Report to be submitted to October CPHAC meeting with corrected data and how waiting times are best addressed, eg through budget reprioritisation, involvement of the PHO, etc.	Acting ED MHAID	Report included in CPHAC agenda.	Completed
Sept 2021	**South Dunedin Health and Wellness Hub** (Minute 8.0)	Progress report on development of Te Kaika to be submitted to October meeting.	EDSP&C	Included in agenda papers.	Completed
Sept 2021	**Volumes Report** (Minute 9.0)	Report analysing performance against last year's results to be submitted to October meeting.	EDSS	On agenda	Completed
Sept 2021	**Staff Disability Awareness Training** (Minute 9.0)	Check to be made that completion rates are being reported to DSAC.	EDQ&CGS		
Sept 2021	**Mental Health Review Implementation** (Minute 11.0)	Board to be provided with bi-monthly progress reports.	Acting ED MHAID		November 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2021	**Care Capacity Demand Management** (Minute 17.0)	CCDM success measures/gains to be included in future reporting.	CNMO	The CCDM core data set has 23 measures. *(Please refer to Safe Staffing Healthy Workplaces Unit slides in Diligent Resource Centre).* The measures are designed to help the organisation to understand how well CCDM is working. 21 of the 23 core data set measures are available now and equal priority is placed on: ▪ quality patient care, ▪ quality work environment and ▪ best use of health resources. Staff from all levels of the organisation can use the core data set and each inpatient ward should review their specific data at their regular Local Data Council (LDC) meetings. Many of the measures have been available and reported on at various levels to date; however all data measures are now being incorporated into a single *Power BI CCDM dashboard* to allow high level views and drill downs to ward level. It is proposed that the Finance, Audit and Risk Committee is the most appropriate sub–committee for the new CCDM Power BI reporting to be presented routinely as the three domain measures fit with the key FARC agenda aligning to quality, work environment/health & safety and resources. To be confirmed at the Board meeting 5 October 2021.	

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING

4 October 2021

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

DISABILITY SUPPORT ADVISORY COMMITTEE MEETING

4 October 2021

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

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 6 September 2021, commencing at 9.00am via zoom

Present:	Mrs Jean O'Callaghan	Chair
	Dr John Chambers	Committee Member
	Hon Pete Hodgson	Board Chair and Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mr Ben Pearson	Crown Monitor
	Mr Peter Crampton	Board Member
	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Dr Hywel Lloyd	Acting Executive Director Quality and Clinical Governance Solutions
	Mr Gilbert Taurua	Chief Māori Health Strategy & Improvement Officer and Interim Executive Director Mental Health
	Mr Patrick Ng	Executive Director Specialist Services
	Dr Nigel Millar	Chief Medical Officer
	Ms Kaye Cheetham	Chief Allied Health Scientific and Technical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Rory Dowding	Interim Executive Director Strategy, Primary and Community
	Ms Tanya Basel	Executive Director People and Capability
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting. Mr Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer/Interim Executive Director Mental Health acknowledged the recent passing of Moana Theodore's father-in-law, Richard Skipper and provided an opening karakia.

2.0 APOLOGIES

Apologies were received from Committee members Dr Justine Camp and Dr Moana Theodore. Apologies for lateness were received from Crown Monitors, Mr Roger Jarrold and Mr Ben Pearson and Committee member, Dr John Chambers and Miss Lesley Soper for early departure at 11.00am.

3.0 DECLARATION OF INTERESTS

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

The Chair asked for any changes to the registers to be sent to the Personal Assistant and reminded everyone of their obligation to advise the meeting should any potential conflict arise during discussions. The Chair asked that the Interests Register be updated to show her appointment as a member of the Idea Service

Board for the IHC group, noting that it was for the Service Delivery arm, looking after people in the community.

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

***It was resolved**:*

"That the minutes of the meeting held on 5 July 2021 be approved and adopted as a true and correct record of the meeting."

5.0 MATTERS ARISING

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

6.0 REVIEW OF ACTION SHEET

The Committee considered the action sheet and attached information papers and the verbal update from the Executive Director, Specialist Services (EDSS), Mr Patrick Ng. The presentation on workforce modelling for the future for the new Dunedin Hospital has been held over till the next meeting, with the need for further work to be done to reflect more accurate assumptions from inception. Significant workforce challenges are being signalled.

The Committee considered the reports attached to the action sheet and the verbal updates. The following highlights were noted:

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

- The EDSS confirmed that the rural hospitals appear to have adequate capacity in terms of beds.
- The shortage of inpatient beds in Southland is a challenge and more beds are to be opened on the Southland Hospital site. This has been budgeted for in the current financial year.
- It was agreed that future reports are to include staffed beds, in addition to physical and resourced beds. The EDSS advised he would update future reports to include a column showing the average bed closures for the month.

Crown Monitor, Roger Jarrold joined the meeting.

- Members are to be updated on what the risk to patient care and delivery is as a result of staffing shortages.
- The Day of Surgery Admittance beds are showing as '0' resourced as there are no overnight stays.

Aged Residential Care bed numbers (tab 5.2)

- The issue of workforce shortages is on-going.
- Whilst the report shows the total number of patients receiving care in a sub-optimal location as 30 at 23 August 2021, this needs to be balanced against the fact that on average there are over 100 people plus per month going into residential care.
- People have a choice of what residential care they wish to go into and may choose to wait in the community for longer to get their preferred choice.

Letters Review (tab 5.3)

- Members noted their concern over the lack of progress with the rationalisation of the template letters.
- An update was provided on the misunderstanding around the Oncology letters.
- A request was made that the letters currently going out be looked at and changed. This should be done quickly and sensitively.
- The Acting Executive Director Quality and Clinical Governance Solutions provided an assurance that action would be progressed prior to the next HAC meeting, ensuring that the most sensitive letters are addressed first.

Crown Monitor, Ben Pearson and Committee member, Dr John Chambers, joined the meeting.

- The Board Chair suggested that the process be project managed.
- It was agreed that the Service Managers need to implement the agreed changes as part of the process.
- The Ministry of Health needs to agree to any changes to the standard letters.
- It was agreed that a project plan is to be provided for the next meeting and that the EDSS liaise with Service Managers to confirm their responsibilities as part of the process.

Recruitment Update (tab 5.4)

An update was provided by Ms Tanya Basel, Executive Director People and Capability, with the following key issues highlighted:

- The challenge with recruitment and the impact on immigration and residency with the closed borders due to COVID.
- The recruitment campaigns currently underway.
- A request was made for future reporting to include the length of time that a vacancy exists and potential risks and problems as a result of delays in recruitment.
- Future reporting is to include vacancy forecasting.
- The Executive Director People and Capability agreed the need to provide detailed service planning.
- The importance of workforce planning and the need to keep a focus on vacancies and be proactive and aware of upcoming retirements and resignations and undertake advance planning for recruitment.
- A request was made for staff turnover rates to be included in future reporting. For the past financial year the staff turnover rate was 9.4% against a national average of 12.1% across the 20 DHBs.
- A request for a more accurate means of capturing the SMO vacancies, e.g. by service.
- Opportunity for Medical and Radiation Oncology trainees to take up positions within Southern DHB and recruitment requiring Registrars to work across the district. The CMO advised that one RMO contract has a limit on distance so RMOs cannot rotate more than 60km. There are a number of specialties that allow rotation across the district and the South Island.
- The HAC Chair advised that further discussion will be held on workforce at the Board meeting on 7 September 2021 and noted the importance of recruitment and retention of health professionals within Southern DHB.
- The Chief Nursing and Midwifery Officer, Mrs Jane Wilson, provided an update on the shortage of Midwives across Southern DHB and the need to ensure that quarterly reporting for Southern DHB is being presented in the same way as other DHBs. Further work is being done in this area.

Southland Dental Unit's General Anaesthetic Waiting List (tab 5.5)

- The Interim Executive Director Strategy, Primary and Community (EDSPC) apologised that the report was out of date with the ability of dental to operate under Level 3 and 4 with the current COVID outbreak and advised that the mitigation strategies within the report need refreshed.
- A further report will be provided once the impact of the current COVID lockdown on services is known.
- The Board Chair acknowledged the report and noted his concern at the waiting list, which needs to be much lower than 120, noting the impact on children in pain waiting on their dental treatment.
- The CEO confirmed that the issue is Theatre availability and not a staffing resource issue.
- The benefit of having the Surgical Bus was noted.
- A request was made for the opportunity to be taken to investigate the role and effect of fluoridation within Southern DHB, acknowledging that low numbers in some areas may impact the results.
- Discussion was held on the possibility of the Dental School providing dental chairs further south and the EDSPC advised that this would be included in a report on the Dental School being provided for the next Community and Public Health Advisory Committee (CPHAC) meeting.

7.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director of Specialist Services Report

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

Equity

An update was provided, with emphasis on:

- Southern DHB's equity programme and workshops planned.
- The impact of COVID on progress with the plan.
- Proposed visit to Auckland DHB to review Care Capacity Demand Management (CCDM) and meet with relevant individuals in the equity and reporting team so that the tools, approach and data capture used can be reviewed with the intention of informing what could be adopted at Southern DHB.
- Understanding why cardiology appointment attendance rates appear to be improving for Māori, but remain a problem for Pasifika people.
- Further analysis of rurality on equity needs to be explored.
- The report on a study of Māori Lung Cancer patients is pending and the findings from this will inform the work being done.
- The EDSS and General Manager, Surgical and Radiology Services are to meet with Board member, Peter Crampton, to discuss the intersection of rurality, ethnicity and socio-economic deprivation.
- The reference in the report to "opportunities to improve the content of the letters that we generate" was noted and this will form part of the overall project to improve letters.
- A suggestion was made that the Hospital foyers be modified to include a more cultural appearance and incorporate Te Reo Māori and the CEO and Chief Māori Health Strategy & Improvement Officer will explore this further. Whilst there is cultural input into the new Dunedin Hospital, work should be done looking at Southland Hospital and the current Dunedin Hospital.

Surgical Performance - Case Weight Discharges (CWD)

An update was provided, with the following highlighted and the EDSS responded to queries.

- Implementation of acute surgical capacity and the need to increase the hours for acute surgery in Dunedin. An increase of 28 hours per week will be achieved through staffing for a regular eight hour Saturday acute list and staffing to add four hours to one regular acute list every day Monday through to Friday. Francis Health identified the 28 hours when they assisted Southern DHB with its elective work. The additional acute hours will result in more elective surgery as it is anticipated that there will be less cancellations.
- The EDSS provided a verbal update on CWD performance against plan and advised on the challenges with Southland Hospital. To improve the situation in Southland the following is planned:
  - Funding is available in the current year to open 12 additional in-patient beds in Southland.
  - Planning is underway for the fifth Theatre.
  - Additional staffing is required, particularly in the Perioperative teams.
- An update was provided on the Production Plan, which is being looked at alongside the Elective Services Plan.
- A shortfall has been identified and initiatives have been put in place to address this, including putting acute capacity into Dunedin.
- Changes to the production plan model will be undertaken, based on improvements achieved from implementing the initiatives outlined.
- The extent to which the successful implementation of CCDM will result in more consistent patterns in keeping inpatient beds open.
- Concerns were raised around the ability to staff a fifth Theatre in Southland and whether there is capacity to provide additional weekend work. An update was provided by the EDSS, noting that regular elective work does not generally happen in either Dunedin or Southland Hospital at the weekend. There is a regular planned acute list undertaken on a Sunday in Dunedin.
- The EDSS responded to concerns raised relating to the comparison between outputs in July 2020 and July 2021. Further discussion is to be held at the Finance Audit and Risk Committee meeting.
- An update was provided on the relationship between acute and elective surgery. It is critical to identify how many patients are getting their acute surgery within a clinically appropriate time to avoid harm.
- Coming out of COVID, higher volumes of outsourcing will be required to recover the elective plan. The numbers required will be higher than what can be provided through local providers and capacity outside the district will need to be explored.
- The EDSS responded to concerns raised around the use of the prioritisation tool across the district and apparent inequity in access to services between Dunedin and Southland and noted that a district approach is being used. He advised the need to further investigate to see if there is more that can be done to ensure the resources are being shared across the district. The CEO advised the need to apply the prioritisation tool in a different way to achieve a more equitable outcome across the district.
- Clarification was provided on progress with the purchase of the MRI machine and the savings gained by including the purchase in a package of three with two CT scanners. Board approval will be sought at the Board meeting on 7 September 2021.

- Further discussion was held on:
  - The standard intervention rates in Southland.
  - Emergency Department (ED) presentations in Southland and the need for on-going support from WellSouth PHN.
  - The high intervention rates for Cardiac Surgery, noting that Cardiac is an "entitlement based service".
  - ESPI 2 breaches, access to Orthopaedic Surgery and recruitment to Orthopaedic Surgeon position in Southland.
  - The EDSS is to report back on the status of recruitment into the Orthopaedic specialist positions in Southland and a comparison against the recruitment process in Dunedin. The report is to include feedback on how much the caseload is being distributed across Southern DHB and whether there is capacity to do more of that for Orthopaedics.
  - The importance of having a uniform prioritisation tool across the district so any gaps can be readily identified.
  - Recruitment to specialist positions in Southland needs to be a major focus for HR.
  - Acknowledgement of the national shortage of Orthopaedic Surgeons and exploring ways of reducing the lists utilising resources we do have, e.g. Physiotherapists and upskilling General Practitioners to do simple procedures.
  - Utilisation of the MRI facility which is being run into the evening and at weekends.
  - A triaging service is now in place for ENT minor lesion procedures to be done in the community by General Practitioners with a special interest (GPSI). There is potential for more work to be done in this area.
  - There is funding available to expand the role of Physiotherapists. However, there is a significant shortage of Physios in Southland.
  - There is a shortage of six Dentists in Southland resulting in young people not being able to get oral health check-ups.
  - Whether there is a planning process looking at the configuration of GPSIs throughout the district and the load they may take off the surgical waiting lists. The EDSS is to arrange for the information, in a review undertaken by the General Manager Surgical and Radiology, looking at the ability of GPSIs to do minor skin lesions in the community to be included in the next HAC agenda. A request was made for reporting on the actual and potential capacity for GPSIs to take load away from in-patient hospital care. The EDSPC advised that the use of GPSIs in Southland as outlined was a planned investment to address a gap in service in the Southland community in a planned and co-ordinated way by the provider arm, primary care and the funder arm of Southern DHB.
  - The pressures on the Emergency Department (ED) in July 2021, particularly in Dunedin, and the response to the Nurses issuing a Performance Improvement Notice (PIN). The EDSS provided an update on the actions taken as a result of the PIN. A report will be provided for a future meeting outlining the actions taken as a result of the PIN and any recommendations.

Financial Performance Summary

Crown Monitor, Mr Roger Jarrold, queried the low bed days for July 2021 (compared to March, April May and June 2021) as outlined in appendix one of the Finance Report. The EDSS is to investigate and report back on the low bed days.

The EDSS presented the Specialist Services financial results (tab 6.2) for the month of July 2021, outlined the contributing factors to the positive variance of $200K for

the month and noted the key drivers for the results. He responded to members' queries.

An update was provided on the challenges with the implementation of the Finance, Procurement and Information Management (FPIM) system reporting for the month and it is anticipated that the actual figures for the month will change. Taking the expected adjustments into account, it is anticipated that the $200K favourable result is likely to be a circa $200K unfavourable result.

***It was resolved**:*

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

8.0 GENERAL

Production Plan

The HAC Chair advised the need for HAC and Finance Audit and Risk Committee (FARC) members to see the Production Plan with the outsourcing. Further work is required to ensure everything is included when refining and developing the Production Plan further and the EDSS advised that the team are keen to see how Auckland does it, to help inform the local process. The Crown Monitor, Mr Roger Jarrold, noted that the average length of stay increased markedly in July 2021 and he noted the importance of CCDM and rostering aligning with the production planning.

The CEO advised on the areas of Production Planning and Production Engineering and noted that money is available for Production Engineering, which will look at the flow right across the system. It is proposed to look at how Auckland DHB does their Production Planning and then Southern DHB will recruit to supplement skills in this area.

RMO Rostering

The EDSS advised on progress with centralisation of RMO rostering. An update will be provided for the next meeting.

9.0 CONFIDENTIAL SESSION

At 11.17am the CMHSIO provided a closing karakia and it was resolved that the Hospital Advisory Committee move into committee to consider the previous public excluded meeting minutes.

***It was resolved**:*

"That the minutes of the public excluded session of the Hospital Advisory Committee meeting held on 5 July 2021 be approved and adopted as a true and correct record."

A patient complaint related to transfer of a patient between hospitals within Southern DHB was noted. An official letter was not received by Southern DHB and the issue raised the need for better systems and processes to be put in place. As the matter had not been publicly notified, further discussion is required outside the meeting.

The meeting closed at 11.54am.

Confirmed as a true and correct record:

Chair: _____ Date: _____

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 5 October 2021

Recommendation

That the Board:

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

Purpose

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

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

1. Organisational Performance

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

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

Financial performance for the month of August is a deficit of $4.336 million compared to a budgeted deficit of $2.465 million, and hence an unfavourable result against plan for the month of $1.871 million. The year to date deficit is now $4.806 million compared to a budgeted deficit of $3.689 million, or $1.117 million.

The result for August has been directly impacted by the deferral of a significant amount of planned care due to the COVID-19 lockdown. This impacted revenue by $3.1 million which makes the August result very understandable. We are engaging with the Ministry of Health to identify a solution to this problem. In the 2020 lockdown DHBs were given certainty of revenue for the lockdown time period.

It is important to note that unlike the 2020/21 year, the impact of both the Holidays Act and accelerated depreciation of the existing Dunedin Hospital has been included in our budget and the results have these impacts accounted for now.

From a volumes perspective:

- Total case weighted discharges were down 878 or 16.8% for the month compared to the plan, and down 521 or 10.7% on the same month last year. Year to date case weighted discharges were down 623 or 6.2% year to date against plan
- Medical case weights are up 43 or 1.1% year to date and 40 or 1.1% compared to last year
- Surgical case weights are down on plan 746 or 13.7% with acutes down 169 or 3.1% with electives being down 577 or 19.7%. It is interesting to note that surgical acutes are down 145 case weights or 11.6% for the month of August compared to August 2020 which is concerning given that acute activity should presumably have been minimally impacted (noting medical acutes were up for the same time period year on year)
- Raw discharges are down 669 or 12.3% for the month against plan, and down 419 or 8.1% compared to last August. Year to date raw discharges are down 580 or 5.4% compared to last year
- Average case weight per discharge for medical cases is very similar with a small reduction of 0.9% suggesting that the average complexity as measured by case weights is now very similar to last year. However, surgical case weights have increased by 7.2% with elective increasing by 7.4% and acute increasing by 7.0% suggesting that the average complexity has increased
- Mental Health bed days are 1,434 or 21.8% below planned levels for the month (indicating a 78.2% bed occupancy) and 255 of 4.7% down on year to date August 2020. This indicates overall bed occupancy is reducing
- Emergency Department attendances are down 953 or 11.5% compared to August 2020 with Dunedin down 9.5%, Southland down 15.0% and Lakes down 8.3%. This is clearly a reflection of the COVID lockdown.

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

2. Top Five Risks

Risk	Management of Risk Avenue	Effectiveness
Adverse clinical event causing death, permanent disability, or long term harm to patient	SAC system in place with all SAC 1 and 2 events being reviewed and reported to the Clinical Council, Executive Leadership Team and Finance, Audit and Risk Committee This category also captures outcomes from delays in care such as is being experienced in Oncology and previously Colonoscopy, Urology etc	Need to improve feedback loop and extend to near miss events Southern has developed a track record of addressing significant issues, however, has not historically been utilising information effectively enough to ensure that they are forward looking to identify emerging issues in a more timely manner
Adverse health and safety event causing death, permanent disability or long term harm to staff, volunteer or contractor	Health and Safety Governance Group with agreed charter and work programme reporting regularly to the Finance, Audit and Risk Committee	Need to improve feedback loop and extend to near miss events

Risk	Management of Risk Avenue	Effectiveness
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, digital transformation business case in development, disaster recovery plans in place to address critical failures	Moderate effectiveness, state of facilities in Dunedin well documented, Mental Health business case needed. Capacity issues in Southland
Critical shortage of appropriately skilled staff, or loss of significant key skills	Workforce strategy developed, however more robust action planning required	Further focus must be applied
Misappropriation of financial resources provided by the Crown for optimising the health and well-being of our community	Delegation of authority policy, internal audit work programme, external audit. All reporting through the Finance, Audit and Risk Committee	Improvement through upgrading financial system will assist in more effective management of risk

3. Strategic Refresh Update

We are in the process of signing a contract with Sapere to undertake the clinical services design piece of work. To date we have had the initial project discovery meeting with the key leaders and sponsors and just this past week a project kick-off meeting was had where we covered off the high-level timeline, identification of key stakeholders and critical next steps. The approach is to analyse data and evidence, to generate insights that will prompt rich discussions with health service and stakeholder groups. Two distinct workstreams have been identified being: the analytical workstream and the services planning workstream.

The next steps are for the Sapere team to send us a formal data extract request so that they can get the data analysis underway. Further consideration of the desired governance structures will be addressed and may take the form of a steering group to oversee the project direction. Also discussed were tentative indications of when the stakeholder consultation will take place. At this stage it does look like Christmas/New Year will intersect the project, but we will look to minimise any impact that may have as much as possible.

To support the delivery the Chief Executive's office and the Sapere project team have scheduled fortnightly project catchups to monitor progress.

4. Annual Plan 2021/22

A complete Board signed Annual Plan was submitted to the Ministry of Health, for Ministerial approval, on 10 August.

Statement of Service Performance (SSP)

The team is in the final stages of completion for the 2020/21 Statement of Service Performance. The 2020/21 SSP is required for review by auditors on 30 August.

Service Planning

The annual cycle for service planning for 2022/23 has started, with an October workshop planned for the Medicine, Women's and Children's Health Directorate, and one for the Surgical Services and Radiology Directorate at a later date. The aspiration is to have early alignment of the budget and capital expenditure process with the service planning annual timetable, and regular catch-ups with the Executive Director Corporate Services have been set up to assist in this.

A brief discussion with the Clinical Council this month on service planning and changes in models of care prior to moving to New Dunedin Hospital was very useful. Service planning will include proposed changes to models of care, and the challenge is how to involve the stakeholders from across Directorates and across the sector (primary and community

5. Ongoing COVID Management Response

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

Public Health Response as at 1700hrs 26 August 2021

On 17 August New Zealand entered level 4 lockdown after a community case of COVID-19 delta variant was discovered. A nationwide public health response was launched to contact trace all potential cases arising from exposure locations.

We currently have six contact tracing teams (with up to 12 staff) operating on a seven-day week roster. The Ministry of Health has a priority list for contact tracing: 1) healthcare workers, 2) symptomatic essential workers, 3) symptomatic other, 4) essential workers. Each contact tracing team has a Contact Tracing Team Lead who allocates out work to the team and provides oversight and support for their team.

Due to the recent pause on all Quarantine Free Travel, seven of the Queenstown Airport Health Team alongside 22 wider DHB staff are supporting this work. These staff are provided with National Contact Tracing Solution (NCTS) training and logins and are added to a contact tracing team. The contact tracing teams are balanced as much as possible with experienced and new contact tracers.

As at 26 August, in the Southern district there were:

- 122 disease contacts in quarantine, 15 of which are symptomatic
- 0 Cases
- 732 disease contacts are being managed by our contact tracing teams.

The Public Health service stood up an Emergency Operations Centre (EOC) to ensure that they had adequate capacity in place to respond to the work being assigned to us. The current ready capacity for Southern is: 12 cases daily, 137 new contacts daily, 597 contacts in follow up, and to surge to 50% more on each.

Community Managed Isolation Quarantine (MIQ)

A Community MIQ Service Coordination Manager has recently been appointed to Public Health. Community MIQ bridges the gap between self-isolation and isolation/quarantine in a Managed Isolation Quarantine Facility by providing an enhanced community option for cases and higher-needs contacts to ensure that they have the support they need to be able to isolate/quarantine successfully in the community. It has been developed with the understanding that different cases/contacts in the community have different needs and will require different approaches and support in order to successfully isolate/quarantine. Community MIQ is an end-to-end model of case/contact management, funded by the Ministry of Health and delivered by DHBs.

COVID-19 Cases on MV Mattina - Update

As previously reported, the Public Health team has been responding to positive cases of COVID-19 in crew on board the MV Mattina ship in Bluff. All cases and contacts have now been released from self-isolation and quarantine and on 19 August, the ship was granted pratique, which means the ship is now eligible to have dealings with a port. The response to this has raised a number of issues that need to be resolved for the future including clinical

oversight of cases, accommodation and transport. Unfortunately, due to the Auckland August COVID-19 outbreak this debrief has been postponed.

Staffing over Level Three and Four Lockdown

It has been pleasing to see how staff have supported each other across the services throughout the lockdown, particularly in the areas of contract tracing where significant and immediate support was required, COVID vaccination and screening at hospital sites for visitors once we moved to Level 3. Staff across these services have been responsive and flexible in stepping up to help where most needed and have demonstrated the core values of this organisation.

6. COVID-19 Vaccination Programme

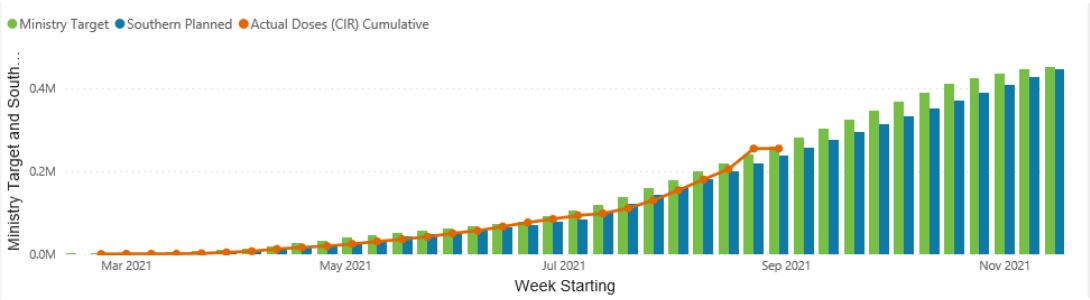
As of 20 September 2021, the COVID-19 vaccination programme in the Southern Region surpassed 350,000 doses given.

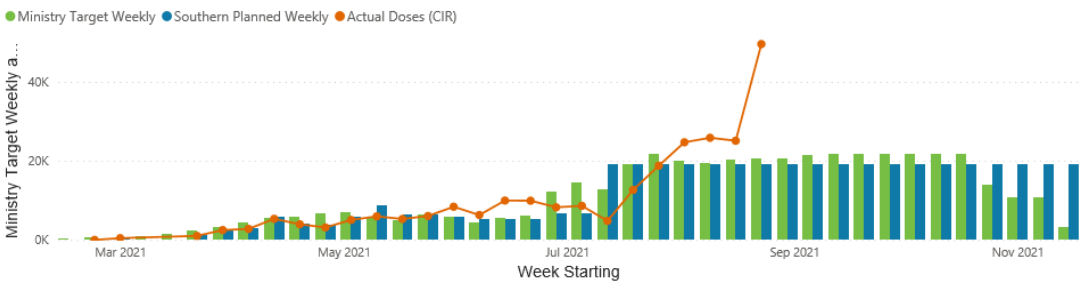
This represents 77.9% of eligible people with a first dose and 42.8% being fully vaccinated.

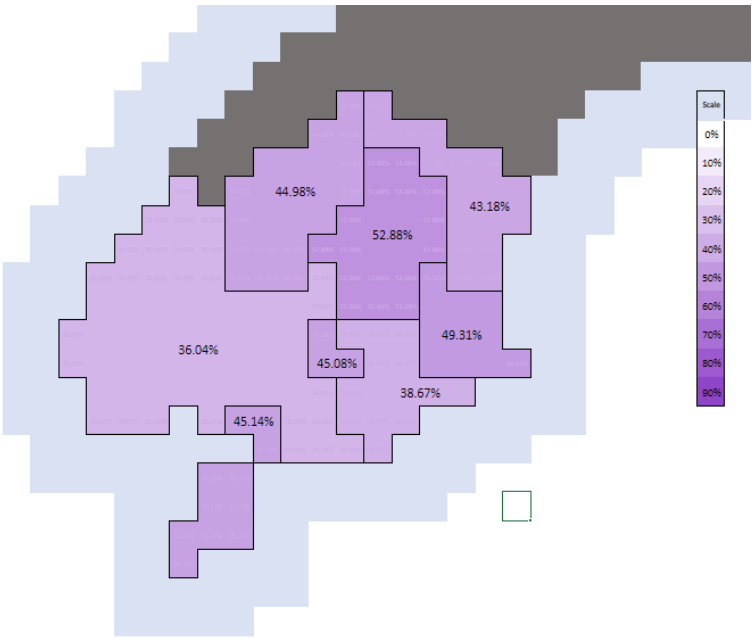
This positions Southern as the top DHB based on population vaccinated. Southern is also a leading DHB with the numbers of Māori and Pacifica vaccinated, as well as the disability and mental health communities.

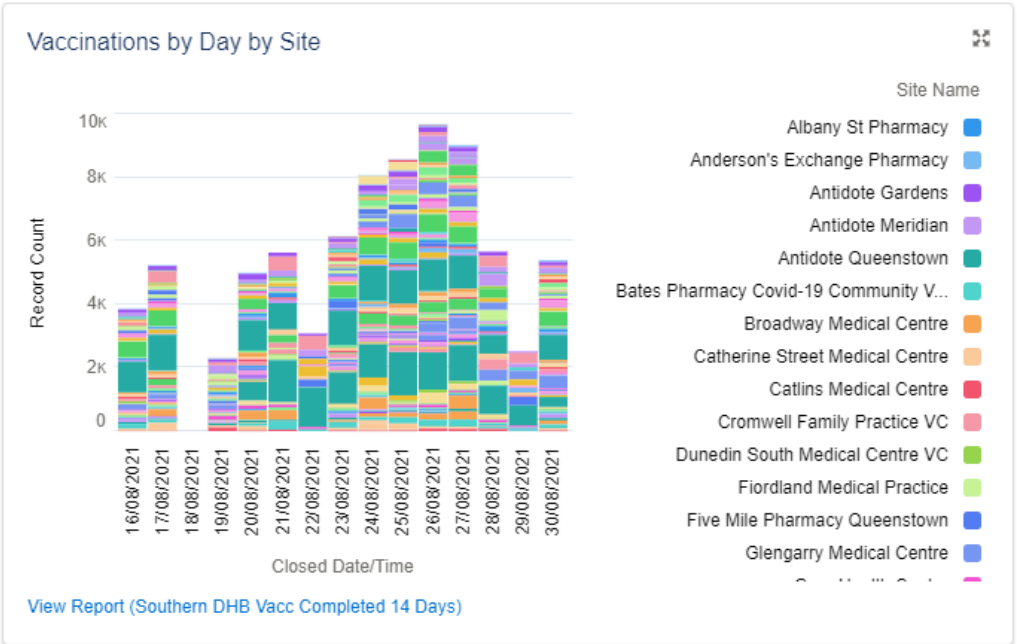
We have further confirmed first dose activity within 'Book my vaccine', however much of the current planned activity is focussed on second doses. We are seeing a ramping down in volumes as we head towards 80% of the population vaccinated and are shifting the focus of the programme away from delivering volume and towards vaccination of harder to reach people and populations. The goal is to vaccinate 90% of the population by end of December 2021.

This means a focus on equity, workplaces, outreach and mobile services, vaccinating the very rural/remote communities and often our providers working together to get the most effective delivery models.





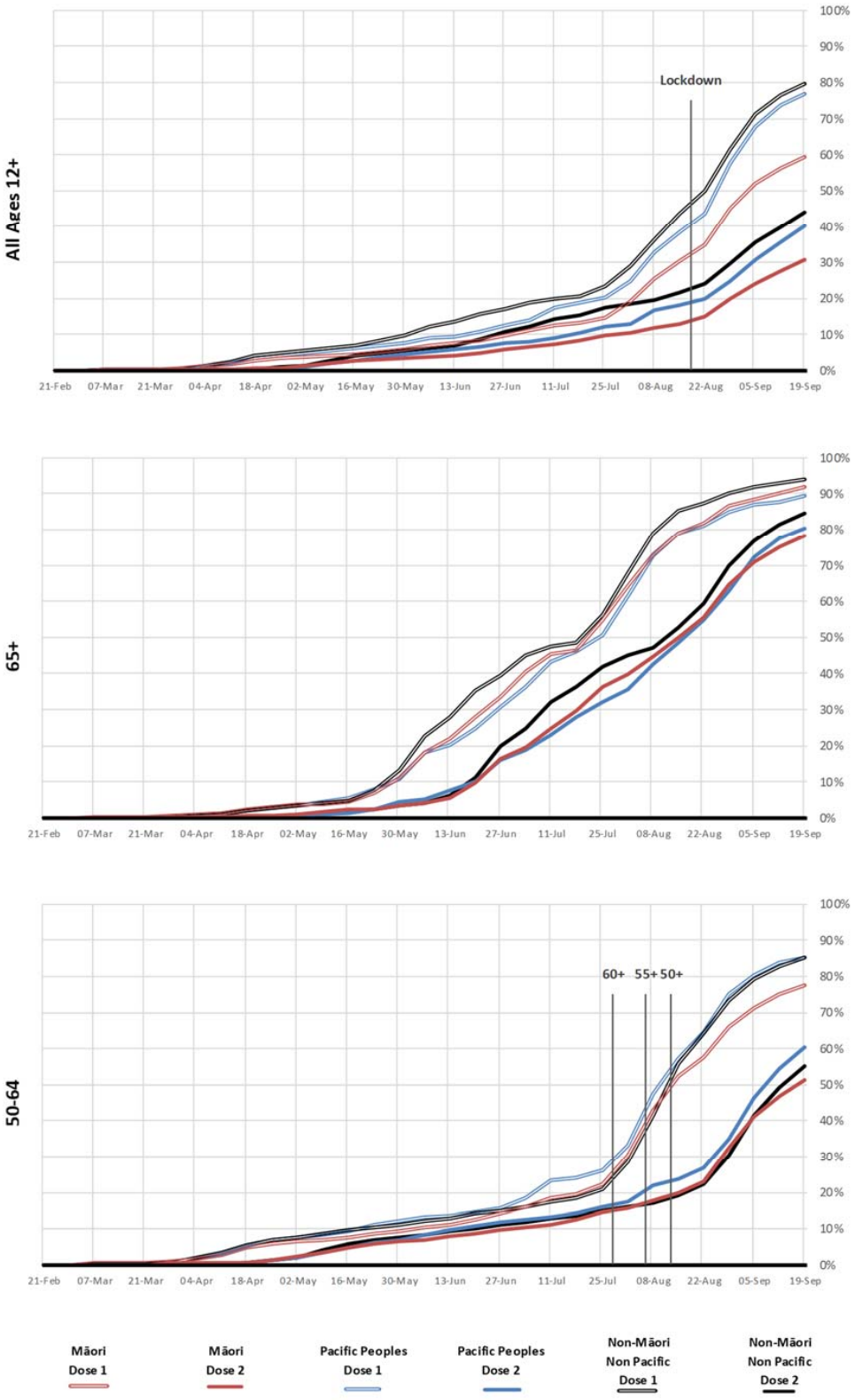




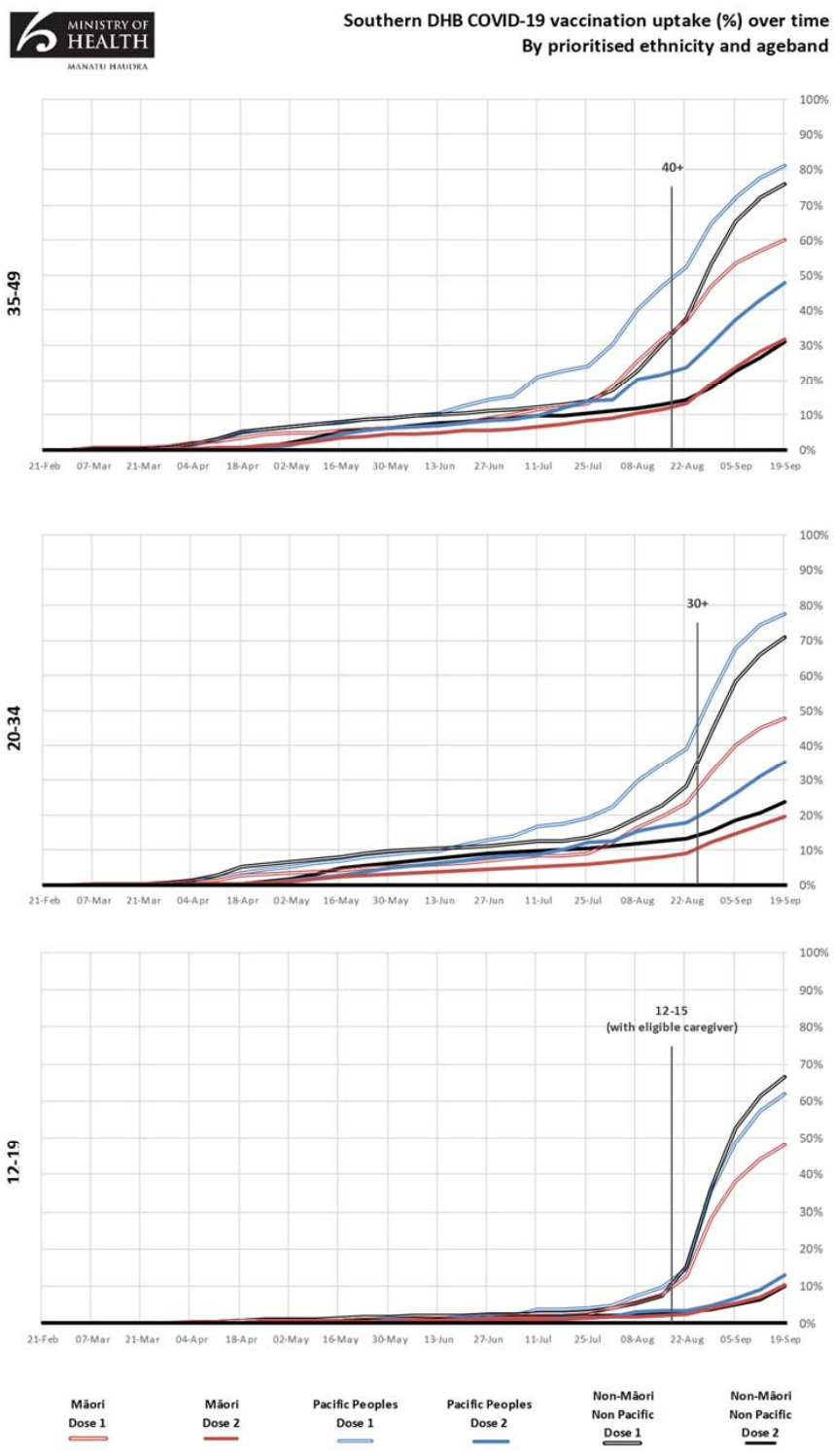
The series of graphs on the following two pages show COVID vaccination uptake over time by prioritised ethnicity and age band.

MINISTRY OF HEALTH
MANATŪ HAUORA

Southern DHB COVID-19 vaccination uptake (%) over time
By prioritised ethnicity and ageband



Vaccination data sourced from the Covid Immunisation Register (CIR)
Data sourced from Health Service User 2020 (HSU) population



Vaccination data sourced from the Covid Immunisation Register (CIR)
Data sourced from Health Service User 2020 (HSU) population

7. Elective Service Performance Indicators

The government policy for Elective Services is such that only patients for whom we have the capacity to see and then as needed treat within four months should be added to the waiting list. As at mid September there were 4,124 patients on the inpatient waiting list and 2,442 on the outpatient waiting list. A considerable number of patients had breached the four month expectation. There will be many reasons for this including:

- The impact of COVID and the restriction on services resulting in patients being delayed
- Patients on the waiting list but not ready for surgery, either due to personal choice or for other clinical reasons (these patients should never have actually been added, they should have only been added when they were ready)
- Patients who were not able to attend
- Patients who were added to the waiting list for procedures that due to their priority are very low priority patients and have always been usurped by higher priority patients
- Some of the patients on the waiting list when contacted have already had their procedure undertaken elsewhere (in private) or no longer need the procedure.

Historically, a number of services had the attitude that having patients on the waiting lists was a good way of demonstrating unmet need, however this is a flawed logic as in many instances general practitioners (GPs) and senior medical officers (SMOs) knew where the thresholds were and as such did not refer patients below this to the hospital. The better way of measuring unmet need is to compare intervention rates in Southern with intervention rates in the rest of the country.

As Chief Executive, I have asked on a number of occasions for the service to identify a mechanism to focus on the long wait patients and to either:

1) Provide the service that was promised
2) Consider removing the patients from the waiting list. This option should only be considered where the patient is on the waiting list but have to await the outcome of other related issues, of they were added to the wait list for procedures that are so low priority they will not receive the service anytime in the near future.

In the second instance, care would need to be taken to communicate with the SMOs involved, the patient's GP and the patient themselves. While there will be some reactions to this action, it is more honest than to simply leave patients on a waiting list knowing they are never going to be called.

The first priority is to focus on the patients waiting more than one year. Once this has been addressed, the intention will then be to focus on all patients who are over the four month limit. The tables for patients over one year are as follows:

Outpatient Wait List (ESPI 2)

Patient Count	over 365
ESPI 2 breaches	(Multiple Ite

NHI Count	Age Band										
District	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100	Grand Total
OTAGO				4	2	4	3	6			19
Endocrinology								1			1
General Surgery				1	1	1	1	4			8
Neurology				1			1	1			3
Neurosurgery					1	1					2
Ophthalmology				1							1
Plastic Surgery							1				1
Vascular Surgery				1		2					3
Southland	1	4	2	4		7	1	5	3	2	29
E.N.T			1			2		1	1	1	6
ENT Surgical			1			1		1	1	1	5
General Surgery				3		3					6
Nursing									1		1
Orthopaedics	1	4		1		1	1	3			11
Grand Total	1	4	2	8	2	11	4	11	3	2	48

Patient Count	over 365 d

NHI Count	Age Banc										
District	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100	Grand Total
OTAGO	9	10	12	16	19	44	80	91	32	2	315
Orthopaedics	1	6	7	7	8	31	52	65	24	2	203
Vascular Surgery				1	1	4	12	11	3		32
E.N.T	6	2	2	6	7	4	2	2			31
Plastic Surgery	2	2	1	2		1	6	4			18
General Surgery					1	2	7	2	3		15
Ophthalmology					2	2	1	6	2		13
Urology			1					1			2
Neurosurgery			1								1
SOUTHLAND	1	5	10	2	6	11	15	7	3		60
Surgical Services			5	1	4	5	7	2	2		26
ENT Surgical	1	5	4			3	4	4			21
Orthopaedic Surgery			1	1	2	3	3	1			11
Urology									1		1
Ophthalmology							1				1
Grand Total	10	15	22	18	25	55	95	98	35	2	375

8. New Dunedin Hospital – Parking

The scope of the New Dunedin Hospital has always only included 250 car parks, which is approximately the same number of car parks that the existing hospital has within it. This is only enough for some of the DHB vehicles, a small percentage of the workforce and limited outpatient parking. We are also cognisant that the development has taken out a car parking building, which staff and visitors would have previously utilised.

We have determined that it would be sensible to go to the market to identify partners who may wish to invest in the development of a car parking building to be located within the campus plan. The exact location where a potential car parking building could be located will be determined through the master site planning process, which is now underway. We would anticipate that the parking would be available for staff wishing to lease parking more proximal then where they may presently be leasing parking, and for visitors. Selecting a partner early will allow for them to be involved in the design and configuration of any solution developed. It is expected that this parking would be operated by an appropriate entity with the skills and expertise of managing this form of operations. It is expected that this parking would need to operate on a user pays basis, but the details will need to be worked through as planning progresses. It is hoped that the development of the facility may be able to

precede a lot of the wider construction process to allow for facilities for the many contractors who will need to access the site during the construction process.

9. Dialysis Chairs Southland Hospital

The two dialysis chairs have been commissioned in Southland Hospital. Due to COVID restrictions there was not a formal opening, and this will be planned for a time when we are back in Alert Level 1.

It is important to note that the dialysis room at Invercargill is for away from home haemodialysis. The patients who will be using the room will predominantly be people who live distant to Invercargill, most likely from outside our region. There will be the occasional person who may live in Southland who does not have the ability to dialyse at home, but it is not for training or an alternative to home dialysis.

We have put a note about the facility on the renal page of our website, which also notes the facility at Dunstan.

10. Action Plan from Leena Singh's Report

The action plan for the recommendations in Leena Singh's report is attached as Appendix 1.

11. Specialist Services Productivity in August Impacted by COVID

From 18 August until 31 August outpatient, procedures and inpatient activity was impacted by COVID Alert Levels.

Approximate productivity losses (compared to normal) are as follows:

		% of Normal	% Lost
Outpatients	Southland Medical	45%	55%
	Southland Surgical	49%	51%
	Dunedin Medical	66%	34%
	Dunedin Surgical	49%	51%
		Average	***48 %***
Inpatients	Southland Surgical	41%	59%
	Dunedin Surgical	55%	45%
		Average	***52 %***

Overall, we lost circa 50% of our planned care activity during the period from 18 August to 31 August. We lost the least activity for Dunedin medical outpatients, who managed to maintain circa 66% of their regular outpatient activity (either in person or via telehealth), and we lost the most outpatient activity for Southland medical, where only 45% of normal activity was able to be retained.

For inpatients we managed to maintain 55% of normal Dunedin activity, but we only managed to maintain circa 41% of normal Southland activity. Southland's perioperative workforce was lean prior to COVID (with rosters occasionally unable to be filled due to staff illness), and COVID exacerbated these challenges with staff having to remain at home because they couldn't get childcare due to the lockdown. This translated into only being able to run between two and three of the four elective theatre lists on a regular basis during this period.

The lost activity will now have to be caught up and an enhanced recovery plan will need to be developed. The teams have started to apply their attention to this, ahead of formal Ministry guidance which we anticipate in the coming months.

12. Specialist Services Recruitment Challenges

As noted in Hospital Advisory Committee (HAC) and other reporting, the ability to get medical, nursing and allied staff into the country has been very problematic and this has contributed to staffing shortages in a number of key areas (e.g. physiotherapy, anaesthetic technicians and nursing). The Director of Nursing has led a piece of work seeking to improve the rate at which we can recruit nurses. The Director of Allied Health has led a significant piece of work to try to improve the physiotherapy shortage. Physiotherapy in Southland in particular is a key issue, with staffing down from an establishment of 15 FTE to 5 FTE (i.e. two-thirds of positions are vacant). 5 FTE have been confirmed as new hires in the coming months and some short term help has been planned with support from Nelson Marlborough, but vacancies remain a key issue. An initial discussion has been had about the benefits of running a Haines Attract style campaign to improve the rate at which we are able to fill these vacancies, and this will be worked through in more detail. We remain at risk of not being able to get overseas recruits into the country given the situation with the availability and timing for MIQ slots. We have confirmed nine new anaesthetic technician trainees for next year (the most we have ever had). This maximises the number of trainees that we can train and will benefit us in the coming years by creating additional trained anaesthetic technicians (i.e. bolstering our workforce). Medical imaging technologists also have a larger number of vacancies (10) in Southland and would benefit from inclusion in a Haines Attract style campaign.

Perioperative staffing in Southland has continued to be an issue, with occasional theatre lists dropped due to the inability to staff them with anaesthetic or nursing staff. Nursing will be back to full recruitment in the coming months but there are pending retirements so we will work with the perioperative manager to establish what can be done to over-recruit in anticipation of these future vacancies.

13. Southland Theatre Productivity

Southland theatre productivity continues to be a challenge due to perioperative vacancies, inpatient beds and staff illness. We have asked the Planned Care Manager to formulate a productivity improvement plan for Southland which captures the following elements:

- Implementing an initial four inpatient beds as soon as possible, and then progressively implementing a further eight inpatient beds in the Assessment, Treatment and Rehabilitation (ATR) unit.
- Working with the Director of Allied Health to assist with reducing the vacancies in physiotherapy where possible (we will look to work together on developing a proposal around a Haines Attract style campaign).
- Ensuring that any gaps that appear on the Southland lists are filled, either with short notice elective cases or re-assigning lists where specialities aren't able to fill them.
- Other initiatives as these are identified as we progress the work programme.

14. Production Plan

Earlier in the year a rudimentary production plan was developed which identified that we would lose 1,200 CWD of activity (on planned delivery of circa 17,500 CWD) if our productivity challenges from last year continued. We are now working on re-baselining the plan on the following basis:

- Adding the productivity improvement that will be achieved from implementing the additional acute theatre capacity in Dunedin.
- Adding the productivity improvement from the inpatient beds planned for Southland.
- Accounting for the lost elective productivity due to the COVID lockdown.

- Adding the productivity improvement from what we believe will be additional available outsourcing across the district.

The objective will be to get this plan to balance to our annual elective target and/or to keep identifying initiatives that will allow us to balance, i.e. our objective is to try to improve internal elective delivery, and to effectively offset the lost surgery due to COVID to achieve the elective target for the year. The re-baselined plan will be shared with the Chief Executive and once agreed to will form the basis on which we attempt to recover our lost surgery.

15. Oncology

Our Oncology wait list recovery work is well documented on a weekly basis and will not be extensively repeated here. However, key notes are as follows:

- The Ernst and Young (EY) work is now underway, initial meetings with stakeholders have been planned and there has been an initial meeting with the Executive Director Specialist Services (EDSS) to explain what is available from the national data collection and the methodology that EY is starting to work on for the comparison of data.
- We have approved a clinical nurse specialist for haematology who will make a meaningful difference to follow up work, enabling the clinicians to see more first specialist appointments (FSAs). The recruitment for this position is now underway.
- We are seeking to take a similar approach for medical oncology on a fixed term basis whilst we await the additional medical oncologist capacity (1.8 FTE) which have been recruited, but won't commence until February 2022.

16. Emergency Department (ED) Southland

With the Board having signed off the ED Expansion Case for Southland work is now underway to progress with the detailed design. We anticipate that the selection of the design architects will occur in the coming month, and that the detailed design work will get underway as soon as possible. We will provide timeframes for the initial design work as soon as they become available.

17. Fifth Theatre Southland

A new design has been proposed (and agreed by stakeholders) as the preferred way forward with the fifth Southland theatre. This proposal requires the sterile supply unit to be relocated and for the administration and management teams currently in the office where the proposed construction of the new sterile supply unit would occur to be moved. The proposal requires $4m to $5m, and the Executive Director Corporate Services has written to the Ministry requesting additional capital assistance as the original capital commitment obtained by the EDSS as part of COVID recovery was only $3m. Concept design work is continuing in parallel with the intention of presenting a streamlined business case as soon as possible. The business case will focus on outlining the preferred option, rationale and cost (rather than making an extensive case for a fifth theatre). This will enable the case to be completed faster and upon approval for construction to occur faster.

18. Primary Maternity

Primary Birthing Units Business Case

The business case for Ministry of Health (MoH) funding for construction of two rural Primary Birthing Units has been drafted and has been sent to the MoH for feedback before final submission. The business case is based off the updated Options Paper approved by the Board in June 2021 and has been formatted into the Better Business Case format. This Business

Case was also to be presented to the Executive Leadership Team (ELT) at their 16 September meeting.

The Southern DHB drafts people are currently working on a design for the new birthing unit which will be sent to a Quantity Surveyor for a more robust estimate of costs.

Preparations are underway for Requests for Proposal (RFP) for both Service Provider(s) and Design/Architectural services. The RFP for the service provider is taking precedence to ensure that the successful party(ies) can be involved meaningfully in the design process. Work is underway to identify suitable land in Wanaka and discussions between various stakeholders are ongoing.

Telehealth Clinics

Monthly telehealth clinics have been available in Wanaka for the past year. This service is now being trialled in Lumsden, to be accessed by women in the Lumsden and Te Anau area who would usually travel to Invercargill for secondary care appointments. There is also equipment and training in place to establish telehealth clinics in the Central Otago Maternity Unit.

Child and Maternal Hubs

Work is being finalised on an updated Service Specification for Child and Maternal Hubs, which will provide a level of consistency across providers, whilst retaining the ability for these spaces to be community-led.

19. Southland Physiotherapy Service

Southland physiotherapy continues to have vacancies that are currently impacting on service delivery and staff wellbeing, especially for the inpatient team. There has been a lot of effort put into recruitment which is starting to show results. Five offers from overseas have been accepted, with the first arriving in Invercargill at the end of August. The others are still waiting for MIQ placements, placing a significant amount of uncertainty of when they will arrive. Recruitment for new graduates has commenced with a good number of applications received.

Staff from Dunedin continue to support their colleagues in Invercargill with a rotational roster with a senior physiotherapist travelling to Invercargill for five days each week. This has been interrupted temporarily during Levels 4 and 3 lockdowns, but the impact of this has been minimised by reduced work, and hence reallocation across the existing team.

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

The RN shortage in Aged Residential Care (ARC) continues to worsen with a very limited pool of available nurses. The number of shifts not covered by an RN continue to increase. Even with mitigations put in place, this is concerning.

The ARC RN Workforce Steering Group continues to meet and has developed a well-supported action plan. Actions that have resulted from our ARC RN Workforce Steering Group are:

- Workforce Co-ordinator 0.6 FTE started 25/8/2021 for six months and an additional 0.5 FTE will commence in October
- Workforce Co-ordinator is going to work to identify and support Internationally qualified nurses (IQNs) who haven't achieved registration in NZ
- Work continues with Nurse Advisor from the Ministry of Health who is seeking advice regarding strategies to support the sector. Advice has been provided on IQNs, Nursing Council processes and supported mentorship linking to the rotational programme and bonding schemes

- ARC Workforce Steering Group has linked with the Ministry of Business, Innovation and Employment (MBIE) who may write a Workforce Insights report based on the ARC survey results alongside sharing information on retention programmes for the sector.

Infection Prevention and Control Support to Aged Residential Care

The Aged Residential Care (ARC) Infection Prevention and Control (IPC) Clinical Nurse Specialists have been particularly valuable to the ARC sector this month:

- Supporting 17 Acute Respiratory Infection Outbreaks in facilities. Currently (at the end of August) there are seven active outbreaks. With the Public Health team prioritising COVID-19 work, the IPC Clinical Nurse Specialists have supported facilities through these outbreaks
- Providing excellent advice and support to facilities in Alert Level 4, answering questions and concerns, facilitating conversations between hospital wards and ARCs, supporting patient flow
- Supporting facilities to safely allow visiting for end of life residents in Alert Level 4.

21. Māori Enrolment update

The tables below outline the latest Māori enrolment data based of monthly files from the National Enrolment Service (register of national enrolment and health idendity/demographic data). The lower table providers a locality breakdown across the Southern DHB region and the Māori Health Directorate is supporting with possible solutions to support general practices with the lowest number of Māori vaccination rates through the WellSouth call centre.

	Feb-21	Apr-21	Jun-21	Aug-21
Central Otago	1,877	1,893	1,881	1,918
Clutha	1,838	1,856	1,863	1,855
Dunedin	9,495	9,530	9,597	9,611
Gore	1,821	1,843	1,861	1,854
Invercargill	9,291	9,356	9,353	9,363
Queenstown Lakes	1,932	1,969	2,019	2,062
Southland	1,760	1,785	1,817	1,835
Waitaki	1,924	1,930	1,917	1,941
	29,938	**30,162**	**30,308**	**30,439**

	Feb-21	Apr-21	Jun-21	Aug-21
Alexandra	937	949	945	960
Balclutha	885	893	895	897
Bluff	724	736	743	750
Cromwell	615	612	605	628
Dunedin	8529	8543	8596	8,609
Gore	1210	1229	1248	1,258
Invercargill	8567	8620	8610	8,613
Kirow	182	184	184	180
Lawrence	147	154	155	155
Lumsden	151	158	160	161
Mataura	611	614	613	596
Milton	473	476	480	474
Mosgiel	690	695	707	706
Oamaru	1443	1469	1452	1,470

Otautau	341	350	361	363
Outram	100	98	98	98
Owaka	147	148	148	150
Palmerston	299	277	281	291
Port Chalmers	176	194	196	198
Queenstown	1671	1708	1746	1,782
Ranfurly	168	168	168	170
Riverton	208	208	210	215
Roxburgh	157	164	163	160
Tapanui	186	185	185	179
Te Anau	354	366	385	388
Tuatapere	250	242	244	244
Wanaka	261	261	273	280
Winton	456	461	457	464
	29,938	**30,162**	**30,308**	**30,439**

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

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

23. Pou Whakatere Māori Public Health Role

The Southern DHB has appointed Sarah Martin to the role of Public Health Pou Whakatere that will work with the Service Manager, Chief Māori Health Strategy and Improvement Officer (CMHSIO) and leadership team to drive strategies and initiatives to improve population health outcomes for Southern. The role has an emphasis on improving health equity and outcomes for Māori. It will provide strategic oversight to advances public health action that improves the health and wellbeing of Māori and their whānau across the Southern Health System. The role aims to utilise Te Pae Mahutonga, the principles of the Ottawa Charter, health in all policies frameworks, community development and collaborative partnership approaches. The role will maintain a strategic relationship with the Māori Health Directorate and clearly will need to develop and maintain strategic relationships with Te Runanga o Ngai Tahu, its constituent papatipu Runaka, the Iwi Governance Committee, Māori Health Providers, Aukaha, Te Ao Mārama all of which will support health in all policies and collaborative approaches to address the social, economic and environmental determinants of health. The role will support Public Health with their recruitment strategy and workforce development plan to actively improve cultural safety practices among Public Health and increase Māori workforce within this directorate.

24. Te Whare Tukutuku

The CMHSIO presented on 8 September to the Oraka Ararau zoom hui facilitated by Te Whare Tukutuku in place of the Māori Pre-Cutting Edge National Addiction Conference which was to be held in Dunedin. The session looked at the Health and Disability System

Review and the subsequent health reforms under the Department of the Prime Minister and Cabinet, Transition Unit. It profiled community wellbeing localities and provided some thoughts on the implications of the health system reforms on the addiction treatment sector with a particular focus on Māori.

25. Organisational Development (OD)

Current work by the OD team falls under four focus areas:

Change

- The Change Cycle Workshops started in August with more to follow in September (Leading Others and Accreditation Programme)
- Diversity and Inclusion: more Accessibility Game workshops due in August are now planned for September while LGBTQI+ workshops are still in discussion.
- Te Reo Māori training in collaboration with the Māori Health Directorate – Education Perfect's Te Ao Māori Course (online learning modules to be completed over a 12-month period) has been made available to staff. This was originally piloted with a small group of staff including educators and facilitators across the system. The initial demand has well exceeded the number of spaces available, more funding from the Māori Health Directorate has been made available to support additional places.

Performance

- Small working group led by OD moving forward with implementation of healthLearn as our one learning management system provider. Team meets on a regular basis including this month. Team consists of other educators in the learning and development space including the practice development unit. The date for full transition is end of September.
- Supported graduate nurses (entry to practice programme) with virtual facilitation in support of the courageous conversations and speak up modules.

Leaders

- LEADS program: the team has had to re-arrange a number of face to face workshops (8) that were due to be held in August including Dunedin, Lakes District and Southland Hospitals. These will now be held in late September/early October. Revised dates have also been agreed for continuation of our LEADs programme which started in July.
- The team has been supporting our two new accredited leadership courses, Introduction to Team Leadership (NZ qualifications level three) and First Line Management (NZ qualifications level four). The maximum numbers are set at twenty. There has been significant interest from healthcare partner agencies which we are keen to support.

Wellbeing

- The team has customised and rolled out a virtual workshop on Wellbeing (MHF resource - Working Well) which has the support of clinical educators/facilitators and our Aukaha Kia Kaha Committee.
- Updating the COVID-19 SharePoint this month, adding in more wellbeing resources in particular. This has been well supported by the Communications Team which is also evidenced in the increasing number of visits to the SharePoint site which has more than doubled in the last couple of weeks.

26. Recruitment Challenges

Immigration

Restrictions on Immigration / Border closure challenges include:

- Immigrants needing to come to NZ on a visitor visa, in the hope it can become a work visa on arrival;
- MIQ spots are few and far between;
- Paperwork required to support immigration is becoming a significant job with emergency requests and time sensitive allocations adding to paperwork already required;
- The number of current employees that will require Immigration support with their visa renewals and impending Immigration will significantly increase with the changes pending.
- The pathway to residency will cease to exist in the near future which will present challenges for attraction of key talent into our long term vacancies.

Corporate vacancies

- Impacted by the government pay freeze and the impending Health NZ changes.
- We are seeing candidates pull out, being offered higher salaries elsewhere, and significant decreases in candidate applications.

Nursing / Healthcare assistant recruitment

- Observing a decline in numbers of applications across all vacancies and reduced quality of talent.
- Vacancies are rising, in particular with Care Capacity and Demand Management (CCDM) resource.
- There is a plan to attract a Healthcare assistant cohort.
- All New Graduate nurses on the New Entry to Practice (NETP) programme are employed on a fixed term contract, these nurses are to be offered permanent contracts for retention purposes.

General

Ideas being considered to support the attraction of talent to Southern DHB:

- Develop and implement employee referral programme
- Review relocation policy to include all disciplines (not just senior medical officer and executive team)
- Develop Employer brand across Southern DHB to sell 'our story' in the market.

27. Communications

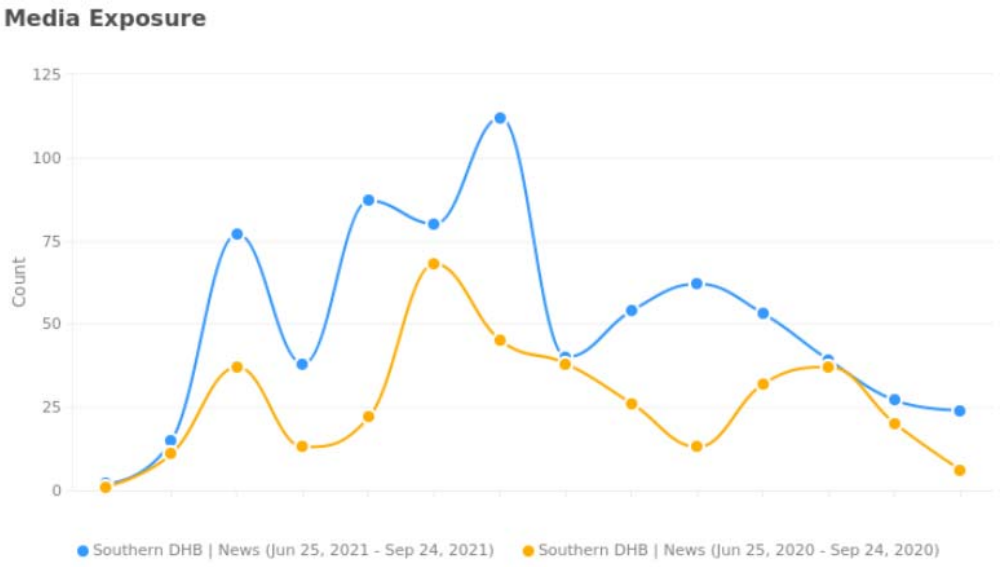
Media volumes have been consistent and busy, exceeding the same period in 2020.

This has been significant driven by the COVID outbreak in Auckland, and our move through alert levels, with implications for our services, public health evaluations of alleged breaches of travel restrictions, the offers of Southern DHB staff to support the Auckland workforce, and interest in the future of managing COVID cases in the Southern district.

The rollout of the COVID vaccine programme remains an intensive area of focus for communications. We are pleased to have been acknowledged for leading the country for first doses, and for Maori, as well as for our efforts in reaching more marginalised communities. Developing communications strategies to support outreach programmes and reach those yet to be vaccinated is a significant focus.

Other areas of media interest and communications activity have included installation of a new computed tomography (CT) scanner, staff shortages particularly relating to nursing and midwifery workforces, and Mental Health Awareness Week.

All of which was eclipsed by social media posts calling for knitting for newborns, generating over 2,500 reactions, a wonderful restocking of supplies in our maternity ward, and even inspiring Richie McCaw to learn to knit.



Chris Fleming
Chief Executive Officer

28 September 2021

Appendices

1. Action Plan from the recommendations in Leena Singh's report

Recommendations from Leena Singh's Report – September 2021

Legend

	Good progress against action.
	Issues exist. Actions may be delayed in schedule
	Issues exist. Action is off critical path.
	Item complete
	Not started

Action Item	Action Required	Action timeframe		Action Owner	Comment
Within Three Months (July – Sept)					
1	All Datasets to be distinguished by Ethnicity and action areas of disparity	~~31 August 2021~~ – complete & ongoing		Chief Māori Health	Specific ethnicity business analyst starts with the reporting team on the 18th of October and work is progressing ensuring all ethnicity data is captured.
2	Realign Executive Portfolios to better focus on the key critical issues of each area. Consider aligning executive portfolios with Canterbury DHB	~~30 July 2021~~ 31/10/2021 Re-baselined given need for additional consultation periods.		Chief Exec	Proposal for change consulted upon in late August / early September. Significant feedback received. Split process into two stages: - Decision document released addressing Strategy, Primary & Community - Further consultation document being released by XXXXX covering the Provider arm structure Considered Canterbury and other South Island structures as a part of consultation process
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	~~31 August 2021~~ Re-baselined in line with the delay on the P&A framework and re-structure. This is a dependent 31/10/2021		ED Specialist Services	See item above. The realignment of the portfolios addresses this issue as well. Director Quality & Clinical Governance Support to be accountable directly to the Clinical Chiefs. The Chair of the Clinical Council and the Director Quality & Clinical Governance Support to review the structure of

Action Item	Action Required	Action timeframe		Action Owner	Comment
	enable improved clinical practice, operational efficiencies and financial payback.				the service to ensure that it aligns with the needs of our organisation
4	Design, implement and embed an accountability and performance framework	31/10/2021		EDCQG ED Corporate Services ED Strategy, Primary & Community PACEO	A draft performance pack has ben developed and our IT team have been working on cleaning the data soeurces and we have engaged some external assistance to fastrack the development of a bespoke dashboard. Awaiting some final quality metrics to finalise the test pack. Aiming to have a first run-through with the operational management team, Exec in the 3rd week of October. The weakness in the framework being proposed is that it did not flow up and down the organisation it stopped at the Executive Director level and nothing was pulled together to support the Chief Executive or report through to the Board and / or governance committees. This is being worked through as the framework must flow up and down throughout the organisation.
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			EDCQG	Clinical risk register now migrated onto safety first and is being worked through the services. This will be integrated into the Performance and Accountability framework. Corporate risks will be developed in the same solution, in the meantime the standalone strategic risk register will continue.
11	Partner financial analysts/management accountants with GMs to ensure robust and documented financial analysis occurs	Complete end Aug 2021		ED Corporate Services	In place
14	Review and revise delegations to align with the accountability framework	September 2021 - Complete		ED Corporate Services	Complete.
21	Establish, communicate and implement recovery plans for FCT and ESPI compliance along with ensuring the additional CT is fully utilised post commissioning			ED Specialist Services	Oncology improvement planning underway in partnership with the Cancer Control Agency. Weekly reporting is occurring and a work plan has been developed.

Action Item	Action Required	Action timeframe		Action Owner	Comment
					Service improvement manager now recruited and will lead the ESPI recovery programme across both sites which builds on the prioritisation tool implementation that has occurred to date. Additional CT now commissioned and recruitment is underway for additional staffing required.
22	Implement recovery plan for orthopaedics	Recovery Plan completed end of August 2021		ED Specialist Services	Orthopaedic cases being completed at Timaru hospital to assist with wait list. Discussions underway to complete higher volumes at Mercy Hospital in Dunedin in partnership with our orthopaedic surgeons to take advantage of additional beds being opened at Mercy (with available budgets). Overall recovery plan being developed for the district which incorporates these initiatives. Will present completed plan once fully quantified but work up these initiatives ahead of this.
25	Revise the AT roster to improve the health and wellbeing of the staff and improve theatre utilisation			ED Specialist Services	Roster revised however difficulties in implementing due to recruitment challenges
Three to Nine Months (October to June)					
5	Establish a clear clinical governance framework, embed discipline around meeting structure, action follow through and focus	September 2021 - complete		Chair of Clinical Council	Clinical Governance Framework developed and presented to the Board at the Sept 7th meeting, by the new Chair Dr David Gow and Hywel Lloyd fully endorsed.
7	Board to set the risk appetite for the organisation and executive to roll out to the organisation and embed into process and system	July 2022		EDCQG	Linked to risk maturity journey that is underway led by the Quality Team.
8	Reconcile budget to activity, identify clinical and cost variation against peer DHBs and assign appropriate costs savings against those areas.	Stage 1 – Sept 2021 to have completed reconciliation Stage 2 – ? – peer		ED Corporate Services	Yet to be commenced

Action Item	Action Required	Action timeframe		Action Owner	Comment
	Implement formal reporting structures to monitor and manage progress Hold Executives and managers responsible for ensuring the achievement of targeted savings	review		CEO	Through performance and accountability framework
12	Look to Canterbury for their costing system and consider expanding it into Southern to assist in understand cost structures	Costing system selected end Oct 2021		ED Corporate Services	Decision previously made to implement the same costing system as Canterbury District Health Board, however during due diligence the stability and quality of the Canterbury implementation is questioned, and the outputs are not utilised. RFP Process now commenced to consider viable options
15	Implement project discipline, require robust reporting around project milestones, financial performance against activity and benefit realisation	Have PM in place by end of August 2021.		PACEO	Establishment of ePMO – underway. Recruitment for Portfolio Manager in flight.
20	Prioritise data driven work practices, including production planning and forecasting	End of July – RFP closes End of August – selection of vendor		ED Specialist Services and ED Corporate Services	Production engineering resource being sourced through RFP currently and internal resource being reviewed also. Forecasting needs to be improved. Review of bed forecasting tools available elsewhere (Auckland) will occur as part of a visit to review their CCDM practice.
24	Appoint an HoD for ICU across both Dunedin and Southland and assign responsibility for improving clinical support and governance of both ICU			ED Specialist Services and Chief Medical Officer	Discussion required with CMO, EDSS and GM Surgery & Radiology. Discussion will be booked for early July and progress update provided once had.
26	Proceed with the planning of an expanded footprint in Southland ED in conjunction with the PHO and GPs around how to improve access outside of the core ED. Planning must include an emphasis on innovative models of care rather than just footprint.			ED Specialist Services	Floorplan developed and benchmarking has now been provided. Developing the overall business case for an August Board Meeting. PHO Programme Director has also been contracted to develop joint programme of work between the PHO and DHB with the aim of reducing presentations which should be attended to in primary care.

Action Item	Action Required	Action timeframe		Action Owner	Comment
	Investigate the possibility of an onsite GP service next to the ED with a combined triage and pathways			ED Strategy, Primary & Community	PHO / Runaka led clinic being established as step 1, second step will be a new Community Health Hub focussed on Urgent Care / VLCA practice
27	Create a strategy and implement around a culture of performance and engagement to improve morale			ED People & Capability	
28	Embed operational, strategic and compliance KPIs in all rural contracts, networking them together where practical			ED Strategy, Primary & Community	To be developed during the 2021/22 year for implementation for the 2022/23 year (from 1 July 2022).
Already in Place or Progressing					
10	*Implement annual asset replenishment targets, adjust frequently to ensure capital expenditure is spent within the financial year. Streamline and delegate the financial process of approval of capital items <$50k to service level*				*This is a part of the capital planning process, and wider Asset Management Plan development* *Process for capital approval contained within the delegations policy*
13	Focus on placing 80% of most commonly used data sets into Power BI, establish a data dictionary and rollout fully to all clinical leaders and service managers	Ongoing		ED Corporate Services	Progressively all data sets are being migrated to Power BI, and there is a data dictionary in place which needs re-socialisation and a process of agreement & embedding.
16	Incorporate the nursing and allied health model of care into the generalism work and roll out an integrated model.	Being implemented in line with the approved business case		ED Specialist Services	Already incorporated into the approved business case, and budgeted for. Nursing and allied components will be implemented to coincide with the completion of the new medical assessment unit.
17	Manage annual leave balances and have them incorporated as core KPI for managers	31 August 2021		ED People & Capability	Leave reporting now in place for all to utilise, roll out of leave management plans underway. Specific KPIs need to be agreed

Action Item	Action Required	Action timeframe		Action Owner	Comment
19	Review all outside of MECA agreements and engage with the relevant services and union to realign pay rates with FTE support			ED Specialist Services / ED Strategy, Primary & Community / Mental Health	Only known arrangements outside MECA are Senior Doctors. Legal process already undertaken and identified that historical personal allowances (circa $1.6 million) are not able to be removed unless individual agreement reached. All additional hours have been turned into FTE and drive now needs to be to ensure each SMO has a timetable which matches their contractual arrangements
23	Take a reflective look on the work performed on the patient flow taskforce group, embed established procedures into BAU and move to focus on the areas of production planning, community based beds/step down facility, frail pathways and stranded patients			Chief Medical Officer, Chief Nursing & Midwifery Officer, and Chief Allied Health, Scientific & Technical Officer	Workshop planned for 7/8 July with senior leaders on each site to establish patient flow work back into BAU. Group already established to look at frail elderly. Group working through the feasibility of interim care beds. Paper presented to exec on additional resourcing for stranded patient team
18	Centralise the management of the RMO unit	31 August 2021		ED Specialist Services	The centralisation of the RMO unit will be incorporated into the proposed position description for the General Manager's Dunedin and Southland Hospitals to align with the changes to the provider arm that are implemented coinciding with the CEO changes to structure.
30	Streamline the procurement approval pathway to Ensure timely decision making and implementation.			ED Corporate Services	
On Hold					
29	Investigate a combined Lakes/Dunstan/Private provider partnership for the lakes district improving access for the community with refined models of care including increased nursing support				Awaiting Strategic Refresh

FOR APPROVAL

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

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

Meeting of: Board Meeting 5 October 2021

Recommendation

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

Purpose

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

High Level Summary

2. **Financial**

The August financial result was affected by the Covid lockdown with the reduced level of surgical planned care being delivered, this has led to a loss of revenue amounting to $3.1m. The revenue has not been recognised as the work may have to be completed from additional sessions or outsourcing which will need to be paid for. This adverse variance may continue for the full financial year but move from adverse revenue to adverse employee or outsourcing costs. This resulted in the month of August being a deficit of $4.3m against a budget of $2.4m, if we did not have the lock down we would have had a positive result against budget.

We have raised the issue of lost revenue associated with the deferred planned care with the Ministry of Health and are awaiting a position from them. In 2020 lockdown the DHBs were enabled to recognise the revenue associated with this deferred work. If this occurs again then financial performance to date will retrospectively improve.

Cash flow

While the closing cash balance is positive to budget, this is primarily driven by the timing difference in the balance sheet, and the capital cash flow being below budget. A full analysis of both the capital plan and the cash flow will be included in the Nov 2021 FARC meeting.

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 August 2021
Report Prepared by:	Finance
Date:	14 September 2021

Report to Board

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

The net deficit for the month of 31 August 2021 was $4.3m, being $1.9m unfavourable to budget.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 August 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						
105,041	102,797	2,244	F	Government & Crown Agency	209,781	205,889	3,892	F	1,187,928	1,233,735
1,154	847	307	F	Non-Government & Crown Agency	1,994	1,695	299	F	12,489	10,168
106,195	103,644	2,551	F	*Total Revenue*	211,775	207,584	4,191	F	1,200,417	1,243,903
				EXPENSES						
41,917	41,295	(622)	U	Workforce Costs	82,173	81,794	(379)	U	481,291	502,352
3,957	3,939	(18)	U	Outsourced Services	8,097	7,890	(207)	U	47,821	46,095
9,183	9,491	308	F	Clinical Supplies	18,717	18,915	198	F	111,249	107,947
5,799	5,514	(285)	U	Infrastructure & Non-Clinical Supplies	11,334	11,017	(317)	U	62,476	64,767
46,503	42,725	(3,778)	U	Provider Payments	89,932	85,403	(4,529)	U	489,958	506,799
3,172	3,145	(27)	U	Non-Operating Expenses	6,328	6,254	(74)	U	37,059	40,249
110,531	106,109	(4,422)	U	*Total Expenses*	216,581	211,273	(5,308)	U	1,229,854	1,268,209
(4,336)	(2,465)	(1,871)	U	**NET SURPLUS / (DEFICIT)**	(4,806)	(3,689)	(1,117)	U	(29,437)	(24,306)

Revenue was $2.6m favourable to budget.

The main drivers of the Government Funding variance of $2.2m are COVID-19 Surveillance & Testing funding $2.2m higher than budgeted and unbudgeted revenue for COVID-19 Vaccination Programme $3.2m. This is offset by a reduction of $3.1m related to under-delivery of Planned Care procedures resulting from preparing for the Nurses strike and reduced activity in Lockdown Level 4.

In addition, Pharmac have advised that nationally, only $14m has been identified by Pharmac as pharmaceutical expenditure related to COVID-19 for 2021/22. In light of this, the MoH has reduced

Population Based Funding by $76m for the 2021/22 year and Southern DHB's share is $5.2m. We have recognised a net revenue reduction of $0.9m YTD in August 2021.

Expenses were $4.4m unfavourable to budget.

The Workforce costs were $0.6m unfavourable including $1.1m unbudgeted Vaccination programme costs.

Medical personnel incurred increased costs due to vacancies cover while Nursing and Management/Admin personnel were also unfavourable as a result of the unbudgeted Vaccination programme.

Clinical Supplies were $0.3m favourable, due in part to reduced activity during Lockdown Level 4. Implants and Prostheses were $0.4m favourable, offset in part by Air Ambulance at $0.2m unfavourable with 46 missions in the month.

Provider Payments were $3.8m unfavourable, reflecting unbudgeted Mental Health expenditure and COVID-19 Vaccination expenses (both offset by additional revenue).

Monthly Result – By Key Drivers

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

SOUTHERN DISTRICT HEALTH BOARD
Summary of Monthly Results - By Key Drivers
For the month of Aug 2021

	Month Actual Total $000	Month COVID-19 Vaccination $000	Month COVID-19 Resurgance $000	Month Transtasman Border $000	Month BAU $000	Month Budget Total $000	Month BAU Variance $000		Month Actual COVID-19 Testing $000	Month Budget COVID-19 Testing $000	Month Variance $000	
REVENUE												
Government & Crown Agency	105,041	3,299	178	42	99,359	102,297	(2,938)	U	2,163	500	1,663	F
Non-Government & Crown Agency	1,154	-	-	-	1,154	847	307	F	-	-	-	
Total Revenue	106,195	3,299	178	42	100,513	103,144	(2,631)	U	2,163	500	1,663	
EXPENSES												
Workforce Costs	41,917	1,101	138	42	40,636	41,295	659	F	-	-	-	
Outsourced Services	3,957	107	-	-	3,850	3,939	89	F	-	-	-	
Clinical Supplies	9,183	12	-	-	9,171	9,491	320	F	-	-	-	
Infrastructure & Non-Clinical Supplies	5,799	181	4	-	5,614	5,514	(100)	U	-	-	-	
Provider Payments	46,503	1,896	-	-	42,444	42,225	(219)	U	2,163	500	(1,663)	U
Non-Operating Expenses	3,172	-	-	-	3,172	3,145	(27)	U	-	-	-	
Total Expenses	110,531	3,297	142	42	104,887	105,609	722	F	2,163	500	(1,663)	
NET SURPLUS / (DEFICIT)	(4,336)	2	36	-	(4,374)	(2,465)	(1,909)	U	-	-	-	

While COVID-19 Surveillance & Testing activity was budgeted for the 2021/22 financial year, Incremental, Vaccination and Trans-Tasman service provision were not.

Financial Position Summary

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

Actual 30 June 2021 $000		Actual 31 August 2021 $000	Budget 31 August 2021 $000	Actual 31 July 2021 $000	Budget 30 June 2022 $000
	CURRENT ASSETS				
7,582	Cash & Cash Equivalents	23,028	869	27,666	7
62,935	Trade & Other Receivables	63,614	57,578	57,156	48,474
6,159	Inventories	6,101	5,569	6,525	5,235
76,676	*Total Current Assets*	92,743	64,016	91,347	53,716
	NON-CURRENT ASSETS				
325,558	Property, Plant & Equipment	322,063	327,991	324,588	362,457
6,258	Intangible Assets	7,629	7,436	6,072	20,704
331,816	*Total Non-Current Assets*	329,692	335,427	330,660	383,161
408,492	**TOTAL ASSETS**	422,435	399,443	422,007	436,877
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	-	-	33,663
72,840	Payables & Deferred Revenue	84,244	66,065	83,306	69,492
235	Short Term Borrowings	171	169	170	1,979
82,596	Holidays Act 2003	83,707	83,854	83,212	90,146
95,374	Employee Entitlements	101,692	91,221	98,287	88,211
251,045	*Total Current Liabilities*	269,814	241,309	264,975	283,491
	NON-CURRENT LIABILITIES				
856	Term Borrowings	838	856	912	10,754
19,411	Employee Entitlements	19,409	20,144	19,411	20,144
20,267	*Total Non-Current Liabilities*	20,247	21,000	20,323	30,898
271,312	**TOTAL LIABILITIES**	290,061	262,309	285,298	314,389
137,180	**NET ASSETS**	132,374	137,134	136,709	122,488
	EQUITY				
486,579	Contributed Capital	486,579	489,193	486,581	495,164
108,500	Property Revaluation Reserves	108,500	108,500	108,500	108,500
(457,899)	Accumulated Surplus/(Deficit)	(462,705)	(460,559)	(458,372)	(481,176)
137,180	*Total Equity*	132,374	137,134	136,709	122,488
	Statement of Changes in Equity				
165,991	Opening Balance	137,180	138,188	137,180	138,189
(29,437)	Operating Surplus/(Deficit)	(4,806)	(3,689)	(471)	(24,307)
1,333	Crown Capital Contributions	-	2,635	-	9,313
(707)	Return of Capital	-	-	-	(707)
137,180	Closing Balance	132,374	137,134	136,709	122,488

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 August 2022

	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	207,868	206,884	984	1,240,738	189,863
Non-Government & Crown Agency Revenue	1,936	1,639	297	9,832	1,388
Interest Received	58	56	2	336	48
Cash was applied to:					
Payments to Suppliers	(119,910)	(120,340)	430	(719,719)	(122,915)
Payments to Employees	(71,094)	(86,633)	15,539	(498,453)	(75,240)
Capital Charge	-	-	-	(7,142)	-
Goods & Services Tax (net)	(256)	(2,210)	1,954	(2,604)	(257)
Net Cash Inflow / (Outflow) from Operations	18,602	(604)	19,206	22,988	(7,113)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	-	-	-	-	-
Cash was applied to:					
Capital Expenditure	(3,073)	(8,678)	5,605	(71,902)	(2,672)
Net Cash Inflow / (Outflow) from Investing Activity	(3,073)	(8,678)	5,605	(71,902)	(2,672)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	-	2,635	(2,635)	8,556	-
Cash was applied to:					
Repayment of Borrowings	(83)	(66)	(17)	(879)	(231)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	(83)	2,569	(2,652)	7,677	(231)
Total Increase / (Decrease) in Cash	15,446	(6,713)	22,159	(41,237)	(10,016)
Net Opening Cash & Cash Equivalents	7,582	7,582	0	7,582	31,011
Net Closing Cash & Cash Equivalents	23,028	869	22,159	(33,655)	20,995

Overall cash on hand is higher reflecting the delay in planned capital expenditure and payment of employee entitlements (i.e., Annual Leave).

The timing delay of capital works has also impacted on the drawdown of funding, highlighted by the unfavourable variance in the Cash flow of financing activities.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 31 August 2021

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	1,077	2,985	1,908	U	1,256
Clinical Equipment	1,154	3,732	2,578	U	1,742
Other Equipment	39	145	106	U	110
Information Technology	623	292	(331)	O	548
Motor Vehicles	-	-	-	O	-
Software	180	1,525	1,345	U	647
Total Expenditure	3,073	8,679	5,606	U	4,303

At 31 August 2021, our Financial Position on page 4 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $329.7m, which is $5.7m less than the budget of $335.4m.

The Board endorsed the 2021/22 capital plan on 3 August 2022. The cashflow also reflects the delay in invoicing for a number of large capital projects. These include Clinical Equipment (IV Volumetric Pumps, CT Scanner and Dunedin X-Ray), Buildings & Plant (Security Access/Control and Queen Mary) and Software (SI PICs).

Financial Audit 2020/21 Accounts

Audit NZ have advised that there is a potential delay in providing Audit clearance of our accounts due to issues outside the control of both SDHB and the Audit NZ audit team working on the SDHB accounts.

These delays are caused by Covid delta with resources in other entities that provide information being diverted. Audit NZ intends to complete the fieldwork locally, and the delay affects the clearance of the opinion of our accounts. The statutory deadline was extended to Dec 31 and Audit NZ still intends to work to meet this deadline.

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

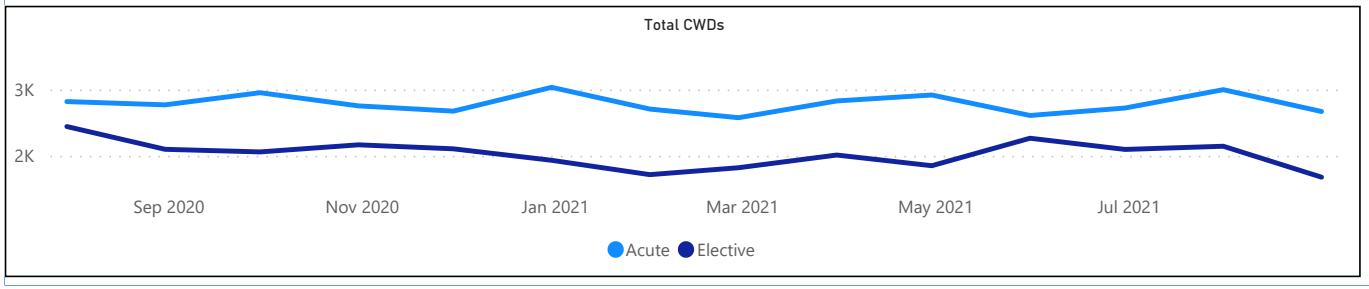
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year On Year YTD Variance
Surgical Caseweights												
Surgical Elective	967	1,507	-540	-36	1,396	-428	2,352	2,929	-577	-20	3,050	-698
Surgical Acute	1,109	1,325	-216	-16	1,254	-145	2,352	2,520	-169	-7	2,396	-44
Total	**2,077**	**2,832**	**-755**	**-27**	**2,649**	**-573**	**4,704**	**5,450**	**-746**	**-14**	**5,446**	**-742**
Medical Caseweights												
Medical Elective	280	319	-39	-12	352	-72	681	620	61	10	724	-43
Medical Acute	1,468	1,585	-117	-7	1,408	60	3,070	3,088	-18	-1	2,987	83
Total	**1,748**	**1,904**	**-156**	**-8**	**1,761**	**-13**	**3,751**	**3,708**	**43**	**1**	**3,711**	**40**
Maternity Caseweights												
Maternity Elective	430	389	40	10	350	80	788	760	28	4	765	23
Maternity Acute	92	99	-7	-7	107	-15	245	192	53	27	205	40
Total	**521**	**488**	**33**	**7**	**457**	**65**	**1,033**	**953**	**80**	**8**	**970**	**63**
Total	**4,346**	**5,224**	**-878**	**-17**	**4,867**	**-521**	**9,487**	**10,111**	**-623**	**-6**	**10,126**	**-639**

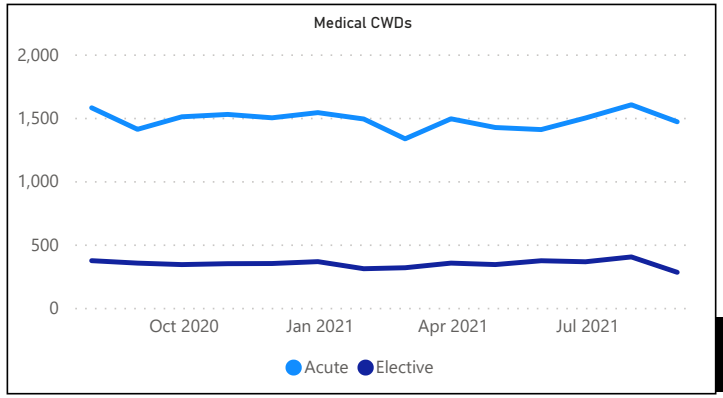
TOTALS

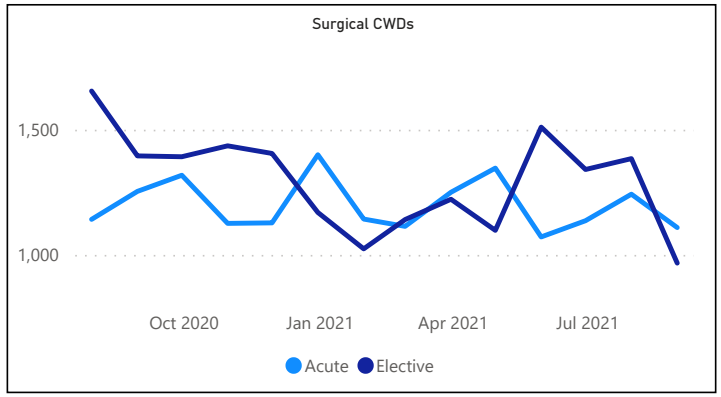
Acute	2,669	3,008	-339	-11	2,769	-100	5,667	5,801	-134	-2	5,587	79
Elective	1,677	2,216	-539	-24	2,098	-421	3,821	4,310	-489	-11	4,539	-718
Total	**4,346**	**5,224**	**-878**	**-17**	**4,867**	**-521**	**9,487**	**10,111**	**-623**	**-6**	**10,126**	**-639**

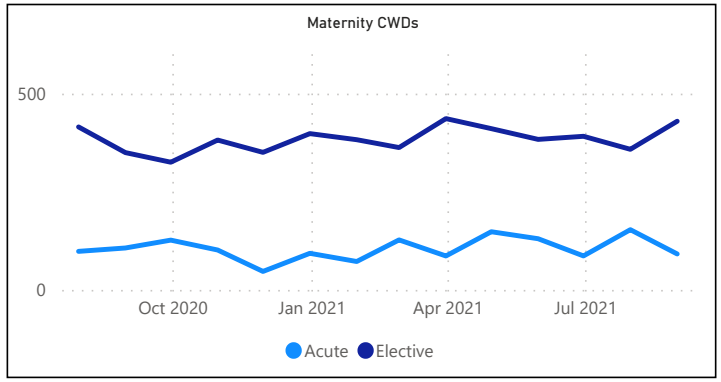
TOTALS excluding Maternity

Acute	2,577	2,909	-332	-11	2,662	-85	5,422	5,608	-187	-3	5,382	39
Elective	1,247	1,826	-579	-32	1,748	-501	3,033	3,550	-516	-15	3,774	-741
Total	**3,824**	**4,736**	**-911**	**-19**	**4,410**	**-586**	**8,455**	**9,158**	**-703**	**-8**	**9,157**	**-702**









SERVICE PROVIDER RAW DISCHARGES

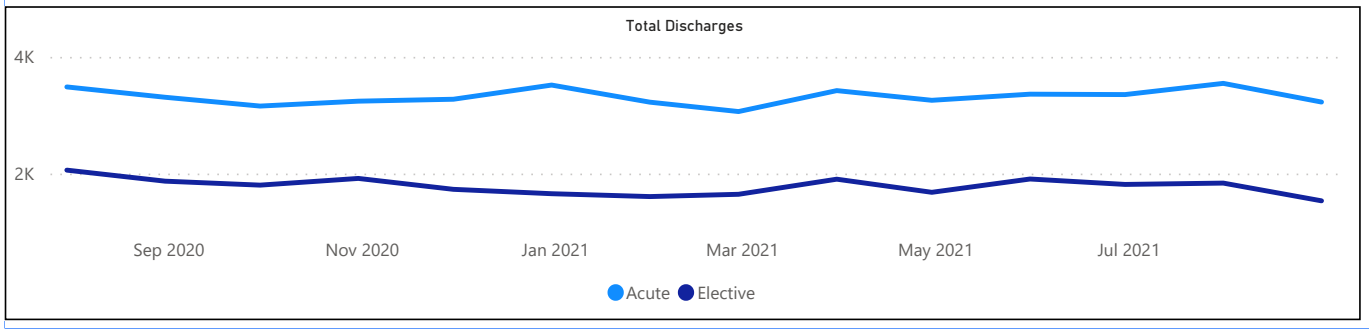
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Surgical Discharges												
Surgical Elective	631	1,056	-425	-40	946	-315	1,529	2,053	-524	-26	2,129	-600
Surgical Acute	744	859	-115	-13	854	-110	1,526	1,635	-109	-7	1,663	-137
Total	**1,375**	**1,915**	**-540**	**-28**	**1,800**	**-425**	**3,055**	**3,688**	**-633**	**-17**	**3,792**	**-737**
Medical Discharges												
Medical Elective	345	369	-24	-6	410	-65	788	717	71	10	799	-11
Medical Acute	2,381	2,536	-155	-6	2,342	39	5,035	4,947	88	2	4,912	123
Total	**2,726**	**2,905**	**-179**	**-6**	**2,752**	**-26**	**5,823**	**5,663**	**160**	**3**	**5,711**	**112**
Maternity Discharges												
Maternity Elective	557	521	36	7	514	43	1,053	1,017	36	4	1,001	52
Maternity Acute	101	88	13	15	112	-11	211	172	39	23	218	-7
Total	**658**	**609**	**49**	**8**	**626**	**32**	**1,264**	**1,189**	**75**	**6**	**1,219**	**45**
Total	**4,759**	**5,428**	**-669**	**-12**	**5,178**	**-419**	**10,142**	**10,541**	**-399**	**-4**	**10,722**	**-580**

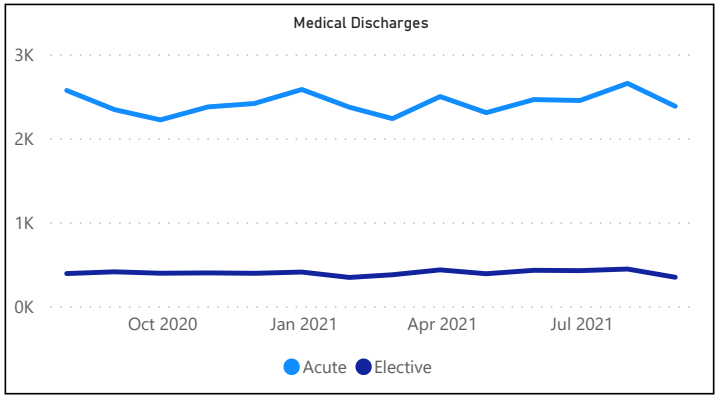
TOTALS

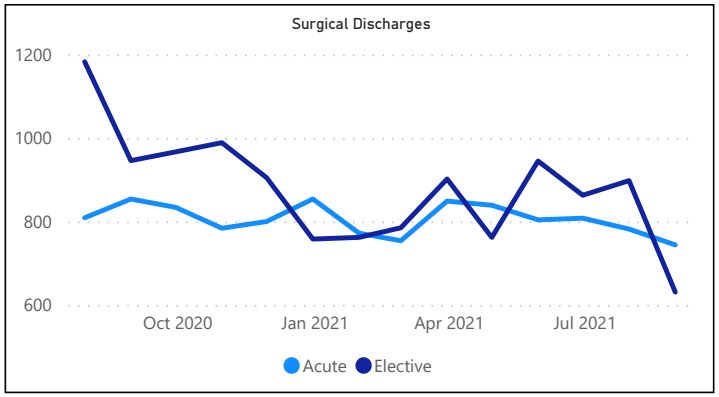
Acute	3,226	3,482	-256	-7	3,308	-82	6,772	6,753	19	0	6,793	-21
Elective	1,533	1,946	-413	-21	1,870	-337	3,370	3,787	-417	-11	3,929	-559
Total	**4.759**	**5.428**	**-669**	**-12**	**5.178**	**-419**	**10.142**	**10.541**	**-399**	**-4**	**10.722**	**-580**

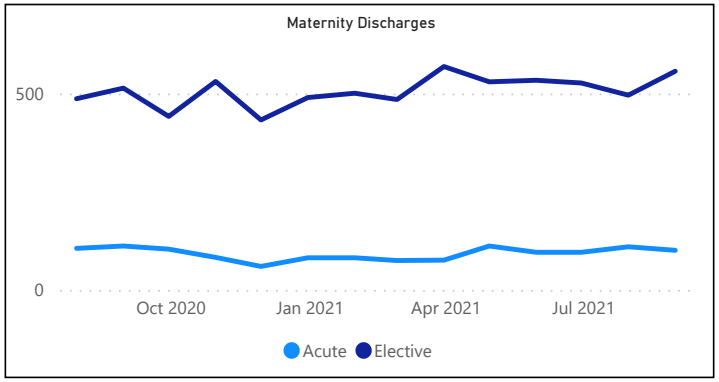
TOTALS excluding Maternity

Acute	3,125	3,394	-269	-8	3,196	-71	6,561	6,582	-21	0	6,575	-14
Elective	976	1,425	-449	-32	1,356	-380	2,317	2,770	-453	-16	2,928	-611
Total	**4,101**	**4,819**	**-718**	**-15**	**4,552**	**-451**	**8,878**	**9,352**	**-474**	**-5**	**9,503**	**-625**



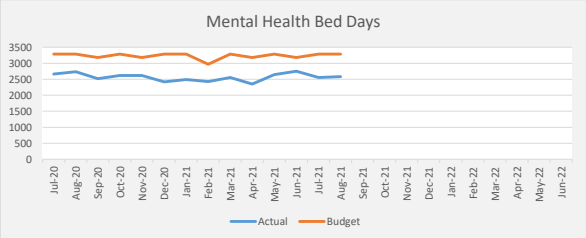




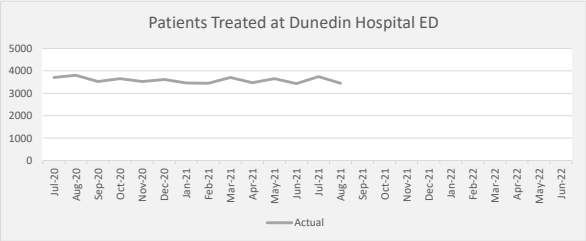


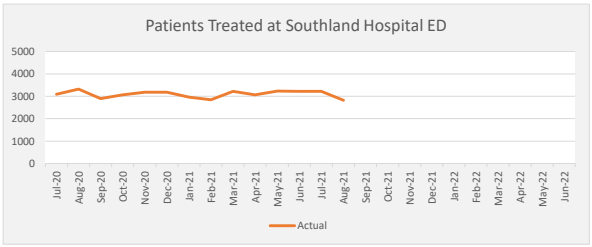
OTHER ACTIVITY

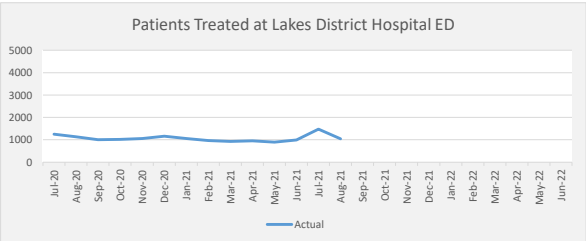
Aug-21				Aug-20	YEAR ON YEAR		YTD 2021/2022				YTD Aug-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,580	3,286	(706)	-21%	2,731	(151)	Mental Health bed days	5,138	6,572	(1,434)	-22%	5,393	(255)

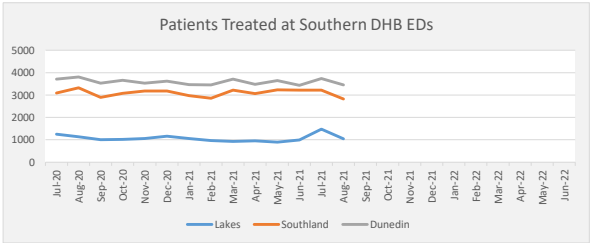


Aug-21	Aug-20	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2021/2022	YTD Aug-20	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,446	3,806	(360)	Dunedin	7,187	7,510	(323)
1,045	1,139	(94)	Lakes	2,522	2,386	136
2,823	3,322	(499)	Southland	6,040	6,410	(370)
7,314	8,267	(953)	**Total ED presentations**	15,749	16,306	(557)









FOR INFORMATION

Item: July 2021 internal elective volumes compared to July 2020

Proposed by: Patrick Ng, Executive Director, Specialist Services

Meeting of: 05 October 2021

Recommendation

It is recommended that the Board notes the key reasons for volume variances between July 2021 and July 2020.

Summary

Dunedin Case Weight Discharges (CWD) for Elective Surgery, Acute Surgery and Medical Inpatients were down by -1.3% in 2021 and this was also reflected in inpatient bed nights used, which were down by -2.1%. Surgery (elective and acute surgery) was also down by -2.1% whilst surgical minutes were down by -8%, suggesting that we delivered more CWD for the theatre minutes we used in July 2021. Overall, underlying internal CWD delivery was similar in July 2021 to July 2020 but we could have delivered +104 CWD more surgery if we had used the same theatre minutes in 2021 that we used in 2020.

Southland Case Weight Discharges (CWD) for Elective Surgery, Acute Surgery and Medical Inpatients were up by +1.3% in 2021. Inpatient bed nights had -0.6% growth once medical inpatient CWD growth was accounted for. Surgery (elective and acute surgery) was down by 5.5% whilst surgical minutes were down by +5.4% which is directionally similar. However, there was a high level of overall substitution in Southland, with -107 CWD of elective surgery lost but more than offset by increased acute surgery and medical inpatient CWD. Overall, high acute and medical demands directly impacted on Southland's elective surgical performance when July 2021 is compared to July 2020. In Southland we could have delivered +32 CWD more surgery if we had used the same theatre minutes that we used across elective and acute surgery in July 2020.

Purpose

1. To clarify what drove performance in each year so that a valid comparison can be made between July volumes delivered in 2021 compared to July 2020.

Background

On face value the elective case weight delivery (CWD) was higher in July 2020 than what was achieved in July 2021 and a piece of analysis work has been undertaken to explain the key differences between the two July months.

This report has focused on comparing internally delivered volumes (elective surgery, medical case weights and acute surgery). Outsourced surgery was higher last year than this year, primarily in Dunedin, as last year we sought to catch up from the COVID lockdown and we maximised what we could get done before the private hospitals filled their lists back up. To improve the comparability of the two years we have focused on the change in internal elective delivery by backing out the impact of the additional outsourcing work which was completed in 2020.

Other differences between the two July months include there being an extra working day in July 2020 and additional catchup lists being run in the weekends in July 2020.

Dunedin Explanation:

Internal elective case weight delivery was -50 CWD this year compared to last year. The explanations are captured in the following bridge.

Bridge (elective internal):		
a Weekend Lists in 2020	-15	-1%
b 1 Less Working Day 2021	-41	-3%
c Unexpected Loss OT 6	-30	-2%
d Other	36	2%
	-50	-3%

a) Weekend lists completed in July 2020 explained -15 CWD of difference between years.

b) An additional working day in July 2020 explained an additional -41 CWD.

c) In July 2021 operating theatre 6 was out of commission for a week which had a -30 CWD impact.

There is a further +36 CWD that we aren't able to explain between the years (d).

However, total CWD across elective surgery, acute surgery and medical inpatients was -44 CWD on total volume of 3,428 CWD, translating into a 1.3% reduction in CWD volume overall. This is due to combined acute surgical and medical CWD increasing slightly (6 CWD) year on year.

We then cross referenced this to the theatre minutes that were used in July 2021 and July 2020, and we have also cross referenced this to the inpatient bed days used in both years.

In terms of the elective theatre minutes used, there is an overall reduction in theatre minutes used in July 2021 compared to July 2020 of -8.0% across elective and acute surgery.

In comparison, elective surgery and acute surgery were down a total of -43 CWD on 2020 volumes of 2,046 CWD, indicating a CWD deterioration of -2.1%. This suggests that we delivered more surgery for our theatre minutes in 2021 compared to 2020, which is both a slight productivity gain, but also an opportunity cost as we would have delivered more surgery if we had used the same theatre minutes that we used last year. The opportunity cost translates into +104 CWD of additional activity that could have been delivered if we had used the same number of theatre minutes as we used last year.

In cross referencing to the inpatient bed nights used, we found that once we had accounted for the extra medical inpatient stay case weights, there was an underlying reduction in bed nights used of -147 bed nights. On 2020 volumes of 7007 bed nights this translates into a reduction in bed nights used of -2.1%.

Overall conclusions for Dunedin:

Overall, on a CWD basis there is a -1.3% productivity loss compared to 2020 across elective surgery, acute surgery and medical inpatient case weights, including known differences which are accounted for in the bridge included in this analysis. There is also a reduction of inpatient bed nights of -2.1%, which is directionally consistent. However, the elective and acute CWD were -2.1% less in July 2021 compared to July 2020, whilst the theatre minutes used were -8.0% less July 2021 compared to July 2020.

This leads us to conclude that underlying productivity across elective surgery, medical case weights and acute surgery was marginally lower in 2021 than in 2020 once the key differences explained in the bridge are taken into account, but CWD delivered for the theatre minutes used was actually slightly higher in 2021 than in 2020. There is an opportunity cost, as if we had used the same theatre minutes that we used in July 2020, we would have delivered a further +104 CWD of activity.

Once key differences are explained, internal CWD productivity is very comparable between July 2021 and July 2020, but we do need to note the opportunity cost of the theatre minutes not used compared to July 2020.

The differences noted above are shown in the following table.

Dunedin 2021 July Internal Volume Delivery Compared to Dunedin 2020

	Elective Surgical	Elective Medical	Total Elective Delivery (CWD Actual)	Acute Surgical	Non-Elective Medical	Total Non-Elective (CWD)	Total Activity CWD
CWD July 2020	1,217	332	**1,548**	829	1,051	**1,880**	**3,428**
CWD July 2021	1,066	356	**1,422**	861	1,025	**1,886**	**3,308**
	-151	25	**-126**	32	-26	**6**	**-120**
Outsource Change	76		**76**				**76**
Net Intenal Delivery Change	**-75**	**25**	**-50**	**32**	**-26**	**6**	**-44**

Bridge (elective internal):

a	Weekend Lists in 2020	-15	-1%
b	1 Less Working Day 2021	-41	-3%
c	Unexpected Loss OT 6	-30	-2%
d	Other	36	2%
		-50	-3%

Differences 2021 to 2020 (elective)	**-50**
Difference 2021 to 2020 acute	**6**
Total Variance for all Case Weight Discharge Activity (2021 compared to 2020)	**-44**
Overall Productivity Change 20201 to 2020 in CWD:	**-1%**

Cross Refence 1:

Elective Theatre Minutes 2021	71,603		
Elective Theatre Minutes 2020	81,316		
Change in Theatre Minutes:	-9,713		
Percentage Change:	-12%		
Bridged Elective Productivity (-75 CWD X 70 minutes)	-5,700	(Explained elective surgical minutes lost).	
Residual Productivity Gain / Opportunity Cost	-4,013	-5%	(Residual surgical minutes lost).
Opportunity Cost in Lost CWDs	**-54**		

Acute Theatre Minutes 2021	53,347	
Acute Theatre Minutes 2020	54,561	
Additional Acute Theatre Minutes:	-1,214	
Percentage Change:	-2%	
Bridged Acute Productivity (32 CWD x 65 minutes)	2,080	
Residual Productivity Gain / Opportunity Cost	- 3,294	
Opportunity Cost in Lost CWDs	- **47**	

Total Residual Productivity Gain / Opportunity Cost (in minutes)	-	**7,307**
Overall reduction in surgical minutes used (elective and acute) 2021 compared to 2020		**-8%**
Total Lost CWDs Due To Productivity Reduction	-	**104**

Cross Reference 2:

Total Inpatient Bed Nights 2020	7,007
Total Inpatient Bed Nights 2021	6,856
Change in Inpatient Bed Nights	-151
Percentage Change:	-2%
Change in Bed Nights Associated with Medical CWD (4 days ALOS X -1 CWD):	-4
Change in Bed Nights net of Medical Case Weight Change:	-147
Net Change in Inpatient Bed Nights July 2021 to July 2020 (elective & acute surgery):	**-2%**
Note: Outsourcing volumes were lower in 2021 than in 2020	*-76*

Southland Explanation:

There is, however, a more significant elective productivity loss in Southland, primarily due to higher medical and acute CWD activity leading to reduced elective CWD activity.

Internal elective case weight delivery was -107 CWD this year compared to last year. Compared to last years' volumes of 478 CWD this translates into a -22.4% reduction in activity. Acute and Medical CWD volumes were +120 more than last year and on last years' volumes of 840 this is a +14.2% increase. This translates into a total CWD variance across elective surgery, medical case weights and acute surgery of +12 CWD on volumes of 1,319, which is an overall increase of activity of +0.9%.

In terms of the reduction in underlying internal elective activity in 2021 compared to 2020, it is explained by the following bridge.

a Weekend Lists in 2020	-8	-2%
b 1 Less Working Day 2021	-12	-3%
c Other (note - primarily explained by acute and medical)	-87	-18%
	-107	-22%

a) Weekend lists completed in July 2020 explained 8 CWD of difference between years.

b) An additional working day in July 2020 explained an additional 12 CWD.

Whilst there was a deterioration of -107 CWD for elective surgery in 2021 compared to 2020, there was an increase in acute surgery and medical inpatient, which led to an overall CWD increase in July 2021 compared to July 2020 of +12 CWD. This indicates that the lost elective surgery CWD were (slightly) more than offset by other additional activity in acute surgery and medical inpatient CWD.

We then cross referenced this to the theatre minutes that were used in July 2021 and July 2020, and we have also cross referenced this to the inpatient bed days used in both years.

The overall movement on theatre minutes (elective and acute) was -2,502 minutes on 2020 volumes of 46,224 minutes, representing a -5.4% reduction in minutes used. Elective and acute surgery CWD were down -41. On July 2020 volumes of 751 CWD this represents a reduction of -5.5%. For Southland the reduction in surgical CWD therefore appears well aligned to the reduction in theatre minutes that were used.

In cross referencing to the inpatient bed nights used, we found that 2,613 bed nights were used in July 2020 and 2,757 bed nights were used in July 2021. This translated into a +5.5% increase in bed nights used year on year. However, after accounting for additional medical inpatient CWD delivered in July 2021 compared to July 2020 we find that there is a -0.5% change in bed use year on year.

Overall conclusions for Southland:

Overall, on a CWD basis there is a +0.9% productivity **gain** compared to 2020 across elective surgery, acute surgery and medical inpatient case weights, including accounting for known differences in July 2021 compared to July 2020. There is a -0.6% change to inpatient bed nights used once the additional inpatient medical CWD is accounted for. The elective and acute surgical CWD were -5.5% less in July 2021 than in July 2020, and this is consistent with the -5.4% reduction in theatre minutes in July 2021 compared to July 2020.

This leads us to conclude that underlying CWD productivity across elective surgery, medical case weights and acute surgery was marginally higher in 2021 than in 2020, particularly once key differences explained in the bridge are taken into account. There is also an opportunity cost, as if

we had used the same theatre minutes that we used in July 2020, we would have delivered a further +32 CWD of activity.

However, the key observation for Southland is that acute CWD and medical inpatient CWD (driven by demand) were substituted for elective CWD, leading to lost elective CWD of -107 CWD when July 2021 is compared to July 2020.

Southland 2021 July Internal Volume Delivery Compared to Dunedin 2020

	Elective Surgical	Elective Medical	**Total Elective Delivery (CWD Actual)**	Acute Surgical	Non-Elective Medical	Total Non-Elective (CWD)	**Total Activity CWD**
CWD July 2020	438	40	**478**	313	528	**840**	**1,319**
CWD July 2021	321	45	**366**	384	576	**960**	**1,326**
	-117	4	**-112**	71	49	**120**	**8**
Outsource Change	5		**5**				**5**
Net Intenal Delivery Change	-112	4	**-107**	71	49	**120**	**12**

Bridge (elective):

a	Weekend Lists in 2020	-8	-2%
b	1 Less Working Day 2021	-12	-3%
c	Other (note - primarily explained by acute)	-87	-18%
		-107	-22%

Differences 2021 to 2020 (elective)	**-107**
Difference 2021 to 2020 (non-elective)	**120**
Total Variance for all Case Weight Discharge Activity (2021 compared to 2020)	**12**
Overall Productivity Change 20201 to 2020:	**1%**

Cross Refence 1:

Elective Theatre Minutes 2021	17,956		
Elective Theatre Minutes 2020	25,877		
Change in Theatre Minutes:	-7,921		
Percentage Change:	-31%		
Elective Productivity Bridge (112 CWD X 60 minutes)	-6,720	(Explained elective surgical minutes lost).	
Residual Productivity Gain / Opportunity Cost	-1,201	-5%	(Residual surgical minutes lost).
Opportunity Cost in Lost CWDs	**-20**		

Acute Theatre Minutes 2021	25,766	
Acute Theatre Minutes 2020	20,347	
Change in Theatre Minutes:	5,419	
Percentage Change:	27%	
Bridged Acute Productivity Bridge (71 CWD x 65 minutes)	4,615	
Residual Productivity Loss / Opportunity Cost	804	
Opportunity Cost in Lost CWDs	**12**	

Total Residual Productivity Gain / Opportunity Cost (in minutes)	-	**397**
Overall reduction in surgical minutes used (elective and acute) 2021 compared to 2020		**-5%**
Total Lost CWDs Due To Productivity Reduction	-	**32**

Cross Reference 2:

Total Inpatient Bed Nights 2020	2,613
Total Inpatient Bed Nights 2021	2,757
Change in Inpatient Bed Nights	144
Percentage Change:	6%
Change in Bed Nights Associated with Medical CWD (3 days ALOS X 53 additional CWD):	159
Change in Bed Nights net of Medical Case Weight Change:	-15
Net Change in Inpatient Bed Nights July 2021 to July 2020 (elective & acute surgery):	**-1%**
Plus Productivity Change in Outsourcing:	-5

Recommendation

It is recommended that the Board notes that:

Underlying internal elective delivery was broadly comparable between July 2021 and July 2020 for Dunedin once known differences (per the bridge in the analysis) are taken into account. However, we have delivered slightly more CWD for the theatre minutes that were used than we did in 2020 and there is an opportunity cost – if we had used the same theatre minutes as we did in 2020, we could have delivered an additional +107 CWD across elective and acute surgery.

Underlying internal elective delivery was significantly lower (-107 CWD) in July 2021 compared to July 2020 for Southland. However, there is a direct substitution of both acute surgery CWD and medical inpatient CWD taking up what would otherwise have been elective surgical CWD resources (theatres and beds). I.e., acute and medical demands directly impacted on Southland elective surgical performance when July 2021 is compared to July 2020.

FOR INFORMATION

Item: Quality Dashboard – August 2021

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

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – October 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
   - A focus on equity is currently being prioritised, as a change in the graphs require IT resource to complete
4. Other
   - Please note comments in the discussion section

Background

5. The Executive Quality Dashboard was created in 2019. It presents key metrics for the Southern region across the dimensions of effectiveness, patient experience, efficiency, and timeliness. It is intended to highlight clinical quality risks, issues and performance at a system wide level.
6. The dashboard elements has been transitioned into Power BI and is widely available to staff via the PowerBi reporting platform. There are still some design features that require fine tuning and consistency such as axis naming conventions, easy to read axis and some other individual features. The IT reporting team are working on this and expect improvements to be noted each month.
7. Changes to dashboards and/or creation of new indicators or charts take one full time IT/reporting analyst two weeks to complete. To help the IT/reporting team prioritise the most important work requests, the ED Quality and Clinical Governance Solutions has established a weekly prioritisation meeting. The team are finding this very helpful to date.
8. Please note: Southern includes hospitals in the Southern Region. Dunedin relates to Dunedin Public Hospital. Wakari is included in the Southern Region reporting. Unless otherwise stated any definitions in the commentary for Southern apply to Dunedin and Invercargill

Discussion

9. Complaints remain at high levels with little change in the last few months. The covid vaccination clinics and communications around appointments are part of reason for the higher-than-normal volume of complaints.

10. The drop-in hours for planned and actual theatre utilisation were a result of the Covid level 4 lockdown. As expected, the drop was not as marked when compared to the 2020 first wave lockdown. There was also an increase in theatre short notice postponements. This is a feature for Dunedin hospital. This was also seen in the first wave lockdown. But there was also an increase in July. A contributing factor is the high demand for acute theatre hours and increase in the numbers of booked cases.

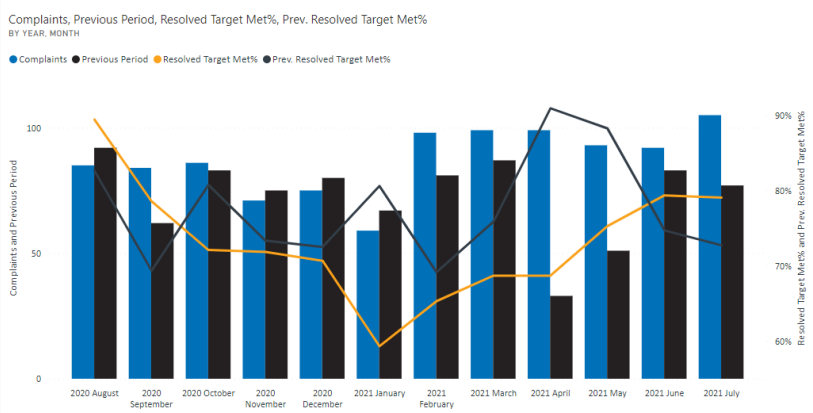
Next Steps & Actions

The quality of the graph images and text is an issue we are working to address. The creation of the Quality Dashboard is a manual time-consuming process. The capturing and pasting together of the report result in a loss of resolution.

Appendices

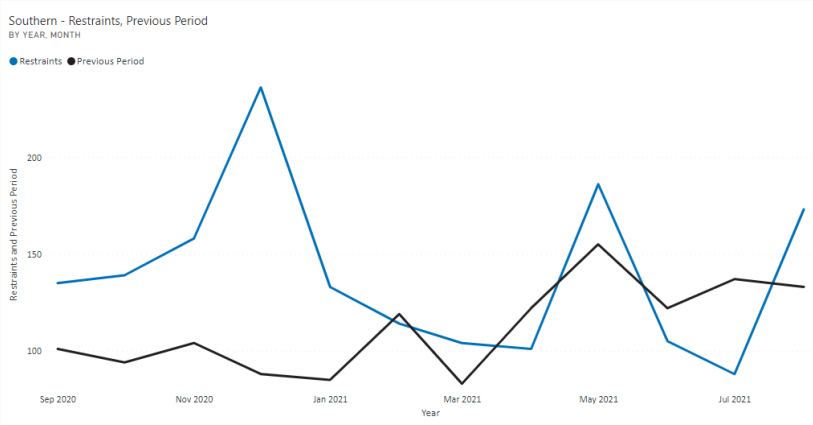
Appendix 1 **Executive Quality Dashboard – Southern Region, Dunedin & Southland Hospitals**

Executive Dashboard – Patient Experience (Southern)

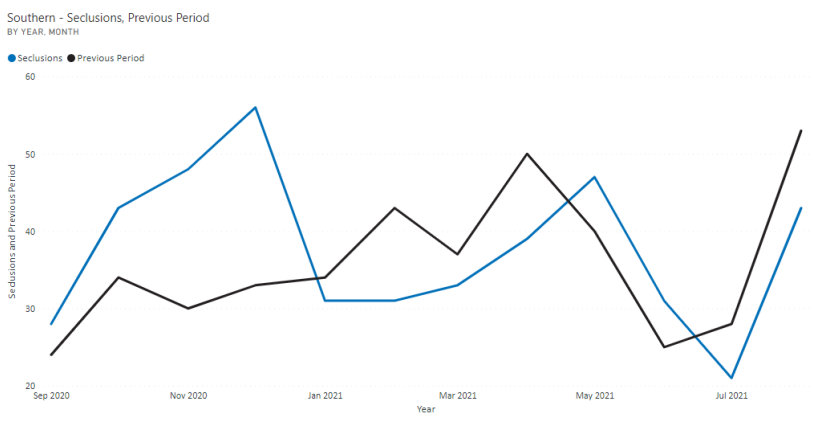


Safety 1st data.
Complaints
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.
Resolutions
There is a one month (20 working days) time period for complaints to be resolved, or to communicate additional time required to the patient. For that reason the current reporting month will always appear as a lag.

Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.

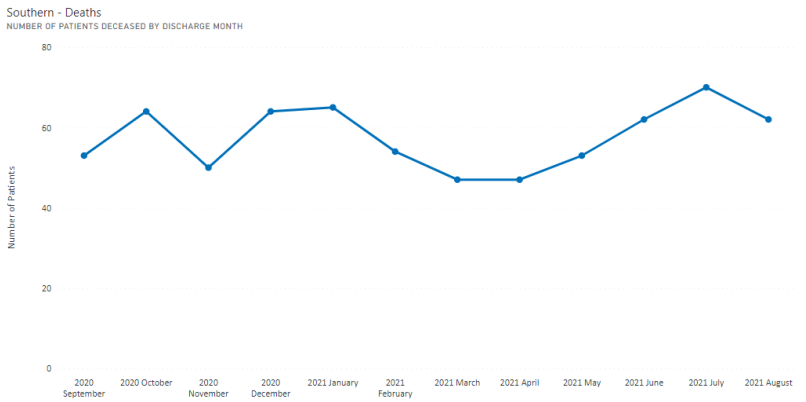


Restraints
Safety 1st data. The number of restraint events per month.
Restraints data includes Dunedin, Invercargill, Wakari & Lakes.



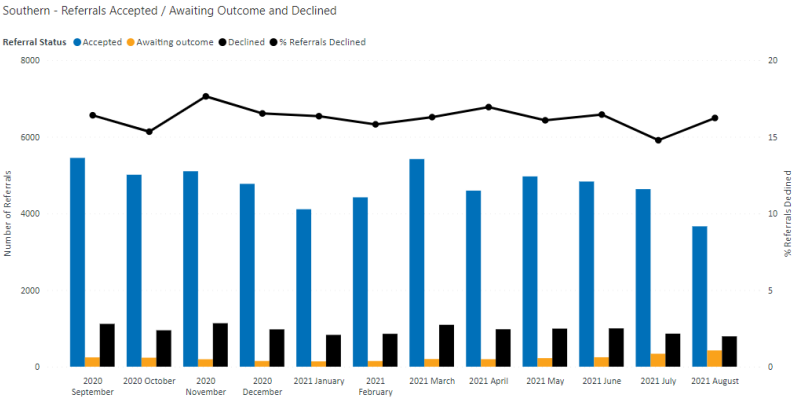
Seclusions
IPM and HCS data. The number of seclusion events per month.

Executive Dashboard – Experience (Southern)

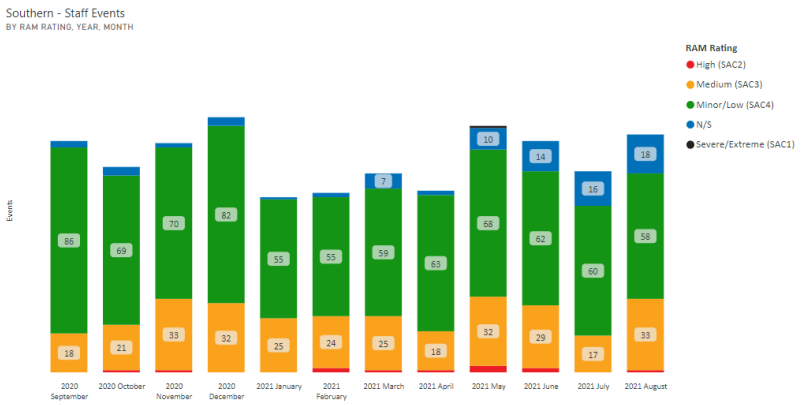


Deaths
Number of patients deceased by discharge month.

"Across the region there has been a rising number of deaths in hospital since March. This is not driven by more deaths in our major hospitals. Deaths in Dunedin and Invercargill are relatively stable. However there has been an increase in deaths in hospitals in the other hospitals in our region. This is coming off a very low base and the increased number of deaths, while at the higher end of the range, are not unusual. If this trend continues we will look at this issue in more depth using standardised mortality ratios and other tools to ascertain if this requires further action. Deaths are down a little so month so we will continue to monitor."



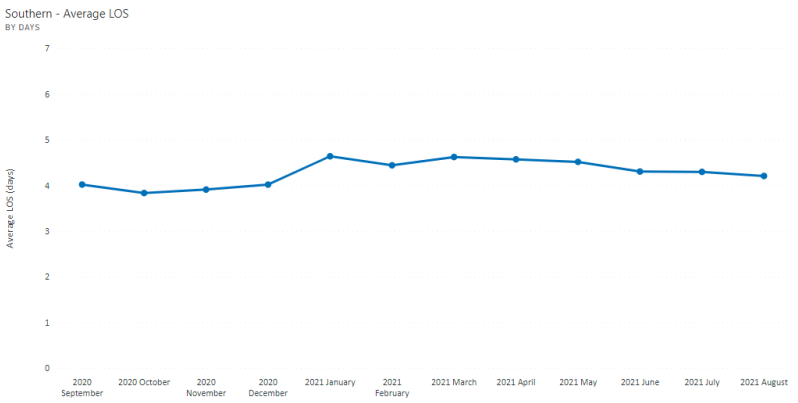
Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



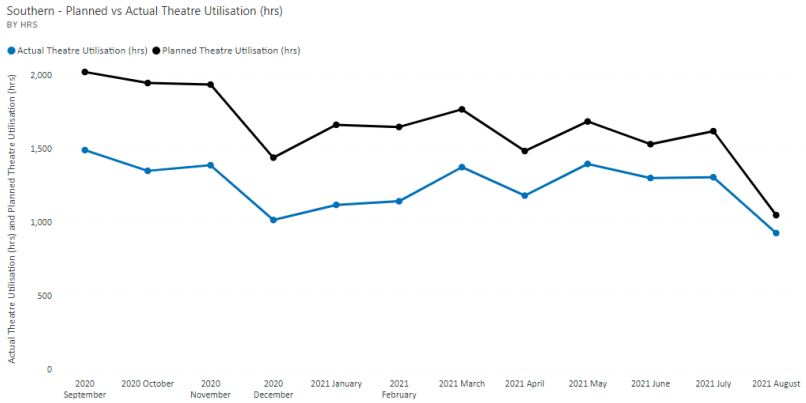
Safety 1st data.
The monthly number of reported staff adverse events
Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

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)

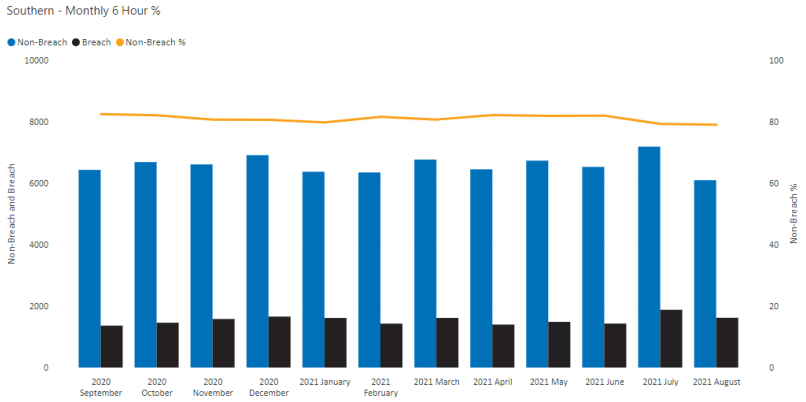


Average Length of stay
Average Length of stay by specialty of all patients present in the hospital at any point of time



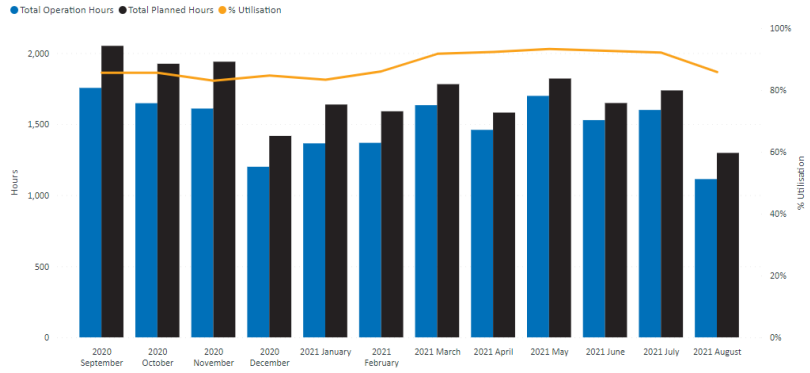
Actual Theatre Utilisation
Actual theatre utilisation given by CaseLength Time = Anaesthetic Time + Procedure Time
Anaesthetic Time = Time duration between "Anaesthetic Start Time" and "Patient Ready for Procedure Time"
Procedure Time = Time duration between "Procedure Start Time" and "Procedure Complete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

Operating hours dipped in August due to the COVID resurgence



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 (%)

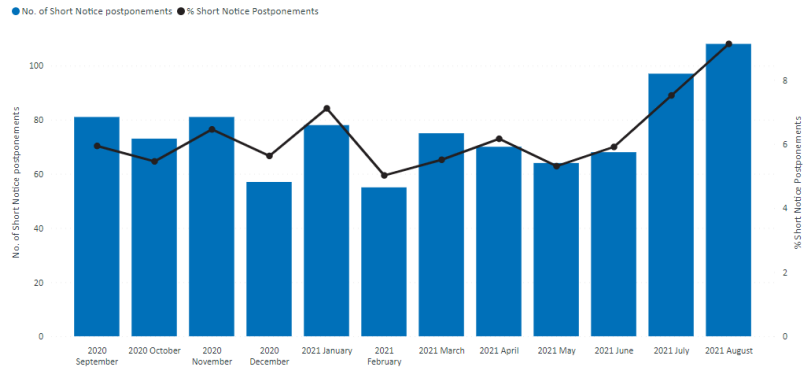
Numerator: Planned and acute operations from when the patient is brought into operating theatre to the patient leaves
"Theatre cleaning time included - Cleaning time of 12 mins per operation"

Denominator: Planned session time

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

Theatre hours are down in August due to the Covid resurgence

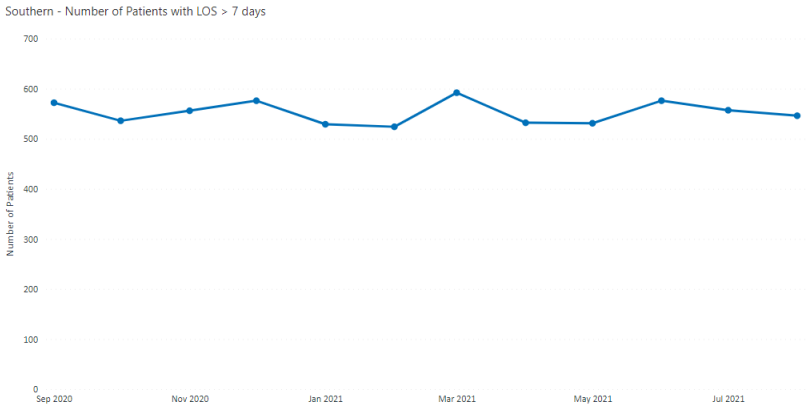
Southern DHB - Short Notice Postponements



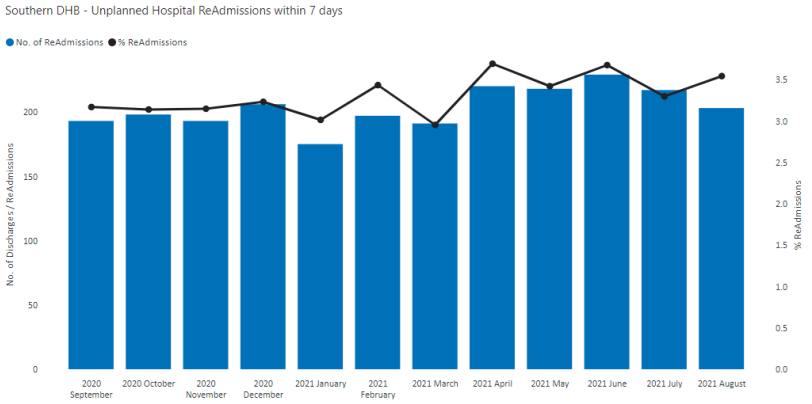
Short Notice Postponements
Theatre postponements within 24 hours of the scheduled procedure

Short notice postponements are up in August due to the Covid resurgence

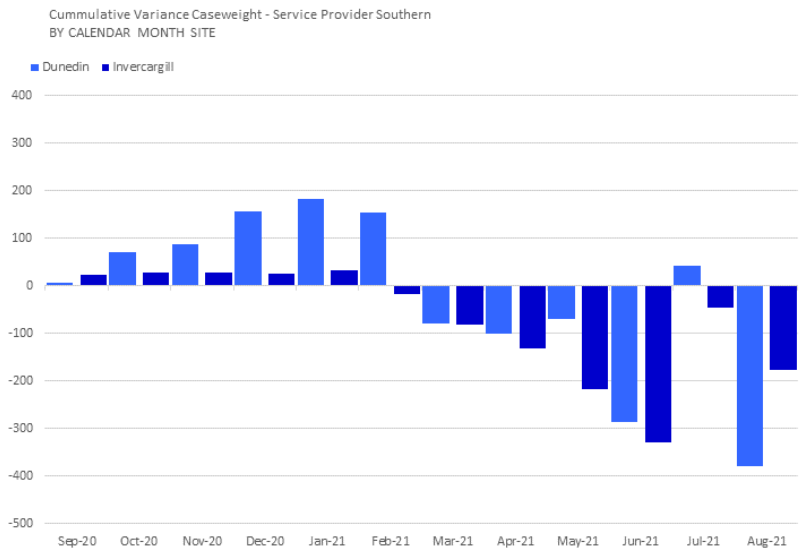
Executive Dashboard – Timely (Southern)



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



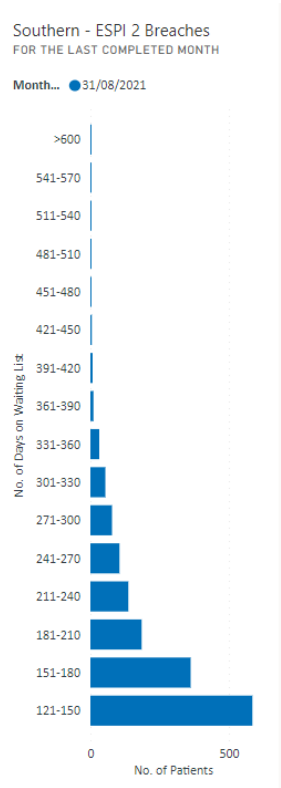
Unplanned Hospital Readmissions within 7 Days
Acute / Unplanned readmissions within 7 days of the initial discharge from hospital organised on the basis of the month of discharge

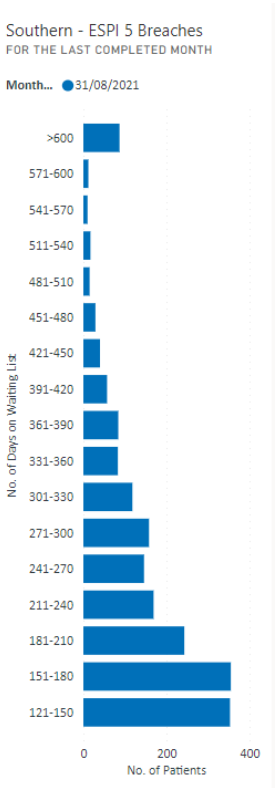


Cumulative Variance Caseweight
Column chart has cumulative variance case weight for Service provider which compares case weight with production plans based on MoH targets and work done in Southern DHB facilities, the Southern DHB's own population minus outflows plus inflow.
The graph shows how ahead or behind the actuals for Dunedin and Invercargill with 33 purchase units within the elective initiative in the last 12 months

Targets for this financial year have been received from the Ministry.
Phasing is currently being finalised

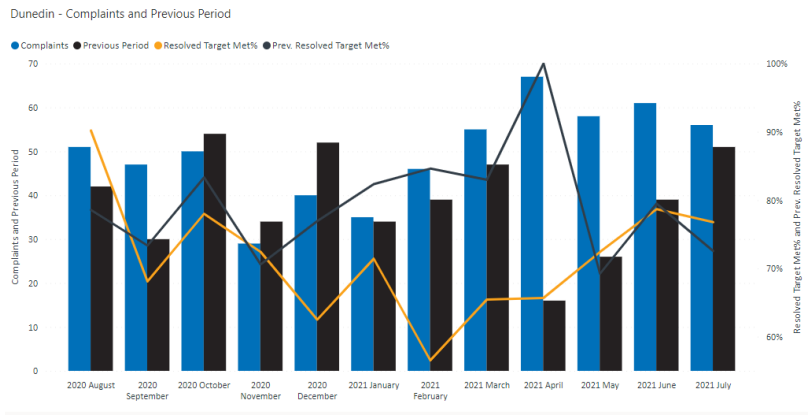
Surgery was reduced in August due to Covid leading to targets being missed





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

Executive Dashboard – Patient Experience (Dunedin)



Safety 1st data.

Complaints

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Resolutions

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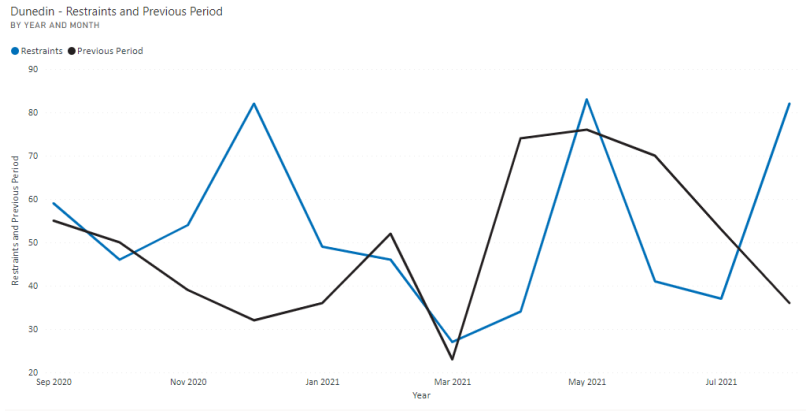
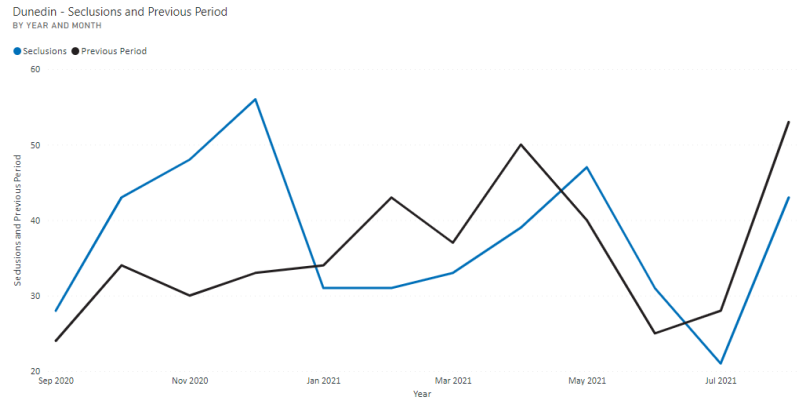


Restraints

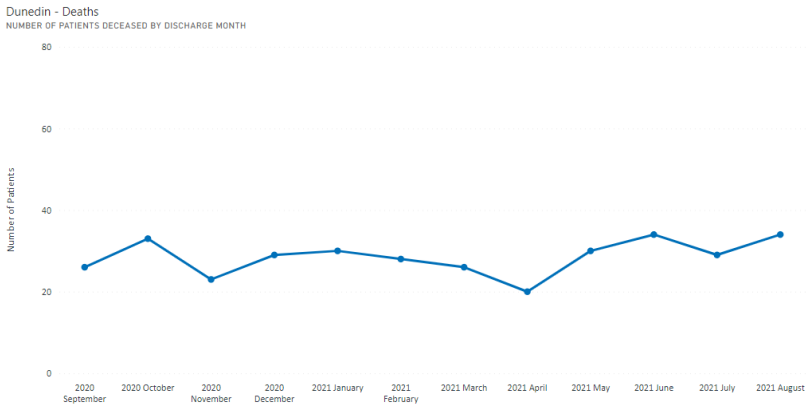
Safety 1st data. The number of restraint events per month. Restraints data for Dunedin only.



Seclusions

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

Executive Dashboard – Effectiveness (Dunedin)



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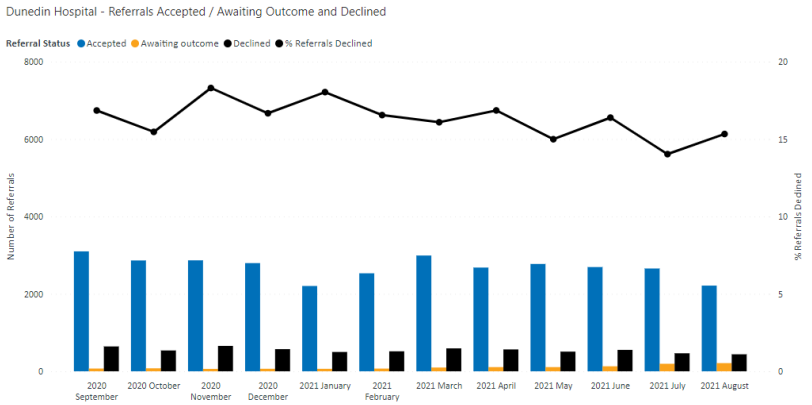

Referrals accepted (authorised), awaiting outcome or declined by month.
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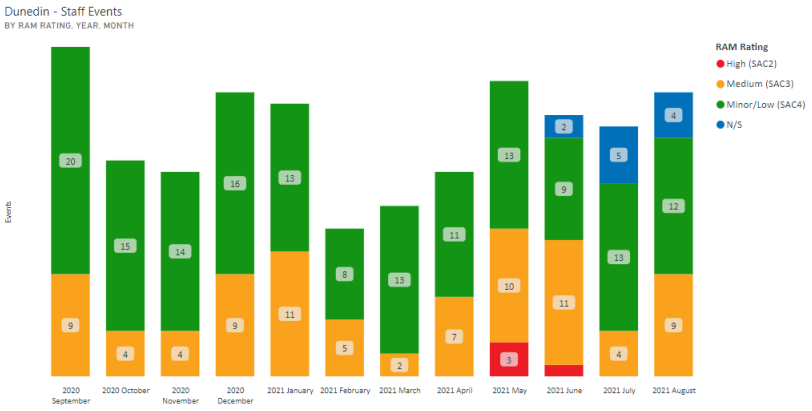

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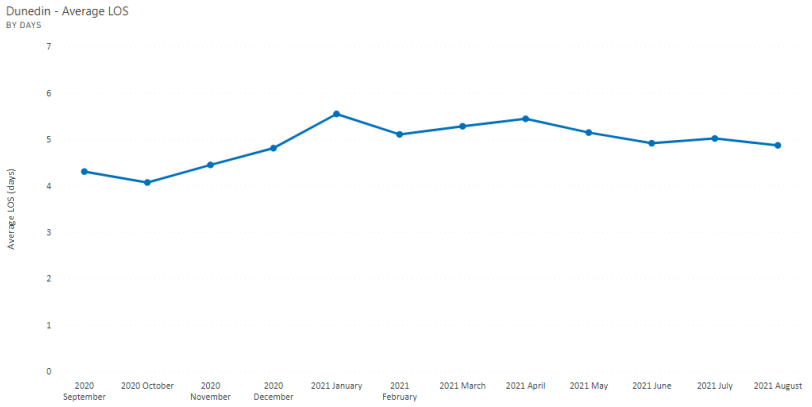
Executive Dashboard – Efficiency (Dunedin)



Average Length of stay
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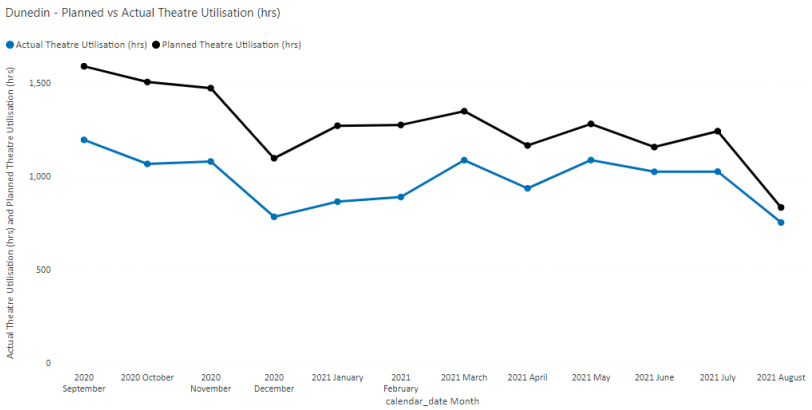

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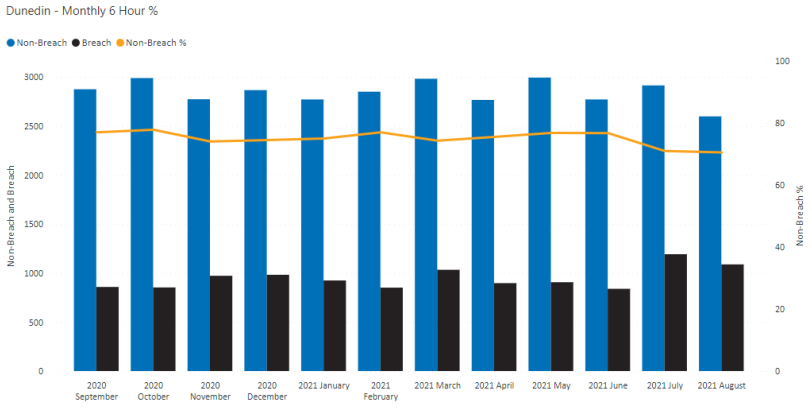
Theatre hours are down in August due to Covid resurgence



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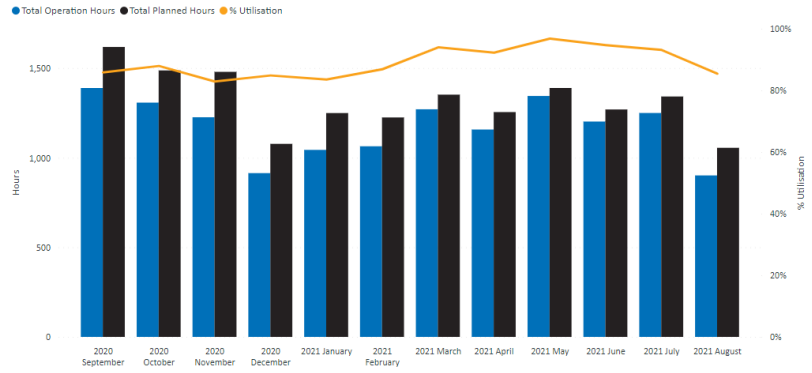

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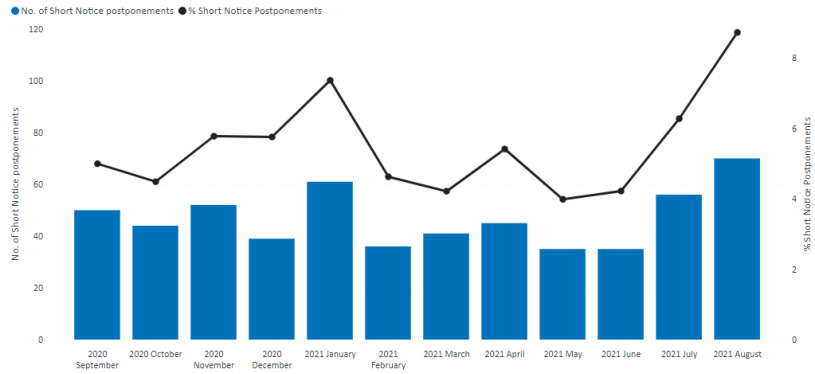
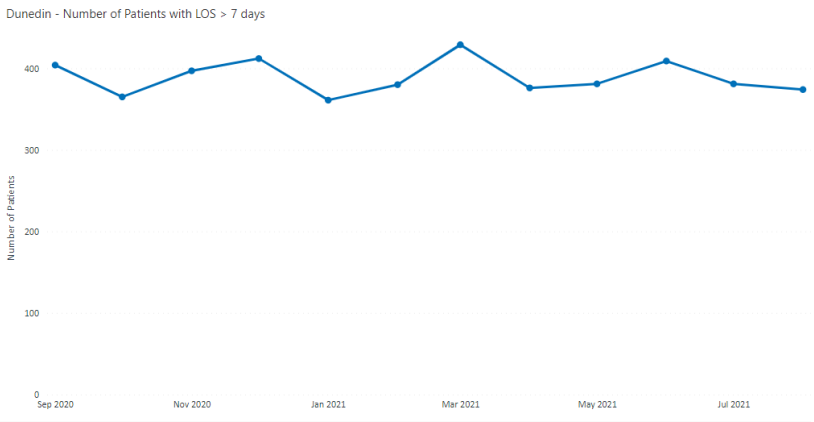
Dunedin - Short Notice Postponements



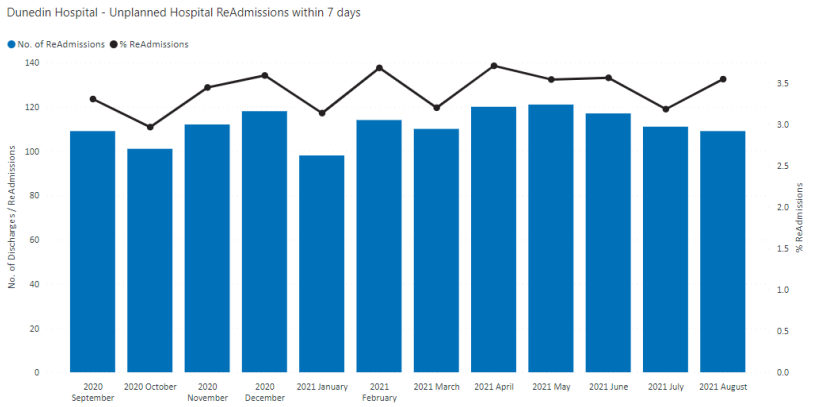
Short Notice Postponements
Theatre postponements within 24 hours of the scheduled procedure

Short notice postponements are up in August due to the resurgence of Covid

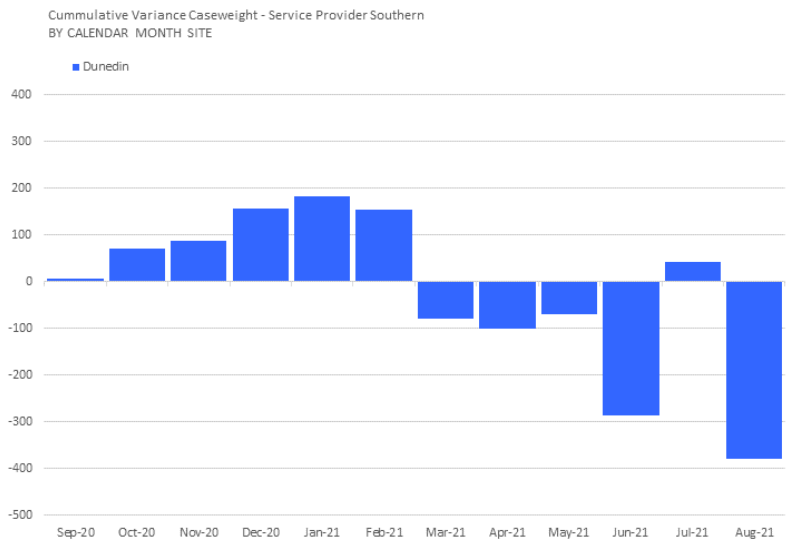
Executive Dashboard – Timely (Dunedin)



Number of Patients with LOS > 7 Days
Number of patients per month who have a LOS > 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
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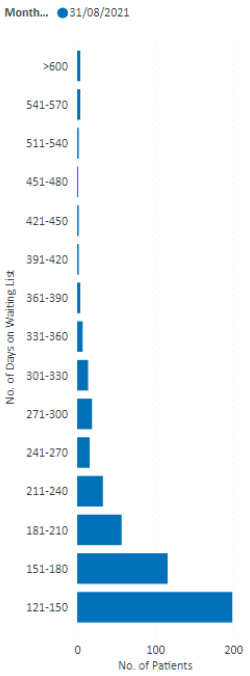
The graph shows how ahead or behind the actuals for Dunedin and Invercargill with 33 purchase units within the elective initiative in the last 12 months.

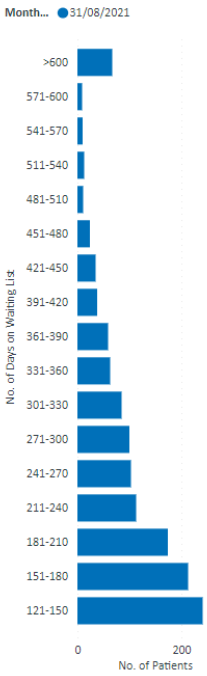
Targets for this financial year have been received from the Ministry.
Phasing is currently being finalised

With the resurgence of Covid less surgery was performed in August which widened the difference between actual and target caseweights

Dunedin - ESPI 2 Breaches f...



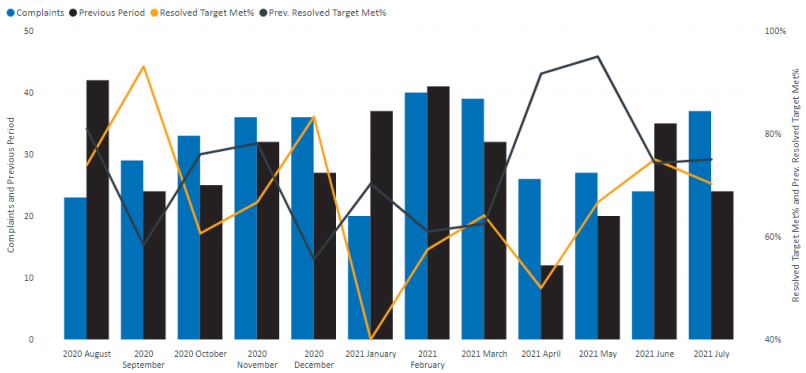
Dunedin - ESPI 5 Breaches f...



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.

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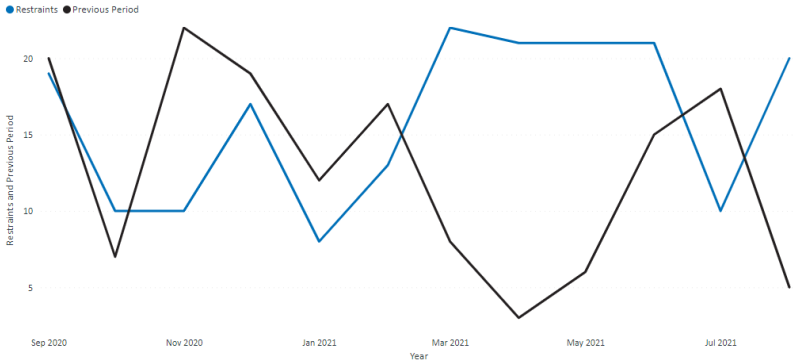
There is a one month (20 working days) time period for complaints to be resolved, or to communicate additional time required to the patient. For that reason the current reporting month will always appear as a lag.

Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.

Invercargill - Restraints and Previous Period

BY YEAR AND MONTH



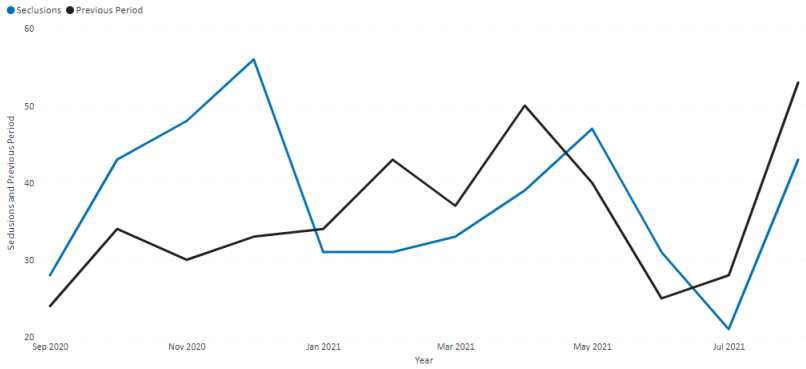
Restraints

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

Restraints data for Invercargill only.

Southern - Seclusions and Previous Period

BY YEAR AND MONTH



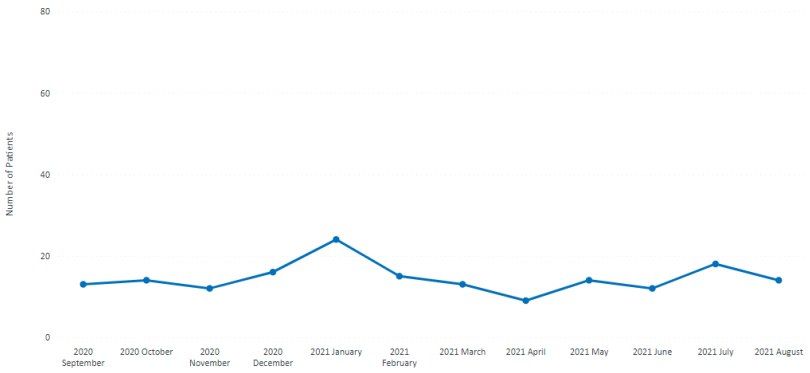
Seclusions

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

Executive Dashboard – Effectiveness (Invercargill)

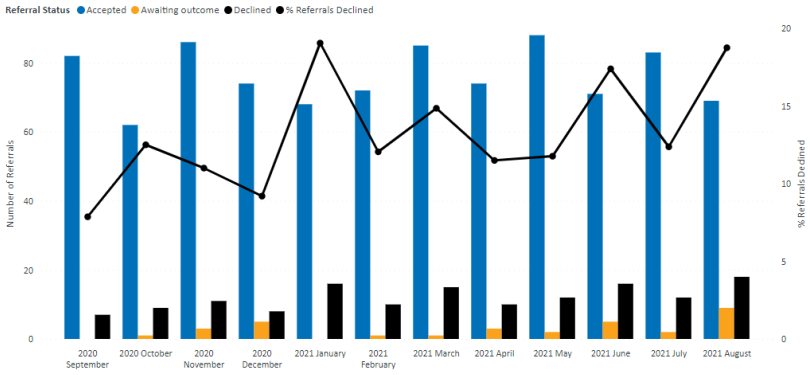
Invercargill - Deaths

NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH



Deaths
Number of patients deceased by discharge month.

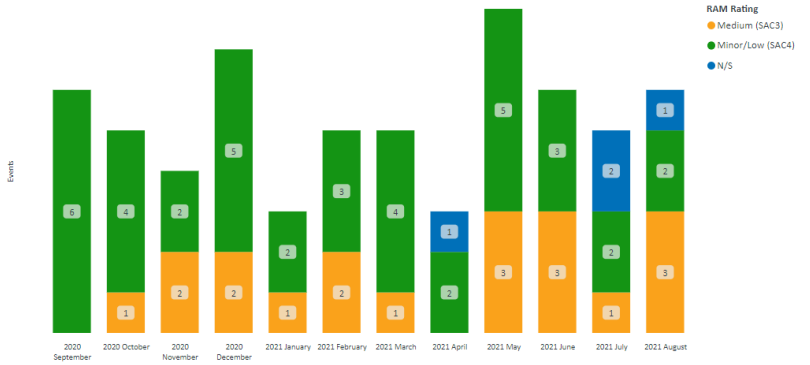
Invercargill Hospital - Referrals Accepted / Awaiting Outcome and Declined



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

Invercargill - Staff Events

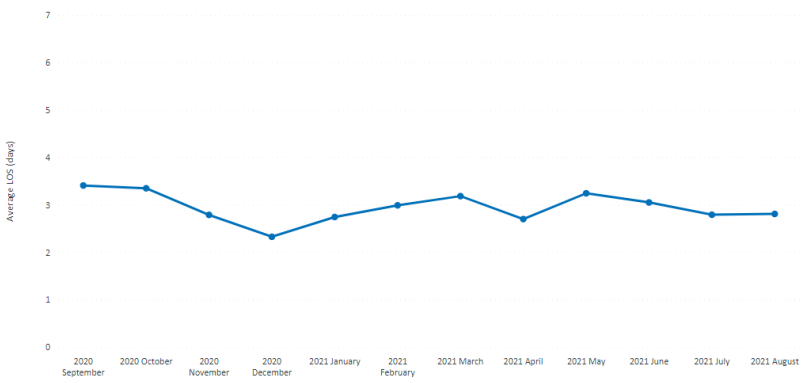
BY RAM RATING, YEAR, MONTH



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

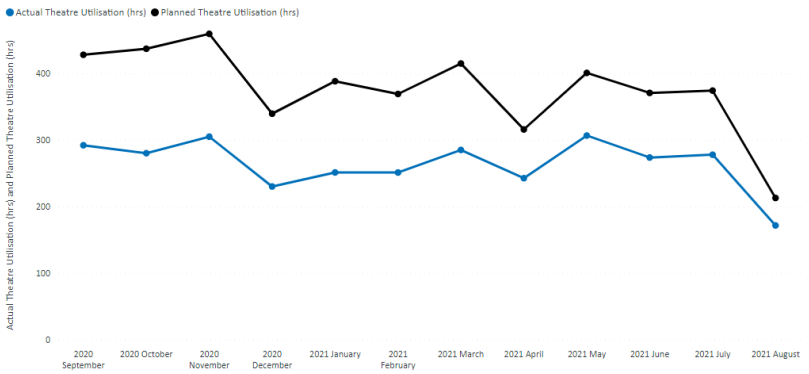
Executive Dashboard – Efficiency (Invercargill)

Invercargill - Average LOS (days)



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

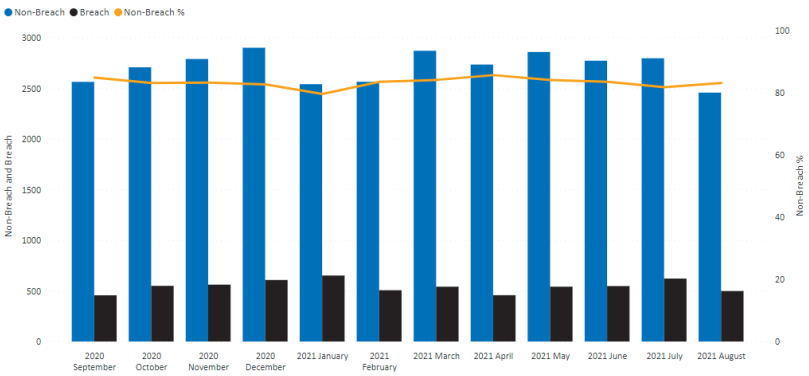
Invercargill - Planned vs Actual Theatre Utilisation (hrs)



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

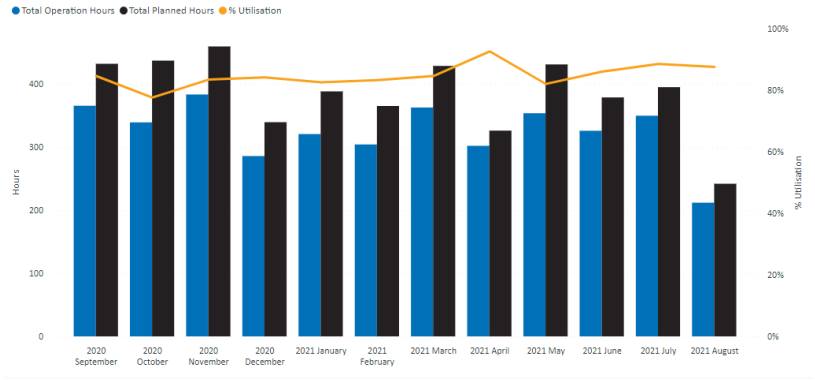
Surgery hours were down in August due to the resurgence of Covid

Invercargill - Monthly 6 Hour %



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

Invercargill - Average Theatre Utilisation (%)



Average Theatre Utilisation (%)

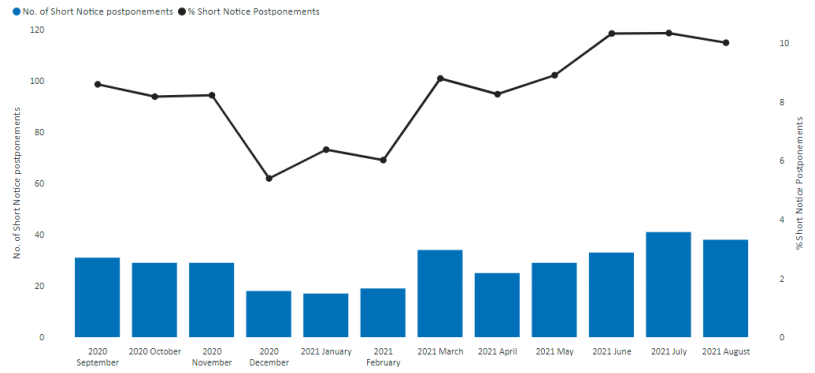
Numerator: Planned and acute operations from when the patient is brought into operating theatre to the patient leaves
"Theatre cleaning time included - Cleaning time of 12 mins per operation"

Denominator: Planned session time

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

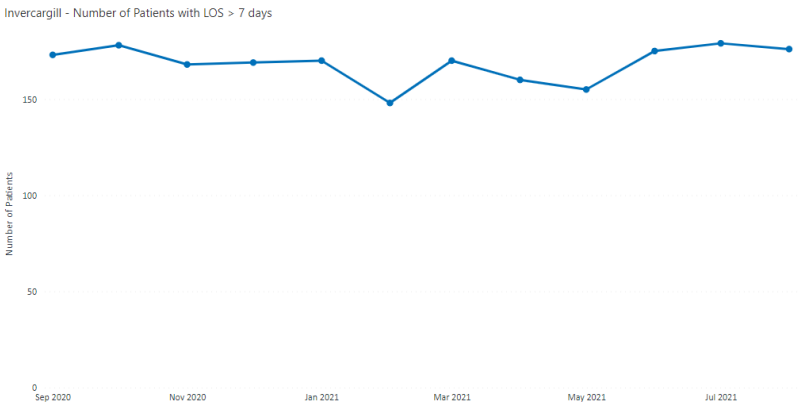
Less surgery was performed in August due to the resurgence of Covid

Invercargill- Short Notice Postponements

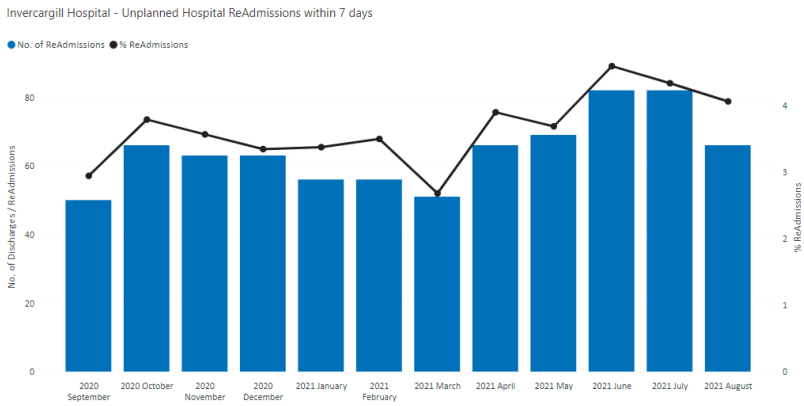


Short Notice Postponements
Theatre postponements within 24 hours of the scheduled procedure

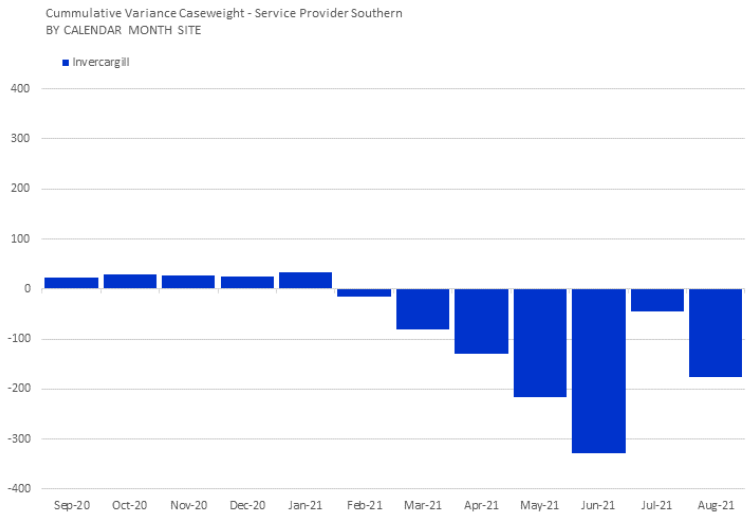
Executive Dashboard – Timely (Invercargill)



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



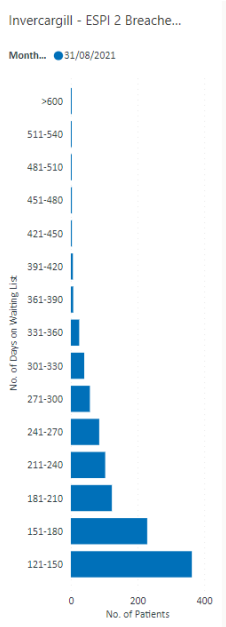
Unplanned Hospital Readmissions within 7 Days
Acute / Unplanned readmissions within 7 days of the initial discharge from hospital organised on the basis of the month of discharge

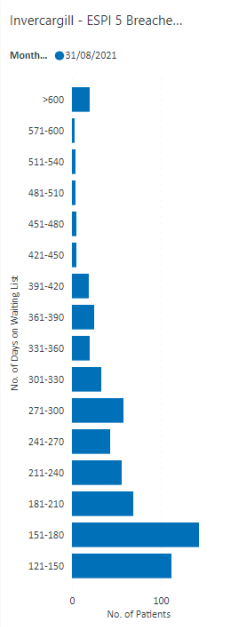


Cumulative Variance Caseweight
Column chart has cumulative variance case weight for Service provider which compares case weight with production plans based on MoH targets and work done in Southern DHB facilities, the Southern DHB's own population minus outflows plus inflow.
The graph shows how ahead or behind the actuals for Dunedin and Invercargill with 33 purchase units within the elective initiative in the last 12 months.

Targets for this financial year have been received from the Ministry.
Phasing is currently being finalised

With less surgery being performed in August, due to Covid, the difference between target and actual caseweights has widened





ESPI 2 and ESPI 5

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

EDSS Report monthly change report: August 2021

EXECUTIVE SUMMARY – PATRICK NG

Vacancies in key areas (e.g. the perioperative team in Southland, the physiotherapy team in Southland and the Obstetrics & Gynecology SMO service in Southland) remain concerning. Support requested with our HR colleagues for a targeted campaign acknowledging that arrival of overseas candidates may be slowed by access to NZ and to MIQ slots which is a national issue. An improvement programme is underway to clinically review all patients on our wait lists > 365 days and to systematically work these patients off waiting lists. Most specialties have small numbers. Orthopedics and ENT have larger numbers and require a tailored approach.

PERFORMANCE AREA	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
Case weights surgery			CWD impacted by L4 / L3 lockdown with an estimated 650 CWD of activity lost. An update to our rudimentary production plan has been completed to provide an indication of how much can be caught up with outsourcing + internal productivity improvements.
Discharges			Impacted by L4 and L3 lockdowns, per CWD comments.
ED six-hour target			Daily presentation numbers and did not waits improved, but this was largely driven by COVID lockdown. Pressures were consistent with July at the beginning of August.
Cancer target <62 days			August (provisional) 62 day performance has maintained the improvement seen in July (79%) compared to the prior year to date 71% YTD average. As well as improving reporting, twice monthly meetings are starting to identify system delay themes (e.g. access to MRI in Dunedin, access to theatre O&G Southland).
FSA (ESPI 2)			Initial focus on systematically addressing patients waiting > 365 days. Improvement manager starts on 1 November and his top priority will be a full recovery plan for outpatient and inpatient long waiting patients across specialitie, including latest growth of wait list due to COVID lockdown.
Elective treatment< 4 months			Orthopaedics (district) and ENT (Sthld) 64% of total breaches. Wait lists exacerbated due to lost productivity during COVID lockdown. 2nd draft of recovery plan notes outsourcing capacity tight within the district. Internal productivity improvement plus out of district outsourcing key focal areas.
Medical imaging CT			85.9% for the district best result in sometime. 2nd Dunedin CT machine now live in Dunedin. In use, but training occurring simultaneously. Anticipating good, additional capacity from the 2nd machine.
Medical imaging MRI			Slight performance improvement (from 44 to 47%) from last month sustained this month. Purchase order raised for 2nd MRI machine and building work planning is underway.
Colonoscopy 14 days			Achieved target despite COVID L4/L3. 94.2% overall against target of 90%.
Colonoscopy 42 days			Achieved target despite COVID L4/L3. 83.8% overall against target of 70%.
Colonoscopy 84 days			Recovery trajectory impacted by COVID L4/L3 and will now need to be re-planned.

CURRENT ISSUES	UPDATE/ACHIEVEMENTS	UPCOMING KEY DELIVERABLES
Elective surgical delivery	Planning underway to activate 4 inpatient beds in Southland by the end of the year and additional beds (4-8) from early next year with a nurse training model to staff them.	Recovery remains focused on lifting outsourcing volumes and using Timaru capacity. Orthopaedic cases at risk due to physio staffing. DAH has gained support from Nelson from October.
Financial performance	YTD CWD deficit to plan biggest financial issue due to CWD lost during COVID. Anticipating that Ministry recovery plan will fund unearned CWD revenue.	Savings plans worked through with Finance and will be presented at the next Audit & Risk Committee.

Oncology Sustainability Planning

- Radiation Oncology wait list has dropped from a peak of 160 and is currently 76 (as at 27.09.21).
- Ernst & Young benchmarking exercise is underway and will look at data from a number of sources – internal interviews and interviews with the other cancer centres, the national collection, information collected by the CCA. The final report will 'normalise' the data to make it comparable and will then advise us where our key gaps (and investment priorities) are.
- Medical Oncology has successfully recruited the two permanent SMO roles (1.8 FTE) they identified that they needed and these will start circa February 2022.
- A clinical nurse specialist has been hired and will provide meaningful additional capacity for the haematology wait list by taking FU volume off SMO's. Anticipated to add capacity from early November.

Planned Care Recovery

- Deliberate effort made to maximise planned care that could be delivered during L4/L3 in August. This has reduced the amount of backlog that needs to be caught up. Pro-forma production plan developed to determine the amount of lost activity that can be caught up internally and needs to be caught up with outsourcing.

Production Planning Implementation

- Second draft of production plan drafted for COO and CEO review. Key focal areas to improve performance will be additional inpatient beds in Southland and provision of acute capacity in Dunedin. Some negotiation with anaesthesia required in order for this to be supplied (Dunedin). Will also need to stocktake what can be delivered by outsourcing and what may need to be outsourced out of the district where local private capacity is inadequate. Circa 680 CWD from COVID to catch up represents 3.9% of annual production but current productivity challenges (e.g. perioperative staffing gaps in Southland) also need to be worked through and offset.
- Robust assumptions about how CCDM will positively impact on planned care performance over the remainder of the year also need to be added in.

People & Capability monthly change report: August 2021

EXECUTIVE SUMMARY – TANYA BASEL

Leadership/Management vacancies remain high with a vacancy rate of 23.86%.
Focus has been predominantly on supporting immigration of both new staff and existing staff needing to return to NZ
Proposal for change for Tier 2 and 3 remains a priority with decision document to be released and a further consultation period for changes to the Specialist Services Directorate required.

PERFORMANCE AREA	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
HR Dashboard Development			• Work progresses on getting alignment on data and linking information to what is provided to TAS for the Health Workforce Information Platform.
Workforce Strategy & Action Plan			• Work continues on key aspects of the Workforce Strategy and Action Plan with specific focus on Leadership Development, NDH Workforce planning and Equity in Recruitment processes.
Health & Safety			• Supporting Mask Fit Testing • Reviewing injury prevention options to reduce lost time and high sick leave due to injury.

SOUTHERN DHB TOTAL VACANCIES

	Admin	RN / RM	AHS&T	SMO	RMO **	Mgmt	Support	August TOTAL
Budgeted FTE	615.71	1895.39	774.58	322.84	332.74	139.14	103.68	4,184.08
FTE vacant	37	90.30	72.64	31.1	42.60	33.20	17.10	323.59
% of workforce vacant	6.00%	4.76%	9.37%	9.6%	12.8%	23.86%	16.39%	7.73%
Number of vacancies	49	131	92	36	43	36	33	420

Workforce (FTE)	Māori	Pacific	All
Allied Health	42.2	3.9	766.5
Management / Admin	33.4	7.3	812.6
Medical	13.0	7.7	480.5
Nursing	92.0	15.9	1914.9
Support	3.5	2.0	51.7
Total	**184.1**	**36.7**	**4026.1**

Time to hire (Ave Days)	
SMO	271.6
Nursing	51.7
Allied Health	67.2
Mngt/Admin	57.7

CURRENT ISSUES	SUMMARY OF RISK	MITIGATION STRATEGIES
Recruitment	• CCDM, Digital program increasing workload in recruitment and admin areas	• Appointment of fixed term recruitment advisor for Digital program underway
Immigration	• Health care workers struggling to convert work visas to residence visas at present. • MIQ and visa process constraining international recruitment.	• Communication between MOH, MBIE and INZ continues with little positive changes to date.
Bargaining	• PSA and MERAS have reached agreement on the latest round of bargaining. • NZNO is yet to reach settlement	• Preparation for strike action has been undertaken but no further strike notices have been issued by NZNO.

Our strategic priorities and feedback from the 2020 staff engagement survey drives 4 areas of focus.

1 Change

- Change Cycle workshops have commenced for Leading others and Train the Trainer Accreditation.
- Diversity and Inclusion – Accessibility Game workshops continued in August and collaboration with Māori Health Directorate to develop LGBTQI+ workshops is still progressing
- Te Reo Māori training has had positive uptake with more funding required to support interest.

2 Performance

- HealthLearn work continues with small group to move from Ko Awatea to HealthLearn as platform for online training and development.
- Graduate Nurses facilitated session to support new practice programme with courageous conversations and speak up.

3 Leaders

- LEADS program – due to lockdown, number of face to face sessions had to be changed.
- Engaging with Learning works – funded program focussed on Team Leadership and First line leadership – supports up to 20 people. Interest received from other Healthcare partner agencies.

4 Wellbeing

- Mental Health Foundation training for staff and managers conducted during lockdown, online.
- SDHB Wellbeing sharepoint site was updated with relevant tools and support during Lockdown in August.

Strategy, Primary & Community monthly change report: August 2021

EXECUTIVE SUMMARY – RORY DOWDING

PERFORMANCE AREA	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
COVID-19 Response			• The Southern DHB COVID-19 vaccination programme now has over 100 vaccination sites across the Southern district with multiple delivery streams. • Māori and Pacific Population Rollout – In August, new clinics opened at the Pacific Island Advisory Cultural Trust, Invercargill, Pacific Trust Otago and Te Rau Aroha Marae. Level 4 lockdown saw two significant drive through pop-ups with one operated by Otakau Health Services and another in Queenstown. These took considerable pressure off local General Practices which could not deliver large volumes of swabbing along with vaccinations • Vaccinations of our older populations at Aged Residential Care facilities are complete. All 65 facilities across the Southern district have had first and second clinics onsite. A process will be embedded to allow new residents to be vaccinated through until the end of the year. • Other strategies are being developed and implemented for Disability Residents Support Services recipients, Mental Health Residential, ethnic communities and workplaces. • On 17 August New Zealand entered level 4 lockdown after the discovery of a community case of COVID-19 delta variant. To support contact tracing, Public Health South employed six contact tracing teams (with up to 12 staff) operating on a seven-day week roster. • A Community MIQ Service Coordination Manager has recently been appointed to Public Health South. Community MIQ bridges the gap between self-isolation and isolation/quarantine in a Managed Isolation Quarantine Facility. Community MIQ is an end-to-end model of case/contact management, funded by the Ministry of Health and delivered by DHBs.
Immunisation			• The Measles Campaign (15 5o 30 year olds) was put on hold at the direction of the Ministry of Health due to COVID prioritisation. Planning work scheduled to recommence in August has been postponed; COVID-19 resourcing into priority areas has taken precedence. The VPD Immunisation team continue to provide support to the COVID-19 vaccination programme.
Maternity Central Otago			• Work is well underway to design the new Primary Birthing Unit in Clyde, which the Central Otago Maternity Unit (COMU) in Alexandra will transition across to. A design will be circulated to steering group members for feedback, and priced by a Quantity Surveyor, by the end of August.

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

Strategy and Planning

- **Annual Plan and SSP**: A complete Board signed Annual Plan was submitted to the Ministry of Health, for Ministerial Approval, on 10 August. The team completed the 20/21 Statement of Service Performance for review by auditors on 30 August.
- **HNA:** The team is working towards the completion of a Health Needs Assessment (HNA) for the Southern district. The HNA reports on 82 indicators across 4 key domains – demography, health drivers, health status and health services. The project is currently publishing indicators in a graduated approach in the southernhealth.nz website.
- **Service planning:** The team has offered to meet with Service Managers to assist them in preparing/updating high level service plans for 22/23 - this should be underway by October this year. Efforts continue to align budget discussions and service planning. Medicine, Women's and Children (MWC) are about to trial a "budget bid proforma." Surgical and Radiology Services, and MWC are planning District planning meetings, scheduled for later this year.

Clinical Project Management

- **Emergency Q (ED triage digital platform**): A project manager has recently been identified to support platform implementation, alongside the WellSouth Project Team. Initial meetings have taken place between WellSouth, SDHB and Healthcare Applications CEO, Morris Pita to gain further information prior to implementation.
- **Frail Elderly Pathway:** This project's objective is to develop a best practice pathway for our frail elderly population accessing supports in the community. A steering group has been formed, made up of key clinicians working in primary, community and secondary care as well as Community Advisors. Key components of the clinical pathway have been identified and work groups are forming to investigate and make recommendations to the Steering Group. The first workgroup to be formed will explore and make recommendations around Shared Care Plans. Discussions are currently underway to investigate Mosgiel as an area to initiate a local prototype for this clinical pathway.
- **Te Kaika:** This Community Wellness Hub will integrate MSD, SDHB and the Te Kaika Primary Care team, to provide holistic support to people in the South Dunedin region. The property design is currently a key focus of the project to enable the build to be completed within the specified time (aiming for completion November 2023) . Completion of a frozen floor plan is anticipated to occur end of September 2021. The clinical co-design phase is anticipated to start in October and will be highly collaborative between all their organisations.
- **Dental School and COHS:** A project has recently been implemented to review and make appropriate changes to the way the contract runs between the Oral Health Services and the University Dental School. Initial meetings have been set up to review the current situation and investigate future opportunities. Greater visibility of the current paediatric waitlists has been identified as a current priority**.**

SP & C monthly change report for August Cont.

Primary Maternity

- The Central Otago Maternity Unit (COMU) in Alexandra is operational under the Southern DHB, as of 1 July 2021. This facility will continue to service antenatal, birthing and postnatal stay women until it is transitioned across to the Clyde Primary Birthing Unit, at which point a new service provider will be contracted for the operational running of the facility.
- Monthly telehealth clinics have been available in Wanaka for the past year. This service is now being trialled in Lumsden, to be accessed by women in the Lumsden and Te Anau area who would usually travel to Invercargill for secondary care appointments. There is also equipment and training in place to establish telehealth clinics in COMU.
- Work is being finalised on an updated Service Specification for Child and Maternal Hubs, which will provide a level of consistency across providers, whilst retaining the ability for these spaces to be community-led.

Refugee services

- The Invercargill Colombian migrant and refugee community have organised into a grassroots Non Government Organisation (NGO) – Migrants and Refugees of Colombia (MaR). A consistent issue raised by MaR involves the mental health challenges of the Colombian community and access to mental health care.
- In Dunedin, we are accepting and supporting the resettlement of Afghan refugees. Through WellSouth and via WhatsApp, we have been advising Afghan refugees of mental and social wellness support as well as translating official NZ government announcements of potential support for Afghans who may be in imminent danger.

Oral health

- **Tele-Dentistry:** Project ramping up and next level work with the new telehealth project manager for the Southern DHB to get our systems and processes up and running and aligned with the rest of the Southern DHB. Teams established and evidence gathered of success of Tele-Dentistry from across the world.
- **Spatial Equity:** Meetings held with Strategy and Planning Team. Agreement to proceed with a pilot project on service distribution regarding population, access to service, distribution, and equity.

Aged Residential Care

RN Staff shortage

- The RN shortage in Aged Residential Care (ARC) continues to worsen with a very limited pool of available nurses. The number of shifts not covered by an RN continue to increase. Lockdown has exacerbated these problems.
- Beds are remaining empty because of safe staffing. Some facilities ae not admitting new residents.
- The ARC RN Workforce Steering Group has developed a well-supported action plan. Work continues with the Nurse Advisor from the Ministry of Health who is seeking advice regarding strategies to support the sector.

Aged Residential Care Occupancy/Volume Analysis

- The levels of occupancy in Aged Related Residential Care (ARRC) have stabilised and we are seeing an overall decline in bed utilisation compared to six months ago. Rest Home level continues with a gradual reduction. Both Hospital Level Care (HLC) and Dementia utilisation have stabilised after growing in the first half of the last financial year.

Public Health South

Communicable disease

- There has been a large number of Respiratory Syncytial Virus (RSV) cases and outbreaks in early childhood centres (ECC's) in the district. RSV is a common respiratory virus that causes respiratory tract infections, including the common cold, and is highly contagious. However, very young children and premature babies can become very sick and may require hospitalisation. Health Protection Officers (HPOs) have provided public health advice to ECC's and work with centres to help manage these outbreaks.

COVID-19 case on MV Mattina

- As previously reported Public Health has been responding to positive cases of Covid-19 in crew on board the MV Mattina ship in Bluff. All cases and contacts have now been released from self-isolation and quarantine. On 19 August, the ship was granted pratique, which means the ship is now eligible to have dealings with a port.
- The response to this has raised a number of issues that need to be resolved for the future including clinical oversight of cases, accommodation and transport.

Population Health Services

- In response to Alert Level 4, Population Health has scaled down service provision in many services, including Before School Checks, Youth Clinics and services in schools. Delivery of core services and follow ups has been prioritised.
- Population Health leadership has looked to increase available capacity to support priority areas of Contact Tracing and COVID-19 vaccinations/administration support.

Rural health

- Rural Trust Hospitals have activated their Emergency Operations Centres in response to the Level 4 lockdown. Adjustments to plans to manage the risk of airborne spread of COVID-19 is challenging in facilities with no negative pressure rooms. The Hospitals have collaborated to share information to mitigate these risks.
- The decision by the Technical Advisory Group (TAG) that Rural Trust Hospitals would transfer COVID-19 positive patients who needed hospitalisation to Dunedin Hospital, has meant their planning needed to target management of High Index Suspicion patients whilst awaiting test results

Corporate Services - Digital monthly change report: August 2021

EXECUTIVE SUMMARY – NIGEL TRAINOR

Digital services are operating within budget and making progress on strategic projects. A lot of work on and the environment is functioning well

PERFORMANCE AREA	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
My Lab (Physical space developed to assist with Change in technology and behaviours)			• No Progress
New Dunedin Hospital – Digital Programme			• **Amber status due to tight timelines for DBC and risk of missing key dates, currently tracking to plan of final draft to Board November 2nd.** • **BC** complete pending cabinet approval • **DBC** – Sapere engaged to author the document, workshops held and first draft commenced • **EY engagement** for financial cost model, sample patient journeys & solutions requirements library **COMPLETE** • **Digital Infrastructure Design Consultant** – RFP complete, contract negotiations complete and board paper for approval submitted • **Systems Integrator** – Working group (NDH, MoH & Digital) submitting a recommendation on how best to procure and contract these services. RFI held with the market to obtain feedback on options. • **NDH Room design** – Digital continues to work with NDH to support standard & variant room designs • **NDH FF&E** – Work just begun with Digital team on detailing scope & specifications
Digital Strategy Update			
South Island PICS			• Capex for full programme budget($16.9m) raised • Project Board & Steering group being formalised • Initial project resources recruited and starting work • Planning session with regional team & Orion Health held • Discovery workstreams (Processes, Integration & Migration) commenced

CURRENT ISSUES	SUMMARY OF RISK	MITIGATION STRATEGIES
Recruitment of roles (Digital)	Finding & attracting quality resource to the Digital roles required	May need to engage consultants to fill gaps

Digital Strategy

Epiphany – Regional ECG repository – Replanning of project underway following incumbent PM resignation
Consult Request – 84 services live, 18 planned
Medchart 10.1 upgrade – Software quality issues raised with MoH, vendor (Dedalus) has responded with improved QA testing and now planned for October ’21.
Records Scanning – Final draft of business case in review with service
EDIS upgrade – Implementation plan with ED service underway, expected late Sep ’21
Microsoft 365 – New 365 specialist resource recruited, work on MS Teams & SharePoint solutions continues
Axe the Fax – Work with services to change processes & deploy shared mailboxes continues
Web Scheduler – Pilot continues, planning for BAU rollout underway
Risk Manager – Implementation complete, BAU handover underway
Printer replacement – Wakari & Queenstown underway
Cherwell upgrade – Configuration and design work continues
MDM room refit – RFP complete, final draft of business case underway
Allied Health Tracking solution – Final draft of business case complete
Eye Imaging software – Final draft of business case underway
Radiology systems upgrade & rurals rollout - PACS upgrade planned, planning with Dunstan & Oamaru underway
HCS ward handover – Dunedin sites now live, Invercargill planning underway
Vocera (Handsfree comms) – Vendor engaged and project planning underway
ICU Business case – Requirements workshops commenced
Fresenius Pumps – Server build underway with new pumps expected to arrive Sept ‘21

Corporate Services – Finance, Property & Facilities monthly change report: August 2021

EXECUTIVE SUMMARY – NIGEL TRAINOR

Very productive month of August, the financial result came in under budget, however we did not deliver the planned elective services. A number of projects in the Building and Property area made progress, these are covered below. Holidays Act is stalled due to the need to get some National decisions and also resource issues at SDHB.

PERFORMANCE AREA	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
Financial Sustainability			• The month August has a negative variance against budget of $1.8m, this was mainly due to the effect of the Covid lockdown on planned care where $3.1m of revenue was not recognised, this is to be discussed with MOH
Holidays Act 2003			The MOH have appointed KPMG to provide a Program Management role to the national work on the Holidays Act. There are still a number of issues that require a decision. Locally we have received some system updates, but due to staff shortages these have not been tested, I have approved an additional resource to ensure the Payroll manager is freed up to do this testing.
ICU - Dunedin			Working with both the design and engineer team to progress the rectification of this work
Accountability and Performance Framework			Project is making progress.

CURRENT ISSUES	SUMMARY OF RISK	MITIGATION STRATEGIES
Savings Plans	Finance, Property & Facilities will be meeting to ensure the directorate is aligned with the savings plan	Meeting will establish milestones ensure that progress is tracked and reported
Holidays Act 2003	National decisions	Raise nationally to ensure decisions are made in timely manner

Budget 2021/22

Finance, Property and Facilities are on budget, there are risks with costs of Insurance, energy, food and maintenance costs.

Property & Facilities	Completion Date	RAG Status
MAU – project is behind due to the complexity of decanting the Fraser building, once we have suitable accommodation for the Community team we will be able to make up time	Decant plan completed end Oct 21	
CT – Dunedin CT building work is on target, now just waiting the arrival of the CT	Completed	
ED Invercargill extension Plan and business case complete and on next Board agenda for approval	Detail design completed Dec 21	
5th Theatre Invercargill design has been complete now with the QS, it will be over the $3.0m budget, so will need to have conversation with MOH on the higher costs	Business case to Board Dec 21	
CSD – Dunedin, awaiting confirmation of decant and will meet with Oncology staff this month to confirm	Completion date for CSD Dec 22	

Q & CG monthly change report August 2021

EXECUTIVE SUMMARY – HYWEL LLOYD

Airborne isolation facilities remain an ongoing risk with immediate mitigating plans implemented in Southland for the COVID-19 admission. Vacancies & extended leave within the Q&CG Directorate are causing capacity issues, recruitment is in progress. There was no administrative support dedicated to the directorate during August.

Higher numbers of complaints and compliments, which also require a response, are stretching the depleted Feedback Administrators ability to meet the HDC code requirements.

Good progress has been made with the risk register to improve the management of clinical risk in the organisation. Covid resurgence planning has been a focus this month with 86% of plans being reviewed. There is considerable uncertainty in the system and large numbers of vacancies creating capacity issues.

SERVICE UPDATES	PREVIOUS MONTH	CURRENT MONTH	COMMENTS
Consumer Experience			Consumer complaints remain at over a hundred a month, compliments have also increased related to vaccination services. The feedback team are under pressure to respond within the expected time frames
Quality & Performance Improvement			The Southland QI team are being supported from Dunedin due to unpaid leave and secondments. Covid alert levels and associated role changes have reduced the teams effectiveness this month
Patient Safety & Risk			Dunedin HAC have reduced to below the 75th centile they remain stubbornly red compared to comparator organisations. The risk register majority roadmap is on track.
Emergency Management			Replacement interviews are scheduled for the replacement of the Emergency Response Manager. Covid resurgence plans are being reviewed and good progress as been achieved. Cyber

QUALITY IMPROVEMENT ACTIVITIES	
ALL	QI projects have no roadblocks requiring Executive attention. The team have been utilised in the Covid resurgence planning and taken on change in roles to respond to the change in alert levels

CURRENT ISSUES	SUMMARY OF RISK	MITIGATION STRATEGIES
Risk of cross infection managing patients with infectious diseases	Airborne Isolation Rooms have poor compliance with current standards	Procurement of additional HEPA Air Filtration Units, UV-C Lamps and portable Air Extraction Units, IPC working with B&P
Cyber attack on IT systems.	Business Impact Analysis for IT. Only BPS and Procurement have produced the requested BIA for a Waikato IT event.	Current IT security policies. The Emergency Response team are following up with services to progress towards a BCP.
High vacancy levels	Staff vacancies are affecting effectiveness of Q&CGS	Recruitment and staff working longer hours to maintain effectiveness
Hospital Acquired Complications Dunedin	Dunedin has stubborn red HAI rates	Implementation of Performance & Accountability

Risk Management Maturity Journey:

Good progress has been achieved with the clinical risk register. Clinical council has signed off on the identified risk. All DLTs have contribute to the register. The next stage is to present the register to FARC in September and progress to migrate to electronic system.

Clinical Governance & Service Level Accountability:

The Recognition & Response Committee has had its inaugural meeting. The CG function of clinical council will be strengthened with focus on patient safety, patient experience of care. Engaging the work force on matters of CG is a priority.

Revision of the council sub-committees is underway to balance this with operational responsibility and accountability of patient harms.

Stranded Patients:

Patients with lengths of stay > 21 days have complex care needs. We are working with Executive Director Specialty Services to progress investment in an interdisciplinary team to support our complex care Clinical Nurse Specialist.

FOR INFORMATION

Item: **Quarter Four 2020/21 Reporting: Summary of Southern DHB Performance Reporting to the Ministry of Health**

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

Meeting of: Board, 5 October 2021

Recommendation

That the Board notes the content of these papers.

Purpose

1. To provide an overview of DHB Performance Reporting to the Ministry of Health for Quarter Four 2020/21, including comment where targets or expectations have not been met.

Specific Implications for Consideration

2. Financial

- Recovery due to missed targets may have financial implications.

3. Quality and Patient Safety

- Reports may signal need for improvements in service quality.

4. Operational Efficiency

- Reports may signal need for improvements in operational efficiency.

5. Workforce

- Recovery due to missed targets may have workforce implications.

6. Equity

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

7. Other

- Not identified

Background

8. The monitoring framework sets out DHB requirements to report achievement against Non-Financial Performance Measures and Crown Funding Agreements (CFA). Progress towards each measure is assessed and reported to the Minister of Health according to the reporting frequency outlined in the indicator dictionary for each measure.

Discussion

9. The document, *Performance Monitoring Report Q4 20/21*, summarises Southern DHB quarter four Performance Reporting to the Ministry of Health. This report includes comment where targets or expectations have not been met.

Next Steps & Actions

10. Southern DHB will submit quarter one 21/22 performance monitoring reports to the Ministry of Health on 20 October. The compiled document, *Performance Monitoring Report Q1 21/22*, will be submitted to the Board following Ministry of Health ratings and final feedback.

Appendices

Appendix 1 Performance Monitoring Report Q4 2020/21

Southern DHB Non-Financial Performance Reporting Q4 2020/21

The monitoring framework sets out DHB requirements to report achievement against Non-Financial Performance Measures and Crown Funding Agreements (CFA).

Performance Measure Reporting

Performance Measures are categorised into five different areas related to Government planning priorities.

- Better population health outcomes supported by strong and equitable public health services
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by primary health care
- Improving child wellbeing

Progress towards each measure will be assessed and reported to the Minister of Health according to the reporting frequency outlined in the indicator dictionary for each measure (found on the NSFL https://nsfl.health.govt.nz/accountability/performance-and-monitoring/performance-measures/performance-measures-201920)

A resolution plan, that outlines the actions being taken to address poorer than planned performance, must be supplied where performance does not meet the agreed expectation. Where a performance measure description does not include specific assessment criteria, the following criteria will apply:

Assessment Criteria/Ratings for Performance Measures

Rating	Abbrev	Criteria
Outstanding performer/sector leader	O	1. This rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations. 2. This rating is applied when the DHB has met the target agreed in its Annual Plan and has achieved the target level of performance for the Māori population group, and the Pacific population group. Note: this rating can only be applied in the fourth quarter for measures that are reported quarterly or six-monthly. Measures reported annually can receive an 'O' rating, irrespective of when the reporting is due.
Achieved	A	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. For those measures where reporting by ethnicity is expected, this rating should only be applied when the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and the Pacific population group.

		4. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	1. Target/expectation not fully met, (including not meeting expectations for Māori and Pacific population groups) but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved, and a resolution plan satisfies the assessor that the DHB is on track to compliance for the requirements not met.
Not achieved – escalation required	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

Notes: 1) NR refers to 'No report has been received' 2) NA refers to 'Not applicable'

Annual Plan Reporting

Reporting against Annual Plan actions is provided through Status Update Reports. Reporting is categorised according to Planning Priority area.

CFA Variation Reporting

Reporting is required against Crown Funding Agreements (CFAs). Assessment criteria are different to the criteria applied to performance measures. The progress and developmental reporting nature for CFA variations is more compliance based, and therefore the target-oriented nature of performance measure assessment is not considered appropriate. The assessment criteria detailed below reflect the more qualitative nature of this component.

Assessment Criteria/Ratings for CFA Variations

Category	Abbrev	Criteria
Satisfactory	S	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	B	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not Acceptable	N	1. There is no report 2. The explanation for no report is not considered valid.

Confirmed Ministry of Health Ratings: If a DHB receives a rating of P, B or N for a particular measure or CFA Variation, the Ministry's assessor will outline the reasons in the Ministry feedback section and the DHB will be expected to submit an updated report/further comment during the confirmed reporting round. Supplying the requested information may result in the DHB receiving an improved score in the Confirmed Assessment round. However, this is not guaranteed.

Poor Performance Reporting: If a DHB fails to submit a required report against any health target, performance measure or CFA Variation, receives an 'N' rating in the Confirmed assessment round, or is determined to have significant emerging performance issues or service coverage issues, these issues will be highlighted to the Minister in the Performance Issues Section of the DHB's Quarterly Dashboard Performance Report.

Index

Key to Owner Initials

Initial	Owner	Title/Directorate
RD	Rory Dowding	Acting Executive Director Strategy, Primary & Community
PN	Patrick Ng	Executive Director Specialist Services
GT	Gilbert Taurua	Chief Māori Health Strategy & Improvement Officer
HL	Hywel Lloyd	Acting Executive Director Quality & Clinical Governance Solutions
NT	Nigel Trainor	Executive Director Finance, Procurement and Facilities
JW	Jane Wilson	Chief Nursing and Midwifery Officer

Summary of Reports with 'N' Ratings

Code	Performance Measure	Final Rating	Change from previous rating	Page number	Owner initials
Child Wellbeing					
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	N	↓	11	RD
CW05	Immunisation coverage: FA1 eight-month old	N	→	11	RD
CW05	Immunisation coverage: FA2 5-year old immunisation coverage	N	→	13	RD
CW05	Immunisation coverage: FA3 HPV coverage	N	→	14	RD
CW08	Increased Immunisation (at 2 years)	N	↓	17	
Improving Wellbeing through Prevention					
PV01	Improving breast screening coverage and rescreening	N	→	44	RD
Better population health outcomes supported by strong and equitable public health services					
SS11	Faster cancer treatment (62 days)	N	→	39	PN
Better Population Health Outcomes supported by Primary Health Care					
PH04	Better help for smokers to quit (primary care)	N	↓	46	RD

Executive Summary: Southern DHB Non-Financial Performance Reporting

Performance Measures Overview

Performance area	Number of outstanding measures	Number of achieved measures	Number of partially achieved measures	Number of not achieved measures	Unreported measures	Unrated measures	Total number of measures
Child Wellbeing	1	2	2	5			10
Improving Mental Wellbeing		8	3				11
Better Population Health Outcomes supported by Strong and Equitable Public Health Services	1	9	7	1	1	1	20
Improving Wellbeing through Prevention				1			1
Better Population Health Outcomes supported by Primary Health Care		1	2	1			4
Status Update Reports – Annual Plan Actions		2	5				7
Totals	2 (4%)	22 (42%)	19 (36%)	8 (15%)	1 (2%)	1 (2%)	53

Crown Funding Agreements Overview

	Number of satisfactory ratings	Number of further work required ratings	Number of not acceptable measures	Unreported	Unrated	Total number
Crown Funding Agreements	3	2			2	7

Summary of Quarter 4 Ratings 2020/21

Code	Performance Measure	Final Rating	Change from previous rating	Page number	Owner initials
Child Wellbeing					
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	N	↓	11	RD
CW05	Immunisation coverage FA1: 8-month old immunisation coverage	N	→	11	RD
CW05	Immunisation coverage FA2: 5-year old immunisation coverage	N	→	13	RD
CW05	Immunisation coverage FA3: HPV coverage	N	→	14	RD
CW08	Increased immunisation at 2 years of age	N	↓	17	RD
CW03	Improving the number of children enrolled and accessing the Community Oral Health Service	P	→	10	RD
CW07	Improving newborn enrolment in General Practice	P	↓	17	RD
CW09	Better help for smokers to quit (maternity)	A	↑	19	RD
CW12	Youth mental health initiatives (Youth primary mental health and Improve the responsiveness of primary care to youth)	A	↑	19	RD
CW10	Raising healthy kids	O	↑	19	RD
Improving Mental Wellbeing					
MH02	Improving mental health services using wellness and transition (discharge) planning	P	→	20	GT
MH03	Shorter waits for non-urgent mental health and addiction services for 0-19 years of age	P	→	21	GT
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	P	→	22	GT
MH01	Improving the health status of people with severe mental illness through improved access frequency	A	→	20	GT
MH04	Mental Health and Addiction Service Development FA1: Primary Mental Health	A	→	21	GT

MH04	Mental Health and Addiction Service Development FA2: District Suicide Prevention and Postvention	A	→	21	GT
MH04	Mental Health and Addiction Service Development FA3: Improving Crisis Response Services	A	↑	21	GT
MH04	Mental Health and Addiction Service Development FA4: Improve outcomes for children	A	→	21	GT
MH04	Mental Health and Addiction Service Development FA5: Improving employment and physical health needs of people with low prevalence conditions	A	→	22	GT
MH06	Mental health output delivery against plan	A	→	22	GT
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	A	→	22	GT
Better population health outcomes supported by strong and equitable public health services					
SS11	Faster Cancer Treatment (62 days)	N	→	39	PN
SS01	Faster cancer treatment (31 days) indicator	P	→	23	PN
SS02	Delivery of Regional Service Plans	P	→	23	RD
SS03	Ensuring delivery of service coverage	P	↓	23	RD
SS07	Planned Care Measures	P	→	23	PN
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA2: Improving the quality of data submitted to National Collections	P	→	35	NT
SS10	Shorter stays in emergency departments	P	→	36	PN
SS15	Improving waiting times for colonoscopies	P	→	41	PN
SS04	Implementing the Healthy Ageing Strategy	A	→	23	RD
SS05	Ambulatory sensitive hospitalisations (ASH adult)	A	→	23	RD
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	A	→	36	NT

SS12	Engagement and obligations as a Treaty partner	**A**	→	**41**	GT
SS13	Improved management for long term conditions FA1: Long Term Conditions	**A**	→	**41**	RD
SS13	Improved management for long term conditions FA2: Diabetes services	**A**	→	**41**	RD
SS13	Improved management for long term conditions FA3: Cardiovascular health	**A**	→	**41**	RD
SS13	Improved management for long term conditions FA4: Acute heart service	**A**	↑	**41**	PN
SS13	Improved management for long term conditions FA5: Stroke service	**A**	↑	**41**	RD
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA1: Improving the quality of identity data within the NHI	**O**	→	**35**	NT
SS17	Whanau ora	**No report**		**43**	NT
	Care capacity demand management calculation	**No rating**		**44**	JW
Improving Wellbeing through Prevention					
PV01	Improving breast screening coverage and rescreening	**N**	→	**44**	RD
Better Population Health Outcomes supported by Primary Health Care					
PH04	Better help for smokers to quit (primary care)	**N**	↓	**46**	RD
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	**P**	↓	**45**	RD
PH03	Improving Māori enrolment in PHOs to meet the national average of 90%	**P**	→	**46**	RD
PH01	Improving system integration and SLMs	**A**	↑	**45**	RD
Annual Plan Status Update Reports					
Updates	Annual Plan actions: Improving wellbeing through prevention	**P**	→	**49**	RD
Updates	Annual Plan actions: Improving sustainability	**P**	→	**51**	NT
Updates	Annual Plan actions: Improving mental wellbeing	**P**	→	**51**	GT
Updates	Annual Plan actions: Better population health outcomes supported by primary health care	**P**	→	**52**	RD

Updates	Annual Plan actions: Better population health outcomes supported by strong and equitable public health services	**P**	→	**53**	PN
Updates	Annual Plan actions: Improving child wellbeing	**A**	↑	**57**	RD
Updates	Annual Plan actions: Give practical effect to He Korowai Oranga – the Māori Health Strategy	**A**	→	**57**	GT

FA=Focus area

Crown Funding Agreements (CFA) Variations		Final Rating	Change from previous rating	Page number	Owner initials
CFA	DHB level service component of the National SUDI Prevention Programme	**B**	→	**58**	RD
CFA	Primary Health Care Services	**B**	→	**60**	RD
CFA	B4 School Check Services	**S**	→	**60**	RD
CFA	Well Child Tamariki Ora Services	**S**	↑	**61**	RD
CFA	Health Services for Emergency Quota Refugees	**S**	→	**61**	RD
CFA	COVID-19 Primary Care Digital Enablement Funding Support	**No rating**		**61**	NT
CFA	COVID-19 DHB Digital Enablement Funding Support	**No rating**		**61**	NT

Summary of Southern DHB Performance Reporting – Quarter 4 2020/21

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td>Child Wellbeing</td><td></td><td></td><td>Achieving Government's Priority Goals/Objectives and Targets</td></tr>
<tr><td>CW03: Improving the number of children enrolled and accessing the Community Oral health service</td><td>P</td><td>RD</td><td>Result: Number of enrolled pre-school and primary school children overdue for their scheduled examination, Jan-Mar performance as at 31 March 2021
<table>
<tr><th></th><th colspan="4">Percent overdue</th></tr>
<tr><th></th><th>All ethnicities</th><th>Māori only</th><th>Pacific only</th><th>Other</th></tr>
<tr><td>Preschool children (age 0-4)</td><td>16%</td><td>19%</td><td>24%</td><td>15%</td></tr>
<tr><td>Primary school children (age 5-8)</td><td>30%</td><td>11%</td><td>16%</td><td>34%</td></tr>
<tr><td>Total</td><td>25%</td><td>14%</td><td>19%</td><td>28%</td></tr>
</table>
MoH feedback:
• Please continue to maintain your focus and effort on services for high needs/high risk children, while also reducing the number of children in arrears.

Southern DHB narrative report:
• Substantial increase in arrears across the district
• We prioritise Māori and Pacific children for both early enrolment into the service and first appointments and when due Māori and Pacific take priority

Actions to address issues/barriers impacting on performance:
• Staffing continues to be an issue and recruitment to positions is constant
• The first part of a calendar year sees a lot of time and resource placed into supporting new graduates into practice; this is labour intensive for the service to ensure graduates are fully competent and well orientated to the service
• Redirect of double mobile and staff to an area well behind to support the high numbers of children overdue - this was a big effort and the area is now under control
• Risk based assessment initiative started this year sees low risk patients on an 18 month recall moving forward
• Not enough chairs for the Dunedin City area - refurbished one clinic to add a chair, exploring further options for mobile bollard or another chair</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			New initiatives and successes • Relocating mobiles to areas of high arrears, exploring options
CW04: Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	**N**	**RD**	Result: 2020 result is 53%. This compares to 75% in 2019. Target of 85% was not achieved. MoH feedback: • Because this is a decrease from 2019, Southern DHB have been given a not achieved rating. However, we do acknowledge the difficulties in maintaining utilisation rates given the impact of COVID-19 in 2020. Thank you for your efforts and we look forward to seeing improved results in the 2021 calendar year. Southern DHB narrative report: • A number of issues have influenced the poor outcome of the Southern DHB results for 2020, the long term injury of our Adolescent Coordinator and an inability to backfill into the position, diminishing dental access in Southland resulting in some dentists struggling to service or accept any further adolescents into their service. • We recognise the need to review the service and redefine and balance contractors' capability against organisational expectations. Provide support and improve monitoring of the service. • With that in mind the plan going forward ○ Assess current service delivery, specifically looking for gaps or barriers. ○ Develop a quality structure along with the Adolescent Coordinator position to support and problem solve issues that may arise. ○ Improvement of monitoring and reporting ○ Develop a closer working relationship with our contractors to assist in removing any barriers to care delivery
CW05: Immunisation coverage: FA1 eight-month old immunisation coverage	**N**	**RD**	Result: 93.0% total coverage; Māori infant immunisation coverage at 89.5%. Rank 2nd[h] out of 20 DHBs (total coverage). Target: 95%. National result: 87.3% for total population. MoH feedback: • It's clear you have been impacted by competing COVID-19 demands over Q4. Are there staff in any other areas that can be brought in and trained to help clinical staff focus on core vaccination work? • Have you been able to continue the work with Kaupapa services, and has the 0800 number been useful this quarter? MoH final feedback: • Thanks for your detailed response, very useful to see all the work that's going on across teams to boost immunisation

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			Southern DHB response to MoH feedback: There appear to be significant workforce pressures in the sector – Southern DHB is no exception. • Due to subject matter expertise within Vaccination Cold-Chain management services, staff with this skillset have been redeployed to support the Southern COVID vaccination programme as it works to upscale capacity for COVID vaccinations across the district. This has impacted the team greatly. • The team is looking to develop capacity in-house and training nurses to complete Outreach Services, with a view to develop a staff member into an additional Immunisation Coordinator role (dependent on budget allocation). • The staff are working ongoing with Kaupapa services with the vision to build capacity and increase vaccinations in this space. Although this is happening, it is still taking time to achieve this fully. Liaison with the Plunket service has also been happening to strengthen communications and vaccinations in this space. • Due to the strong relationships between the vaccination services of Te Punaka Oraka (Public Health Nursing) and the National Immunisation Register, staff will be meeting fortnightly to ensure recovery in this space is made through strong prioritisation of this work. • Further action will commence in relation to the National Immunisations Register for targeted areas of opportunity. • The 0800 number has been used but review needs to be undertaken to ensure this is being utilised fully. Southern DHB narrative report: • Total population coverage for 8 months was 93%; therefore Southern DHB did not achieve the 8-month target this quarter. • It is pleasing to see that Southern continues to perform well against other DHBs nationally for coverage of this age group. In Q4 Māori children coverage for this age group has increased by 5% and Southern lead nationally for the 8-month event. • In quarter 4, 136 of 152 eligible Māori children were fully vaccinated. 3.9% declined. • It is pleasing to see that Southern have achieved equity for Pacific children. Actions to address issues/barriers impacting on performance • In quarter 4, COVID-19 Vaccination roll out impacted greatly on Services and created drivers affecting Southern coverage. Outreach services were disrupted until Mid-May due to staff supporting COVID-19 vaccination clinic roll out. Staff worked in vaccination clinics and provided cold chain support. • NIR staff were directed to support the COVID Immunisation Register (CIR) work which impacted on NIR's ability to follow-up overdue childhood immunisations. Two NIR staff were seconded to CIR until April 2022.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• The Outreach service is recovering from the impact COVID has had on its workforce and has spent time recruiting and orientating new staff into the role. VPD team are working with NIR to identify children that have missed immunisation events. • Immunisation Coordinators have had little availability due to COVID demands. This has limited their ability to update overseas records to ensure immunisation records are updated in NIR in a timely manner.
CW05 Immunisation coverage FA2: 5-year old immunisation coverage	**N**	**RD**	Result: 90.1% for total population and 84.9% for Māori population. Target: 95%. Southern DHB: rank 3rd out of 20 DHBs (total population). National result: 85.0% for total population. NB: Achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. MoH feedback: • It's clear you have been impacted by competing COVID-19 demands over Q4. Are there staff in any other areas that can be brought in and trained to help clinical staff focus on core vaccination work? • Have you been able to continue the work with Kaupapa services, and has the 0800 number been useful this quarter? MoH final feedback: • Thanks for your detailed response, very useful to see all the work that's going on across teams to boost immunisation Southern DHB response to MoH feedback: There appear to be significant workforce pressures in the sector – Southern DHB is no exception. • Due to subject matter expertise within Vaccination Cold-Chain management services, staff with this skillset have been redeployed to support the Southern COVID vaccination programme as it works to upscale capacity for COVID vaccinations across the district. This has impacted the team greatly. • The team is looking to develop capacity in-house and training nurses to complete Outreach Services, with a view to develop a staff member into an additional Immunisation Coordinator role (dependent on budget allocation). • The staff are working ongoing with Kaupapa services with the vision to build capacity and increase vaccinations in this space. Although this is happening, it is still taking time to achieve this fully. Liaison with the Plunket service has also been happening to strengthen communications and vaccinations in this space.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• Due to the strong relationships between the vaccination services of Te Punaka Oraka (Public Health Nursing) and the National Immunisation Register, staff will be meeting fortnightly to ensure recovery in this space is made through strong prioritisation of this work. • Further action will commence in relation to the National Immunisations Register for targeted areas of opportunity. • The 0800 number has been used but review needs to be undertaken to ensure this is being utilised fully. Southern DHB narrative report: • Total population coverage for 5 years has decreased to 90%; therefore Southern DHB did not achieve the 5-year-old target this quarter. • Southern coverage for Māori has decreased by -7% • In quarter 4, 115 of 133 eligible Māori children were fully immunised at 5 years. • There were 8.3% that declined. Actions to address issues/barriers impacting on performance • In quarter 4, COVID-19 Vaccination roll out impacted greatly on services and created drivers affecting Southern coverage. Outreach services were disrupted until Mid-May due to staff supporting COVID-19 vaccination clinic roll out. Staff worked in vaccination clinics and provided cold chain support. • NIR staff were directed to support the COVID Immunisation Register (CIR) work which impacted on NIR's ability to follow-up overdue childhood immunisations. Two NIR staff were seconded to CIR until April 2022. • The Outreach service is recovering from the impact COVID has had on its workforce and has spent time recruiting and orientating new staff into the role. VPD team are working with NIR to identify children that have missed immunisation events. • Immunisation Coordinators have had little availability due to COVID demands. This has limited their ability to update overseas records to ensure immunisation records are updated in NIR in a timely manner. New initiatives and successes • NIR will assign an administrator to track and trace overdue children for this age group.
CW05: Immunisation coverage FA3: HPV (Cohort 2006)	**N**	**RD**	Target: Equitable immunisation coverage across their Māori, Pacific (where relevant) and total populations, aiming at coverage of 75 percent for each group for those in the relevant birth cohort

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>
Southern DHB result: Immunisation coverage HPV (Cohort 2007)
<table>
<tr><th>HPV-1</th><th>Māori</th><th>Pacific</th><th>Asian</th><th>Other</th></tr>
<tr><td>Girls</td><td>69.3%</td><td>78.7%</td><td>83.2%</td><td>74.3%</td></tr>
<tr><td>Boys</td><td>67.8%</td><td>64.3%</td><td>84.4%</td><td>72.7%</td></tr>
<tr><td>Total HPV-1</td><td>68.5%</td><td>71.7%</td><td>83.9%</td><td>73.5%</td></tr>
<tr><th>HPV-All
Final dose coverage</th><th>Māori</th><th>Pacific</th><th>Asian</th><th>Other</th></tr>
<tr><td>Girls</td><td>59.6%</td><td>76.0%</td><td>77.6%</td><td>67.2%</td></tr>
<tr><td>Boys</td><td>58.8%</td><td>58.6%</td><td>80.1%</td><td>67.0%</td></tr>
<tr><td>Total</td><td>59.2%</td><td>67.6%</td><td>79.0%</td><td>67.1%</td></tr>
</table>

MoH feedback:
• National HPV immunisation coverage for the 2007 birth cohort to end June is 62.7 percent for girls and 62.4 percent for boys, and 62.5 percent overall. Rates remain well below the 75 percent target for HPV coverage nationally.
• Please continue to encourage families to book their young people in for any missing HPV, Boostrix or MMR vaccinations wherever you can.
• Have the planned clinics in alternative settings, eg marae been able to go ahead, and if so how effective have they been?
• Great to hear sexual health is now on board and providing HPV as well. We encourage you to consider HPV in any immunisation programme planning that you may do.

MoH final feedback:
• Thanks for your detailed responses and your ongoing efforts to improve HPV coverage.

Southern DHB response to MoH feedback:
There appear to be significant workforce pressures in the sector – Southern DHB is no exception.
• Due to subject matter expertise within Vaccination Cold-Chain management services, staff with this skillset have been redeployed to support the Southern COVID vaccination programme as it works to upscale capacity for COVID vaccinations across the district.
• This has impacted the team greatly and unfortunately clinics in settings such as marae are yet to take place. However, there has been coverage in Enhanced Youth Health Clinic settings and repromotion of these clinics will take place to build awareness. We will look to review capacity for marae clinics.
</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• Staff are also working ongoing with Kaupapa services with the vision to build capacity and increase vaccinations in this space. Although this is happening, it is still taking time to achieve this fully. Southern DHB narrative report • Total population coverage for Human papillomavirus vaccination, fully immunised was 67%, therefore Southern DHB did not achieve the 75% target quarter 4. • Southern continues to perform above the national total 62% HPV-all coverage and performing consistently against other DHBs nationally. There is a 10% percentage HPV-all increase on the previous year which was 57% coverage • In Q4 Māori HPV-all coverage for HPV-all is 59% and increase of 1% from previous year and is above the national average 57% HPV-all coverage. Equity gap is 11% and requires additional response. Initiatives outlined below to decrease barriers. • It is pleasing to see that Southern has achieved 68% which is an 18% increase for Pacific HPV-all in 2020-21 from previous year. Actions to address issues/barriers impacting on performance • For Quarter 4 results, COVID-19 outbreak and subsequent vaccination programme in the Southern district impacted on the general delivery of HPV vaccinations across providers in the Southern area as staffing was redeployed to Covid-19 response. The HPV school based program has continued to provide two-dose program in schools despite disruptions to service. • The vaccination providers across general practice and school-based program, Māori and Pacific continue to be stretched requiring additional workforce capacity to provide all scheduled and other vaccinations particularly as COVID vaccination is the key priority currently. • Immunisation Coordinators have had little availability due to COVID demands. This has limited their ability to support practices to precall and recall young people that have not participated in the school based program • Reaching target requires additional communication to practices with a priority precall and recall for Māori, Pacific and high deprivation. Further planning includes encouraging access to HPV vaccination in sexual health clinics and rural youth health clinics and reaching out to kaupapa Māori health and Pacific services. COVID vaccination program is currently increasing the capacity both in personnel and in equipment and training for Māori providers to be able to deliver vaccinations through their services. In time, this will decrease barriers to access to all vaccinations. Immunisation coordinators are currently working with these providers to develop capacity.

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>New initiatives and successes
Sexual health services now has access to NIR and are screening young patients for HPV vaccination and are now able to provide the vaccination to priority population groups</td></tr>
<tr><td>CW07: Improving newborn enrolment with General Practice</td><td>P</td><td>RD</td><td>Result:
<table>
<tr><th>Newborn enrolment</th><th>Results 6 weeks of age</th><th>Target</th><th>Results 3 months of age</th><th>Target</th></tr>
<tr><td>Māori</td><td>57.0%</td><td>55%</td><td>73.3%</td><td>85%</td></tr>
<tr><td>Pacific</td><td>N/A</td><td>55%</td><td>57.7%</td><td>85%</td></tr>
<tr><td>Asian</td><td>65.5%</td><td>55%</td><td>96.6%</td><td>85%</td></tr>
<tr><td>Other</td><td>73.5%</td><td>55%</td><td>99.5%</td><td>85%</td></tr>
<tr><td>Total</td><td>69.7%</td><td>55%</td><td>93.4%</td><td>85%</td></tr>
</table>
MoH feedback:
Well done for meeting your overall targets. Performance is mixed with overall targets being met and an equity gap between Māori and Pacific tamariki and non-Māori/Pacific tamariki. Narrowing the equity gap remains a tight focus.
Southern DHB narrative report:
WellSouth works with practices to ensure that all babies referred to them are enrolled in their mother’s practice.
Our Health Care Home Programme works directly with practices to improve processes around enrolments and has a focus on equity to make practices more aware of service gaps in the community.
The WellSouth Health Promotion team runs a breast-feeding support network across the South that helps to connect mothers with the services to which their babies are entitled, including services at general practice. We have identified that this service is less successful in Māori communities, in particular, and have reached out to Māori providers in Southern to work together on ways to improve visibility amongst new Māori mums.
In May 2021 we are rolling out the NHC’s Gen 2040 Programme and hope that using the Gen 204 screening tool we can improve both connections to a LMC and enrolment of newborns in general practice.</td></tr>
<tr><td>CW08: Increased immunisation at 2 years of age</td><td>N</td><td>RD</td><td>Result: 91.3% for total population and 86.5% for Māori population. Rank 4th out of 20 (total population).
National result: 85.4% for total population
Target: 95%. Achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent.</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			MoH feedback: • Initial Feedback National immunisation coverage for last quarter at the key 2-year milestone age is now 85.4 percent, well below the 95 percent target and a further 2.6 percent lower than quarter three. • Significant drivers behind this included a 6.3 percent decrease in coverage for tamariki Māori and a 5 percent decrease for those children in deprivation levels 9-10. • It's clear you have been impacted by competing COVID-19 demands over Q4. • Are there staff in any other areas that can be brought in and trained to help clinical staff focus on core vaccination work? • Have you been able to continue the work with Kaupapa services, and has the 0800 number been useful this quarter? MoH final feedback: • Thanks for your detailed response, very useful to see all the work that's going on across teams to boost immunisation Southern DHB response to MoH feedback: There appear to be significant workforce pressures in the sector – Southern DHB is no exception. • Due to subject matter expertise within Vaccination Cold-Chain management services, staff with this skillset have been redeployed to support the Southern COVID vaccination programme as it works to upscale capacity for COVID vaccinations across the district. This has impacted the team greatly. • The team is looking to develop capacity in-house and training nurses to complete Outreach Services, with a view to develop a staff member into an additional Immunisation Coordinator role (dependent on budget allocation). • The staff are working ongoing with Kaupapa services with the vision to build capacity and increase vaccinations in this space. Although this is happening, it is still taking time to achieve this fully. Liaison with the Plunket service has also been happening to strengthen communications and vaccinations in this space. • Due to the strong relationships between the vaccination services of Te Punaka Oraka (Public Health Nursing) and the National Immunisation Register, staff will be meeting fortnightly to ensure recovery in this space is made through strong prioritisation of this work. • Further action will commence in relation to the National Immunisations Register for targeted areas of opportunity. • The 0800 number has been used but review needs to be undertaken to ensure this is being utilised fully.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			Southern DHB narrative report: • Total population coverage for 2 years has decreased to 91%; therefore Southern DHB did not achieve the 2-year-old target this quarter. • While we have not reached target Southern performance rates remain high for this age group. • Southern coverage for Māori and Pacific has decreased, increasing Southern equity gap. • In quarter 4, 115 of 133 eligible Māori were fully immunised at 2 years of age. Of these 8.3% had declined. • In quarter 4, 39 of 43 eligible Pacific were fully immunised at 2 years of age. Of these 2.3% had declined. Actions to address issues/barriers impacting on performance • In quarter 4, COVID-19 Vaccination role out impacted greatly on Services and created drivers affecting Southern coverage. Outreach services were disrupted until Mid-May due to staff supporting Covid 19 vaccination clinic roll out. Staff worked in vaccination clinics and provided cold chain support. • NIR staff were directed to support the COVID Immunisation Register (CIR) work which impacted on NIR's ability to follow-up overdue childhood immunisations. Two NIR staff were seconded to CIR until April 2022. • The Outreach service is recovering from the impact COVID has had on its workforce and has spent time recruiting and orientating new staff into the role. VPD team are working with NIR to identify children that have missed immunisation events. • Immunisation Coordinators have had little availability due to COVID demands. This has limited their ability to update overseas records to ensure immunisation records are updated in NIR in a timely manner. New initiatives and successes • New staff have now been recruited to the Outreach team. They are extremely motivated, focused and will prioritise Māori and vulnerable children to ensure their vaccinations are given on time.
CW09: Better help for smokers to quit-Maternity	**A**	**RD**	
CW10: Raising Healthy Kids	**O**	**RD**	
CW12: Youth mental health initiatives	**A**	**RD**	

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td>Improving Mental Wellbeing</td><td colspan="2"></td><td>Achieving Government's Priority Goals/Objectives and Targets</td></tr>
<tr><td>MH01: Improving the health status of people with severe mental illness through improved access</td><td>A</td><td>GT</td><td></td></tr>
<tr><td>MH02: Improving mental health services using well and transition (discharge) planning</td><td>P</td><td>GT</td><td>Results: Improving mental health services using well and transition (discharge) planning
<table>
<tr><th></th><th>Percent of clients with a transition (discharge) plan</th><th>Target</th><th>Percent of clients with a wellness plan</th><th>Target</th></tr>
<tr><td>Community</td><td>63.3%</td><td>95%</td><td>82.4%</td><td>95%</td></tr>
<tr><td>Inpatient</td><td>100.0%</td><td>95%</td><td></td><td></td></tr>
</table>
Southern DHB commentary:
• We continue in Southern to maintain a focus on clients' transition plans and monitoring is occurring with unit managers. Ongoing work is occurring re the quality of the plans and sharing with GP's
• Across the Southern region we continue to maintain a focus on client's transition plans, and that sharing of these plans is occurring with GP's and whanau

Inpatient clients
• All clients discharged from inpatient settings have in place a discharge plan that is uploaded into the clinical workstation (Health Connect South), accessible also by GPs / PHOs via HealthOne.
• Inpatient units continue to support all clients have a discharge plan which continues to be uploaded to HCS.

Community clients:
• Our up-to-date analysis of community clients (current and discharged) shows trends and any improvements over time.</td></tr>
</table>

<table>
<tr><th>Measure</th><th></th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td>MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds</td><td></td><td>P</td><td>GT</td><td>Results: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds
<table>
<tr><th></th><th>Percent of 0-19 year olds seen within 3 weeks</th><th>Target</th><th>Percent of 0-19 year olds seen within 8 weeks</th><th>Target</th></tr>
<tr><td>Mental Health Provider Arm</td><td>69%</td><td>80%</td><td>90%</td><td>95%</td></tr>
<tr><td>Addictions (Provider Arm and NGO)</td><td>67%</td><td>80%</td><td>89%</td><td>95%</td></tr>
</table>
Southern DHB narrative report:
Identify what processes have been put in place to reduce waiting times
• Data on wait times is produced for the teams and they are able to identify any issues and look at strategies to review this. In the smaller teams the impact of vacancies has an impact on this.
• Teams continue to monitor there wait time and review these. Vacancies continue to have an impact on this and the acuity of referrals being received

Explain variances of more than 10% in waiting times
• We have seen an increase in waiting times to access services for this age cohort in some areas. This is particularly noticeable in our NGO sector and has been attributed to post pandemic factors. We have mitigation actions in place which include funding more FTE in NGOs that provide services to this age group and we have commissioned additional services with He Ara Oranga funding for Access and Choice programmes, in particular the Integrated Primary Mental Health Service.

Additional commentary – Alcohol and other Drug Services
• In addition to that which is outlined above, Alcohol and Other Drug services are dispersed and located in our rural / provincial teams. Screening occurs at all entry points in our services and the most appropriate pathways and treatment modalities are instigated based on patient need, either Addiction services or Adult Mental Health are able to source advice from each other if required. Southern is part of the South Island regional addiction work plan in collaboration with the other South Island DHBs.</td></tr>
<tr><td rowspan="4">MH04: Mental health and addiction</td><td>FA1</td><td>A</td><td>GT</td><td>FA1: Primary mental health</td></tr>
<tr><td>FA2</td><td>A</td><td>GT</td><td>FA2: District suicide prevention and postvention</td></tr>
<tr><td>FA3</td><td>A</td><td>GT</td><td>FA3: Improving crisis response Services</td></tr>
<tr><td>FA4</td><td>A</td><td>GT</td><td>FA4: Improve outcomes for children</td></tr>
</table>

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
service development	FA5	**A**	**GT**	FA5: Improving employment and physical health needs of people with low prevalence conditions
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders		**P**	**GT**	Result: For the period between 1 Jan21 and 31 Mar21, the percentage (of DHB population) of patients under section 29 in Southern DHB who are: Māori 232/100,000, non-Māori 85/100,000. Due to data availability, data are 3 months in arrears for each quarter. Expectation: Reduce the rate of Māori under s29 of the Mental Health Act by at least 10% by the end of the reporting year. Southern DHB narrative report: • Following the review of the Southern DHB Māori Directorate, Māori health staff are settling into their roles, which we hope will achieve better integration and access to cultural care, particularly where Māori may present in crisis, and in the CMHT settings. MHA client numbers by ethnicity (including Māori) continue to be incorporated into SMO annual performance reviews to raise awareness of personal and relative numbers of Māori under the MH Act. • While this data is subject to ongoing scrutiny and monitoring, the Zero Seclusion strategy group continues to be re-energised, working closely with HQSC. The focus remains on the point of admission through the crisis teams and CMHT's, and emphasis on the quality of EWS and RPP's being completed with consumers. It is hoped the combination of this focus and increased cultural access may help to reduce use of the MH Act at the point of relapse or crisis and/or during the course of their inpatient stay overall, but in particular for Māori. • The DAMHS is intending to review the number of Māori who have been on section 29's for longer than 5 years. This will provide a good opportunity to understand the issues that are impacting on the use of compulsion to engage Māori service users in mental health care.
MH06: Mental health output delivery against plan		**A**	**GT**	
MH07: Improving mental health services by improving inpatient post discharge follow-up rates		**A**	**GT**	

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
Better Population Health Outcomes Supported by Strong and Equitable Public Health Services				**Achieving Government's Priority Goals/Objectives and Targets**
SS01: Faster cancer treatment (31 days)		**P**	**PN**	Result: 78.8% achievement (target 85%), ranked 19th out of 20 DHBs. National result: 85.6% • Refer to SS11 Faster cancer treatment (62 days) for Southern DHB narrative. MoH feedback: • Te Aho o Te Kahu notes Southern DHB only achieving 78.8 percent.
SS02: Delivery of Regional Service Plans		**P**	**RD**	SIAPO reports on activity and progress of the South Island Health Services Plan.
SS03: Ensuring delivery of Service Coverage		**P**	**RD**	MoH feedback: • Please continue to maintain your focus and effort on services for high needs/high risk children, while also reducing the number of children in arrears. Southern DHB narrative report: • Refer to report for CW03: Improving the number of children enrolled and accessing the Community Oral Health Service
SS04: Implementing the Healthy Ageing Strategy		**A**	**RD**	
SS05: Ambulatory sensitive hospitalisations (ASH adult)		**A**	**RD**	
SS07 Planned care measures	Planned care measure 1	**P**	**PN**	Planned care measure 1: Planned Care Interventions MoH feedback: • A lot of work remains to be done to get to compliance. ESPI 5 (particularly orthopaedics) and radiology are of major concern. Look forward to seeing plans for increased delivery across the board.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				Southern DHB report:

Procedure	Result	Target	Actions to achieve compliance	When will compliance be achieved
Inpatient Surgical Discharges	94.4%	95%	• Additional money from the improvement action fund has been allocated for inpatient procedures to be outsourced. • Services to be targeted are orthopaedics, general surgery, ENT and urology. This will bring the volumes into compliance for 2021/22.	• By end of 2021/22 financial year this will be compliant.
Minor Procedures	94.8%	95%	• A contract has been signed with GP providers for skin lesions to be done in the community. This will shift a portion of patients who would normally be seen and treated in secondary care into primary care and increase the volume of minor procedures. • An improved reporting system for 2021/22 is being developed and this will ensure that all minor ops done outpatient settings are correctly identified and coded appropriately.	• By end of 2021/22 financial year this will be compliant.
Inpatient CWDs	97.5%	95%	• No response required	
Planned care interventions	94.8%	100%	• Inpatient Surgical Discharges - from July 2021 there will be	• Discharges are planned to meet the target by the fourth quarter of 2021/22.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses				
							a planned increase in outsourcing and outplacing. • Minor Procedures - as above. • Non-surgical interventions - An Orthopaedic Waitlist Programme commenced in the last quarter of 2020/21 and this has been expanded for 2021/22. This focuses on enabling people to self-manage their condition and to get fit prior to surgery to aid early recovery.	

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td>Planned care measure 2</td><td></td><td>PN</td><td>Planned care measure 2: Elective Service Patient Flow Indicators

Southern DHB report:
<table>
<tr><th></th><th>Result</th><th>Target</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>ESPI 1</td><td>100%</td><td>90%</td><td>• No response required</td><td></td></tr>
<tr><td>ESPI 2</td><td>19.5%</td><td>100%</td><td>Actions that are part of the improvement action plan for 2021/22 are to:
• introduce the MOH prioritisation tool to balance capacity and demand for FSA appointments to more services (it is currently running successfully in orthopaedics and general surgery)
• run additional clinics with current staff
• employ Fellows for Orthopaedics and General Surgery for 12 months
• use the acuity tool to ensure that long wait patients are seen
• waitlist maintenance i.e. regular checking of longwaiting patients
• employ specialist nurses for general surgery and orthopaedics to see patients within their scope which allows SMOs to see FSA patients
• ensure that clinics are booked with a minimum number of FSA's</td><td>• Achievement and compliance will vary by service and is planned to occur 2021/22</td></tr>
<tr><td>ESPI 3</td><td>0.2%</td><td>0%</td><td>• No response required</td><td></td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Measure</th><th></th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td rowspan="2"></td><td></td><td rowspan="2"></td><td></td><td>
<table>
<tr><td>ESPI 5</td><td>37.5%</td><td>100%</td><td>• From July 2021 additional money is being spent on outsourcing with our usual providers. This will be used to target long waiting patients.
• Additional orthopaedic cases (approx. 70 pa) will go to South Canterbury DHB.
• A business case has been presented to the ELT regarding increasing the number of acute sessions and opening additional beds, as these are common causes for cancellations.</td><td>• Achievement and compliance will vary by service and is planned to occur in 2021/22</td></tr>
<tr><td>ESPI 8</td><td>99.6%</td><td>100%</td><td>• No response required</td><td></td></tr>
</table>

Expectations:
<table>
<tr><td>ESPI 1 target</td><td>DHB services will appropriately acknowledge and process more than 90% of referrals in 15 calendar days or less.</td></tr>
<tr><td>ESPI 2 target</td><td>No patients are waiting longer than four months for their first specialist assessment (FSA.)</td></tr>
<tr><td>ESPI 3 target</td><td>0 patients in Active Review with a priority score > the aTT (Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)</td></tr>
<tr><td>ESPI 5 target</td><td>0 Assured patients are waiting over 120 days (Patients given a commitment to treatment but not treated within four months)</td></tr>
<tr><td>ESPI 8 target</td><td>100% of patients were prioritised using nationally recognised processes or tools</td></tr>
</table>
</td></tr>
<tr><td>Planned care measure 3</td><td>PN</td><td>Planned care measure 3: Diagnostics waiting times Angiography, Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)</td></tr>
</table>

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				Southern DHB report:

Diagnostic	Result	Target	Actions to achieve compliance	When will compliance be achieved
Angiography	93.2%	95%	Based on the Q4 results ending June 21, the target was achieved	Will be achieved by end of quarter one (30 September 2021)
CT	72.8%	95%	• Southern DHB continues to outsource additional CT examinations to Pacific Radiology in order to meet demand. • The catchment area(s) of Southland, Dunedin and Queenstown Lakes Hospitals have been adjusted to shift some demand away from Dunedin, where it is heaviest. • MITs at Dunedin Hospital are undertaking additional lists throughout July and August in order to reduce the wait list in the lead up to the arrival of the additional CT scanner for Dunedin Hospital. This is the principle strategy for improving performance against the indicator. • The scanner is anticipated to be operational from 06 September 2021.	• With the three initiatives underway SDHB expect to be compliant by February 2022.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses				
				MRI	47.9%	90%	• Capacity is not available for additional sessions at Dunedin; Southland does however continue to provide spaces for examinations of Otago patients. • Outsourcing of examinations to Pacific Radiology continues as the main strategy to prevent further deterioration in performance. • The principle strategy to improve performance is the installation of an additional scanner at Dunedin Hospital. A location has been found, adjacent to the existing scanner and engineering feasibility of this option has been established. The clinical team have indicated their preference and the final stages of the procurement process are underway, with vendor selection expected by end August 2021, at which time a CAPEX	• SDHB expect to be compliant by December 2022.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

				approval request will be submitted. • Lead time of equipment is estimated to be six months, however as major building works are anticipated, the lead time for the whole project is expected to be c. 12 months.	

CT Monthly Performance

Month	Performance
Jan 2020	48.7%
Feb 2020	62.1%
Mar 2020	64.7%
Apr 2020	61.9%
May 2020	66.2%
June 2020	73.7% (estimated)

CT - additional commentary

- Dunedin Hospital continues to experience very high levels of acute demand, which at times require the postponement of elective examinations. Southland Hospital continues to perform at a higher level than Dunedin. Performance has improved this quarter, estimated result for June needs to be treated with some caution, however additional lists were carried out most weekends of June in public and at Dunedin Hospital, explaining this improvement. This will not be sustainable over a lengthy period, however it should ensure the waitlist does not significantly worsen prior to the commissioning of the new scanner at that site.
- Southern DHB continues to outsource examinations of Dunedin patients to private and trust scanners located in Dunedin and Oamaru. Outsourcing is a limited option owing to low capacity in private CT and the distance Dunedin patients are required to travel to receive their examination in Oamaru. Southland Hospital continues to refer patients living in parts of northern Southland to the scanner at Lakes Hospital.
- Building works required to accommodate an additional diagnostic CT scanner at Dunedin Hospital are underway and expected to be complete by 6 August 2021. The scanner at the time of writing is in Singapore and is expected to arrive at Lyttleton on 09 August 2021. This is c. 10-11 days behind schedule. The expected date for the

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				additional scanner to become operational is now likely to be in week 2 of September 2021 vs the original date of 27 August. The new scanner, when commissioned, should increase elective capacity at Dunedin considerably and while an increase in referrals to CT is a likely outcome, in the short term the waiting list should be reduced to target levels by the end of the calendar year. • Southland is completing work on clinical preference for a replacement scanner, expected to be purchased in the 2021/2022 financial year. This will also include improvements to the CT suite which are considered necessary for reasons of patient safety and efficiency improvement. There is likely to be a six to ten week outage associated with this work. The Request for Proposal has asked vendors to offer solutions to offset this and it is likely based on the proposals received that much of the disruption this work is expected to cause will indeed be mitigated by the offered solutions. MRI monthly performance **Month** / **Performance** Jan 2020 — 31.7% Feb 2020 — 42.2% Mar 2020 — 44.9% Apr 2020 — 42.7% May 2020 — 41.2% June 2020 — 48% (estimated) MRI - additional commentary: • Demand for both acute and elective MRI exceeds capacity at Dunedin and this is the most significant contributor to DHB performance. • Southern DHB continues to outsource examinations weekly to a private provider; the improved result for June is largely due to extra sessions provided privately in June. The provider has been asked to consider options for more extensive support over the short to medium term. • Alongside this work is progressing on purchase of an additional MRI scanner at Dunedin Hospital. The intention is for the investment to be made in the 2021/2022 financial year. Clinical preference is expected to be known before end July 2021. • Due diligence on a potential location within Radiology is underway and again this work is expected to be concluded end July. This is highly likely to have a long lead time and cannot reasonably be expected to be in place until 2022/23. Southland Hospital MRI is continuing to examine some Otago domiciled patients.

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td></td><td>General comments:
The District Radiology Ten Year Strategy, sponsored by the Executive Director of Specialist Services is in draft. Progress has been delayed due to the focus since the last report being on Capital and other projects. Work is expected to resume in Q1 2021/22.</td></tr>
<tr><td></td><td>Planned care measure 4</td><td></td><td>PN</td><td>Planned care measure 4 : Ophthalmology Follow-up Waiting Times

Southern DHB report:
<table>
<tr><th></th><th>Result</th><th>Target</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>Ophthalmology Follow-up Waiting Times</td><td>18.9%</td><td>0%</td><td>Actions that are part of the improvement action plan are to provide locums, run additional clinics and utilise community optometrists.
Currently fully staffed on both sites however it will likely take most of the year to recover (without further COVID resurgence).
Ophthalmology is particularly susceptible to reductions during COVID due to overcrowding in waiting rooms and close proximity during outpatient clinics.</td><td>The recovery trajectory as part of the improvement action plan sees the follow up waiting list reduced to zero by December 2021.</td></tr>
</table>
Expectation: No patient will wait more than or equal to 50% longer than the intended time for their appointment.</td></tr>
<tr><td></td><td>Planned care measure 5</td><td></td><td>PN</td><td>Planned care measure 5: Cardiac Urgency Waiting Times</td></tr>
</table>

<table>
<tr><th>Measure</th><th></th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Southern DHB report:
<table>
<tr><th></th><th>Result</th><th>Target</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>Cardiac urgency waiting times</td><td>10</td><td>0</td><td>• We continue to monitor and prioritise clinical need. This includes, weekly MDT meeting for the following week surgery plus outplacing at private hospital for lower risk outpatients.</td><td>• Our current cardiac waiting list numbers (as at 8/8/21) are 29 Outpatients and 2 Inpatients. In the month of July - 8 acutes, 9 electives and 9 TAVIs were completed.
• We aim to continue full production, contingent on ICU bed access and currently run 1 list per month in the private sector to assist compliance with our waiting list by the fourth quarter 20/21.</td></tr>
<tr><td>Cardiac delivery</td><td>98%</td><td>95%</td><td>• No report required</td><td></td></tr>
</table>
Cardia urgency expectation: All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency</td></tr>
<tr><td></td><td>Planned care measure 6</td><td></td><td>HL</td><td>Planned care measure 6: Acute Readmissions

Southern DHB report:
<table>
<tr><th></th><th>Result</th><th>Target</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>Acute readmissions</td><td>12.1%</td><td>≤11.7%</td><td>• Readmission analysis continues. Analysis is indicating General Medical and 8 Med as having higher readmission rates, especially within the Long Term Condition patients.
• Dunedin - COPD bundle continues to do well in</td><td>• Southland – Audit delayed but expected to be run this quarter on all COPD and Diabetes readmissions to uncover themes.
• Dunedin - Ongoing with COPD bundle and analysis of areas for improvement.</td></tr>
</table></td></tr>
</table>

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th colspan="5">Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="5">lowering readmission rates.
• Southland - Unit Manager Medical, Quality Improvement and Clinical Director Medical met to highlight areas where improvement could occur.</td></tr>
<tr><td></td><td>Planned care measure 7</td><td></td><td>PN</td><td colspan="5">Southern DHB report: Planned care measure 7: Did Not Attend (DNA) rates for First Specialist Appointment by Ethnicity (developmental)

<table>
<tr><th>FSA DNA by ethnicity</th><th>Result</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>Data Quality</td><td>Developmental</td><td>• Analysis of DNA rates by ethnicity presented to Telehealth group, Māori leadership group, Administration team, Faster Cancer Treatment Steering Group, Rural Hospitals.</td><td>• Education package completed for Admin and Outpatient Nursing staff. Education workshops started and on track (will continue over Q1 and 2 in 2021/22).
• Co design of strategies and priorities on track for end Q1.</td></tr>
<tr><td>Variance</td><td></td><td>• We require a suite of measures to monitor equity for intervention, referral and waiting times rates.
• Our target is to have no difference in rates between Māori, Pacifica and Other.</td><td>• Suite of tools established for monitoring equity in outpatients. Co-design of prioritised strategies is underway and on track.</td></tr>
</table></td></tr>
</table>

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1	O	NT	Focus Area 1: Improving the quality of data within the NHI
	Focus Area 2	P	NT	Focus Area 2: Improving the quality of data submitted to National Collections Indicator 1 – Not achieved Indicator 2 – Outstanding Indicators 3 – Achieved MoH feedback: • Indicator 1: NPF collection has accurate dates and links to NBRS, NMDS and NNPAC for FSA and planned inpatient procedures - thank you for keeping us informed of your progress and while we can see only minimal improvement at the moment we are looking forward to a significant change over the next quarter. • Indicator 2: National Collections Completeness – congratulations on achieving high results for data submitted to NMDS, NNPAC and PRIMHD. However, we did notice missing NNPAC (ED) volumes for Gore hospital this quarter. • Indicator 3: Assessment of data reported to the National Minimum Data Set (NMDS) – well done on the continued achieved rating. Southern DHB narrative report: Indicator 1 • NMDS and NBRS Recently, we discovered a significant issue with the NPF extract which is (we think) the key reason we have number for NMDS and NBRS matches of single percentage digits. We have a method to bypass the issue, and simultaneously get the issue resolved by MKM (extract vendor), the bypass was started on Saturday 17th July and is expected to have 66,000 activity records ready to send to MoH by Friday 23rd July. We will then send multiple batches up to the MoH. • NNPAC - With our Karisma feed it was discovered that our event ids will not match as the data element (NNPAC ID) in the NPF extract is being truncated. This issue is known by the MoH and they are working on it. This accounts for some unmatched records but the vast amount of them are because of the issue above, we are re-working (combining into on) the interfaces between our source data and the extracts so we can keep a much better where the holes/flaws are. Indicator 2 - SDHB is very pleased with the Outstanding rating for this Quarter

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td rowspan="2"></td><td></td><td></td><td></td><td>Indicator 3 - SDHB has an achieved rating which is in line with all other DHB's however we continue to refine our processes as we look to improve.

Southern DHB Indicator 1 report: Not achieved
<table>
<tr><th>Collection</th><th>Description</th><th>%</th><th>Rating</th></tr>
<tr><td>NBRS</td><td>NBRS exits link to a NPF activity record with matching exit/activity date.</td><td>9%</td><td rowspan="3">Not achieved (Achieved is greater than or equal to 90% and less than 95%, based on average rating across the three collections.</td></tr>
<tr><td>NMDS</td><td>NMDS waitlist events link to a NPF encounter with matching procedure date.</td><td>7%</td></tr>
<tr><td>NNPAC</td><td>NNPAC attended FSA events link to a NPF encounter with matching date of service.</td><td>38%</td></tr>
</table></td></tr>
<tr><td>Focus Area 3</td><td>A</td><td>NT</td><td>Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)</td></tr>
<tr><td colspan="2">SS10: Shorter stays in emergency departments</td><td>P</td><td>PN</td><td>Result: 82.0% admitted, discharged, or transferred from an Emergency Department (ED) within six hours (target is 95%). Ranked 14th out of 20 DHBs. National result is 83.1%.

MoH feedback:
Good progress with implementing escalation processes. Slow exit to wards from ED is area of concern
Additional Feedback: Clearly Dunedin is struggling to meet the target, followed by Southland, while Lakes is achieving overall.
The different performance for Māori and Pasifika in Lakes is likely to reflect statistical variation due to small numbers.
The admitted patient streams are driving this performance and your efforts to improve care for admitted patients with implementation of the ‘generalist’ model are noted.
The ED short stay rate is <15% and subsequent admission to ward rate is <20% suggesting appropriate use of ED short stay.
That near 1% of your included patients stay <15minutes in ED indicates the appropriate group is mostly being measured with respect to the target. Good progress with implementing escalation processes. Slow exit to wards from ED is area of concern
Southern DHB narrative report:</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>
Percent managed within 6 hours by facility
<table>
<tr><th>Facility</th><th>% managed within 6 hours</th></tr>
<tr><td>Dunedin ED</td><td>75.65%</td></tr>
<tr><td>Lakes District ED</td><td>95.60%</td></tr>
<tr><td>Southland ED</td><td>84.70%</td></tr>
<tr><td>Southern DHB</td><td>81.99%</td></tr>
</table>

Actions undertaken this quarter to maintain or improve the indicator
• Dunedin hospital escalation plan implemented regularly as part of business as usual
• Dunedin Fit 2 to sit ambulatory area utilisation improving
• ED variance response management implemented
• Patient Flow task force to improve patient flow across hospitals continues
• Dunedin ED better utilisation of Resus space
• New generalist model of care implementation 80% underway
• Dunedin ED Surge plan in place.
• Care bundles in place

Planned work for next quarter
• Patient flow work across the hospital continues
• Progress build and design of MAU in Dunedin hospital

Barriers to achieving or maintaining the indicator
• Bed pressures, elective delays continue throughout the hospitals with wards closing beds
• Nursing strike across both hospitals
• Southland ED continues to exceed capacity and overflows into other areas as required.

Data on acutely admitted patients
<table>
<tr><th></th><th>Total Attendances</th><th>In ED over 6 hrs</th><th>% over 6 hrs</th></tr>
<tr><td>Not admitted</td><td>18,160</td><td>1,784</td><td>9.82%</td></tr>
<tr><td>Admitted</td><td>5,276</td><td>2,437</td><td>46.19%</td></tr>
<tr><td>Total</td><td>23,436</td><td>4,221</td><td>18.01%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>
For those Admitted to an inpatient ward, provide a separate report of target performance by service
<table>
<tr><th></th><th>Total admitted from ED</th><th>In ED over 6 hrs</th><th>% over 6 hours</th></tr>
<tr><td>Medical (incl. all subspecialties</td><td>2,876</td><td>1,380</td><td>47.98%</td></tr>
<tr><td>Surgical (all subspecialties excl Ortho and O&G)</td><td>1,369</td><td>724</td><td>52.89%</td></tr>
<tr><td>Orthopaedics</td><td>592</td><td>208</td><td>35.14%</td></tr>
<tr><td>O&G</td><td>149</td><td>55</td><td>36.91%</td></tr>
<tr><td>Other</td><td>290</td><td>70</td><td>24.14%</td></tr>
<tr><td>Total</td><td>5,276</td><td>2,437</td><td>46.19%</td></tr>
</table>
Provide data on the number and proportion of patients admitted to an Emergency Department Short Stay Unit (SSU) that are subsequently admitted to an inpatient ward
<table>
<tr><th></th><th>Admitted to SSU</th><th>Transferred to inpatients from SSU</th><th>% transferred</th></tr>
<tr><td>Total</td><td>2,686</td><td>475</td><td>17.68%</td></tr>
</table>
Provide data on what proportion of patients counted in your denominator that have an Emergency Department stay <15 minutes and where they go (discharged or admitted)
<table>
<tr><th></th><th>Total ED attendances</th><th># under 15 mins and discharged</th><th># under 15 mins and admitted</th><th>Total stayed under 15 mins</th><th>% < 15 mins</th></tr>
<tr><td>Total</td><td>23,436</td><td>293</td><td>23</td><td>316</td><td>1.35%</td></tr>
</table>
Acute demand actions from Annual Plan 20/21

Acute Data Capturing: Please provide an update on your plan to implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021
</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• DXC (Vendor) has been requested to modify EDIS to allow capture of SNOMED codes. DXC have estimated that this upgrade and functionality will be available to all EDIS clients by Q4 2020/21 (dependency on DXC). Note this is a delay from Q2 2020. • Given the delay in delivery of required functionality in EDIS the review of code sets and process changes were delayed until Q2 2020 and now has been completed. • A detailed implementation plan will be provided to the Ministry in Q3 2020/21. Including review of code sets, process changes, iPM collection for rural ED's, report and NNPAC extract reviews/changes, interfacing review, testing and training. • SDHB is targeting Q4 2020/21 for the implementation of SNOMED for ED (dependency on DXC delivery). To improve Patient Flow, please report on actions from your Annual Plan that: Improves patient flow for admitted patients • Enhanced generalism, new model of care underway. Implementation ongoing. Work is occurring at Southland ED and initiatives include a fast track area, a PAU and scoping out opportunities for facility upgrade to provide dedicated short stay units (MAU) Improves management of patients to ED with long-term conditions • Supporting patients to remain at home or if an ED presentation or hospital admission is necessary to return home quickly and facilitated by allied health (HOME) Team established across Dunedin and Southland sites. Improve wait times for patients requiring mental health and addiction services who have presented to the ED • Dedicated SMO liaison holding mental health portfolio and recruitment of a dedicated Mental Health Educator in place Improves Māori patients experience in ED • Dedicated FTE Monday to Friday is in Dunedin and Invercargill EDs
SS11: Faster cancer treatment (62 days)	**N**	**PN**	Result: 62.1% achievement, ranked 19th out of 20 DHBs. National average: 83.9%. Target is 90% MoH feedback: • Te Aho o Te Kahu notes that Southern DHB has not achieved the target for SS11 of 90 percent.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

Heat map of 62 day capacity breaches by treatment modality, 1 Jun 2020 to 30 June 2021

Treatment modality	Brain CNS	Breast	Gynaecological	Haemotological	Head and neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urological
Chemotherapy	0	2	1	3	2	3	1	0	0	0	2	1
Concurrent radiation therapy and chemotherapy	0	0	0	0	0	4	1	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	1
Palliative care	0	0	1	1	0	0	1	0	0	0	1	0
Patient died before treatment	0	0	0	0	0	1	0	0	0	0	0	0
Radiation therapy	1	0	0	0	1	4	5	0	1	0	0	1
Surgery	0	8	12	0	1	12	0	1	1	6	1	11
Targeted therapy	0	0	0	0	0	0	0	0	0	0	0	1

Southern DHB narrative report:

- An increase in FCT resource by 1.0 FTE (total 1.5 FTE) has been approved and instigated. Projects are being identified and prioritised for service improvement.
- There are continuing delays with diagnostic imaging at the Dunedin site contributing to delays in treatment times.
- The Māori Leadership Group are requesting a break down of all Māori patients who have breached the 62 day to give them context around the breaches. Three breaches for this cohort in Q3: x 1 as patient choice, x 1 as clinical choice and x 1 as capacity.
- Patient pathways have started to be developed and/or updated to enable the FCT team to “delay code” correctly, this is a continuing work in progress.
- Ethnicity identification is going to be a priority amendment for the FCT tracker to enable easier filtering and auditing.
- FCT identified “lost” patient in Southland, due to tests (Lab & Radiology) being requested by Locum Consultants & not being copied to SDHB surgeons. This led to a service review and generated a system improvement.

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td colspan="2"></td><td></td><td></td><td>• The Māori Lung audit has been completed and will be presented to the SDHB Clinical Council on 12th August 2021.</td></tr>
<tr><td colspan="2">SS12: Engagement and obligations as a Treaty partner</td><td>A</td><td>GT</td><td></td></tr>
<tr><td rowspan="5">SS13: Improved management for long term conditions (LTC)</td><td>Focus Area 1</td><td>A</td><td>RD</td><td>Focus Area 1: Long term conditions</td></tr>
<tr><td>Focus Area 2</td><td>A</td><td>RD</td><td>Focus Area 2: Diabetes services</td></tr>
<tr><td>Focus Area 3</td><td>A</td><td>RD</td><td>Focus Area 3: Cardiovascular health</td></tr>
<tr><td>Focus area 4</td><td>A</td><td>RD</td><td>Focus area 4: Acute heart services</td></tr>
<tr><td>Focus Area 5</td><td>A</td><td>RD</td><td>Focus Area 5: Stroke service</td></tr>
<tr><td colspan="2">SS15: Improving waiting times for colonoscopies</td><td>P</td><td>PN</td><td>MoH feedback:
• Thank you for the information detailing your planned recovery of the maximum surveillance colonoscopy target by January 2022 and a further week by week breakdown of how many weeks patients have been waiting beyond maximum wait times.
• We note ongoing achievement of NBSP KPI 306 and the recommended non-urgent target, with steady improvement in recommended surveillance performance thank you.
• Ministry does need to see steady progress over quarters 1 and 2, 2021-22 with all maximum wait times met as anticipated.

Southern DHB report: Improving waiting times for colonoscopies
<table>
<tr><th></th><th>Indicator</th><th colspan="3">Q4 Result</th><th>Comments</th></tr>
<tr><th></th><th></th><th>Mar</th><th>Apr</th><th>May</th><th></th></tr>
<tr><th></th><th></th><th colspan="3">14 days or less</th><th></th></tr>
<tr><td>Improving waiting times for colonoscopies</td><td>90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less, 100% within 30 days or less</td><td>90.0%</td><td>83.3%</td><td>77.3%</td><td>Just below target. Small numbers within this group and so represents 1 patient and relates to patient factors as opposed</td></tr>
</table></td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses					
								to scheduling or capacity issues. Expect to be compliant in Q1 2022. One patient waiting outside 30 days – as above and to be followed up.
					42 days or less			
				70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less	91.6%	80.6%	86.0%	Four patients outside of 90 days. Two waiting for GA list. Two to be followed up.
					84 days or less			
				70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less	46.8%	53.4%	52.7%	151 patients outside 120 days Dunedin hospital has completely recovered. Efforts to improve the situation in Southland continue by ensuring that all lists are filled, Saturday lists undertaken, offering all patients appointments in Dunedin, where appropriate (and as staffing/capacity allows), prioritising this list for recovery and prioritising colonoscopy over gastroscopy.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			<table><tr><td></td><td></td><td></td><td></td><td></td><td>Current predictions are that maximum surveillance wait times will be recovered by February 2022 (predicted) assuming no change in current delivery schedule</td></tr></table> Bowel screening: Results: 99% (total population), 97.3% Māori and 100% Pacific who returned a positive FIT had a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system. Target: 95%
SS17 Delivery of Whānau Ora	**No report**	**GT**	MoH feedback: • Could the DHB please provide the reporting information in the correct template? Southern DHB narrative report: • The Southern DHB is supporting a Māori Speech Language Therapist with a national rehabilitation collaborative under the patient safety and Quality Commission. The SLT is passionate about improving the health outcomes of Māori patients and after completing the Health Quality & Safety Commission trauma quality improvement facilitator course has enabled her to increase her knowledge, and at the same time complete a project that aims to streamline the transition from hospital to home of Māori traumatic brain injury (TBI) patients. • The project aims to engage Whānau Ora Navigation to support Māori patients with traumatic brain injury while they are in hospital and to assist with transition back into the community to strengthen outcomes for this complex patient group. The SLT facilitated training to a large group of Whānau Ora Navigators on 1 July 2021 in Dunedin aimed at increasing their knowledge of TBI and we are also considering a business case for the Southern DHB to appoint a Whānau Ora Navigator to support the roll out of this pilot. The file attached provides an overview of the training being delivered to our Southern Whānau Ora Navigators. • Feedback from patients currently points to the fact that the transition home from hospital services is difficult to navigate for whānau. Through this project we are hoping better communication and relationships between DHB, ACC and kaupapa Māori services will help to better support whānau in this transition and ensure the services they receive are appropriate. • We are trialling this with small numbers through the ISIS Centre. Collecting appropriate data from this trial will mean we can adjust this process as required as we review the data and feedback. If the data shows a positive

<table>
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<tr><td></td><td></td><td></td><td>impact, we then have a clear basis for expanding to other areas and making a case for more resourcing in the area of kaupapa Māori advocacy and navigation for patients discharging from hospital.
• Our aim statement for this project is that 80% of Māori patients discharged from the ISIS ward in 2021 who have input from kaupapa Māori services report faster improvements in Te Whare Tapa Wha outcome measure than those who do not receive this input.</td></tr>
<tr><td>Care capacity demand management calculation</td><td>No rating</td><td>JW</td><td>Ministry of Health does not provide ratings or feedback for this measure.</td></tr>
<tr><td>Improving Wellbeing through Prevention</td><td colspan="2"></td><td>Achieving Government's Priority Goals/Objectives and Targets</td></tr>
<tr><td>PV01: Improving breast screening coverage and rescreening</td><td>N</td><td>RD</td><td>Result: BSA coverage (%) of women aged 45-69 years in the Southern district, for the two years ending 31 March are highlighted in the table below. Target: 70%. National coverage for the total population: age 45-69: 67.2%.

<table>
<tr><th></th><th>Age 45-69</th></tr>
<tr><td>Māori</td><td>65.0%</td></tr>
<tr><td>Pacific</td><td>59.6%</td></tr>
<tr><td>Asian</td><td>50.3%</td></tr>
<tr><td>Other</td><td>69.1%</td></tr>
<tr><td>Total SDHB</td><td>68.1%</td></tr>
</table>
MoH feedback:
• As of 31 March 2021 Māori coverage rates for those aged 45-69 are 65% and non-Māori coverage 68.3%. Pacific coverage rates 59.6%
• Please report coverage rates by age band 45-69 years not 50-69 years.
• We encourage you to continue working with your Lead Provider and other stakeholders to reduce the inequities in coverage rates for priority group women

Southern DHB narrative report:
• Breast Screen Otago Southland Pacific Radiology continue to provide Support to Screening and the Regional Coordination Service which supports patient-centered bookings for newly enrolled and priority women who are not participating in screening.
• Priority has been given to book our Māori and Pacifica women in which they are offered an appointment and rescreen in advance of other women. This service also supports data matching at practice level, as well as other community initiatives to support enrolment and participation of women.
• Please refer to full reports submitted to the NSU.</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
Better Population Health Outcomes supported by Primary Health Care			**Achieving Government's Priority Goals/Objectives and Targets**
PH01: Improving system integration and SLMs	**A**	**RD**	
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	**P**	**RD**	MoH feedback: • The Ministry notes no current results from Stage 3 EDAT of the percentage level of match in ethnicity data were given MoH final feedback: • Kia ora, thank you for the clarification. It is encouraging to hear that that WellSouth is planning to explore how to improve the mismatch of ethnicity recorded. Southern DHB response to MoH feedback: • Thank you for your question regarding the Stage 3 EDAT. WellSouth PHO advises that a formal Stage 3 audit was not undertaken. • Of note, however, the WellSouth ethnicity audit tool indicates that 98.46% of enrolled patients have an ethnicity in the practice PMS that matches the ethnicity in the NES. Also, as part of its support to general practices, WellSouth provides data to all practices about the level of ethnicity mismatch and how to resolve it. • Finally, 3.2% of patients described as Māori in one register do not match that recorded in the other, and 3.7% of Pacific people are similarly mismatched. WellSouth is using these evident mismatches to explore further ways to raise the already high ethnicity match percentage (>90%). This may also indicate more favourable Māori primary care enrolment than what is currently being reported. Southern DHB narrative report (submitted by WellSouth) • Ethnicity data is recorded by all WellSouth associated general practices using a standardised enrolment form. • Practices completed an ethnicity data audit to achieve cornerstone/foundation standard accreditation (indicator 6.2) which all WellSouth practices have achieved. A further audit will be required for reaccreditation shortly. • WellSouth provides practices with a list of patients with missing ethnicity data via Thalamus Reporting as shown below.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• WellSouth continues to assist Practices with their Māori health plans including promoting the objectives below. *Objectives* Ethnicity data - Primary Care ethnicity data audit toolkit (EDAT) implemented • Primary Care EDAT completed and recommendations implemented (3 yearly) • Monitor register for unknown ethnicity and actively update records • Date due: • Date completed: • Target: No patients with unknown ethnicity Practice enrolment - Facilitate and ensure ongoing enrolment for all eligible Māori • Actively facilitate re-enrolment for Māori patients due to drop off the practice register (not seen within 3 years) • Actively facilitate enrolment for any unenrolled Māori into your practice • Target: No Māori patients drop off the practice register (not seen within 3 years) • Target: increase in the number of Māori enrolments in the practice
PH03: Improving Māori enrolment in PHOs to meet the national average of 90%	**P**	**RD**	Result: WellSouth PHO enrolment for the total population was 92% and was 79% for Māori. National enrolment for Māori was 85%. Target: 90%. MoH feedback: • Thank you for your detailed report which lists 79% of Māori enrolment in a PHO in Southern DHB. • The Ministry notes the data challenges listed and a range of initiatives to increase Māori enrolment. Good to see this standard agenda item for CPHAC and the level of reporting provided. Southern DHB narrative report: • Improvement of Māori enrolment is of serious concern for the Southern District Health Board and the Community and Public Health Advisory Committee (CPHAC) and the file that was attached is the latest report to CPHAC on our plan to increase enrolment. • The issue of Māori PHO enrolment is now a standard agenda item for CPHAC and they will have regular updates to monitor this health target.
PH04: Primary health care: Better help for	**N**	**RD**	Result: • 77.2% (total population) were given brief advice and support to quit smoking. Decrease of 3.7% from last quarter.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
smokers to quit (primary care)			• 75.7% of Māori and 72.7% of Pacific people were given brief advice to quit smoking. Rank: 8th out of 20 DHBs (total population). National result: 76.1% (total population) • Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit. MoH feedback: • Your final result is 77.2%. This is a 3.7%% decrease from last quarter and you did not achieve the target. 75.7% of Māori and 72.7% of Pacific populations were given brief advice to quit smoking. • Please note that the result for Southern DHB's cessation support indicator is 23.7%. The national result for this indicator is 33.5%. This indicator shows the % of current smokers who have been given or referred to cessation support services in the last 15 months. The cessation support indicator result is for DHB use only and will not be publicly reported. You can use this indicator as a proxy measure of how well the clinicians are engaging with cessation services and how frequently they refer smokers to these services • Well done on the increases in your result, the focus on this target is paying off, well done. • I've asked John to contact you regarding the evidence that providing brief advice to smokers has an impact. • Every single health practitioner should be providing brief advice and support to quit to every smoker. • Dr. John McMenamin (Target Champion – Primary Care) is available via teleconference to discuss ways of improving the DHBs Target results. Southern DHB narrative report: *Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?* • As at 29 June, 85% of people recorded as smokers have received brief advice to stop in the past 15 months, up from 80% in the previous quarter. We are unlikely to meet the 90% threshold this quarter. • WellSouth have put considerable resource into this target this year to improve performance and support a general practice workforce that is also being expected to support Covid19 swabbing and vaccinations. WellSouth employs three FTE in their call centre to make calls on behalf of practices. • As part of the Access & Choice programme, WellSouth has implemented Health Improvement Practitioners (HIPs) and Health Coaches in a number of practices across the district and they have been trained to provide brief advice to stop smoking. • In June 2021 WellSouth commenced the implementation of a Vape to Quit programme in partnership with Southern DHB. The programme provides funded vape kits to smokers who meet the criteria in an effort to reduce smoking of combustible tobacco.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? • As at 29 June, 82% of Māori who are recorded as smokers have been given brief advice to stop smoking in the past 15 months. • As well as making smoking cessation calls to the whole population, the call centre has been making wellbeing calls to Māori and Pacific people over 50 years on behalf of practices to encourage the connection with general practice and promote healthy lifestyle choices, including helping them to stop smoking. WellSouth's Access & Choice programme has focused on practices with the greatest number of high needs patients (Māori, Pacific and Q5) first. *Is there any further support you require from the Ministry to achieve the target? If so, what support is required?* • General practice will be at the vanguard of implementing the COVID-19 vaccination programme in the Southern district over the next 6-12 months. The Ministry of Health needs to acknowledge that the general practice workforce is finite and has limited capacity to add more and more programmes without looking at existing programmes and helping them to re-prioritise. • Given that this programme has been in place for a number of years we would like to see some research into the efficacy of the programme – i.e. how many smokers have actually benefitted from the brief advice programme, as this will assist us in promoting it to general practice. *Is there anything else you would like to tell the Ministry?* • This target is defined as: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit • We have little control or visibility over smoking cessation activities in pharmacy or other potential providers. Therefore, we should be removing from the denominator any patient who is coded as a smoker but has not been seen in general practice in the past 15 months. We would be grateful for some clarity over this definition.

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td>Annual Plan Status Update Reports</td><td colspan="2"></td><td>Achieving Government’s Priority Goals/Objectives and Targets</td></tr>
<tr><td>Annual Plan Status Update Reports - Improving wellbeing through prevention</td><td>P</td><td>RD</td><td>MoH feedback and Southern DHB response to MoH feedback:
<table>
<tr><th>Government Planning Priority</th><th>MoH feedback</th><th>Southern DHB response</th></tr>
<tr><td>Environmental sustainability</td><td>• Some actions delayed but mitigation in place. Of note is that Southern DHB have an extensive range of actions for environmental sustainability, which is excellent</td><td></td></tr>
<tr><td>Reducing alcohol related harm</td><td>• It is noted from the quarter 4 report that the development of a triage tool to assess and prioritise license applications has not progressed due to the impact of COVID-19 related work on the capacity of the PHU.
• The report indicates that there is still an intention to complete this action. Will reporting on this action continue into the 2021/22 year?</td><td>• Under the COVID Resurgence planning work is being done to prioritise licence applications under the different levels of COVID response (i.e. how much active contact tracing is required).
• We have three enforcement officers and they do a case by case triage of the licences as they come in to determine what level of risk they are and whether they require to be visited. Each individual enforcement officer does triage licences already there is just no formal tool
• The benefit of having a tool is that it is not up to the individual’s determination of risk. A formalised tool will be</td></tr>
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</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses		
					developed as capacity allows in the 21/22 year. • All licences are assessed as they come to us and high risk licences take priority. For high risk specials for large events, we have pre-event meetings and if issues arose during the events we have post event meetings and generally agree on changes for any further events.
			Environmental and border health	• Action 3 has not been met, please provide a mitigation plan for action 3.	• Two of the three MoOH's have indicated they can attend the October CIMs course to ensure this has been met. The other MoOH will attend one in the new year as the courses do not have capacity for more than two staff at a time.
			Drinking water	• Action no. 4 requires a mitigation plan. • Please let the provider know that potentially, if Taumata Arowai doesn't stand up on 1 November 2021 they may have to deliver this work until at least February 2022.	• DWA's continue to work with supplies to increase compliance - this will continue until handed over to Taumata Arowai regardless of when that occurs. • Work is in progress with the Designated Officers at Public Health to inform those supplies with expired Water Safety Plans of the potential penalties for continuing to stay non-compliant and what work they can do to get there
			Healthy food and drink	• Thank you for your report and your work, good progress.	• No response required

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses		
			Cervical screening	• It is noted that there are some delays post-COVID in some actions, otherwise good progress.	• No response required
			Smokefree	• DHBs have been able to do tobacco related CPO's and there has been no change to the legislation, nor have we have indicated a pause, please provide a mitigation plan.	• In the exemplar that was provided two CPO's were undertaken over the reporting period. There is new legislation as the Smokefree Environments Act is no longer in effect. • The comment in the narrative of the exemplar was around the enforceability of the new Act for which the powers for enforcement don't come into effect until later in 2021. There are a number of DHB's that have been unable to do Vaping related CPO's which is what that comment in the narrative relates to.
Annual Plan Status Update Reports - Improving sustainability	**P**	**NT**	MoH feedback: • We note your update identifying some items are not fully achieved		
Annual Plan Status Update Reports - Improving mental wellbeing	**P**	**GT**			

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td>Annual Plan Status Update Reports - Better population health outcomes supported by primary health care</td><td>P</td><td>RD</td><td>MoH feedback:
<table>
<tr><th>Government Planning Priority</th><th>MoH feedback</th><th>Southern DHB response</th></tr>
<tr><td>Pharmacy</td><td>• For the 'LTC to CLIC service' which is not yet achieved, will this action be carried forward into 2021/22 with follow through to completion?</td><td>• CLIC (Client-Led Integrated Care) programme is almost fully implemented across all 81 Practices. The LTC/Team have been working closely with practices to increase utilisation of the CLIC programme in each practice.
• The following action is included in our SLM Plan for 21/22: Continue the rollout of CLIC (client lead integrated care) and acute care planning programmes to improve management of Long-Term Conditions, aligned to the Primary and Community Care Strategy and development of HCH's. This action rolls over. Maximising utilisation is the focus through 2021/22.</td></tr>
<tr><td>Long term conditions including diabetes</td><td>• We note that you have achieved all your key actions for long term conditions. Well done.
• We note your diabetes actions are nearly complete, with work underway on virtual forums. We would be interested in hearing how these go. We encourage you to continue to improve your</td><td>• Southern DHB plans to re-establish a Virtual Diabetes Register in 21/22
• LTC management through MDTs will be piloted and a telehealth service will be initiated
• The Diabetic Annual Review Programme will be delivered in 21/22, with restoration of the</td></tr>
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Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

	DAR trend, this is hard but important work. Are you continuing incomplete actions in 2021-22	achievement of the targets for DAR and HbA1c. This will be supported by the newly established WellSouth call centre
Primary health integration	• Thank you for your report outlining Southern DHB's progress. The Ministry looks forward to seeing the Health hub objectives continuing into 2021/22 once the work for ALT is reassigned.	• No response required

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
Annual Plan Status Update Reports - Better population health outcomes supported by strong and equitable public health services	**P**	**PN**	MoH feedback and Southern DHB response to MoH feedback:

Government Planning Priority	MoH feedback	Southern DHB response
Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan	• How can you ensure that a Māori COVID-19 response action plan will be effective at increasing vaccine uptake among Pacific people in your locality?	• We are working with the Ministry and wider community providers, including Pacific providers, to plan a cross sector approach in responding to COVID-19 • Pacific Trust Otago will commence vaccinating at their provider site on 21 August with weekly clinics to increase the uptake of eligible Pacific populations and with a focus on Pasifika students at the University of Otago, Dunedin. • Southern DHB will monitor vaccination rates across the district for the Pacific population and

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses		
					compare to vaccination rates for 'other.
			Disability Action Plan	• Congratulations on the launch of your Disability Strategy. Disability - It's great that SDHB has developed the capability to post messages in NZSL to the website and did this for the summary of the Disability Strategy.	No response required
			Acute demand	• Annual Plan report for Q4 Urgent care- have gaps been identified in relation to provision of Urgent and After Hours care in Dunedin and Invercargill After-hours primary care initiatives • MoH rates this performance as "B – Further work required" and has asked for a substantial plan on how this issue will be eliminated.	Yes, gaps have been identified After-hours primary care initiatives • The lack of primary care access for ≤ 14 year old children is concentrated in Invercargill. • Invercargill Urgent Doctor Service is the only after-hours provider that charges under-14s for services. All other parts of Southern District provide free care to under 14 patients after hours. Primary Care Access • Access to Invercargill After Hours has been identified as a risk. Access challenges to Invercargill After Hours Primary Care currently increase presentations to Southland Hospital Emergency Department (ED).

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses		
					• To address this, WellSouth is partnering with Oraka Aparima Rūnaka, Hokonui Rūnanga, Waihōpai Rūnaka and Awarua Rūnaka in its development of a new primary care service. These partnerships will provide an equity-based collaborative approach to integrated service plans and models of care that are whānau-centred. • SDHB and WellSouth are preparing a brief business case for a cloud-based platform which provides real time reporting on wait times for Emergency Departments (ED), Urgent and Primary Care Facilities. This proven platform also allows the public access to wait times and allows them to determine which facility is best for their required medical intervention. Patients can also see the wait times while in ED waiting rooms. Most importantly this platform allows ED staff to digitally transfer appropriately clinically triaged patients to another service (e.g. urgent care facility or general practice) using a voucher for access to subsidised care. The intention of this service is to reduce the number patients receiving treatment in the ED by creating an opportunity to triage people to primary care providers.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses		
			Rural Health	• Thank you for your detailed report. Look forward to hearing in Q1 2021/22.about your locality planning and progress on project for introduction of second tier medical staff.	No response required
			Healthy ageing	Thank you for your report.	No response required
			New Zealand Cancer Action Plan 2019-2029	• We note that you have not met either the 31-day or the 62-day FCT performance measure but that you are proactively working with the MOH and Te Aho o Te Kahu to improve all aspects of your service noting the additional resource that your DHB has put into this understanding where the issues are.	No response required
			Bowel Screening and colonoscopy wait times	• Ministry commends the DHB continuing to meet NBSP KPI 306 and exceed priority population participation rates. This a great achievement. • Please see SS15 reporting feedback regarding the DHB's planned recovery of maximum colonoscopy wait times which remain concerning.	No response required
			Data and digital	• Thank you for your hard work this year. Pleased to see a number of projects completed in spite of resourcing challenges.	No response required
			Delivery of Regional Service Plan (RSP) priorities and relevant national service plans	• Note: The National Hepatitis C Action Plan Māhere Mahi mo te Ate	No response required

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			Ka ā C 2020-2030 (was launched on 28th July)
Annual Plan Status Update Reports - Improving child wellbeing	**P**	**RD**	
Annual Plan Status Update Report - Give practical effect to He Korowai Oranga – the Māori Health Strategy	**A**	**GT**	

Crown Funding Agreements (CFA) Variations

Measure	Final Rating	Owner initials	Ministry of Health Comments and DHB Responses
CFA DHB Level Service Component of the National SUDI Prevention Programme	**B**	**RD**	MoH feedback: • Thank you for your NHI level and narrative report. Good to see the increase in ISSB distribution towards the target compared to last year. Good work on - developing relationships with local weavers thereby helping increase wahakura availability; and identifying the importance of harm reduction messaging and treating it as an essential component of ISSB distribution. Thank you for all your work in SUDI prevention in 2020/21. Southern DHB narrative report:1 January 2021 – 30 June 2021 Outline issues and actions to ensure SSDs and safe messaging is given to hapu mama and whanau: • Provisional Coronial Data indicate activity for SUDI prevention are potentially achieving good outcomes across our district. We are committed to not only providing safe sleep spaces but also delivering harm reduction messaging when safe sleep spaces are distributed. All distributors are trained on the messaging before being able to distribute safe sleep spaces. It is our belief that the combination of a safe sleep space and the messaging that makes a difference. • Distribution of pepi pods and wahakura as safe sleep spaces continued this year with good uptake. Our annual target is 500. We have distributed 439 (88% of our target) for the 2020/2021 year. Whilst this is still slightly below target it is an increase on the previous year, which saw the distribution of 404. We have distributed 380 pepi pods and 59 wahakura. • Distribution of wahakara for Māori and Pacific whanau began in the Southern district with a mihi whakatau held on 4 December 2020 at Hokonui Rūnaka in Gore. The availability of wahakura means that Māori and Pacific whanau have a choice of either a pepi pod or wahakura. Interestingly, 50 Māori whanau chose pepi pods rather than wahakura since wahakura were introduced in early December 2020. For Pacific three wahakura and nine pepi pods have been distributed since 1/1/2021. Further analysis will be undertaken on the data. • Our relationship with local wahakura weavers is now well established. We engage regularly with two local weavers who in turn link with weavers in the community. • These two weavers have offered to do quality checking of all wahakura. This has proven to be extremely helpful to the safe sleep programme ensuring quality of wahakura available for distribution. For quality

Measure	Final Rating	Owner initials	Ministry of Health Comments and DHB Responses
			purposes, weavers has been supplied with a mattress to ensure each wahakura is a perfect fit for the mattress. • These weavers are also now connected to Hapai who invited and funded them to attend a wānanga in Auckland. Learnings from this will help inform how we are to deliver wananga with whanau across the Southern district. • Hapai also funded these weavers to hold two wananga in Dunedin and Invercargill to build weaving capacity. Since then, another Dunedin wananga has focussed on caring for harakeke and the tikanga around this. • Planning is occurring for our first wananga with whanau – currently scheduled for early July. • Harm reduction messaging have been delivered to the weavers at each wananga. Our two main weavers have also asked for a training session on all harm reduction messaging given to hapu mamas so they are up to date and can engage in informal discussions with the latest information. This was a wonderful request as it revealed that they are taking ownership of this knowledge and want to share it with different communities. • The Portfolio Manager is working to update the Power to Protect programme in the Southern district and realises that our two weavers should be invited to attend this training along with other community organisations working with hapu mamas and whanau both pre and post birth. • Southern DHB has responded to Change for our Children on their request to change the current Participation Agreement. The Southern DHB Corporate Solicitor has advised that the current agreement has a clause stating the agreement can be amended at any time by mutual consent of both parties. We do not agree with the change as we do not collect impact reporting data so it cannot be supplied, therefore, we advised we do not consent to the change. • Planning has begun with the National Coordinator of the Power to Protect programme for a refresh of this programme across our district. This will include both Southern DHB and community providers of services. Weavers will also be invited. • The Southern Stop Smoking Incentive Scheme continues across the district to support pregnant women to stop smoking. We continue to work with the provider of this service to increase referrals. Breast feeding: • Community breast feeding pilot at Pacific Trust Otago continues to successfully engage Māori, Pacific, refugee and women from high deprivation areas. We have extended the contract until the 2 July 2022. • The South Island SIAPO WCTO/SUDI Co-ordinator has completed a survey asking women what supported them to breast feed and what difficulties they experienced. A public health registrar is analysing this information and will combine with analysis of the national breast-feeding strategy and other hui findings

Measure	Final Rating	Owner initials	Ministry of Health Comments and DHB Responses
			to be feed into the district wide breast-feeding hui to be held on 31 August 2021. Planning for this hui is now well advanced and community stakeholders are being identified to be invited. This will include Plunket who hold the district wide pregnancy and parenting contract. • Face-to-face interviews are being held with Māori and Pacific women on their breast-feeding experiences because we found they were not well represented in the SIAPO survey. Four interviewers are working across the district identifying and interviewing women. Findings will also be presented at the breast-feeding hui. • Safe Sleep Policy – the revised Safe Sleep Policy has been updated and distributed. • Three local breast-feeding networks continue to meet. • The WellSouth PHO funded peer support programme continues to operate across the district.
CFA Primary Health Care Services	**B**	**RD**	MoH feedback: • Southern DHB has received a Further Work Required rating as the 95 percent target has not been met. Your report indicates that 79.1 percent of children aged 14 years and under in your enrolled population have access to zero fees under 14 care within 60 minutes travel time after-hours. • It is noted that WellSouth and the Invercargill GP network are co-designing a new after-hours service that will address this issue going forwards. • Please provide the Ministry with an update on this service plan once it is available. Southern DHB narrative report: • All practices in the Southern District provide zero fees urgent after-hours coverage to U14s, except those patients using the Invercargill Urgent Doctor Service. • Using the March enrolment data, 57,365 patients aged 0-14 years are enrolled in Southern, 11,991 are enrolled at practices that use the Invercargill Urgent Doctor Service. This means that 79.1% of patients in this cohort have access to zero fees after hours. • WS and the Invercargill GP network are co-designing a new after-hours service that will address this issue and establish a clinically and financially sustainable after-hours service. This service will have zero-fees for under 14s. • Pharmacy across the Southern District provided extended hours but do not open after hours. Pharmaceutical supply is through the provision of an imprest of medicines at Rural GPs. • Finally, please see our Q4 PH01: Improving System Integration and SLMs report for discussion pertaining to SLM milestones and their supporting activities.
CFA B4 School Check Services	**S**	**RD**	

Measure	Final Rating	Owner initials	Ministry of Health Comments and DHB Responses
CFA Well Child Tamariki Ora Services	**S**	**RD**	
CFA Health Services for Emergency Quota Refugees	**S**	**RD**	
CFA COVID-19 Primary Care Digital Enablement Funding Support	**No rating**	**NT**	MoH feedback: • Report noted - it would be good to receive any evaluation you have done on iMedX as other providers also might be interested in this work too Southern DHB narrative report: Our work associated to the enablement funding has three activities. • Implementation and rollout of the iMedX transcription service. This is a web based SaaS solution that enables our clinical and administrative staff to manage dictation and the production of letters remotely, from any location. The service was stood up rapidly during lockdown in 2020 to critical services and the rollout has continued since to remaining services. Mental Health is currently underway before attention turns to our Rural hospitals. This implementation has led to the electronic delivery of letters to GP Practices. • Microsoft Office 365 extension and development of solutions that enhance the clinician experience. The work here has involved the adoption of the bookings app to provide more functionality for Telehealth. • Purchase of Telehealth equipment as we create more MS Teams Rooms to provide better access and equity to equipment across the region.
CFA COVID-19 DHB Digital Enablement Funding Support	**No rating**	**NT**	Southern DHB narrative report: Our work associated to the enablement funding has three activities. • Implementation and rollout of the iMedX transcription service. This is a web based SaaS solution that enables our clinical and administrative staff to manage dictation and the production of letters remotely, from any location. The service was stood up rapidly during lockdown in 2020 to critical services and the rollout has continued since to remaining services. Mental Health is currently underway before attention turns to our Rural hospitals. • Microsoft Office 365 extension and development of solutions that enhance the clinician experience. The work here has involved the adoption of the bookings app to provide more functionality for Telehealth. • Purchase of Telehealth equipment as we create more MS Teams Rooms to provide better access and equity o equipment across the region.

FOR INFORMATION

Item: Performance Dashboard Progress Update September 2021

Proposed by: Principal Advisor to CEO

Meeting of: Board, 5 October 2021

Recommendation

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

Purpose

To summarise progress of the development of the Performance Dashboard.

Specific Implications for Consideration

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

Background

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

Discussion

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

Next Steps & Actions:

The dashboard build is ongoing.

Appendices

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

PERFORMANCE DASHBOARD INITIATIVE

Summary of progress to date:

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

Key:

UAT = User acceptance testing

*Denotes change from last update

Measure (complete or in process of)	Stage
6 Hr Target	Built/Complete
Resourced Occupancy	Complete/Re-build was necessary*
Physical Occupancy	Build in progress/A complete re-build was necessary*
ED Attendances (Rebuild of PoC)	Built/Complete
ESPI 5	Built/Complete
ESPI 2	Built/Complete
CCDM Shifts Below Target	In UAT/ further refinement & testing was found to be needed with business owners*
CCDM Bed Utilisation	In UAT/ further refinement & testing was found to be needed with business owners*
CCDM Care Hours Variance	In UAT/ further refinement & testing in progress (as above) *
CCDM Patient Acuity	In UAT/further refinement & testing in progress (as above) *
CCDM Variance Indicator Score	In UAT/further refinement & testing in progress (as above) *
Caseweights	Built/Complete
Planned Care Caseweights	Built/Complete
Planned Care Discharges	Built/Complete
Raw Discharges	Built/Complete
Head Count (HR Dashboard)	In UAT/on hold due to Performance & Accountability framework work
FTE (HR Dashboard)	In UAT/on hold due to Performance & Accountability framework work
Follow up metric	Built/data & criteria needs confirmation*
HCSS	Built, handover to IS in progress
High-Cost Procedures	Coding underway, in progress
FSA's	In UAT
Average length of stay	In UAT
Worked vs Contracted FTE	Seeking specifications from business owners*
Hospital events as per Escalation Plan	Built/In UAT*
Measure (yet to build)	
Output per FTE	Not Started
Community Pharms	Not Started
High cost Pharms	Not Started
Primary Care (Enrolled Pop)	Not Started
IDF's	Not Started
Mental Health Bed Days	Not Started

Discussion:

The monthly narrative is included below for the ESPI's, 6HR target and ED presentations as is the visual for Resourced Occupancy which is also now complete.

This past month a lot of time has been spent on the CCDM metrics and occupancy – unfortunately despite having occupancy data, it has had to be rebuilt in the back end to be able to be surfaced in this dashboard in a stable sustainable manner which was a time intensive exercise. CCDM metrics has also been resource intensive and is in the final stages of being signed off. The HR metrics are on hold due to prioritisation of the performance & accountability framework, however investigation in the specifications relating to two new metrics has begun and the hospital escalation data has been visualised as well. National benchmarking data is still on the workplan to be added later once all the tiles are complete.

Figure 1:

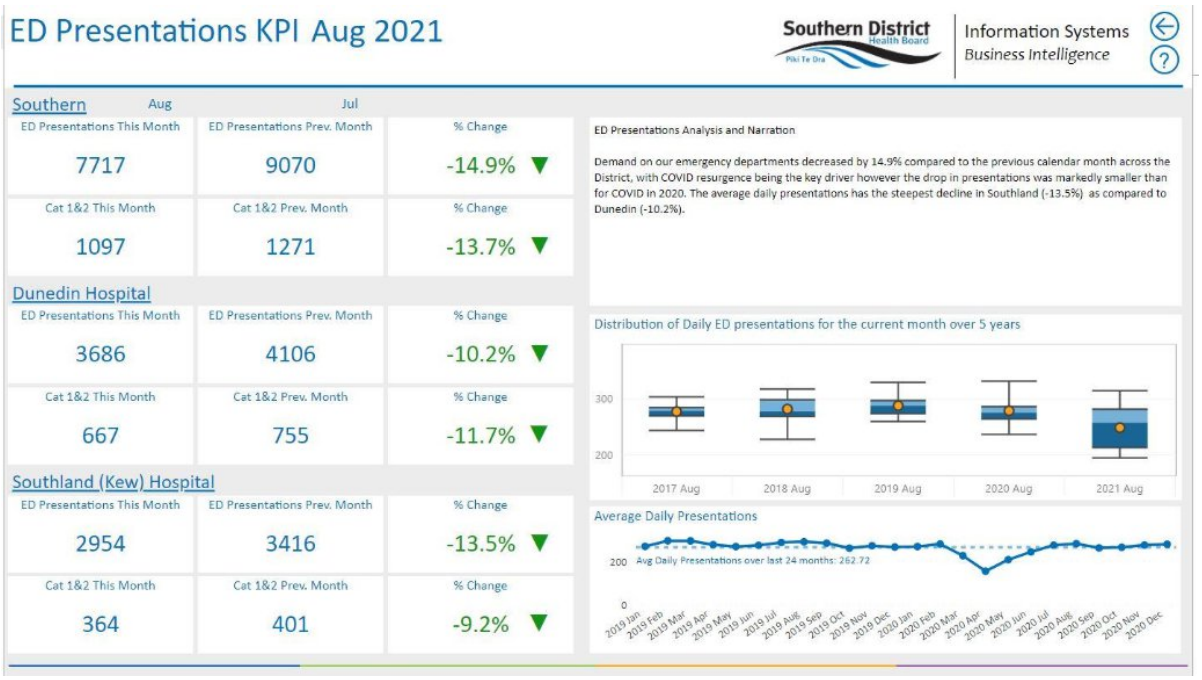


Figure 2:

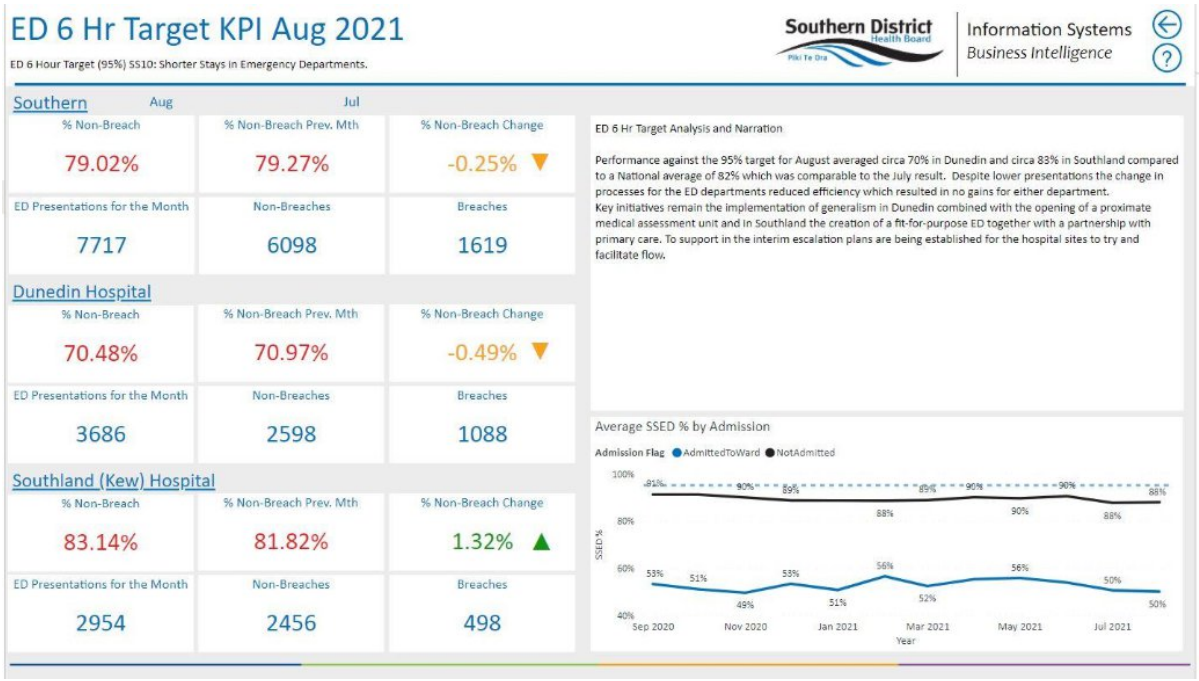


Figure 3:

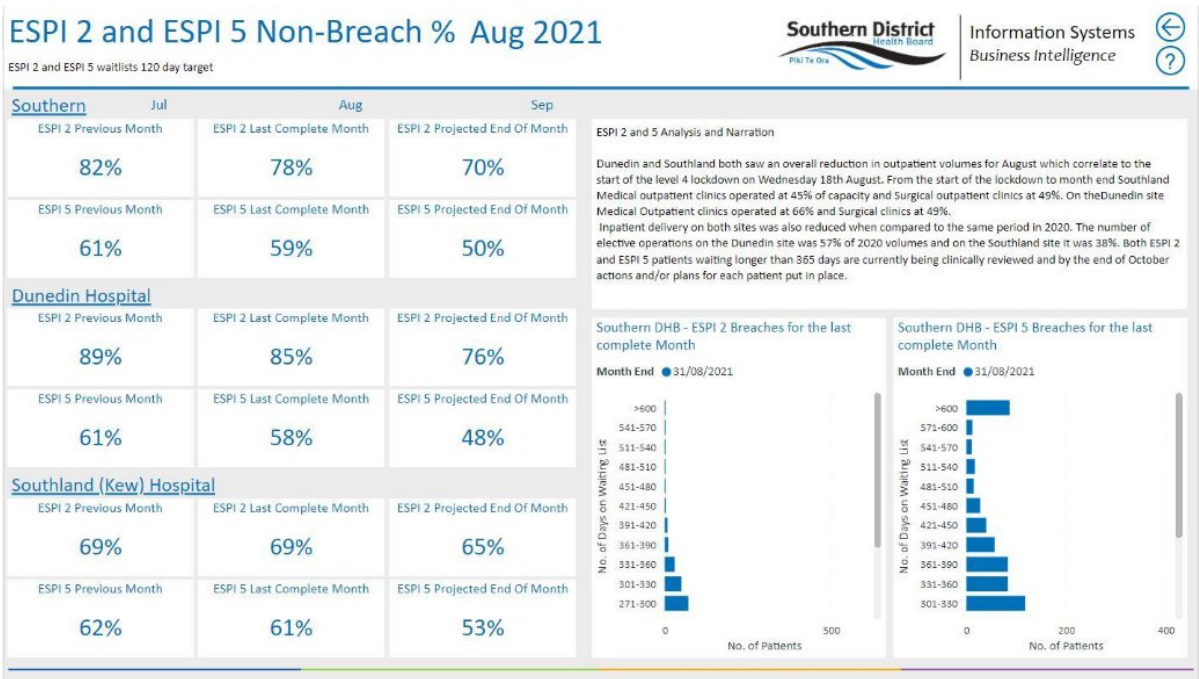
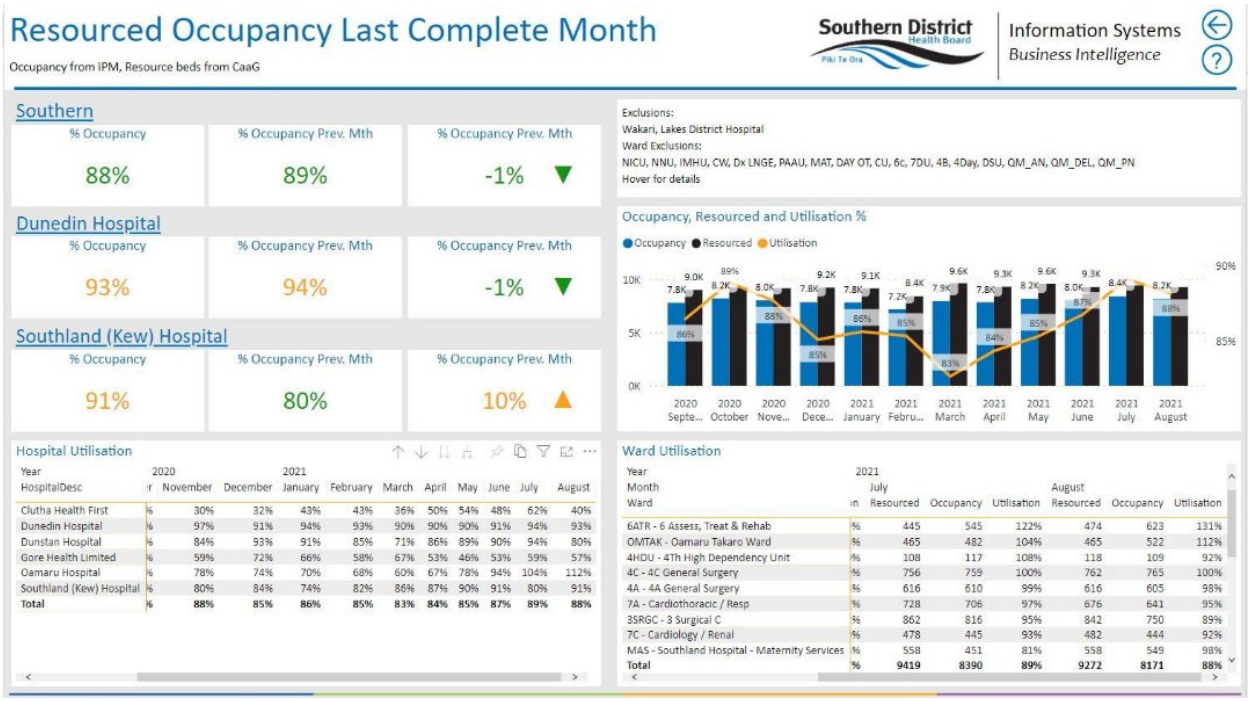


Figure 4:



Risks/dependencies/constraints:

- Resource availability within the IS team is continuing to be stretched – securing the right level of IT resource currently is challenging right across Otago. In addition to this the current pipeline of work including the Performance & Accountability framework is significant.

- There is a bottleneck getting sign-off from the business owners given they are a small group of people with competing priorities and as this dashboard grows there is an operational sustainability question that needs answering around where the appropriate place for the intelligence function is relating to this reporting to be housed.

FOR INFORMATION

Item: Māori Health Actions to Address Amenable Mortality and Conditions

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

Meeting of: Southern DHB Board Meeting – 5 October 2021

Recommendation

That the Southern DHB Board:

- **Notes** the actions undertaken by the Executive on amenable mortality and
- **Endorse** the establishment of a Māori Health Equity Strategy Group

Purpose

The purpose of this paper is to provide an update on the actions from the public excluded Southern DHB Board meeting on 7 September. These actions related to further saving opportunities to support the paper tabled by Moana Theodore in the August meeting. To provide monthly reporting to the Board on the funded and yet-to-be funded positions, the formation of the Māori clinical group and the development of a Māori data policy.

Specific Implications For Consideration

1. Financial
    - There are significant financial implications placed on management as a result of this instruction issued from this Board and the expectations that a further unbudgeted $800k on this year's full annual budget.
2. Workforce
    - Any increase in equity investment will have flow on workforce issues.
3. Equity
    - This paper has a focus on additional equity investment and strategies to improve amenable mortality.

Background

4. Following a paper presented to the August Board meeting on amenable mortality Moana Theodore tabled a paper which proposed significant investment in Māori Health. Whilst not all encompassing the two fundamental drivers were:

    - Comparing investment in Kaupapa Māori Health Services from 2015/16 to 2019/20 Southern District Health Board had a very low level of investment as a proportion of Māori population, and had only increased funding by 0.1% over the 5 years while the national average was circa 35%. If Southern was investing in Kaupapa Māori Health Services on a proportionate population basis compared to the national investment it would need to invest an additional circa $10 million.

    - The amenable mortality rates for Māori are significantly higher than the non-Māori or Pacific People levels.

Discussion

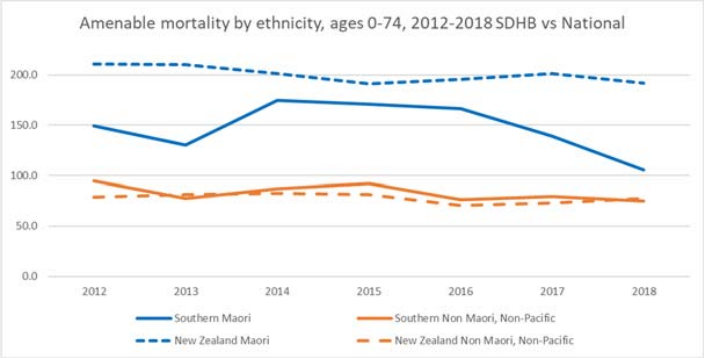
1. **Māori Amenable Mortality Update**

    - The consultancy group Synergia have held meetings on amenable mortality as part of the Strategic Refresh programme. The aim of this work is to develop a strategic briefing for the Southern Health System as we move towards Health NZ and the Māori Health Authority. This document will reflect the high level principles in addressing the issues associated with amenable mortality as reflected in the Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry Wai2575. This will be reflected in the Māori Leadership and Te Tiriti Partnerships principles based on the values tino rangatiratanga, partnership, active protection, and equity.

    - The Southern DHBs Clinical Council acknowledged at their meeting on 23 September the differences in amenable mortality between Māori and non-Māori are inequitable, unjust, unfair and a breach of Te Tiriti o Waitangi. At this meeting it commits to addressing amenable mortality, especially for Māori. That the Clinical Council has made a commitment to the regular collection, analysis and reviewing of amenable mortality and equity data in ways that will influence decision making. That a plan is developed to make changes to service delivery that will decrease amenable mortality rates and influencing current partnerships with other organisations. This will require a different approach for services specifically designed with and for Māori to identify and respond to equity issues. They have supported the recommendation that equity and amenable mortality will be a priority for Clinical Council.

    - The Clinical Council will sponsor a cardiovascular disease group with representation from the Clinical Council in collaboration with the WellSouth Primary Health Network. That a meeting will be coordinated with WellSouth with view to joining up our activities in reducing the burden of diseases as evidenced in the recent amenable mortality paper presented to the Board.

    - The Ministry of Health has subsequently updated the amenable mortality data with an additional three years of information. This suggests a notable decline in the amenable mortality rates since 2016-2018 as outlined in the diagram below by amenable mortality by ethnicity (ages 0-74) Southern DHB versus National.



2. Already Funded Positions:

This update provides a status report on those positions that are already funded or were supported in the 2020-21 financial year.

(i) Clinical nurse specialist cancer – work has progressed canvassing similar roles in place elsewhere e.g. ADHB Kaiārahi Nāhi service and at Midcentral. Discussions occurring across the system re role scope, position description and where position is best placed. Next step is to consult with key stakeholders before recruitment commences to ensure any new role meets desired outcomes.
(ii) Clinical nurse specialist child health - as per 2 (i)
(iii) Information analyst – appointed awaiting a delayed start date
(iv) Kaumātua/Kuia Southland role – advised and funded through MHAID ring fence
(v) Manager of Māori Health in Southland – current vacancy, look to appoint by December.

3. **Newly Funded Positions Update:**

This update provides a status report on those unfunded positions as outlined in Moana Theodore instruction to the Board.

(i) Service Manager Māori workforce strategy - position description developed, approved to recruit from DHB bottom line.
(ii) Clinical Nurse Specialist cardiovascular – as per 2 (i)
(iii) Clinical Nurse Specialist respiratory – as per 2 (i)
(iv) Clinical Nurse Specialist mental health – The MHAID services already has three registered nurses employed across our Māori mental health team.
(v) Research Officer – proposal submitted to the September Board meeting to work with Community and Public Health to advance our research capacity and capability.

4. **Māori Health Equity Strategy Group**

It is proposed that a Māori Equity Group be established to provide support to the Māori Health Directorate and to assist with the development of an appropriate Māori Health Strategy and Action Plan that will achieve greater equity in health outcomes for Māori. It is proposed to have this group established by November.

5. **Māori Data Policy**

   A meeting has been held with Damon Campbell, WellSouth Chief Digital Officer and Matapura Ellison on the development of a Māori data sovereignty policy as part of the data sharing agreement between the Southern DHB and WellSouth. The plan is to develop a kaitiaki group that will sit along side the Southern Health System Clinical Data Governance Group. This kaitiaki group will support the development of an appropriate Māori data sovereignty policy based on the principles set out in Te Mana Raraunga, the Māori Data Sovereignty Network. Matapura Ellison is engaing with Te Rūnanga o Ngāi Tahu on our behalf as they are currently interested in this space. The Principles of Māori Data Sovereignty are included in Appendix 2 for the Board's information.

Next Steps & Actions

Based on the September Board meeting this will be a standing agenda item moving forward.

Appendices

Appendix 1 Te Mana Raraunga, Principles of Māori Data Sovereignty.

Principles of Māori Data Sovereignty

Brief #1 | October 2018

TE MANA RARAUNGA
Māori Data Sovereignty Network

This Te Mana Raraunga (TMR) Brief provides a general overview of key Māori Data Sovereignty terms and principles.

TMR advocates for the realisation of Māori rights and interests in data[1], and for the ethical use of data to enhance the wellbeing of our people, language and culture.

"He rei ngā niho, he paraoa ngā kauae"

"One must have the right principles for important endeavours."

Definition of terms

- **Māori data** refers to digital or digitisable information or knowledge that is about or from Māori people, our language, culture, resources or environments.
- **Māori Data Sovereignty** refers to the inherent rights and interests that Māori have in relation to the collection, ownership, and application of Māori data.
- **Māori Data Governance** refers to the principles, structures, accountability mechanisms, legal instruments and policies through which Māori exercise control over Māori data.

1 Māori rights and interests in data derive from our inherent rights as Indigenous peoples, and unique relationships with land, water and the natural world. These rights are recognised in Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).

Principles of Māori Data Sovereignty

Te Mana Raraunga | Brief #1 | October 2018

01 Rangatiratanga | Authority

1.1 Control. Māori have an inherent right to exercise control over Māori data and Māori data ecosystems. This right includes, but is not limited to, the creation, collection, access, analysis, interpretation, management, security, dissemination, use and reuse of Māori data.

1.2 Jurisdiction. Decisions about the physical and virtual storage of Māori data shall enhance control for current and future generations. Whenever possible, Māori data shall be stored in Aotearoa New Zealand.

1.3 Self-determination. Māori have the right to data that is relevant and empowers sustainable self-determination and effective self-governance.

02 Whakapapa | Relationships

2.1 Context. All data has a whakapapa (genealogy). Accurate metadata should, at minimum, provide information about the provenance of the data, the purpose(s) for its collection, the context of its collection, and the parties involved.

2.2 Data disaggregation. The ability to disaggregate Māori data increases its relevance for Māori communities and iwi. Māori data shall be collected and coded using categories that prioritise Māori needs and aspirations.

2.3 Future use. Current decision-making over data can have long-term consequences, good and bad, for future generations of Māori. A key goal of Māori data governance should be to protect against future harm.

03 Whanaungatanga | Obligations

3.1 Balancing rights. Individuals' rights (including privacy rights), risks and benefits in relation to data need to be balanced with those of the groups of which they are a part. In some contexts, collective Māori rights will prevail over those of individuals.

3.2 Accountabilities. Individuals and organisations responsible for the creation, collection, analysis, management, access, security or dissemination of Māori data are accountable to the communities, groups and individuals from whom the data derive.

04 Kotahitanga | Collective benefit

4.1 Benefit. Data ecosystems shall be designed and function in ways that enable Māori to derive individual and collective benefit.

4.2 Build capacity. Māori Data Sovereignty requires the development of a Māori workforce to enable the creation, collection, management, security, governance and application of data.

4.3 Connect. Connections between Māori and other Indigenous peoples shall be supported to enable the sharing of strategies, resources and ideas in relation to data, and the attainment of common goals.

05 Manaakitanga | Reciprocity

5.1 Respect. The collection, use and interpretation of data shall uphold the dignity of Māori communities, groups and individuals. Data analysis that stigmatises or blames Māori can result in collective and individual harm and should be actively avoided.

5.2 Consent. Free, prior and informed consent (FPIC)[2] shall underpin the collection and use of all data from or about Māori. Less defined types of consent shall be balanced by stronger governance arrangements.

06 Kaitiakitanga | Guardianship

6.1 Guardianship. Māori data shall be stored and transferred in such a way that it enables and reinforces the capacity of Māori to exercise kaitiakitanga over Māori data.

6.2 Ethics. Tikanga, kawa (protocols) and mātauranga (knowledge) shall underpin the protection, access and use of Māori data.

6.3 Restrictions. Māori shall decide which Māori data shall be controlled (tapu) or open (noa) access.

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2 https://www.un.org/development/desa/indigenouspeoples/publications/2016/10/free-prior-and-informed-consent-an-indigenous-peoples-right-and-a-good-practice-for-local-communities-fao/

FOR INFORMATION

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

Proposed by: Principal Advisor to CEO

Meeting of: Board, 5 October 2021

Recommendation

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

Purpose

1. To summarise progress of the SDHB's overall Change Programme
2. To highlight the items in our change programme that contribute directly to the new Dunedin Hospital (NDH)

Specific Implications For Consideration

Background

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

Discussion

This is the third iteration of this report and is a placeholder until we can start reporting out of Cascade which we are in the midst of operationalising. As previously mentioned, we have moved to using a SaaS cloud-based software platform (Cascade) to assist the organisation with the ongoing monitoring of this change programme which will offer an additional level of sophistication and transparency to our portfolio as monitored by the ePMO, but we are not at the reporting stage yet with this – we are still uploading the programme content.

Next Steps & Actions

Continue uploading and refining content in Cascade. On-board exec team and a group of their delegates to assist with providing regular updates which will include some training on how to use the platform.

Appendices

SDHB Change Programme Update Sept 2021

Strategic Change Programme – Progress Update Sept 2021

Regional Lens & Alignment

Southern Strategic Briefing Project Underway

Southern Strategic Priorities 2015	*Strategic Annual Plan Priorities*
Develop a coherent Southern system of care	**Clinical Service Redesign**
Build the system on a foundation of population health, & primary & community care	**Creating an environment for health**
Secure sustainable access to specialised services	**Māori Equity**
Strengthen clinical leadership, engagement & quality improvement	**Systems for Success**
Enhance system capability & capacity	**Enabling our People**
Live within our means	**Primary & Community Care**

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

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**
Patient Flow/Implementation of the SAFER Bundle*	• Dunedin & Southland Master Site-Planning* • **MAU*** • **Oncology Sustainability Planning *** • **Hospital escalation plan*** • Generalism* • Implementation of MH review recommendations * • Security Review*	• Discharge documentation re-design * • Operational Structure reset • Scanning Project *	• Operational Management system implementation (Integrated Operations Centre) • CETES (Clinical Engineering, Tech & Equipment Service • Acute Assessment & Planning Units • 23 Hour Unit
	• Health Needs Analysis* • Primary & Community Work Programme		• Locality Network prototyping
	• Equity actions improvement plan • Implementing Whakamaua: Māori Health Action Plan		• Maori Health Authority Commissioning
• Virtual Health* • FPIM Implementation • HRIS	• District-wide clinical partnerships • Transitions Improvement: Rural transfers & transfers to ARRC • Data & analytics reporting improvement plan • Risk Management maturity journey • Establishment of ePMO & Project Governance Framework* • NDH Workforce Modelling * • PICS Implementation * • Performance & Accountability Framework*	• Clinical Costing System • Right-sizing Southland ED • South Island Digital Transformation * • Production Engineering *	• Central Decision Support Model • Transit Care Units (TCU) • Seven-Day Hospital
	• Wellbeing: Aukaha kia kaha programme • Strengthened Credentialing • **CCDM Implementation*** • Implementation of MH Health & Safety review* • **Disability Strategy Implementation***	• Building internal change capability (L&D/ePMO)	
• Health Care Homes	• Frail elderly pathway • Primary care in Southland • Health Hubs Implementation*	• Maternity Central Otago	

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status Current	Month Status Previous	Additional Comments	Key Risks/Key Dependencies
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)						
Southern Strategic Briefing Project (nee refresh)*	Oct 30th	Board/CEO			Project slightly delayed as a result of the COVID lockdown, however largely on track. Consultation with wider community planned for new year.	Availability of team to meet timeframes & incorporate feedback that has been given.
MAU*	Aug 2022	EDFPF			De-canting of areas underway, construction to begin shortly	Phase 2 of construction to begin Jan 22 based on decant schedule.
Oncology Sustainability Planning*	Ongoing	EDSS			Multiple workstreams in flight, some recruitment progress has been made and the radiation oncology wait list has reduced from 160 to circa 86 with consistent outsourcing assisting in the improvement delivered. Benchmarking work with EY now well underway.	Recruitment Success key dependency/risk
Discharge Summaries Re-design	Dec 2021	CMO/EDQCG			Still in flux, needing to identify project manager to take the workstream forward.	Availability of project resource dependency
Operational structure re-design*	Sept 2021	CEO/ELT			Proposal for change delayed due to second round of feedback to be incorporated.	
Production Engineering	August 31st 2021	EDSS			Re-calibrating this work – Auckland trip to view IOC on hold due to covid. Recruitment for service improvement manager is complete which will enable immediate ESPI recovery work to progress. Post Auckland visit a proposal will be made to improve production engineering using relevant expert roles and toolsets.	Ability to recruit relevant skills into the team will be the key risk to manage once a proposal is developed.
Clinical Costing System Implementation plan	Oct 30th 2021	EDFPF			Decision to progress with system that NMDHB & CDHB use currently. Implementation plan and quote has been requested from vendor.	System integrations & resource management

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

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status Current	Month Status Previous	Additional Comments	Key Risks/Key Dependencies
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)						
Right-sizing Southland ED*	~~30/08/21 BC Signed off.~~ 30/08/2022	EDFPF/EDSS			Business case has been signed off for ED expansion and the development of fit for purpose space, and the detailed design work will now commence. Benchmarking will be undertaken to determine whether further staffing is required (in addition to the additional 4.8 nursing FTE implemented earlier this year). A joint programme of work with the PHO has been initiated to reduce primary care suitable presentations to the Emergency Department.	
ePMO & Project Governance framework*	Oct 30th 2021	PACEO			Portfolio Manager recruitment has been delayed due to candidate pulling out of process. Second recruitment process underway.	Onboarding of Portfolio Mgr. is dependency. Risk to date of implementation now after 2 rounds of recruitment.
Quality Improvement Framework	TBC	EDQCG			Decision made to move this into the Performance & Accountability Framework	The Performance & Accountability Framework
Building internal change capability	Ongoing	ELT/EDP&C			Current covid situation has re-directed HR resource to workforce surge planning	Lockdown and covid has redirected HR workforce
Patient Flow/Implementation of SAFER Bundle*	Ongoing	ELT			Regular 6 weekly SLT patient flow workshops underway to keep momentum up.	Continued collaboration between medical, nursing & allied.
Health hubs Implementation*	Dec 2021	EDSPC			Concept designs completed for Dunedin, next stage rollout in progress with chosen partner. Co-design agreement in place.	
MHAID Review *	TBC	CMHS&I			Senior change manager in place to drive project forward. Project plan being developed.	
Security Review	Dec 2021	EDFPF			Report has been received, reviewing currently.	
MHAID H&S Review	TBC	CMHS&I			Decision by Exec & Board to prioritise MHAID review first with view that this will follow.	Dependent on MHAID overall review being implemented

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

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)						
Hospital Escalation Planning/Standard Operating Procedures*	Ongoing	EDSS			Dunedin's escalation plan has been implemented with a formula to determine when the hospital moves to the next level. Southland is still working on their implementation and have developed a formula to signal when a status change needs to occur. This will now be implemented.	If changes in alert levels (and requested actions concerning discharging) occur frequently, there is a risk that alert fatigue will mean that respondents are less likely to respond to alerts. The mitigation is to consistently follow up the alerts with monitoring for the actions being taken.
Health Needs Analysis *	Dec 2021	EDSPC			Soft launch of 8/82 indicators complete with complete live site end of calendar year.	
Primary & Community Work Programme	Ongoing	EDSPC			Work is progressing but the COVID Vaccination programme has stalled progress in areas	COVID vaccination programme slowed progress
Equity Actions Improvement Programme	Ongoing	CMHS&I			As above	COVID vaccination programme slowed progress
Virtual Health*	2023 embedded by	EDSS			Current covid situation has given telehealth a boost. The ability to hire a fixed term project manager has made a considerable difference and support for multiple services was able to be provided during COVID, allowing greater uptake of the available tools than would otherwise have been the case.	Technology dependency & model of care embedding/patient education. Requires ongoing effort to encourage and embed the change.
FPIM Implementation	1/07/21	EDFPF			Complete, go live achieved on July 1st	

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

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Tranche 1 (Shorter Term Initiatives: immediate, 1-3 years)						
HRIS	Ongoing	EDP&C			Success Factors has been implemented 1st part of 2 part implementation	
NDH Workforce Modelling*	Ongoing/No end date	EDP&C			Completed first iteration of modelling future workforce requirements for services in the Outpatients' Building: this modelling includes draft costings. Will be presented to ELT & CLG.	Health NZ reforms will have an impact from a wider environmental perspective.
Health Care Homes	2021-22	EDSPC			Third tranche completed in Q4.	
Risk Management Maturity *	October 2021	EDQCG			The list of current clinical risks has now been signed off by Clinical Council and shared with FARC. Investigation underway to move data into Safety1st	The target to move to Safety1st by October is at Risk. Pushing this target out to October is possible if RLDATIX bulk upload functionality will handle that.
Scanning Project *	December 2022	PACEO			The Business case is at 70% completion. The preferred option is being worked up with a change management plan before going to ELT.	The people side of change needs to be navigated well in this project as it relies on different ways of working.

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

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Tranche 2 (Mid to Long -Term Initiatives: 2-6 years)						
Maternity Central Otago	2024	EDSPC			Proceed with RFP & advancing of business case collaboratively with MoH. Components of BC have been agreed with Ministry. Draft Business case submitted to Ministry in mid August.	
Dunedin & Southland Master Site-Planning*	TBC	EDFPF			Initial planning meeting with Sapere had and awaiting their project plan.	TBC once project plan signed off
CCDM Implementation*	TBC	EDSS & CNMO			The funding for full implementation is in the current financial year. CCDM is being systematically implemented as staff are able to be recruited.	Shortages of nursing and therefore inability to recruit into the CCDM vacancies is the biggest risk to implementation. The CNMO has developed a plan with a range of initiatives to improve the rate of recruitment.
Primary Care in Southland *	31/10/21	EDSPC & EDSS			Joint work programme with PHO	Workforce risk specifically GP pool
Generalism*	2023/2024	EDSS			Recruitment on track but key benefits will come once the MAU is built and the internal medicine team are able to base themselves next to the ED in the MAU. Work is occurring, led by the Building and Property team, to expedite the de-canting required to initiate the building work.	Dependency of MAU project and associated de-canting. This is now underway.
Digital Transformation (detailed business case)*	September 2021	EDFPF			Complete pending cabinet approval.	Approval processes, overspends & potential resource/skill gaps

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

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Tranche 2 (Mid to Long -Term Initiatives: 2-6 years)						
PICS implementation*	Q4 2024	EDSS			Programme manager re-assigned COVID programme so has been delayed. Has now returned to PICS and has been asked to initiate the first steering group in the next 2 weeks.	Availability of the project manager, availability of the regional PICS team who are currently working on South Canterbury. This will be worked through at the first steering group meeting.
Central Decision Support Model	N/A	PACEO			Conceptual stage – regional discussions South Island wide are occurring.	Robust data warehouse underpinning the model & capability uplift in analytics team.
CETES – Clinical Engineering, Tech & Equipment Service	2024/6	NDH			New Build team/conceptual	
TCU – Transit Care Units	2024/5	NDH			New Build Team/conceptual	
Seven-Day Hospital	2024/6	NDH			Conceptual Stage	Workforce Implications as change in operating model.
Acute Assessment & Planning Units	2024	NDH			New Build Team/Conceptual	
23 Hour Unit	2024	NDH			New Build Team/Conceptual	

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

Strategic Change Portfolio – Progress Update Sept 2021

Initiative/Project	Achieved By	Responsible Owner	Month Status: Current	Prior	Additional Comments	Key Risks/Dependencies
Key Business as Usual Enablers						
Performance & Accountability Framework*	November 2021	ELT			Plan with timeframes being developed by IS team which will involve some external assistance as well.	IS resource issue – being addressed by lead EXEC.
Develop Service Planning further	Ongoing	ELT			Additional investment into service planning has been identified as a need.	Currently 1 FTE.
Health & Safety Workplan	Ongoing/No end date	GM H&S, EDP&C			Workplan progressing, resource under more pressure due to covid	GM H&S resignation.
Wellbeing: Aukaha kia kaha programme	Ongoing/No end date	EDP&C				
Implementing use of Cascade – SaaS tool to monitor our execution of our Strategic Change Programme*	Octobr 2021	PACEO			Cascade account is up and running and the change programme and annual plan are in the process of being populated into the platform.	User adoption.

10

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		

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

FOR INFORMATION

Item:	**Te Kaika Community Wellness Hub**
Proposed by:	Rory Dowding, Executive Director Strategy Primary and Community
	Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer
	Executive Director
Meeting of:	October 2021

Recommendation

That the Board notes the progress of the Te Kaika Integrated Health and Wellness Hub

Purpose

To provide the Board with a status update for the Te Kaika Integrated Health and Wellness Hub project

Background

In December 2020, Ōtākou Health Limited – Te Kāika (OHL) provided the successful response to the SDHB initiated RFP for a community wellness hub in Dunedin. OHL is the runaka owned entity that was founded to develop Te Kāika (the village), an integrated site of health, social and educational services in Dunedin for Māori, Pasifika and low-income Whānau.

Te Kāika is located in Caversham, South Dunedin. Onsite is a medical centre (GP's, Healthcare assistance and nurses), Dental Services provided by the University of Otago, a Mental Health Nurse, Physiotherapist, Arai te Uru Whare Hauora Social Services, Tiaki Taoka (Oranga Tamariki) and Ministry of Social Development also provide an on-site Case Manager and work broker. Presently Te Kāika employs a total of 50FTE across their organisation with 6,500 whānau registered across their services, 35% are Māori and 10% are Pasifika.

Te Kāika's vision outlined in the RFP is to continue to develop the services at this site with the aim of creating a new integrated low-cost health centre to reduce the financial and cultural barriers to wellbeing.

The Proposed Community Health and Wellbeing Hub

The community hub will follow an integrative model of care with the three key organisations (Te Kāika, Ministry of Social Development and the Southern DHB) working cohesively together to support Te Runanga O Ngai Tahu's tribal strategy;

- Whānau rakatirataka is enhanced through access to those resources that support decision making and increased responsibility for wellbeing.
- Whānau expressions of tikaka, their approach to resolving issues is encouraged and supported.
- Access to healthcare is delivered via the concept of a village, where services are provided onsite to deal with the multiplicity of health issues that will reduce waiting times and admissions into hospitals.

- Mātauraka Māori, ensuring we are staying ahead of the curve and leading the way forward with research and best-practice models of wellbeing such as the Nuka Model.
- Workforce Development is about building the capacity of our kaimahi to meet the needs of a growing infrastructure – (taken from OHL – RFP Response)

A significant amount of research has been undertaken by Te Kāika to establish a Whānau- centric model of care which is inter-disciplinary in nature and effectively provides both primary and community services to their local community. The services that we provide from the SDHB will align and be supportive of this model of care.

The proposed hub aims to have the MSD team, SDHB team and Te Kāika primary health services working alongside each other. True integration of services for Whānau will be the key emphasis of this hub, rather than the easier option of co-location only.

The Te Kāika Community Hub is not only designed to be innovative from an integrated models of care perspective, the aim is for this hub to be truly technologically enabled, utilising telehealth and other digital tools to provide optimal care for its enrolled population.

SDHB Services and the Community Wellness Hub

The clinical co-design phase of this project is still in the early phase. However, specific opportunities to incorporate the following services within the hub have been a highlighted. These include;

- SDHB Mental Health Services
- Outpatient Clinics including Paediatrics, Rheumatology, Endocrinology, Cardiology and Diabetes.

The services provided at Te Kāika (at this stage in the co-design process) will be provided to people who are enrolled at Te Kāika and for people with Community Service Cards.

The Co-Design Process

A significant amount of project time and resource has been allocated to the co-design process. This is due, in part, to the importance of creating an effective and cohesive interdisciplinary team and to support our teams to successful change the way they will need to work within this environment.

This process has been split into three components;

- Clinical Co-Design (model of care)
- Property Co-Design (building envelope and internal fit out)
- Operational (co-location) design (MSD, SDHB and Te Kaika Primary/ Community Services)

All components of the co-design process will occur in a highly integrated fashion with an overall Project Manager from Ministry of Social Development taking the lead and reporting back to the Project Board.

Key Stakeholders/ Service Design Team;

Project Sponsor: Donna Matahaere- Atariki, Matapura Ellison, Viv Rickard, Stephen Crombie, Chris Fleming.

For full Governance and working group details refer to Appendix 1. Project Organisational Chart.

Project Update

The property co-design phase is currently a key project focus to ensure that the project is completed at the specified end date. A change of architect and additional resource consent requirements has occurred recently and this has enabled a robust schedule of accommodation to be created. The SDHB property team, alongside the MSD and Te Kāika teams have indicated key clinical and operational requirements to ensure this process is successful. It is anticipated that a frozen floor plan is provided to the Project Board by the end of October 2021. A start date for the build has not yet been identified.

Initial clinical co-design meetings have been held with key SDHB teams (Mental Health, Paediatrics and Outpatients), MSD and Te Kāika to support the property design and ensure the building form fits the function of the hub. A clinical co-design programme/ schedule is currently being developed by the Lead Project Manager (MSD) and project managers from each organisation. This will also include a collaborative communication plan for the project.

Project Close Date

Dependent of resource consent and any delays in building or design processes. The project end date has been advised as being December 2023.

Next Steps & Actions

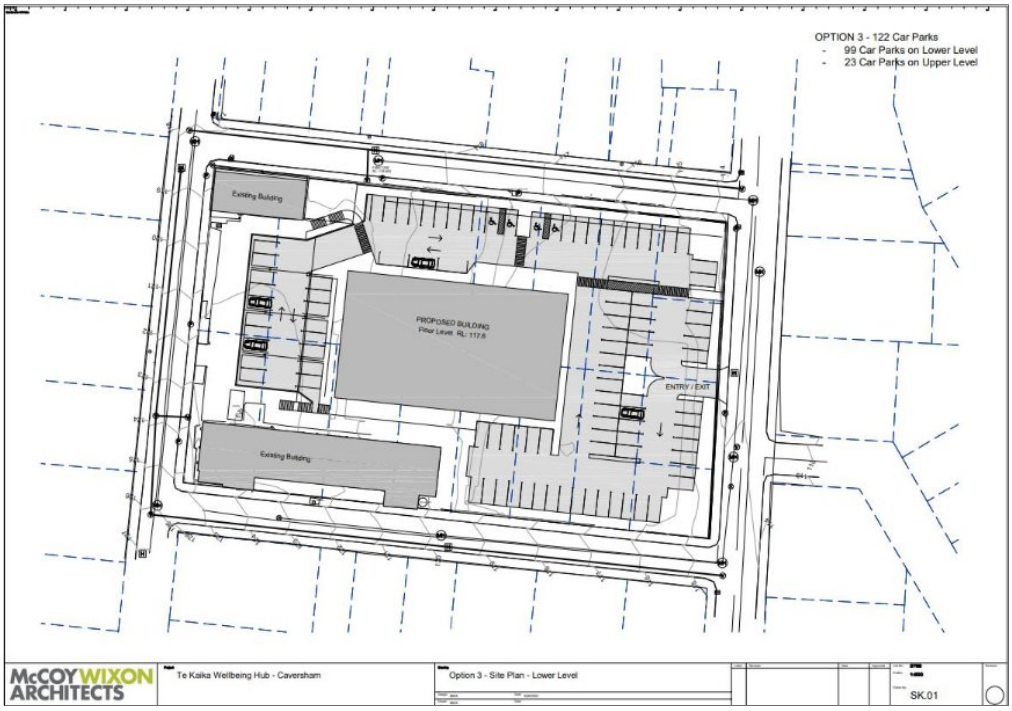
- Heads of Agreement and Property Lease to be signed off.
- Frozen Floor Plan to be signed off by all parties
- Initiate Co-Design (Clinical and Operational) process development incorporating all three organisations. This will include inter-organisational project documentation including project milestone/ timeline chart, project plan with WBS, communication plan, benefits realisation plan and risk register.
- Further identification of key SDHB internal stakeholders and continuation of co-design process with clinical teams.

Appendix

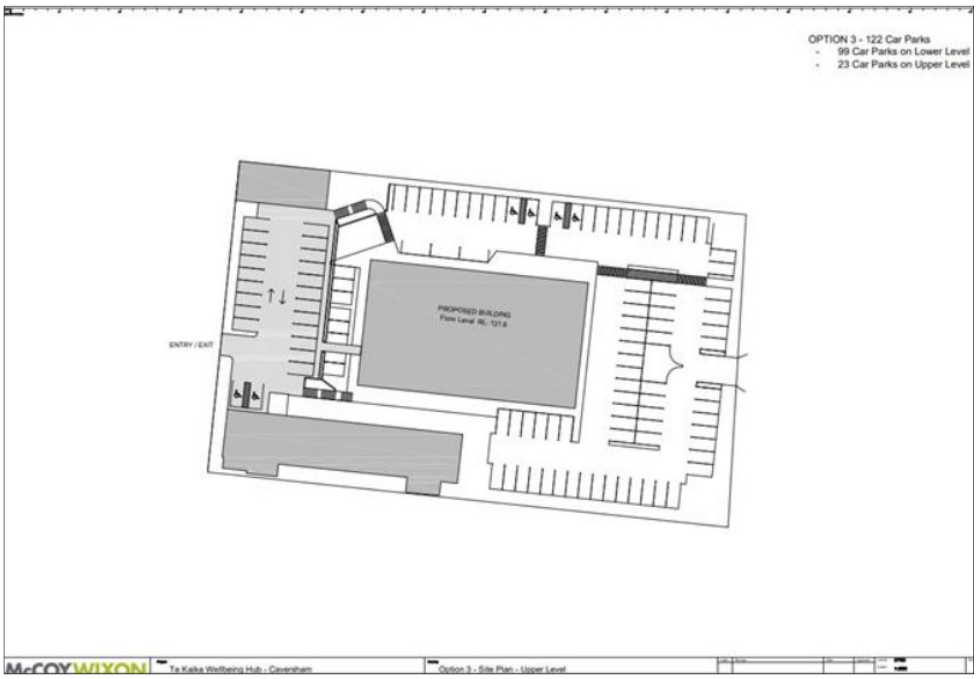
1. Organisational Chart
2. Proposed building design as of September 2021
3. Proposed building design as of September 2021

Appendix 1. Organisational Chart

Appendix 2.



Appendix 3.



FOR INFORMATION

Item: Patient Flow Update Report September 2021

Proposed by: Patient Flow Taskforce

Meeting of: Board, 5 October 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:***
2. ***Operational:*** *Patient Flow improvement work is the remit of all the operational teams working together in a patient-centred interprofessional manner. Strands of this work involves teams and people sometimes working in new ways which can take time and energy to embed sustainably.*
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

There are six particular workstreams identified that the taskforce are committed too and are outlined further in this report. These workstreams will be driven, sponsored, and supported by the taskforce along with involvement from the operational teams that they cross.

Next Steps & Actions:

- ***Establishment of Clinical working party for discharge documentation***
- ***Further monitoring & support of the MAU & ATR project teams***

Appendices

1. ***Patient Flow Taskforce Progress Update***

PATIENT FLOW IMPROVEMENT PROGRAMME

Month #8 Progress Update -

Activity in the following areas is still taking place:

- *Rapid rounds continue to be an effective way of bringing the team together to make efficient decisions however we are still experiencing some variability which we need to focus on removing. These are operating on all wards. Teams continue to grow in their skill in effectively utilising rapid rounds. The next step will be to do some audits of the process in areas to ensure it's working for the teams and they are being executed effectively in an ongoing manner.*
- *In order to expediate transfers to ARRC, particularly on a Friday, two teams on 8 MED are trialling house officers charting medication directly into Medimap to reduce the delays in general practice needing to immediately sign off on any medication changes. Licence for Medimap has been purchased and a local pharmacist will commence training of the system with the house officers. Should this prove to be an efficient way of expediating transfers it will be rolled out to other areas.*

The taskforce has identified six significant workstreams/projects that need to be the focus going forward to keep materially affecting patient flow in a positive manner. The taskforce will continue to provide executive sponsorship and focus to these and drive appropriate resourcing of these projects. These workstreams/projects are:

- **ED Processes – Bed request to bed access** - This has been operationalised with the ED team and Ops and an early September project implementation start date has been agreed on. This process has moved from uncontrolled to controlled (the unpredictable swings have been removed). Now is the time to concentrate analysis on the details of the process to fully understand all the steps and the interdependencies. Using a standard process improvement methodology, it should be possible to progressively improve the process and hence remove this non-value added time.
- **Model of care review for the MAU:** A meeting with the MAU project team and sponsors was had and an agreement on the desired model of care that is being worked towards was re-affirmed and a pathway towards progressing the implementation of that was agreed upon. There are some further elements including recruitment and the facility/decanting that need to occur before fully realising the new model of care and its associated benefits.
- **Parallel processes in ED**: The standard model is for the ED team to fully assess the patient and conclusively determine the need for admission and often the diagnosis. Next this is presented to the in-patient team who attend and assess the patient and make an admission decision. Finally, a bed is booked, and transfer ensues. A parallel model would rely on an early prediction of admission, which can easily be done with a high reliably at the very start of time in ED. Where admission is highly likely or certain then arrangements will be made to book a bed and to consult with the in-patient team. The expectation is that this would bring forward the time when it would be appropriate to transfer the patients to an in-patient bed. It would also allow for better planning at a ward level in that they would be aware of incoming patients ahead of time. There would also be opportunities to agree expedited pathways to in-patient care for specific conditions.
- **AT&R beds in Southland being commissioned:** A project team has been established and is underway working on achieving 4 beds by December and 8 in the new year and then assessing bringing the additional 4 online. The team are exploring ways of operationalising this given the current shortages of both nursing and physiotherapy staff in Invercargill
- **Discharge documentation project:** Nelson Marlborough DHB kindly shared their improvement plan on discharge documentation which offers us an opportunity to explore. A Southern working party (clinical) will be brought together with the aim of providing guidance on the potential effectiveness of the NMDHB model and a pilot organised in a willing area to test it.

- **Set up of an Integrated Ops centre** – Despite not being able to get to Auckland right now, there is plenty of collateral, videos, and the ability to seek information virtually that is being explored through Australian examples (RPA and Gold Coast). This long-term initiative will be dependent on the new operational structure being settled on first, however an exploratory zoom call with the Gold Coast is scheduled for the 28/09.

Current Metrics

**Note, the patient flow dashboards do have the function to provide 'by specialty', 'by ward' and 'by clinician' which users can navigate too users the various filters. These dashboards have been shared with clinical leads and service managers. A change request has been lodged to see a longer time series, therefore trends over time.*

Fig 1. Dunedin – Bed Request to admission time

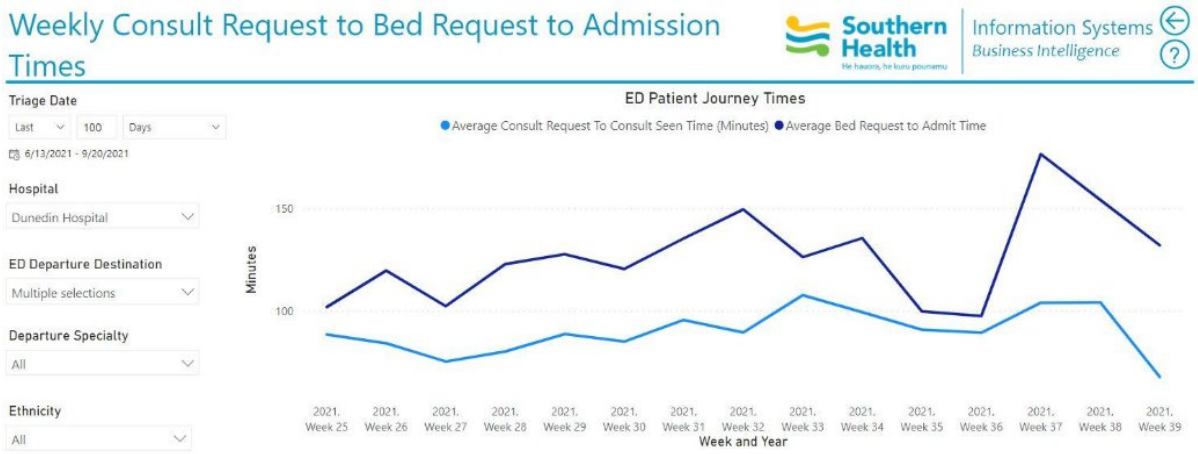


Fig. 2 Southland – Bed Request to admission time

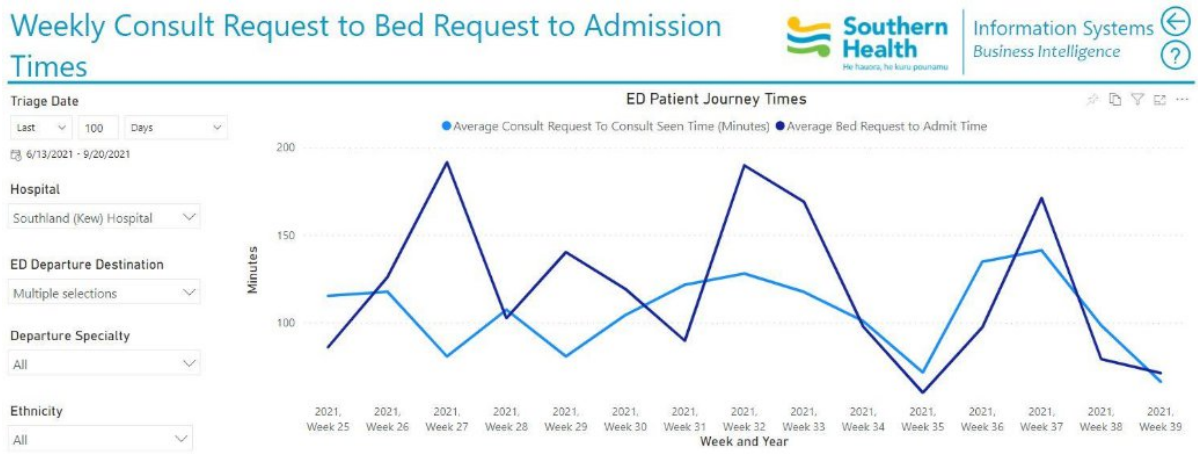


Fig. 3 Dunedin – Discharges before Noon

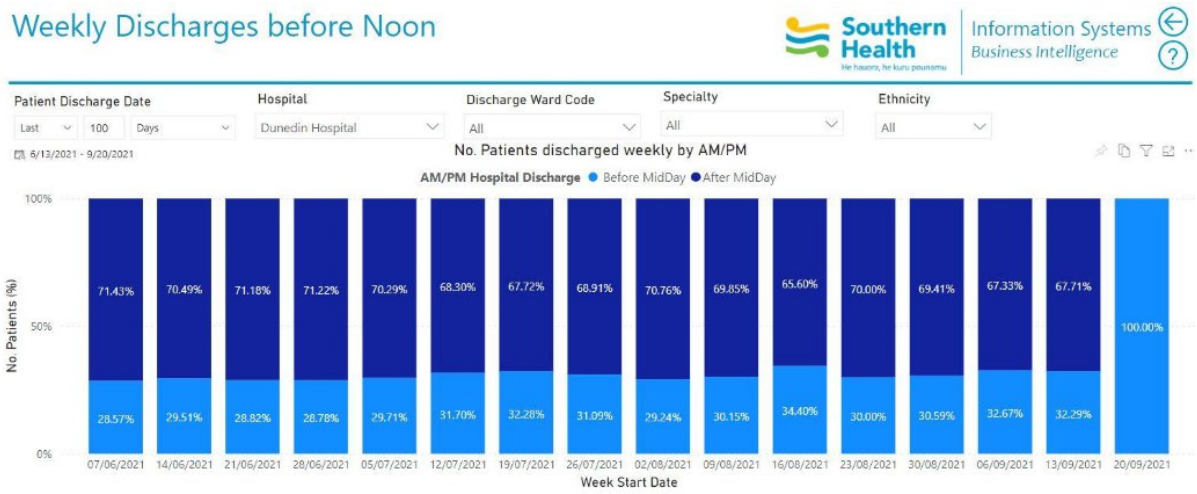


Fig. 4 Southland – Discharges before Noon

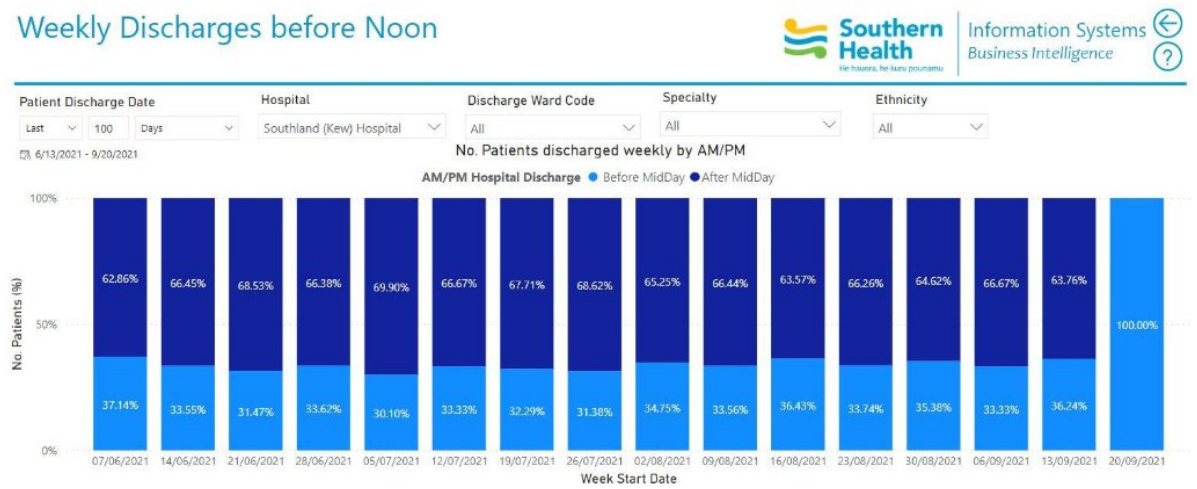


Fig 5. Dunedin – Did not wait

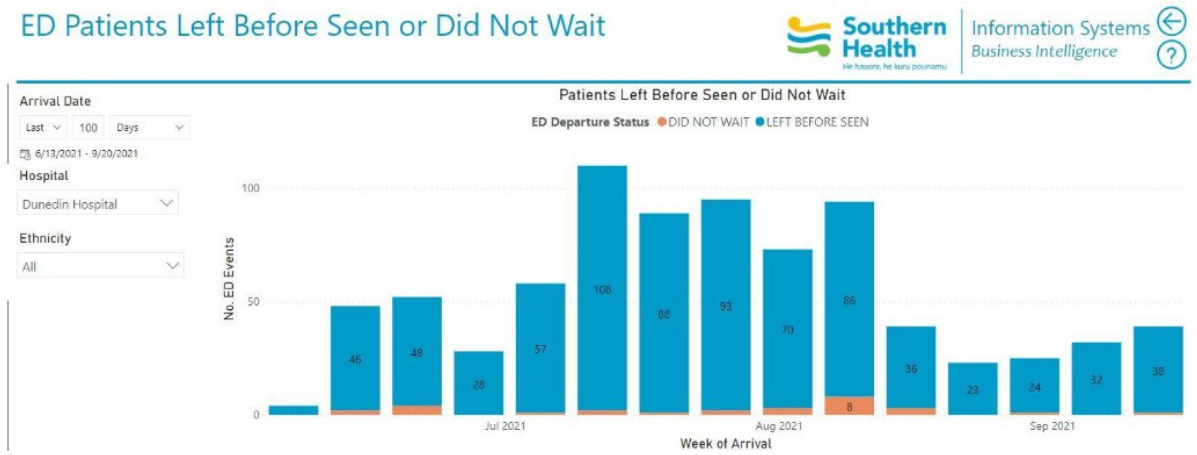


Fig. 6 Southland – Did not wait

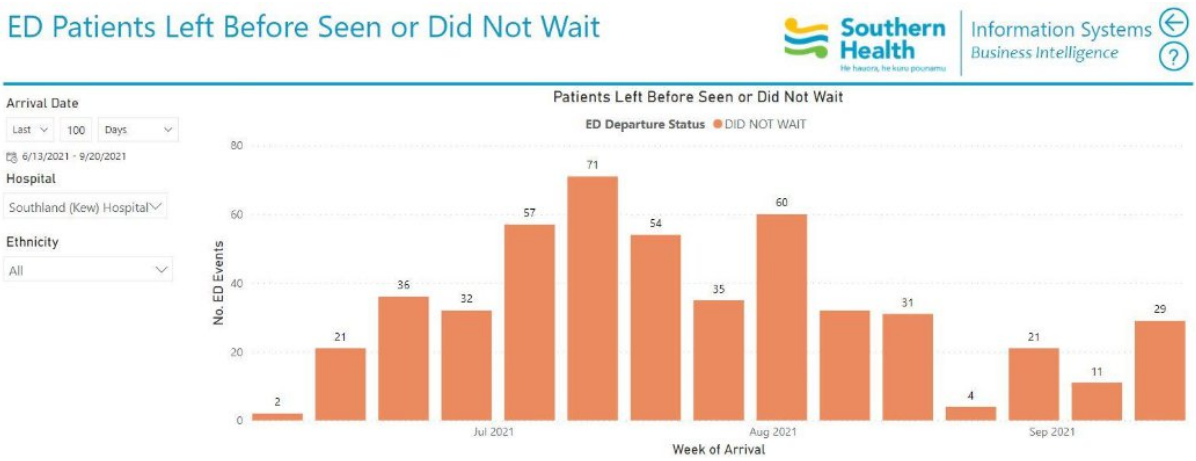


Fig. 7 Dunedin – Weekend vs weekday discharges

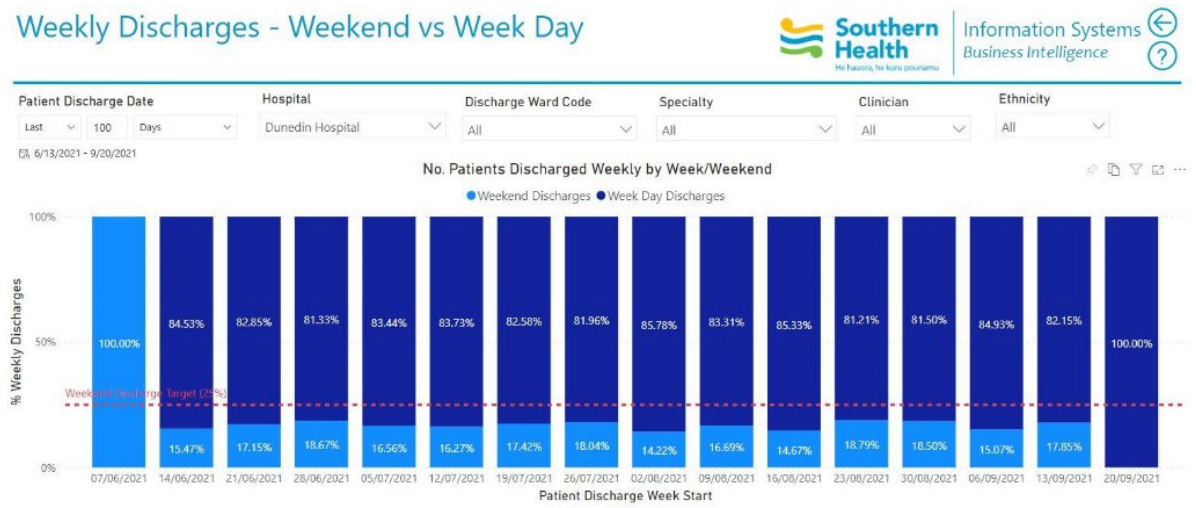


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Fig. 8 Southland – Weekend vs weekday discharges

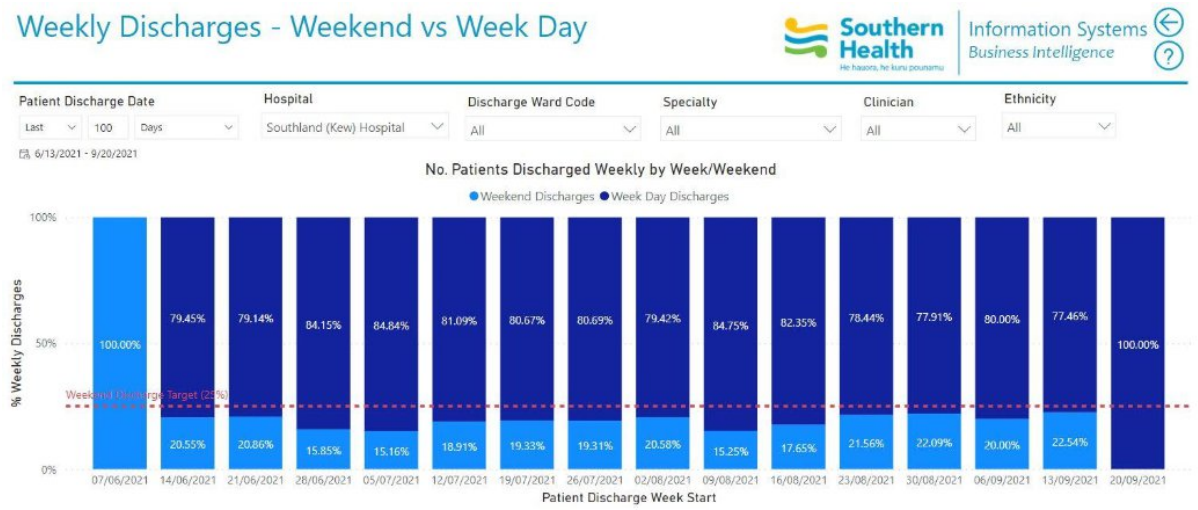


Fig. 9 Dunedin – LOS >21 Days

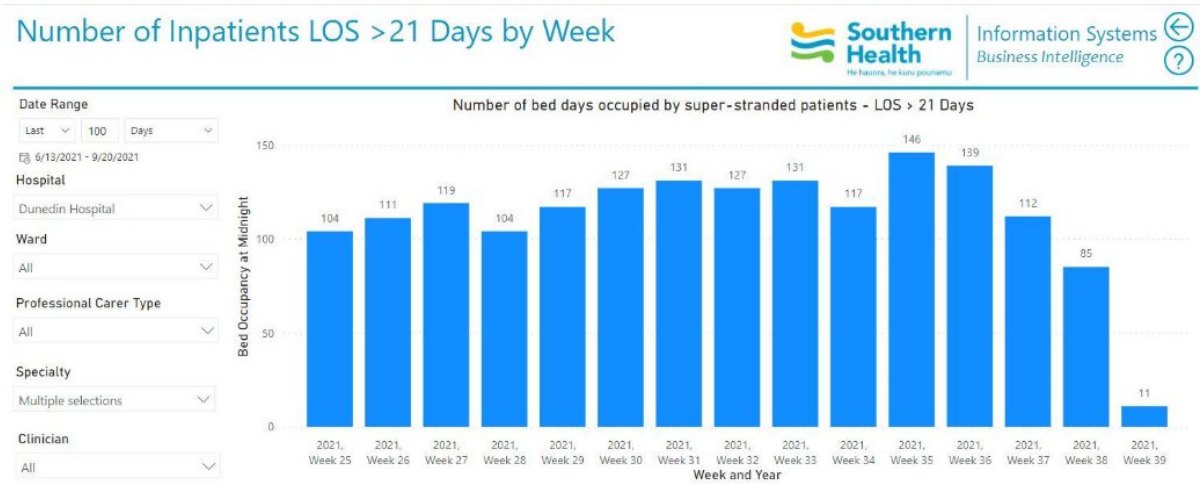
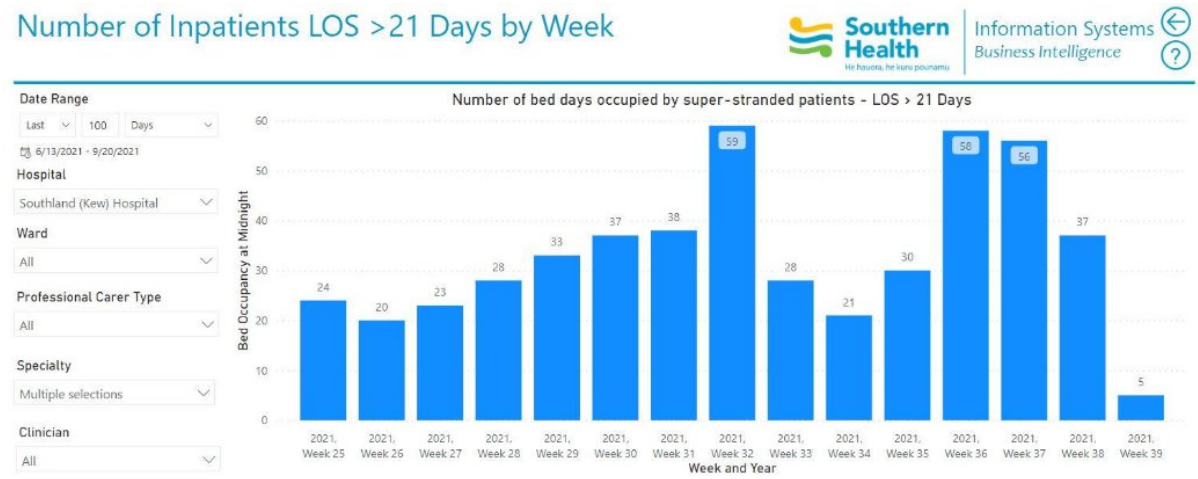


Fig. 10 Southland – LOS >21 Days



FOR APPROVAL

Item: **2022 Meeting Dates**

Proposed by: Board Secretary

Meeting of: Board, 5 October 2021

Recommendation

That the Board adopt the attached meeting schedule for 2022.

Purpose

1. To set dates for next year's Board and Advisory Committee meetings.

Specific Implications For Consideration

2. Equity

   The Iwi Governance Committee will be considering their meeting dates on 4 October 2021.

Appendices

Appendix 1 Draft Board and Advisory Committee meeting schedule for 2022

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SOUTHERN DISTRICT HEALTH BOARD
MEETING SCHEDULE 2022

	FEBRUARY (Invercargill)	**MARCH** (Dunedin)	**APRIL** (Dunedin)	**MAY** (Invercargill)	**JUNE** (Dunedin)
Hospital Advisory Committee	Tuesday 1 9.00 am		Monday 4 9.00 am		Tuesday 7 9.00 am
Finance, Audit and Risk Committee	Tuesday 1 12.30 pm		Monday 4 12.30 pm		Tuesday 7 12.30 pm
Iwi Governance Committee		Tuesday 1 10.00 am		Monday 2 10.00 am	
Community & Public Health Advisory Committee		Tuesday 1 1.00 pm		Monday 2 1.00 pm	
Disability Support Advisory Committee		Tuesday 1 3.30 pm		Monday 2 3.30 pm	
Board Meeting (8.30 am Members Only)	Wednesday 2 9.30 am	Wednesday 2 9.30 am	Tuesday 5 9.30 am	Tuesday 3 9.30 am	Wednesday 8 9.30 am

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) Community and Public Health Advisory Committee ▪ Verbal report of 4 October 2021 meeting b) Finance, Audit & Risk Committee ▪ Unconfirmed minutes of 6 September 2021 meeting c) Iwi Governance Committee ▪ Verbal report of 4 October 2021 meeting	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.
Strategic Refresh Summary Document	To allow activities and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(i) of the Official Information Act.
Oncology	To allow activities (incl staffing) to be carried on without prejudice or disadvantage	Section 9(2)(i) of the Official Information Act.
Māori Health - Assessment of Unmet Need	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Contract Approvals ▪ Strategy, Primary and Community	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
New Dunedin Hospital	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

*S 32(a), Schedule 3, of the NZ Public Health and Disability Act 2000, allows the Board to exclude the public if the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

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