Southern DHB Board Meeting

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

02/11/2021 09:30 AM - 12:30 PM

9.	Strategic Change Programme		CEO	83
10.	Mental Health Review Update		Acting ED MHAID	89
11.	Māori Health Actions to Address Amenable Mortality and Conditions		CMHS&IO	93
12.	Presentations:			98
	12.1	Number 10 Youth One Stop Shop	11.00 am	
	12.2	Workforce	11.20 am EDP&C	98
	12.3	Patient Flow Taskforce	11.00 am Patient Flow Taskforce	113
13.	Resolution to Exclude the Public			121

APOLOGIES

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

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Board, 2 November 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, 5 October 2021, 9.30 am
Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Pete Hodgson	Chair
	Prof Peter Crampton	Deputy Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	
	Miss Lesley Soper	
	Dr Moana Theodore	
In Attendance:	Mr Andrew Connolly	Board Advisor *(by Zoom from 2.04 pm)*
	Mr Roger Jarrold	Crown Monitor *(by Zoom)*
	Dr Ben Pearson	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Ms Toni Gutschlag	Director Service Improvement, MHAID
	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 *(by Zoom)*
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Mr Glenn Symon	General Manager Community 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.

Toni Gutschlag, who was assisting SDHB with Mental Health and Intellectual Disability service improvement, introduced herself to the Board. It was noted that Ms Gutschlag formerly held the role of Deputy Director-General Mental Health and Addiction, Ministry of Health, and was currently Director of Service Improvement.

2.0 APOLOGIES

Apologies were received from Mr Rory Dowding, Acting Executive Director Strategy, Primary and Community, Ms Tanya Basel, Executive Director People and Capability, and Dr David Gow, Chair, Clinical Council.

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 7 September 2021 be approved and adopted as a true and correct record."

I Beekhuis/T Potiki

5.0 ACTION SHEET

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

- The HR dashboard was still being reworked. The Executive Director People and Culture was scheduled to give a presentation to the next meeting.
- Staff disability awareness training completion rates would be reported to the December 2021 Disability Support Advisory Committee meeting.
- Southland site planning had commenced and was expected to be completed in February 2021.

The Board requested an interim report on Southland site planning for its December 2021 meeting.

6.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The Board received a verbal report from Mr Tuari Potiki, Community and Public Health Advisory Committee (CPHAC) Chair, on the CPHAC meeting held on 4 October 2021, during which he informed the Board that the Committee:

- Received a presentation on opioid substitution treatment and the provision of alcohol and drug treatment services across the district;
- Received updates on PHO performance, Māori Health, and the Mental Health Review;
- Endorsed the All District Health Boards' position statements on the Sale and Supply of Alcohol and Smokefree Aotearoa 2025 goal.

Disability Support Advisory Committee

The Board received a verbal report from Dr Moana Theodore, Disability Support Advisory Committee (DSAC) Chair, on the DSAC meeting held on 4 October 2021, during which she advised that the Committee focused on two main items:

- Patient stories, and
- Implementation of the Disability Strategy and Action Plan using a co-design approach.

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee meeting held on 6 September 2021 were taken as read and Mrs Jean O'Callaghan, HAC Chair reiterated that the Committee was focusing on key improvements, risks and issues, as set out in the papers.

7.0 CHIEF EXECUTIVE OFFICER'S REPORT

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

- *Organisational Performance* – The fiscal position was relatively good given the impact of the COVID-19 situation. Clarification had not yet been received from the Ministry of Health on the treatment of the revenue lost because of the COVID-19 lockdown. Caseweights were down by 670 and pressure on ED had reduced during the lockdown period.
- *Annual Plan* – The Minister had approved Southern DHB's 2021/22 Annual Plan.
- *Ongoing COVID Response* - Planning was moving from managing COVID as an endemic, rather than a pandemic, in preparation for the borders opening. Further discussion would be held with the public excluded, as plans had not yet been finalised.

  Southern DHB was leading the country in overall vaccination rates and was striving to reach 90%. Māori rates still had some way to go however.
- *Specialist Services Production Plan* – The Production Plan for 2021/22 would be considered by the Executive Leadership Team (ELT), then submitted to the Hospital Advisory Committee in November 2021.
- *Elective Service Performance Indicators* – Circa 150 patients were reported as waiting over 600 days, which was untenable; 48 outpatients had been waiting over 365 days and 375 inpatients over 365 days.

Ms Gutschlag *left the meeting at 10.20 am.*

- *New Dunedin Hospital Parking* – An invitation for expressions of interest (EOI) to develop a car parking building within the new Dunedin Hospital campus would be issued the following week. The number of parks required would be determined as part of that process.
- *Dialysis Chairs, Southland Hospital* – Two dialysis chairs had been commissioned at Southland Hospital and the three Southland Board members had attended their blessing.
- *Primary Maternity* – The business case for the construction of two rural primary birthing units in Central Otago/Wanaka had been submitted to the Ministry of Health.
- *Southland Physiotherapy Service* – The Chief Allied Health, Scientific, and Technical Officer (CAHS&TO) briefed the Board on the action taken to fill the physiotherapy vacancies in Invercargill and advised that, if all went to plan, they would be fully recruited to by January 2022. The efforts of the existing Southland physiotherapy staff were acknowledged.

- *Aged Residential Care Registered Nurse (RN) Workforce* – The CEO reiterated his concerns about the shortage of RNs in the Aged Residential Care sector.
- *Leena Singh Report* – The report was taken as read and the CEO took questions.

Management responded to questions on planned elective surgery outsourcing, waiting list management, car parking and staff safety, the shortage of RNs in the Aged Residential Care sector, clinical governance responsibility, and the appointment of a Head of Department (HoD) for Intensive Care across Dunedin and Southland Hospitals.

During discussion, the Board requested:

- An update on ESPI performance and a report on standardised intervention rates for the next Hospital Advisory Committee meeting;
- That the appointment of an HoD for ICU across Dunedin and Southland be progressed.

It was resolved:

"That the Board:

- **Receive the CEO's report;**
- **Note the remarkable progress with the COVID-19 vaccination rollout, and**
- **Congratulate all those who have been managing and delivering the COVID-19 vaccination programme and urge them to persevere with increasing the vaccination rate."**

Carried unanimously

8.0 FINANCE AND PERFORMANCE

Financial Report

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

The Executive Director Corporate Services (EDCS) informed the Board that the negative result was attributable to a reduction of approximately $3m of planned care revenue due to the COVID-19 lockdown and advised that cashflow would have to be managed well.

It was suggested that building project management may need to be strengthened. The EDCS reported that an offer had been made to a candidate for the vacant General Manager, Building and Property position.

The EDCS reported that the 2020/21 financial audit had been delayed further, however Audit New Zealand believed they would meet the statutory deadline of 31 December 2021. The Ministry of Health had washed up electives for the year and $2 million less had been received. This was being reviewed by the Executive Director Specialist Service's staff.

Volumes Report

The volumes graphs and a report from the Executive Director Specialist Services (EDSS) analysing performance against the previous year's results (tab 8.2) were received.

The Board requested that the volumes report be further considered by the Hospital Advisory Committee.

Quality Dashboard

The Interim Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) presented the Quality Dashboard (tab 8.3), then took questions.

During discussion the EDQ&CGS advised that:

- The dashboard report to Board was designed to present an overview of flow during the COVID-19 pandemic and the more detailed clinical quality indicators were being submitted to the Finance, Audit and Risk Committee;
- Assistance from IT was required to refine the graphs as part of the development of the quality and accountability framework;
- The report would be reviewed with the Quality Team with a view to clarifying what it was trying to convey and adding clear data definitions and targets.

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).

It was noted that, except for COVID-19, national immunisation rates were falling but a catch-up was being planned for the beginning of the next calendar year.

Quarter 4 2020/21 Performance Monitoring Reporting

The summary of performance reporting to the Ministry of Health for quarter 4 2020/21 (tab 8.5) was noted.

Performance

The Principal Advisor to the CEO presented a progress report on the development of the Performance Dashboard (tab 8.6).

9.0 TE KAIKA HEALTH AND WELLNESS HUB

Albie Laurence, Chief Executive Officer, Te Kaika Community Wellness Hub, and Becky Wilson, Clinical Project Manager, SDHB, were welcomed to the meeting for this item.

The Board received verbal and written updates on the Te Kaika Integrated Health and Wellness Hub project (tab 11).

In presenting to the Board Mr Laurence:

- Outlined the philosophy behind the project, what it was designed to achieve, and how it would be implemented to support moving a population group en masse out of the lower socio-economic demographic using an Iwi-led co-design process;
- Advised that the core focus for the next 18 months was the building of the physical infrastructure but, more importantly, building the service and the team to deliver that service to the population.

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) informed the Board that Te Kaika ran a low cost GP Service, had three dental chairs in partnership with the University of Otago Dental School, and provided integrated health, education and social services (Arai Te Uru Whare Hauora).

Ms Wilson and Mr Laurence gave an overview of project activity to date, during which they advised that:

- A governance project group, a working group, and a property project control group had been formed to support the project. The property design was currently under way for a 3,500 m^2 building across two stories, which would include three types of rooms - clinical rooms, private meeting rooms and other more open spaces on the ground floor. The second floor would be team pod working spaces, that could accommodate virtual or remote care.
- A resource consent hearing was scheduled for 1 December 2021 and the facility should be operating by November 2023.
- The next stream of work would be looking at clinical models of care as part of the co-design process.

Mr Laurence, Ms Wilson and the CMHS&IO then responded to questions on the services that would be provided and the scope for expansion.

The Board expressed admiration and support for the project and extended its congratulations to all involved with it.

It was agreed that management would arrange for the Heads of Agreement to be finalised and seek approval for the lease from the Minister.

In closing, Mr Laurence acknowledged the work the CMHS&IO and CEO had put in over the past 18 months and the support they had provided.

Mr Laurence and Ms Wilson left the meeting.

10.0 MĀORI HEALTH – AMENABLE MORTALITY

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) presented an update on the actions to address the Māori amenable mortality rate (tab 9) and reported that current contract arrangements with Māori providers and service specifications were being reviewed.

The Chief Nursing and Midwifery Officer informed the Board that she had been having discussions with the Auckland DHB on the approach they had taken to applying an equity lens to nursing, as she was concerned about advertising roles before looking at where they were best placed and developing goals to address inequity.

The CMHS&IO reported that he had drafted terms of reference for a Māori Equity Strategy Group, with the aim of establishing that group by November 2021. The membership would be mainly Māori clinical staff.

During its deliberations, the Board:

- Noted that the amenable mortality data for 2018 was provisional;
- Received advice from the CEO that it was important the new positions were put in place and a solution would be found for funding them.

11.0 STRATEGIC CHANGE PROGRAMME

A progress report on the Strategic Change Programme (tab 10) was taken as read and management responded to questions.

12.0 2022 MEETING DATES

The Board adopted the proposed meeting schedule for 2022 (tab 13), noting that the Iwi Governance Committee had agreed to meet in late January.

It was agreed that meetings be tentatively scheduled for July to September 2022 to cover any contingencies.

13.0 PATIENT FLOW TASKFORCE

A progress report from the Patient Flow Taskforce was circulated with the agenda and taken as read (tab 12).

The Chief Nursing and Midwifery Officer commented that:

- The Taskforce were still committed to embedding rapid rounds and an audit was planned to re-evaluate them;
- The metrics had not moved but improvements were still being pursued;
- Discussions had been held with a contact in the Gold Coast regarding the setting up of an Integrated Ops Centre.

The Chief Medical Officer reported that:

- The parallel processes in ED workstream had commenced and explained how that would work;
- Some helpful information had been obtained from the Nelson Marlborough DHB to assist with speeding up the discharge documentation project.

The Chief Allied Health, Scientific and Technical Officer (CAHS&TO) advised that more focus would be put on the medical area.

Karen Browne, Chair of the Community Health Council (CHC), was welcomed to the meeting (via Zoom). Mrs Browne informed the Board that she and June Mills, another CHC member, would be conducting bedside scripted interviews with selected patients over the next couple of weeks to gain an understanding of how things were going according to their planned care.

The Board requested that the results of the patient survey be submitted to its December 2021 meeting.

Taskforce members responded to questions on the number of AT&R beds being commissioned in Southland and the patient interviews.

PUBLIC EXCLUDED SESSION

***At 12.40 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Community 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.

The meeting closed with a karakia at 4.30 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 21 October 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	Needs Analysis research project is underway and steering group meeting is scheduled for Oct 27th. Initial targeted engagement is also underway and a data extract request has been made by Sapere from our systems and IS are working on that now directly with Sapere.	~~Sept 2021~~ ~~December 2021~~ January 2022
Oct 2021	(Minute 5.0)	Interim report to be submitted to the December 2021 meeting.	CEO		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	Staff questionnaire has been distributed to staff for completion by mid-November. HR Dashboard will include diversity by profession and directorate but at this time we are unable to provide the recruitment rate due to system limitations	February 2022

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				Work is being undertaken to have staff update their personal information including ethnicity in Employee Connect.	
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.	DQCGS	See update in Quality Dashboard covering report.	
June 2021	(Minute 6.0)	Completion date to be supplied for adding calibration points and staff information to the dashboards.	DQCGS EDP&C	In progress and will align with HR Dashboard information or as parameters are defined.	January 2022
Sept 2021	(Minute 9.0)	Period covered by dashboard graphs to be extended.	DQCGS	Dunedin dashboard changed to a 36-month timeline. Southern and Invercargill graphs will be moved to a 36-month timeline by 12 November.	
Oct 2021	(Minute 8.0)	Graphs to be discussed with the Quality Team, with a view to clarifying what they are trying to convey, adding clear data definitions and targets.	DQCGS	See update in Quality Dashboard covering report.	
August 2021	**People and Capability** (Minute 8.0)	▪ Comparative data from other DHBs on staff churn and vacancy rate to be provided.	EDP&C	Comparative data will be provided on a quarterly basis in relation to other DHBs and will be included in the HR Dashboard. Q1 FY22 will be provided for the December Board report.	December 2021
		▪ Paper and presentation on the Health workforce to go to the next Board meeting.	EDP&C		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

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2021	**Staff Disability Awareness Training** (Minute 9.0)	Check to be made that completion rates are being reported to DSAC.	DQ&CGS	Will be reported to DSAC - transfered to DSAC action sheet.	December 2021
Sept 2021	**Mental Health Review Implementation** (Minute 11.0)	Board to be provided with bi-monthly progress reports.	Acting ED MHAID		November 2021
Oct 2021	**Elective Services** (Minute 7.0)	ESPI update and standardised intervention rates to be reported to the Hospital Advisory Committee.	COO	Noted.	Complete
Oct 2021	**ICU** (Minute 7.0)	Appointment of an HoD for ICU across Dunedin and Southland to be progressed.	COO/ CMO	Meeting held on 13/10/21, General Manager, Chief Medical Officer, Nurse Director, Chief Operating Officer and ICU Specialist in attendance. There are four actions that need to be undertaken. The timeframe for conclusion of these actions is anticipated to be before the end of the calendar year.	31/12/2021
Oct 2021	**Volumes Report** (Minute 8.0)	Provider discharges report to be further considered by HAC.	COO	Included in the HAC agenda.	Complete
Oct 2021	**Te Kaika Health and Wellness Hub** (Minute 9.0)	Heads of Agreement to be finalised and lease approval to be sought from the Minister.	CMHS&IO CEO		
Oct 2021	**Patient Flow Taskforce** (Minute 13.0)	Results of patient survey to be submitted to the December Board meeting.	CNMO CMO CAHSTO	The first patient experience survey related to patient flow was undertaken on Monday, 18 October. Further surveys to be undertaken with results presented at the December meeting.	December 2021

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Monday, 4 October 2021, commencing at 1.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tuari Potiki	Chair
	Ms Ilka Beekhuis	Deputy Chair *(by Zoom)*
	Prof Peter Crampton	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr John Chambers	Board Member
	Mrs Jean O'Callaghan	Board Member
	Dr Moana Theodore	Board Member
	Mr Roger Jarrold	Crown Monitor *(by Zoom)*
	Dr Ben Pearson	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Mr Rory Dowding	Acting Executive Director Strategy, Primary and Community *(by Zoom)*
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer *(from 1.25 pm)*
	Dr Nigel Millar	Chief Medical Officer *(by Zoom from 1.37 pm)*
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer/Acting Executive Director MHAID
	Ms Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

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

2.0 APOLOGIES

Apologies were received from Dr Doug Hill, Committee Member, and Mr Andrew Swanson-Dobbs, CEO, WellSouth Primary Health Network.

An apology for an early departure was received from the Chief Nursing and Midwifery Officer.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

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

T Potiki/L Kelly

5.0 MATTERS ARISING

There were no matters arising from the previous minutes that were not covered by the agenda.

6.0 CHAIR'S UPDATE

The Chair reported that, at its meeting earlier that morning, the Iwi Governance Committee had discussed COVID-19 management and innovative ways to reach vulnerable communities.

7.0 REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 7) and received the following updates from management.

- An amended Health Food and Beverage Policy, including a water, unfavoured milk, tea and coffee only rule, should be available for the next meeting.
- The Dental paper would be redrafted once the impact of COVID-19 alert level 3 was understood. The anaesthetic waiting list issue related to Dunedin, as well as Southland, with most children on the waiting list being those requiring fillings who would not sit still.

8.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

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

- *Public Health COVID-19 Response* - A number of teams had been stood up to work a seven day roster to support Auckland and had been managing some complex cases and household contacts.

The Chief Allied Health, Scientific and Technical Officer joined the meeting at 1.25 pm.

- *COVID-19 Vaccination Programme* – Southern DHB had one of the highest vaccination rates in the country and a lot of effort was going into achieving equity. Some sophisticated methods were being used to obtain data, so there was a good level of awareness of where the low vaccination rates were within the district.

  While vaccination of the older population in Aged Residential Care facilities was reported as complete, there was a need to ensure that the 100 plus residents going into facilities each month were being vaccinated.

- *Primary Maternity Unit Business Case* – The business case for the construction of two rural primary birthing units had been submitted to the Ministry of Health for feedback and Requests for Proposals (RfPs) had been issued for service providers and design/architectural services.

- *Allied Health* - The Southland Physiotherapy Service continued to have some resource constraints. The Chief Allied Health, Scientific and Technical Officer and her team had been working hard to mitigate and improve the situation.

The Chief Medical Officer joined the meeting by Zoom at 1.37 pm.

- *Annual Plan 2021/*22 – The Minister of Health had signed Southern DHB's Annual Plan for 2021/22 and the Statement of Service Performance (SSP) was in the final stages of completion.

  It was noted that the latest amenable mortality data showed a reduction in variation between Māori and non-Māori, however the data for 2018 was provisional.

Management responded to questions on Public Health staff welfare and Residential Aged Care nursing.

The Committee requested information on whether there was any collaboration with tertiary institutions on the 'Don't Guess the Yes' programme.

Aged Residential Care Registered Nurse Recruitment and Retention

The results of a survey on the recruitment and retention of Aged Residential Care nurses for January-June 2021 were circulated with the SP&C report.

The Acting EDSP&C advised that SDHB needed to be cognisant of draining the Aged Care workforce when it undertook nursing recruitment for initiatives such as Care Capacity Demand Management (CCDM) and opening additional beds at Southland Hospital.

It was resolved:

"That the Committee accept the recommendations set out in the Aged Residential Care Registered Nurse Recruitment and Retention paper."

T Potiki/T King

9.0 PRESENTATION – OPIOID SUBSTITUTION

Dr Michelle MacDonald, Psychiatrist, Lead Clinician and Lead Opioid Clinician, Specialist Addiction Service, Mr Steve Bayne, Service Manager and Acting General Manager Mental Health and Addiction (MHAID) Services, and Ms Toni Gutschlag, Director Service Improvement, Ministry of Health, joined the meeting for this item.

Dr MacDonald gave a presentation on specialist addiction services in Otago and the waitlist for opioid substitution treatment (tab 18), during which she outlined the challenges and barriers to care for clients with substance use disorders, and how they were prioritised for treatment.

During her presentation, Dr MacDonald informed the Committee that:

- Addressing addiction would improve child safety and mental well-being, reduce medical co-morbidity and reduce costs in courts and Corrections;
- The waitlist was put in place to manage clients safely as per Ministry of Health guidelines; however the service was struggling to comply with those guidelines;
- Due to the number of clients on the Opioid Substitution Treatment (OST) programme in Otago, it was taking up nearly 70% of the service's FTE, leaving less time for people with alcohol and other drug problems;
- A barrier to GP addiction services was the cost to clients.

Dr MacDonald's proposed solution was to:

- Move to a specialist service that treats moderate to severe substance use disorders only;
- Ideally, employ more staff, particularly Māori;
- Employ a peer support worker;
- Increase resources in the community to manage the mild to moderate population free of charge.

Dr MacDonald then responded to questions from Committee members regarding Southland services, referral trends, national comparisons, and geographical access.

In thanking Dr MacDonald for her presentation, the Chair noted the importance of addressing alcohol and drug issues, as the downstream impact of not doing so was huge. The review of the Southern mental health and addiction services was designed to look across the system and identify programmes that were not working or needed to be done differently, such as OST. Management were asked to report back on solutions for the Specialist Addiction Service.

10.0 PHO PERFORMANCE UPDATE

A report on primary care performance (tab 10) was taken as read.

The Acting EDSP&C reported that:

- Invercargill Urgent Doctors had agreed to offer zero fees for under 14 year-olds after hours.
- Ambulatory sensitive hospitalisation (ASH) rates were currently very low. This could be due to low levels of respiratory illness as a result of the COVID lockdown.
- The DHB and WellSouth were progressing with the implementation of the Emergency Q tool in Invercargill and Dunedin.

The Chief Māori Health Strategy and Improvement Officer gave a brief update on the progress of Te Hau O Te Ora, the proposed partnered primary care service for Invercargill. He reported that the Hokonui Rūnanga and Awarua Rūnaka had signed an agreement with WellSouth for the provision of those services.

11.0 MĀORI HEALTH UPDATE

The Committee received a report on the Māori Health Directorate work programme (tab 11).

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) reported that:

- A presentation would be made to the Board the following day on the development of the Te Kaika Integrated Health and Wellness Hub;
- The Iwi Governance Committee had spent some time earlier that morning considering the COVID-19 vaccination rollout and the prioritisation of Māori and Pasifika. The DHB was working very closely with its community based partners to increase the level of vaccination.
- Sarah Martin had commenced in the Pou Whakatere Māori Public Health role.

- Janice Donaldson had completed a review of Māori Health provider contracts. It was intended to inject additional investment and change the service specifications prior to Christmas.
- Māori enrolment rates were slowly increasing.

It was agreed that the Māori Health provider contracts review report would be submitted to the next Board meeting.

12.0 MENTAL HEALTH REVIEW

A report on Mental Health and Intellectual Disability (MHAID) waiting times was circulated with the agenda (tab 12).

Ms Toni Gutschlag, Director Service Improvement, Ministry of Health, introduced herself and informed the Committee that she would be assisting Southern DHB with its Mental Health Review for four days every fortnight until April 2022.

The Acting Executive Director MHAID Services reported that:

- The first Southern Health Mental Health and Addictions Change Governance Group meeting had been held the previous week under the chairmanship of Clive Bensemann;
- Additional resources may be needed to support change management, particularly with communications;
- Expressions of interest had been invited for the transition of patients from Ward 11.

Management responded to questions on child and youth services waiting times.

13.0 HOUSING UPDATE

The Committee received a report on the work being undertaken by the Public Health Service on housing (tab 13) and noted the importance of housing conditions in reducing hospitalisations, saving lives, reducing poverty, increasing quality of life, reducing inequality, and helping mitigate climate change.

14.0 PUBLIC HEALTH – HEALTH PROMOTION UPDATE

The Committee received updates on health promotion activity, including reducing alcohol related harm, smokefree and water fluoridation (tab 14).

It was resolved:

"That the Committee recommend the Board endorse the DHB Position Statements on the Sale and Supply of Alcohol Act and the Smokefree Aotearoa 2025 Goal."

L Kelly/P Crampton

15.0 COMMUNITY PHARMACY COMMISSIONING

The Committee considered a report from management in response to a request from community pharmacies to place a moratorium on issuing new pharmacy contracts (tab 15).

It was resolved:

"That the Committee endorse the following next steps and actions recommended by management:

1. **That Southern DHB continues to offer new Integrated Community Pharmacy Services Agreements to all applicants who meet the legislative and regulatory requirements;**
2. **Advocate for Health NZ to develop a national strategy and policy on commissioning community pharmacist services that allows for local commissioning to meet specific local needs;**
3. **Management respond to the community pharmacies that wrote to the Southern DHB."**

16.0 FINANCE REPORT

A report on Strategy, Primary and Community financial performance to 31 August 2021 (tab 16) was taken as read.

The Acting EDSP&C noted that the result for the year to date was largely on budget.

PUBLIC EXCLUDED SESSION

***At 3.04 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Oral Health Services Contracts	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 Committee resume in open meeting and the business transacted in committee be confirmed."

The meeting closed at 3.35 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board

Minutes of the Disability Support Advisory Committee meeting held on Monday, 4 October 2021, commencing at 3.30 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr Moana Theodore	Chair
	Mrs Kaye Crowther	Deputy Chair
	Dr John Chambers	
	Prof Peter Crampton	
	Dr Lyndell Kelly	
	Mr Terry King	
	Ms Paula Waby	*(by Zoom)*
In Attendance:	Mr Pete Hodgson	Board Chair
	Mr Tuari Potiki	Board Member
	Mrs Jean O'Callaghan	Board Member
	Dr Ben Pearson	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Dr Hywel Lloyd	Interim Executive Director Quality & Clinical Governance Solutions
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr John Marrable	Chair, Disability Working Group
	Dr Nigel Millar	Chief Medical Officer *(by Zoom from 4.06 pm)*
	Mr William Robertson	Consumer Experience Manager *(by Zoom)*
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer/Acting Executive Director MHAID
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

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

2.0 APOLOGIES

Apologies were received from Mr Kiringāua Cassidy, Committee Member, Ms Jane Wilson, Chief Nursing and Midwifery Officer, and Mr Rory Dowding, Acting Executive Director Strategy, Primary and Community.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meetings held on 2 August 2021 be approved and adopted as a correct record."

M Theodore/L Kelly

5.0 MATTERS ARISING

There were no matters arising from the previous minutes not covered by the agenda.

6.0 REVIEW OF ACTION SHEET

The Committee received the action sheet (tab 6).

The Interim Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) reported that Southern DHB's 2021/22 Annual Plan had recently been approved by the Minister of Health and the Disability Working Group had drafted their action plan. It was therefore agreed that the action relating to the 2020/21 Annual Plan could be removed from the action list and reporting against the Disability Action Plan would be a recurring agenda item.

The Chair informed the Committee that reporting against the 2020/21 Annual Plan for Quarter 4 had been presented to the September 2021 Board meeting and included a section on disability.

7.0 CHAIR'S UPDATE

The Chair informed the Committee that:

- In preparing the October meeting agenda it had been decided to concentrate on two key items: patient stories and implementation of the Disability Strategy Action Plan. A paper focusing on the various services available in the community for people living with disability would be submitted to the December meeting.

- A report had been submitted to the Community and Public Health Advisory Committee (CPHAC) on Registered Nurse (RN) shortages in Aged Residential Care. The Chair requested that a copy of that report be included in the next set of agenda papers for non-Board Disability Support Advisory Committee members' information.

  CPHAC had also received information on bed availability and COVID-19 vaccination coverage in Aged Residential Care facilities.

8.0 PATIENT STORY

The Committee viewed a video recording of John Marrable's story and experience with the health system, and what could be improved, then Mr Marrable responded to questions on his lived experience.

The Committee was informed that patient stories were used to educate staff and would be a standing agenda item. It was noted that everyone's story was important, including those of whānau.

9.0 DISABILITY STRATEGY AND ACTION PLAN IMPLEMENTATION

Mr John Marrable, Chair of the Disability Working Group (DWG), presented an update on DWG activity and progress on implementing the disability strategy (tab 8.2).

Mr Marrable and Mr William Robertson, Consumer Experience Manager, informed the Committee that:

- The DWG had met twice since the last DSAC meeting and had been working on the draft Disability Action Plan 2021-24, which was now aligned to the Southern Disability Strategy actions.
- A co-design approach was being used to develop the Action Plan. This made the process a little longer but it was important to listen to everyone and bring them on the journey.
- Expected completion dates were still to be added to the Action Plan.
- Positive feedback had been received on The Disability Game, a disability training awareness course for staff. The DWG recommended that the disabilities to be simulated be assigned randomly to participants.
- Mr Marrable had completed accessibility audits for SDHB's Dunedin and Invercargill COVID-19 vaccination clinics and would be conducting a follow-up visit to the Meridian Centre in Dunedin. Wakari would be the next site to be audited.

The Committee:

- Noted the Disability Action Plan was a living document and clear objectives, and timeframes would be added to it;
- Noted the inclusion of equity;
- Thanked Messrs Marrable and Robertson for their work.

10.0 HOME AND COMMUNITY SUPPORT SERVICES (HCSS)

The Committee received a report from the Acting Executive Director Strategy, Primary and Community (EDSP&C) analysing HCSS clients' casemix and hours after reassessment by their provider (tab 9), and the Chief Medical Officer responded to questions on the InterRAI assessment process.

The Committee requested more information on this issue, with examples, to provide it with further reassurance in relation to those clients who had lost functionality but had their hours of service reduced.

The Chair thanked everyone for their attendance and the meeting closed with a karakia at 4.50 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

HOSPITAL ADVISORY COMMITTEE MEETING
1 November 2021

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

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 2 November 2021

Recommendation

That the Board:

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

Purpose

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

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

1. Organisational Performance

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

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

Financial performance for the month of September is a deficit of $5.534 million compared to a budgeted deficit of $2.051 million, and hence an unfavourable result against plan for the month of $3.483 million. The year to date deficit is now $10.341 million compared to a budgeted deficit of $5.740 million, a variance of $4.601 million.

The result for September has been impacted by three key components:

- Pharmac has advised that nationally, only $14 million has been identified by Pharmac as pharmaceutical expenditure related to COVID-19 for 2021/22. In light of this, the Ministry of Health has reduced Population Based Funding by $76 million nationally for the 2021/22 year and Southern's share of this is $5.2 million. We have reduced revenue year to date by $1.1 million despite expenditure being on plan
- Expenditure associated with COVID-19 resurgence planning and activities has a year to date unbudgeted impact of $1.251 million
- Under delivery of planned care, the deferral of a significant amount of planned care due to the COVID-19 lockdown. The COVID lockdown period resulted in $3.1 million deferred activity, and due to staffing challenges, particularly in Southland, a further $600k impact in September. We have engaged 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. The Ministry of Health have indicated that they may fund the impact, but we have not recognised this to date on the basis that to recover this shortfall additional outsourcing will be required.

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 211 or 4.3% for the month compared to the plan, and down 260 or 5.2% on the same month last year. Year to date case weighted discharges is down 669 or 4.4% year to date against plan and 737 or 4.9% against last year
- Medical case weights are up 27 or 0.5% year to date on plan, and very similar to last year being 24 or 0.4% compared to last year
- Surgical case weights are down on plan 804 or 9.9% with acutes down 144 or 3.8% with electives being down 660 or 15.0%. Compared to last year, surgical acute case weights are down 107 or 2.9% and electives are down 704 15.8%
- Raw discharges (actual number of patients) are down 200 or 3.9% for the month against plan, but only down 22 or 0.4% compared to last September. Year to date raw discharges is down 608 or 3.9% compared to last year
- Mental Health bed days are 595 or 18.7% below planned levels for the month (indicating an 81.3% bed occupancy) and 191 or 2.4% down on year to date September 2020. This indicates overall bed occupancy is now only marginally lower than last year
- Emergency Department (ED) attendances are down 420 or 5.7% compared to September 2020 with Dunedin down 7.1%, Southland down 2.9% and Lakes down 8.3%. On a year to date basis ED presentations are down 4.1% with only Lakes having a very small increase.

The Performance Dashboard update has been included as a separate agenda item, there is 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. COVID Endemic Planning

New Zealand has been exceptionally successful with the management of the COVID-19 pandemic to date with its elimination strategy, however with the Delta outbreak within the Auckland region which has spread to parts of the Waikato and Northland, the increasing vaccination rates being experienced in Southern and right throughout the country, and the Government's recent announcements associated with the signalled move to the traffic light system where we will be living with COVID within our community it is vital that we move swiftly into the preparedness for living with COVID in the Southern region. Whether this occurs due to a case leaking out of the higher alert levels as was seen recently in Blenheim, or through the inevitable reopening of our borders, Southern must be ready.

We had already commenced with our planning, being led by Dr Hywel Lloyd, Director of Quality and Clinical Governance Solutions, but this is now being coordinated at local, regional and national levels. Modelling has been undertaken at a national level with various vaccination rate levels being considered, however now that the Government has indicated a move into the new traffic light system when New Zealand gets to a 90% double vaccination level this is a good indicator for the scenarios we need to consider. The numbers are concerning and we must plan for the worst-case scenario which has been modelled at the potential of close to 900 cases a week in the Southern region with a potential weekly hospitalisation level of circa 40 and up to four per week requiring Intensive Care Unit (ICU) level care. Given the average length of stay for patients being hospitalised this would

indicate hospital occupancy of between two to three times this level. Whilst the level of hospitalisations would be challenging if the worst-case scenario unfolded, it is vital that we understand the impact on Public Health, Primary Care, Kaupapa Māori Providers and non-government organisations (NGOs) such as Home and Community Support providers. At least 95% of all cases will be being managed within the community setting. It is therefore vital that whilst robust hospital plans must be in place, primary and community settings, transport arrangements, and psycho-social/welfare arrangements are as critically important.

It is also vitally important that despite our increasing vaccination rates we stop at nothing to make sure that every part of our community has the highest possible vaccination rates. Despite our amazing results Māori, Pacific Island, and lower socio-economic parts of our society continue to lag behind. The vaccination team are doubling down on efforts and working in partnership with people within the community to ensure every avenue is explored and creative ways of getting the vaccine out are pursued.

Hywel Lloyd will present where our planning is up to at the Board meeting. We are creating both a Steering Group and a Governance Group, which will meet regularly over the next few months as this is the biggest single risk for both our organisation and our community. If the endemic is not managed effectively, the health system will be placed under more and more strain and access to planned care will be jeopardised. It is important to recognise that whilst people view planned care as deferrable, when deferred it does have direct impact on many people's quality of life, reduction of pain, and long-term health prognosis. We can not simply cancel this activity to manage we must optimise how both COVID patients are cared for an maximise business as usual including planned and preventative care.

3. Top Six Risks

Risk	Management of Risk Avenue	Effectiveness
Overloaded Health System due to emergence of Covid Endemic within the community	Planning team in place with both a steering and a governance group to ensure systems, processes and practices are optimised. Resource plan being developed with unbudgeted capex and opex requirements.	To be determined. Continual focus essential
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

4. COVID-19 Vaccination Programme

Southern DHB continues to be delivering COVID-19 vaccinations at a rate above the national average and at the end of September was sitting at 80% (377,751) of our population vaccinated. Following Super Saturday on 16 October this has increased to 86.2%, with vaccination data per Territorial Authority as at 6:00am on 17 October as per the table below:

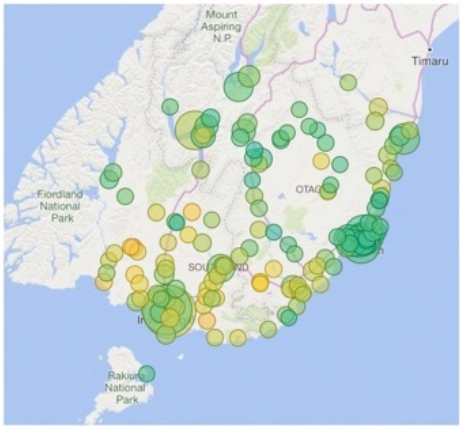
Territorial Authority	Percentage 1st Dose	Percentage 2nd Dose
Central Otago District	87%	72%
Clutha District	79%	59%
Dunedin City	90%	76%
Gore District	78%	62%
Invercargill City	81%	62%
Queenstown-Lakes District	94%	72%
Southland District	77%	54%
Waitaki	81%	63%
Total Population	86.2%	68.5%

We are also a leading DHB for vaccinations delivered to vulnerable populations around disability residential vaccinations, mental health and alcohol addiction vaccinations and Māori and Pacific populations.

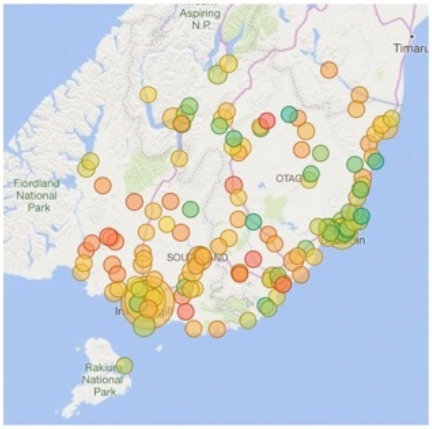
The programme is now entering its final phase, and we are now at a turning point in the programme with regards to 'peak demand'. Reducing throughput has arrived quicker than anticipated due to the surge in demand over lockdown. While this will be a period of clinic consolidation for many providers, it will also be crucial for meeting our vaccine targets in the Southern district. Consequently, the last quarter of 2021 requires a significant shift in our mind-set.

Our key focus in September has been around pivoting our existing vaccination staff from our mass vaccination centres into outreach teams and working alongside our Māori health providers to deliver offsite vaccinations. We are led by our newly acquired Health Service User (HSU) dataset, which shows a breakdown of vaccination status by postcode and allows us to identify specific populations' demographic details.

Data showing vaccination uptake for total eligible population (29 Sept 2021)

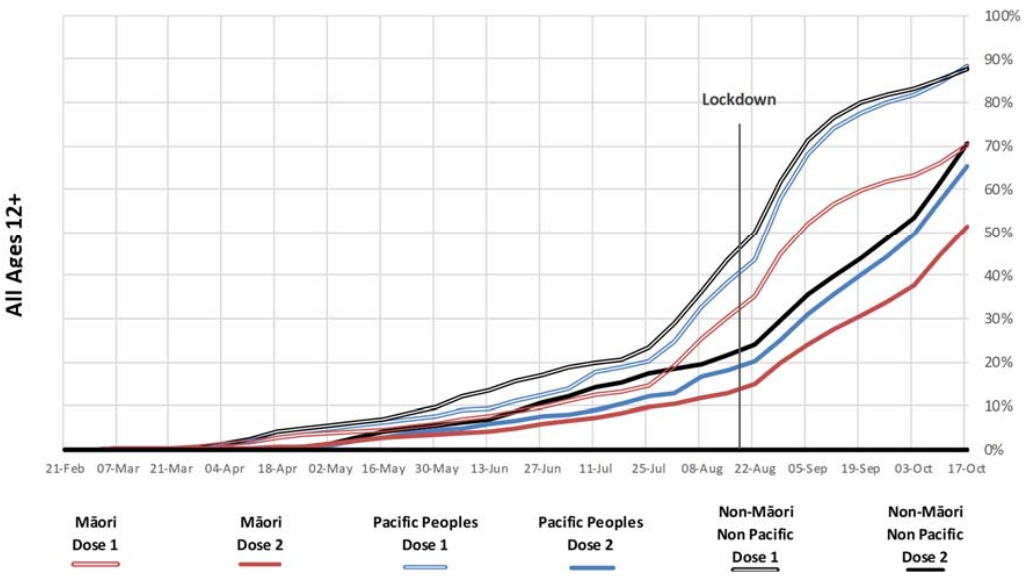


Data showing vaccination uptake for Māori population (29 Sept 2021)



MINISTRY OF HEALTH
MANATŪ HAUORA

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



Māori and Pacific Population Rollout

The Mō tātou Tīpuna Vaccination Centre has relocated to Victoria Road using a drive-through and walk-in model. Mō tātou Tīpuna have been working with Forsyth Barr Stadium to provide a two-day walk-in clinic with a focus on Māori and Pacific University of Otago and Otago Polytechnic students. Recent innovations include a vaccination bus which will provide this service close to home within Dunedin city suburbs with planning for other localities as per the HSU dataset backed Power BI data. COVID-19 vaccination home visits continue to be provided for those Māori who are unable to leave their home. Marae based clinics still occur at Otakou and Puketeraki.

He Puna Waiora Wellness Centre in Invercargill continues to provide supportive vaccination services in partnership with Pacific Island Advisory Cultural Trust; like other providers, there has been a broad mix of populations attending. Advertising and marketing of clinics lead by He Puna Waiora are successful for Māori and Pacific communities. He Puna Waiora Wellness Centre continues to provide vaccinations within the rural areas with good uptake. The strength of relationships between providers and their communities are very evident in the rural vaccination programme that includes Marae based settings and towns such as Ohai.

Awarua Whānau Services continue to provide vaccinations to rural communities, including dose two at Stewart Island. They continue to hold clinics at their premises as requested by their community with good uptake. Awarua Nurse-Led clinics are now incorporating the COVID-19 vaccination programme into their schedule.

Aged Residential Care

Vaccinations of our older populations at aged residential care facilities are complete. Our teams vaccinated residents and staff onsite, with the vaccine delivery supported by general practices, pharmacies and WellSouth flying squads. All 65 facilities across the Southern district have had first and second clinics onsite. In addition, there are processes in place with pharmacies, general practices and the Southern DHB outreach teams to ensure new admissions to aged residential care are vaccinated.

Mental Health and Addictions

All Mental Health residential services in the Southern district have been contacted regarding their resident's eligibility for vaccination, and booking information has been supplied. In some cases, we have arranged onsite vaccinations by pharmacists, general practices and the Southern DHB outreach teams where attendance at the mass clinics were not appropriate for individuals. An interrogation of service user data highlighted that there were 2,300 Mental Health and Addictions services users in our district who were yet to make a booking or receive a first dose. Whakarongorou will call these patients and discuss their vaccination options. The project team is working with the National Needle Exchange Programme to understand what additional support could be provided to their clients.

Disability

Of the almost 1,000 Disability Residential Support Services recipients in the Southern district, most are living in a residential facility. Vaccination arrangements are now in place for all of this cohort, and just 17 vaccinations remain incomplete. This work is being supported by general practices, pharmacies and the Southern DHB outreach teams. Good progress is being made on arrangements for the remainder of the disabled population in our district, using Accident Compensation Corporation (ACC) and Ministry of Health data to identify some groups to target support and information. The project team is working with the Ministry of Education to identify students who receive Ongoing Resourcing funding or High Health Needs funding and provide their families with support and information. Specialist schools were approached for onsite clinics, and they are taking place this month.

Ethnic Communities, including Migrants and Refugees

Three ethnic community clinics took place at tailored community-based locations across the Southern district, two in Dunedin and one in Queenstown, vaccinating close to 180 former refugees and migrants. Through a collaborative approach, key community leaders within the ethnic community, interpreters, internationally qualified nurses, and WellSouth Cross-Cultural Navigators were in attendance.

COVID-19 Vaccination Outreach Service

The COVID-19 Vaccination Outreach Service was developed to provide equitable access to the COVID-19 vaccine. Individuals with a disability, mental illness diagnosis, or health condition that limits their mobility are eligible for referral into this service. General practice and local pharmacy must be approached in the first instance and will provide an outreach service if possible. Referral pathways include: Health Pathways, Whakarongorau, District Nursing, Home Care Support Agencies, Needs Assessment and Service Coordination, WellSouth Call Centre, and Disability service providers. Additionally, individuals can self-refer to this service.

Of the 69 referrals to date, 27 patients received home visits by General Practice and 30 patients received appointments with the COVID-19 Vaccination Outreach service.

Workplaces

Project managers are using HSU data to identify target areas for a vaccination push and are calling workplaces across the district to offer assistance to make COVID-19 vaccinations more accessible to all. WorkSafe has also been approached for a complete overview of large businesses. An expression of interest was sent to workplaces via the Otago Chamber of Commerce, however, this avenue has only yielded one response.

5. Southland Clinical Needs Analysis

A steering group has been established and they will meet for the first time on 27 October. In the meantime, Sapere have made a significant data extract request from our Digital team and they are working through that now. Some initial 1:1 engagement has started to get some momentum going given the late start of the steering group.

6. Specialist Services Productivity in September

Following the step down of COVID restrictions, planned care surgery, procedures and outpatient appointments quickly returned to close to normal levels of activity. For the full month, hospital planned care surgery was adverse to plan by 116 case weights on circa 1,500 case weights of planned activity (i.e. circa 7.7% below plan).

Dunedin has continued to be able to run its operating theatre lists with minimal gaps. Southland continues to face perioperative staffing challenges with nursing FTE gaps of circa 25-30%.

Whilst the Southland team has worked hard to progress with their recruitment efforts these staffing gaps mean that if the perioperative team is in overnight with an emergency case, or if sickness levels are too high, a theatre list is in danger of being cancelled. We have traced the daily theatre operations ('thud') reports for the month of September, and we have found that on average we have lost a half day operating theatre list per day, primarily for these reasons. This means that resolving the perioperative staffing challenges is a significant priority for us.

Anaesthetic Technicians remain a challenge to recruit to, so we have maximised the number of new recruits that we can bring into our training programmes in both Southland and Dunedin. We have also asked Human Resources (HR) to think differently about recruitment and the Haines Attract team went down to Invercargill to talk to the perioperative service and the other services which have significant staffing challenges down there. We are now following up with them to get a proposal for targeted recruitment for Southland.

Southland also has inpatient bed constraints and we have engaged the Assessment, Treatment and Rehabilitation (AT&R) team to get the 12 inpatient beds which are budgeted for in their area underway as soon as possible. We have advertised for the additional nurses required to establish an additional four beds initially in the hope of having four beds 'on stream' by the end of this calendar year.

Because of the challenges associated with recruiting we have also initiated an initiative in parallel that would allow 10 beds to be brought 'on stream' from February 2022. This initiative involves partnering with the nurse training institution in Southland and utilising trainee nurses to staff 10 beds from February. This initiative was proposed by the Director of Nursing for Planning, Funding and Population/Public Health and is supported by our key stakeholders in Southland. We are working towards having this in place in February and it appears to be a good initiative, utilising lateral thinking and good partnerships in order to overcome some of the recruitment challenges that ware are experiencing.

We are yet to receive formal guidance from the Ministry about recovering from the COVID lockdown, but we are working on the assumption that all revenue lost during COVID will be paid and should be utilised to catch up lost surgery. To this end we have tasked the General

Manager Surgical Services and Radiology to double budgeted/planned outsourced surgery for at least the next six months. Private surgical capacity remains tight and a high degree of focus will need to be applied in order to achieve this level of outsourced throughput.

For the last three years we have proactively contacted surgeons in the lead up to January and February to ensure that all theatre lists over these months get utilised. Historically, there was a practice of running January light (either with lower theatre lists or low case weights on those lists) which led to an opportunity cost of lost theatre productivity. We have commenced with this process again in the lead up to January.

With the possibility of endemic COVID leading to fuller hospitals and potentially compromising theatre capacity in the future it remains important that we recover our lost surgery as quickly as we can. We have a weekly meeting established to review the actions underway for patients waiting longer than 365 days and we will utilise this forum to emphasise the need for ongoing delivery of higher outsourcing volumes.

7. Specialist Services Performance and Accountability

We have discussed getting the performance and accountability framework underway with an initial focus on the Surgical Services and Radiology Directorate. We progress this carefully, as the framework assumes the new structure which is still out for consultation. With the Chief Operating Officer (COO) moving to the Chief Digital Officer role, it may also be more logical to hand initiate this in conjunction with the acting COO and they can own it from inception. We will meet and work out the best approach to take in the coming week.

To initiate this we need to have the report pack updated for the current month. The pack then needs to be handed over to the General Manager Surgical Services and Radiology, who, together with the Medical Director and Director of Nursing for that directorate will need to systematically work through the pack, ensure they understand the information contained within it, and prepare for an accountability meeting with the COO, Chief Medical Officer, Director of Quality and Clinical Governance Solutions, the Director of Nursing and the Director of Allied Health together with the Executive Director Corporate Services. The General Manager will then need to systematically step through the pack and explain the performance.

The Chair of the meeting (the COO) will lead a discussion about what actions need to be taken given the performance gaps, and the actions need to be minuted, owned, delivered upon and responded to in the next monthly meeting. This sequence then needs to be repeated each month and a cadence formed around this. We propose preparing this process for the October results and starting the first performance and accountability meetings in November.

The quality of the information in the performance pack is currently a little variable, and it will be important that the information is improved over time, so that real underlying performance is explained, rather than normal statistical variation or measures that don’t point to adverse quality or operational outcomes. However, what is most important is that we get into the cadence of this and the quality of the information reviewed and reported on (and acted upon) can then be systematically improved over time.

8. Oncology

Oncology wait list performance continues to remain stable at reasonably good wait list levels in all three services – radiation oncology, medical oncology and haematology. Successful recruitment of registered medical officers (RMOs) in all three services and of senior medical officers (SMOs) in medical oncology and haematology, and a clinical nurse specialist in haematology will all lead to good levels of capacity from early 2022 calendar year onward. We also appear to have two good physics candidates and interviews are being scheduled for these roles, too.

The Ernst & Young (EY) review is well underway, with all cancer centres now having been interviewed, and quantitative data, qualitative data and empirical data all having been collected. Workshops are scheduled at Southern DHB over the next two weeks and the report will then be finalised from there. We plan to get the report onto an Executive Leadership Team meeting agenda in early November, and then into Board papers for December.

Early findings in the report point to a clear need to develop the future SMO workforce by deliberately investing in RMO trainees (this is a practice that appears well established in the other centres), and we also appear to have relatively high volumes compared to the size of our workforce. Our rurality adds another dimension to our work that does not appear to be as present in most of the other cancer centres. These differences (and others) will now be adjusted for local variations and validated before the overall report is finalised, together with recommendations.

9. Generalism

Generalism has had some initial successes with recruitment of SMOs. However, more recently they have lost a couple of candidates who have pulled out. They have had success with gaining agreement with the sub-specialties and putting service level agreements in place to determine who will be admitted under general medicine. As a consequence, general medicine admissions have increased from circa 55% to circa 63% of medicine patients. Decanting is now underway so that the physiotherapy gym and the specialities housed proximate to it can be moved and construction can be commenced on the medical assessment unit next to the ED.

Whilst we await the building work to be completed, the General Manager Medicine, Women's and Children's Health, General Manager Operations and Director of Nursing Medicine will now progress with recruiting the nursing and allied health roles that were to be recruited when the new medical assessment unit (MAU) had been built. These will be recruited ahead of time and the model of care used in the existing MAU on the seventh floor will now be adapted to fully replicate what the model of care will be when the new MAU opens. Work will also commence on planning and implementing the ward changes necessary to optimise the generalist approach, and therefore minimise the outlier patients that need to be managed.

10. Colonoscopy Report to Southern District Health Board

Attached as Appendix 1 is a report by Andrew Connolly, Chair of the Endoscopy Oversight Group, providing a progress update on the Board's instructions to implement the recommendations of various reviews of the colonoscopy service at SDHB.

11. Southern DHB 2021/22 Annual Plan

The Ministers have approved the 2021/22 Annual Plan and this has now been published on the Southern Health website.

12. Statement of Service Performance

The 2020/21 Statement of Service Performance (SSP) has been submitted for review by Audit NZ auditors, as one component of the Annual Report. An electronic copy of the pre-audited draft Annual Report is to be forwarded to the Ministry of Health by early October.

13. 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; regular catch-ups with the Executive Director Corporate Services are established 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 the new Dunedin Hospital was very useful. Service planning will include proposed changes to models of care; the challenge is how to involve the stakeholders from across Directorates and across the sector (primary and community).

14. Our Ongoing Coronavirus Management Response

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

Public Health Response – Auckland Outbreak Update

Following NZ entering Alert Level 4 at midnight on 17 August our Public Health Service has been assisting the Auckland Public Health Service with a wide range of work – contact tracing, management of symptomatic contacts, investigations of exposure events, non-compliance issues, following up people who were uncontactable and those who were overdue for a test. We also sent staff to work in Auckland.

The Public Health Service set up an Emergency Operations Centre (EOC) to support the response and requests were made to other DHB services for staff to be released to support the workload.

In the early stages of this outbreak we implemented a training schedule to refresh and train new staff in the National Contact Tracing System. Public Health staff had recently completed training on the changes in the platform which assisted with getting the teams up and running. This also meant that they were able to support and mentor new staff when brought into a team. Overall, we trained 97 staff in total (44 staff for refresher and 53 staff for new training).

At our peak we had 80 staff contact tracing and 808 contacts delegated to us for management. The teams were made up of a mix of Public Health, Oral Health, Population Health, and wider DHB staff. We currently have the support from our airport health team as the Quarantine Free Travel Zone is currently closed. Queenstown Lakes District Council also provided us with two Environmental Health Officers to join the contact tracing teams.

While we have now scaled our response back and the majority of staff have returned back to their business as usual, there is still the requirement for contact tracing capacity. This work continues to be delegated to us with symptomatic contacts coming to us daily in smaller quantities. There is still a demand for exposure events to be investigated by Public Health Units outside of Auckland. This means that we still need to have contact tracing teams and staff in place to operate seven days a week. We have two contact tracing teams in place to cover this, predominantly made up of the airport health staff workforce and a couple of Public Health staff. The outbreak is expected to have a long tail that will continue to require a national response. On 29 September Southern has been asked to support ongoing case investigations as part of the Auckland outbreak.

A survey was sent out to everyone who supported our outbreak response. The learnings from this and our response efforts were reflected on in a workshop held on Wednesday 22 September for COVID-19 resurgence planning. The focus on this workshop was to look at what we have learned so that we continue to make improvements and are in a better position for the next outbreak response.

The latest response has provided some great learnings and highlighted a couple of areas that need some improvements. These include:

- Moving between a five and seven day working week. The local outbreak/national response way of working requires us to be able to scale our workforce up and down rapidly. There are many current challenges for our service to be able to do this and further work needs to be done to look into the most efficient and appropriate way of doing this
- Release of staff from the wider DHB to support the required response and how we can on-board and maintain training of these staff efficiently
- Maintaining documentation so that it is relevant, update to date and filed centrally
- The model of how we run our teams to enable us to easily pivot from contact tracing to case management or both
- EOC set up, tasking and single point of contact details
- The current requirement to be a seven-day service for COVID-19 while also maintaining business as usual.

A meeting has been held between Infection, Prevention and Control, Occupational Health, Public Health, Health and Safety and an Infectious Disease Specialist around what plans are in place if there was a COVID-19 positive staff member or patient in our hospitals. A further follow-up meeting will be held in October and a desk top exercise is planned to follow this to test the process and plans that have been developed.

New advice has been provided by the COVID-19 Technical Advisory group to the Aged Residential Care (ARC) planning group based on the high transmissibility and infectiousness of the Delta variant. The advice has changed the preferred option for how to manage a COVID-19 positive patient in an ARC facility – which is to manage patients in a specialist facility. While we do not have any Managed Isolation and Quarantine facilities in the Southern district this will require further planning and consultation with ARC facilities to investigate what is achievable and how we can implement these plans when required.

A collaborative platform has been established between Nelson Marlborough DHB and Southern DHB Public Health analysts to look at what COVID-19 related planning and intelligence processes we can learn from each other and share. Weekly meetings have been held since late August to assist with lessons learnt and new opportunities to learn through sharing opportunities.

Community Managed Isolation Quarantine (MIQ)

A community supported isolation and quarantine service is being established in the wake of the most recent COVID-19 outbreak. The intent is to support positive cases and close contacts in the Southern DHB region who are self-isolating at home and shifting those who are unable to safely self-isolate at home to alternative accommodation. Current accommodation is reviewed and renewed on a month-by-month basis depending on the perceived risk level and Ministry of Health direction.

In addition to accommodation, is providing welfare and wraparound support that may be required for the period of isolation, including and not limited to provision of food, psychosocial support, and animal needs. To facilitate any welfare needs we have been establishing links through the Civil Defence Emergency Management (CDEM) Southland and Otago welfare groups to link into existing networks and resources to manage any incidents that arise.

Intra-regional transport guidelines to move positive cases or close contacts to alternative accommodation are currently awaiting Ministry of Health sign off. Once these guidelines are in place, we will work with a local transport provider to ensure they can meet the movement and infection prevention and control requirements and sign off on the contract.

The Delta variant is more transmissible and has significantly shifted what the potential risks are if there is community transmission in our region. Planning for future events need to take into consideration higher rates of transmission and the potential for more cases in the district. We have been involved in planning workshops with University of Otago, Aged Residential Care, and Mental Health and Addictions as to what considerations need to be in place in the event of a positive case in their facilities.

15. Primary Maternity Unit Business Case

The Business Case for the Primary Birthing Units is largely complete, with the Project Manager and Procurement team working on the procurement model for the service provider, design consultant, and construction provider.

The aim with both is to have the process finalised and sent to the Executive Leadership Team and Board meetings in January and February, respectively, next year.

A draft floorplan has been designed by an internal draftsman, and this has been taken out to two stakeholder workshops with overall positive feedback. Some minor changes have been made as a result, and these will be passed onto the Design Consultant (Architect) when they are brought on board.

16. Allied Health Recruitment

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. One physiotherapist has commenced after going through MIQ. Another two physiotherapists are still navigating the MIQ process and their start dates are unknown at this stage. Another physiotherapist is due to start shortly for a fixed term into next year. Offers to five new graduate physiotherapists are also in the process of being sent out.

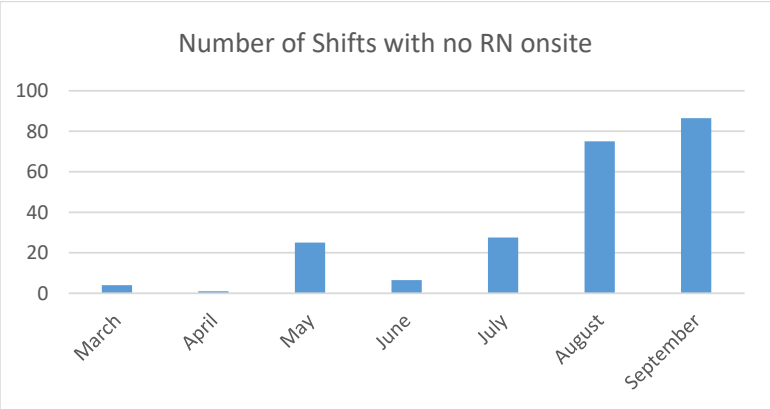
Staff from Dunedin continue to support their colleagues in Invercargill with a rotational roster with a senior physiotherapist travelling to Invercargill for five days each week. This has been interrupted temporarily during Level 4 and 3 lockdown, but the impact of this has been minimised by reduced work, and hence reallocation across the existing team. Outsourcing of outpatient work continues. We have now reached agreement on two external providers supporting inpatient work in a limited capacity.

There are increasing challenges recruiting Allied Health, Scientific and Technical staff across the district – Speech Language Therapists, Anaesthetic Technicians, Medical Imaging Technologists, Sonographers, Pharmacist MOSAIQ Coordinator and Medical Physicists. All available possibilities are being implemented/looked at to recruit to these roles – recruitment campaigns (including overseas), new graduates recruitment, student placements and employment of trainees.

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

The RN shortage in 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.

This information is collected from Section 31 Notifications to SDHB. Facilities are required to notify DHBs of potential health or safety risk to their residents via a Section 31 notification. During September, five facilities reported a total of 86.5 shifts not covered by an RN as required.



The ARC RN Workforce Steering Group continues to guide and monitor their action plan. During September the following work has been undertaken:

- The Workforce Co-ordinator has contacted over a third of the identified internationally qualified nurses already residing in Southern, to identify the supports they require on their pathway to registration.
- Contact has been made with the Nursing Council to overcome issues that are barriers for some of these applicants achieving registration
- Work continues with the Nurse Advisor from the Ministry of Health who is seeking advice regarding strategies to support the sector. Advice has been provided on internationally qualified nurses (IQNs), Nursing Council processes and supported mentorship linking to the rotational programme and bonding schemes.

Southern DHB has agreed to no longer hire ARC nurses while they hold a visa based on the skills shortage list (aged care is on the list, DHBs are not). These visas require the holder to work for a period of time for the stated employer.

18. Aged Residential Care Bed Availability

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

Waiting Lists for Aged Residential Care as at 29 September 2021 are shown in the table below:

	In Hospital	At Wrong Level in ARC	At Home in Community/ Hospice	Total
Psychogeriatric Care (D6) District	2	2	2	6
Hospital Level Care (Dunedin)	1	0	2	3
Hospital Level Care (Southland)	1	0	0	1
Secure Dementia Care (Dunedin)	0	2	0	2
Secure Dementia Care (Southland)	0	5	4	9
Rest Home Care (Dunedin)	1		2	3
Total	*5*	*9*	*10*	*24*

19. Clinical Project Management

Emergency Q (ED patient Triage / Transfer digital platform)

A project manager has recently been identified to support platform implementation alongside the WellSouth Project Management Team. Initial meetings between WellSouth, Southern DHB and the Healthcare Applications CEO, Morris Pita, to initiate a Project Plan and schedule of work.

Frailty Pathway

This project's objective is to develop a best practice pathway for our frail older population accessing supports from the SDHB. Initially the scope of this project was centred on people living in the community. However, a recent evaluation by the Frailty Steering Committee (both community and hospital based) indicated that a change in governance approach is now needed. This is to enable a streamlined 'whole of system' based approach to Frailty.

Subsequently, the Project Manager and Steering Group Chair are currently in the process of merging multiple frailty governance groups together to create one Frailty Council. It is anticipated that working groups will then be created to implementation identified recommendations.

Te Kāika

This Community Wellness Hub will integrate the Ministry of Social Development (MSD), Southern DHB and the Te Kāika Primary Care team. The property design is currently a key focus of the project to enable the build to be completed within the specified time (aiming for November 2023). Completion of the frozen floor plan is anticipated to occur over the next two weeks (early October). The clinical co-design phase is anticipated to start mid – October and will be highly collaborative between the three organisations.

Dental School and Oral Health Service

A project has recently been implemented to review and make appropriate changes to the way contracts operate between the Oral Health Services and the University of Otago, Faculty of Dentistry. Initial meetings have been attended to review the current situation and to investigate future opportunities. Greater visibility of the current paediatric general anaesthetic waitlists has been identified as a priority. A Project Plan has been provided to the General Manager for Oral Health for consideration and sign off.

20. Te Hau o te Ora

WellSouth celebrated a significant milestone on 30 September with the signing of a joint venture agreement between Awarua and Hokonui Runaka. This has cemented the development a primary care service for Invercargill in partnership with Iwi. This could change the model of care and improve Māori access to health services in a locality that has long struggled to support high numbers of unenrolled patients and challenges in providing after hours services with the aim of reducing demand on Southland Hospital. The name 'Te Hau o te Ora' provides a murihiku-centric model of health which in part describes the breath of life and achieving health and wellbeing. The aim of this new service will be to develop a tohunga pathway as an alternative model of care from the traditional general practice service delivery model. Partnering with Runaka is an exciting opportunity and this might include the colocation of services and/or integration of health and social service delivery.

21. She Is Not Your Rehab

The Southern DHB and WellSouth supported 'She Is Not Your Rehab' presentation to a series of Māori whānau members on 11-12 October in Bluff in collaboration with Awarua Runaka and Awarua Synergy. This approach has gained momentum after a book was launch from a Christchurch couple behind the She Is Not Your Rehab anti-violence movement. My Fathers

Barbers, creator Matt Brown has inspired a new generation of men including many from Pacific communities to break free from the cycle of abuse which lead to both him and his wife, Sarah, writing the book - She Is Not Your Rehab, featuring how men can heal from their trauma. The hui was held at Te Aroha Marae and included a workshop with Awarua Synergy staff. They presented their story on how they have managed to break the cycle of abuse, neglect, and violence including alcohol and drug addiction.

22. Te Reo Māori

A collective response from WellSouth, Allied Health, Nursing and the Māori Health Directorate has provided Te Reo Māori enrolments onto an online platform, to support cultural education and address the need to persist with addressing equity and differential outcomes experienced by Māori. The latest report summary provides us with activity data as outlined:

- 235 staff enrolled
- 279 hours online (in total)
- 1,235 logins
- 100 activities completed
- 76,019 questions answered
- Approximately 70 yet to engage

23. Organisational Values

Mathew Kiore, our Pou Tāki Educator, has developed a Te Reo Māori version to our organisational values or Ngā Uara. He has taken the four values of Whaiwhakaaro, Whanaungatanga, Manaakitanga, Pono and placed whakatauki into each of the values giving it a fuller meaning from a Te reo Māori perspective. The challenge with the European words of open, kind, positive and community doesn't truly translate into the concepts underlying the Te Reo Māori translations. This will be taken to the Executive Leadership Team for further discussion and debate shortly.

24. Equity Investment

There are continued expectations from central government that we continue to enhance our responsiveness to equity. The 2021/22 DHB Annual Plan and Planning Priorities Guidance outlines a series of expectations including giving practical effect to He Korowai Oranga, obligations as a Treaty partner and the acceleration of the spread and delivery of Kaupapa Māori services. These are reinforced in Whakapapa, Māori Health Action Plan 2020-2025.

The Southern DHB Board approved an additional increase in equity funding of $1,200,000 for the 2021/22 financial year. Based on our intent to partner more effectively with the Iwi Governance Committee (IGC) this issue was tabled at the August IGC meeting with the aims

to provide an opportunity for them to prioritise the new equity funding allocation. There was overwhelming support that much of this funding should be expended with the Kaupapa Māori providers.

25. Tourism Recovery Fund – Psychosocial Mental Wellbeing Recovery

Te Hau Toka Southern Lakes Wellbeing are embarking on the next phase now to the end of 2021, undertaking a rigorous co-design process with the Queenstown Lakes, Cromwell, Wanaka and Te Anau/Fiordland communities. The intention is to explore with the communities their particular issues and problems which are challenging, then to also engage people in the discussion, the prioritisation and design of what would improve wellbeing. At the same time, we have been gathering information about potential providers, community organisations including NGOs, workshops and programmes that are available locally and nationally which will provide us with a suite of options to best meet the priorities of our communities. It is anticipated that, before the end of the year, we will be working through expressions of interest and funding for programmes of work which align with the recommendations from our process of community consultation. At this stage, we will be better able to engage and consider the possible contributions from organisations such as yourselves, as part of a wider programme of work.

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

We have commenced a two stage procurement process in relation to community based services for mental health and addictions clients, which includes a residential component. The first stage of this procurement process is a request for potential partners to register their interest with us to be part of a series of discussions on what service solutions might exist for those patients presently on Ward 11 at Wakari Hospital, but also for a larger cohort of patients who we struggle to find appropriate supported accommodation solutions in the community.

Once we complete our series of discussions the intent is that these will inform a second stage of the procurement process where we release a Request for Proposals document requesting potential partners to submit proposals for consideration that we will eventually commission as a new service.

With respect to timelines, we issued the Registration of Interest on the government procurement website (GETS) on Monday 27 September. The deadline for questions from potential partners is Thursday 7 October and the date for final receipt of registrations is Thursday 21 October.

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

Since the release of 'Time for Change' in early August significant progress has been made in preparing for the implementation. This includes the engagement of Toni Gutschlag from the Ministry of Health, as well as Leadership Lab. Membership of the Change Governance Group has been finalised and an initial meeting of the Group was held in September. The focus is on the first three month's priorities.

28. Combined Response Team

The Police, St Johns and the Mental Health, Addictions and Intellectual Disability directorate are continuing with their joint planning for the commencement of this new police initiative with a start date now set for 1 November. The Memorandum of Understanding between the

three parties is close to completion. 1.7 FTE Registered Nurses have been appointed and will commence an orientation programme in the near future.

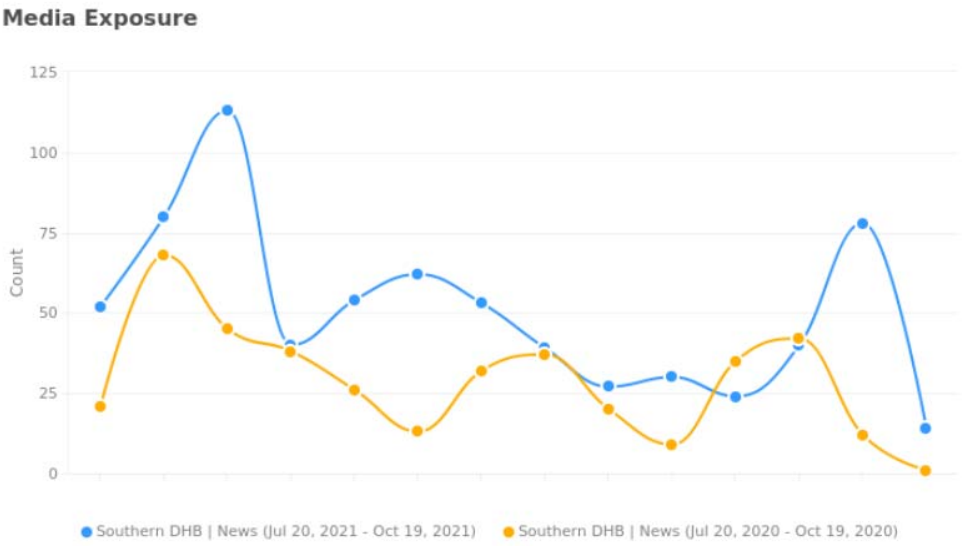
29. Executive Leadership Team Changes

Consultation on the Proposal for Change for Specialist Services closed on 22 October and feedback is now being considered. However, there have been a number of changes within the Executive Leadership Team which should be noted:

- Patrick Ng, previously Executive Director Specialist Services, has been appointed as the Chief Digital Officer. In his new role, Patrick will lead both the implementation of the Digital Transformation Business Case as well as having operational management responsibility for the Data and Digital functions of the SDHB.
- Hamish Brown, currently the Programme Director for the New Dunedin Hospital, has been seconded for a six month period into the Chief Operating Officer role (previously titled Executive Director Specialist Services). A recruitment process will commence early in 2022 for a permanent appointment. Hamish will take up his new role on 8 November 2022.
- Bridget Dickson, Clinical Project Manager – New Dunedin Hospital, will be seconded into the Acting Programme Director New Dunedin Hospital for the same six-month period.
- Simon Crack, Project Manager – New Dunedin Hospital, will be seconded into a temporary Deputy Programme Director New Dunedin Hospital for the same six-month period and will work closely with Bridget.
- Professor John Eastwood – Medical Officer of Health, has been seconded into the Acting Chief Medical Officer for a six-month period replacing Dr Nigel Millar who leaves on 5 November. John recently joined Southern DHB from the Sydney Local Health District where he was Executive Clinical Advisor – Clinical Services & Population Health and Clinical Director of Paediatrics. John is a vocationally registered Paediatrician, as well as Public Health Physician, and he is also a Fellow of the Royal Australasian College of Medical Administrators.
- Andrew Lesperance has been appointed as the Executive Director Planning, Funding & Population/Public Health commencing with us on 6 December 2021. This is the role that Lisa Gestro previously filled with the exception that the Mental Health, Addictions and Intellectual Disability Directorate has been separated into a new role. Andrew is currently the Chief Executive of the Hastings Health Centre which is a large 30+ GP practice based in Hastings. Prior to this Andrew held similar Executive roles to the one he has been appointed to in both Nelson Marlborough and Hawkes Bay District Health Boards.
- Nicola Mutch, Executive Director Communications, has resigned to take up a new role outside of Health in Wellington. Nicola will be leaving us in early to mid-December and a recruitment process will get underway.
- The Executive Director Mental Health, Addictions and Intellectual Disability recruitment process has now closed, and we are reviewing applicants presently.

30. Communications

Media volumes have been consistent and busy over the past three months reporting period, with noticeable peaks associated with caring from COVID cases from the Mattina, the lockdown period in August, and a significant ramping up of the vaccine rollout culminating in Super Saturday. Promoting the vaccine rollout has been a key focus for the team and has dominated media and communications activity. We have also been promoting the importance of being tested for COVID, and there is significant interest in planning for endemic COVID in the Southern district.



Chris Fleming
Chief Executive Officer

22 October 2021

Appendices

1. Colonoscopy Services Report to Southern District Health Board – Andrew Connolly

Colonoscopy Services Report to the Southern District Health Board

25 October 2021

Background:
In October 2021 the Endoscopy Oversight Group received Board instructions to implement the recommendations of various reviews of the colonoscopy service at SDHB.

The purpose of this document is to inform the Board of progress since that time.

Progress on Recommendations: All are either complete or inherently on-going other than the review of letters which has been completed by the EOG but is awaiting formal review by the DHB.

Timeliness:
There are four groups of patients depending on the indication for colonoscopy:

i. Symptomatic urgent
ii. Symptomatic non-urgent
iii. Bowel cancer screening
iv. Surveillance.

Symptomatic categories 1 & 2 meet the Ministry timeframes for the vast majority of patients and have done since the EOG began its work.

Screening meets the Ministry timeframes.

Surveillance data was grossly inaccurate until part-way through 2021. We do, however, know that several hundred cases were overdue when the EOG began work. Currently there are 88 over-due and the number decreases every month.

All surveillance cases are scheduled in accordance with the National surveillance guidelines.

The so-called Category C does not exist. Only one patient from this group still requires a colonoscopy – there have been numerous scheduling issues between the DHB and the patient. The indication is not for symptomatic disease.

Definition of a GI Specialist:
This was rapidly agreed. Subsequently we have confirmed this extends to RMOs requesting on behalf of a GI specialist. We have also confirmed the process around recognition of locum specialists.

Referral Handling:
All GI specialist referrals are automatically accepted. If a significant difference of opinion exists between services, there must be a collegial discussion. A few examples of concerns regarding this process have been raised. Each case has been reviewed by the Chief Medical Officer, and in almost every instance the referral was incomplete in terms of identifying it

was on behalf of a GI specialist. In other cases, the original request was not required once full clinical details were established.

e-Referrals are well established for referrals within the DHB.

All Direct Access referrals for symptomatic reasons are triaged against the national criteria. When declined, these referrals are then automatically sent for an independent review by a surgeon, a nurse, and a gastroenterologist. Any one of these clinicians can accept the referral and a colonoscopy is arranged. A second review occurs for any referrals still rejected.

Ultimately any rejected referral must be considered for any alternate DHB service such as CT colonography or clinic in particular. Those offered no DHB service at all are considered our true declined rate. Whilst the Ministry does not require a DHB to report this, the EOG believes it is essential to monitor access.

The true decline rate is prospectively monitored. This table shows the number of referrals that were declined with no investigation or appointment offered:

	Received	**Declined**	**Decline rate**
Sep-21	443	15	3.4%
Aug-21	590	50	8.3%
Jul-21	513	31	6.0%
Jun-21	447	15	3.6%
May-21	653	43	6.6%
Total	**2646**	**154**	**5.8%**

The EOG notes the need to monitor time to alternate investigations and to review any cancers diagnosed via these alternative paths. To date one cancer has been detected but the EOG believes the decision to refer the case to a CT colonography was appropriate on the information provided on the referral; it clearly did not meet the direct access criteria, therefore the decision to refer for a CTC indicates a strength of our processes. There does not appear to have been a clinically unacceptable delay in obtaining the CT.

Acute Cancer:
The EOG recommended a review of any acute cancer to determine if the DHB had declined a colonoscopy or alternative service within the preceding three years. From 1 January 2021 to 31 July 2021 thirty-three cases presented acutely. Twenty-three were not known to the DHB; of the remaining 10 only one had been declined colonoscopy and whilst offered an alternate service the patient presented acutely prior to a CT.

Cancer pathway following diagnosis:
This work was recommended by the Bissett review, but the National Cancer Agency and the DHB have taken ownership of this issue.

Quality Indicators:
Nationally recognized quality indicators are monitored and discussed under the Quality Assurance processes of the DHB.

Role of CT Colonography:
The surgical departments on both sites have discussed and agreed the criteria for CTC. This is in line with national agreed recommendations. The Gastroenterology service has welcomed this development. As time goes forward, this high degree of consistency will allow for informed investment decisions regarding CT scanning capacity.

Resource use:
Considerable progress has been made to ensure all available sessions are utilized. Currently the services are utilizing 100% of available sessions in Invercargill, and with the exception of two lists lost in August this figure has been met for several months. This is significant progress, but it does need to be sustainable – this will be best achieved by growth in staffing dedicated to each sight as opposed to relying heavily on movement of staff between sites. For Dunedin, there remain under-utilized lists due in particular to nursing shortages. However, the number of unutilized lists is reducing as new staff are employed. Nursing recruitment is occurring at Dunedin and a new colorectal surgeon is arriving soon in Invercargill. There is also as further approved FTE in the current budget that can still be recruited to.

Departmental interactions:
I note a consistently greater degree of trust and collegiality than was historically apparent. However, there remains a need to ensure the challenges faced in delivering a high-quality service do not degrade professionalism. This is best achieved by continued engagement of all parties and I have recommended regular planning meetings between the services be arranged. This recommendation has been received positively by all parties.

General Comments
I have been very impressed by the way in which debate and decision making has been conducted by the EOG. The Project Manager, Ms. Emma Bell, has driven the work and continues to perform the data analysis and day to day administrative tasks. She has now taken the role of Service Manager for Gastroenterology. This will, in my view, continue to ensure adherence to the pathways and processes established by the EOG is maintained.

I am personally very grateful to EOG members and DHB staff involved in the processes for their support, especially during periods of external scrutiny.

The colonoscopy service is performing well and delivering considerable benefit to the public of the region. There is an openness that is refreshing. Opportunities for growth exist including in the arena of training, which in my view is vital for future service provision.

Andrew Connolly
Chair, Endoscopy Oversight Group

FOR APPROVAL

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

Proposed by: Nigel Trainor, Executive Director Corporate Services

Meeting of: Board Meeting, 2 November 2021

Recommendation

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

Purpose

1. To provide the Board and Finance, Audit & Risk Committee with the financial performance of the DHB for the month and year to date ended 30 September 2021.

Specific Implications for Consideration

2. **Financial**

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

Next Steps & Action

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

Appendices

Appendix 1 Financial Report for the Board

Appendix 1: Financial Report for the Board

Southern DHB Financial Report

Financial Report for:	30 September 2021
Report Prepared by:	Finance
Date:	15 October 2021

Report to Board

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

The net deficit for September 2021 was $5.5m, being $3.5m unfavourable to budget.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 30 September 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						
109,857	102,859	6,998	F	Government & Crown Agency	319,638	308,748	10,890	F	1,187,928	1,233,735
983	847	136	F	Non-Government & Crown Agency	2,977	2,542	435	F	12,489	10,168
110,840	103,706	7,134	F	*Total Revenue*	322,615	311,290	11,325	F	1,200,417	1,243,903
				EXPENSES						
42,797	40,860	(1,937)	U	Workforce Costs	124,970	122,654	(2,316)	U	481,291	502,352
4,635	4,040	(595)	U	Outsourced Services	12,757	11,930	(827)	U	47,821	46,095
10,166	9,988	(178)	U	Clinical Supplies	28,883	28,903	20	F	111,249	107,947
6,940	5,422	(1,518)	U	Infrastructure & Non-Clinical Supplies	18,309	16,438	(1,871)	U	62,476	64,768
48,681	42,290	(6,391)	U	Provider Payments	138,554	127,694	(10,860)	U	489,958	506,799
3,155	3,157	2	F	Non-Operating Expenses	9,483	9,411	(72)	U	37,059	40,249
116,374	105,757	(10,617)	U	*Total Expenses*	332,956	317,030	(15,926)	U	1,229,854	1,268,210
(5,534)	(2,051)	(3,483)	U	**NET SURPLUS / (DEFICIT)**	(10,341)	(5,740)	(4,601)	U	(29,437)	(24,307)

Revenue was $7.1m favourable to budget.

The main driver of the Government Funding variance of $7.0m is the unbudgeted revenue for COVID-19 Vaccination Programme of $7.2m. This is partially offset by a reduction of $0.6m related to under-delivery of Planned Care procedures in September.

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 $0.2m in September, taking it to $1.1m YTD.

Expenses were $10.6m unfavourable to budget.

Workforce costs were $1.9m unfavourable including $0.9m unbudgeted Vaccination programme costs.

Medical personnel incurred increased costs due to recognition of the first quarter Continued Medical Education (CME) washup. The Nursing and Management/Admin personnel unfavourable result is mainly driven by the unbudgeted Vaccination programme.

Infrastructure and Non-Clinical Supplies were $1.5m unfavourable, with Energy costs $0.2m, Security Services $0.3m, ITC costs including Software licences $0.6m and Receivables Impairment $0.2m for an ineligible patient's uncollectable debt.

Provider Payments were $6.4m unfavourable, reflecting unbudgeted Mental Health expenditure and COVID-19 Vaccination expenses (both offset by additional revenue).

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.

While COVID-19 Surveillance & Testing activity was budgeted for the 2021/22 financial year, Resurgence, Vaccination and Trans-Tasman service provision were not. It has been assumed the resurgence activity will not be covered by any additional MoH funding.

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 30 September 2021

	YTD Actual Total $000	YTD COVID-19 Vaccination $000	YTD COVID-19 Resurgance $000	YTD Transtasman Border $000	YTD BAU $000	YTD Budget Total $000	YTD BAU Variance $000		YTD Actual COVID-19 Testing $000	YTD Budget COVID-19 Testing $000	YTD Variance	
REVENUE												
Government & Crown Agency	319,638	11,579	178	64	304,045	307,248	(3,203)	U	3,772	1,500	2,272	F
Non-Government & Crown Agency	2,977	-	-	-	2,977	2,542	435	F	-	-	-	
Total Revenue	322,615	11,579	178	64	307,022	309,790	(2,768)	U	3,772	1,500	2,272	
EXPENSES												
Workforce Costs	124,970	2,742	1,386	54	120,788	122,654	1,866	F	-	-	-	
Outsourced Services	12,757	189	-	-	12,568	11,930	(638)	U	-	-	-	
Clinical Supplies	28,883	43	12	-	28,828	28,903	75	F	-	-	-	
Infrastructure & Non-Clinical Supplies	18,309	510	31	10	17,758	16,438	(1,320)	U	-	-	-	
Provider Payments	138,554	8,095	-	-	126,687	126,194	(493)	U	3,772	1,500	(2,272)	U
Non-Operating Expenses	9,483	-	-	-	9,483	9,411	(72)	U	-	-	-	
Total Expenses	332,956	11,579	1,429	64	316,112	315,530	(582)	U	3,772	1,500	(2,272)	
NET SURPLUS / (DEFICIT)	(10,341)	-	(1,251)	-	(9,090)	(5,740)	(3,350)	U	-	-	-	

Financial Position Summary

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

Actual 30 June 2021 $000		Actual 30 Sep 2021 $000	Budget 30 Sep 2021 $000	Actual 31 August 2021 $000	Budget 30 June 2022 $000
	CURRENT ASSETS				
7,582	Cash & Cash Equivalents	2,285	7	23,028	7
61,439	Trade & Other Receivables	71,366	61,000	62,118	48,474
6,159	Inventories	6,310	5,665	6,101	5,235
75,180	*Total Current Assets*	79,961	66,672	91,247	53,716
	NON-CURRENT ASSETS				
325,558	Property, Plant & Equipment	319,144	324,762	319,232	358,043
6,258	Intangible Assets	10,464	18,498	10,460	25,118
331,816	*Total Non-Current Assets*	329,608	343,260	329,692	383,161
406,996	**TOTAL ASSETS**	409,569	409,932	420,939	436,877
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	16,729	-	33,663
72,840	Payables & Deferred Revenue	78,960	65,571	84,243	69,492
235	Short Term Borrowings	172	169	171	1,979
82,596	Holidays Act 2003	84,326	84,483	83,707	90,146
95,374	Employee Entitlements	100,669	86,896	101,692	88,211
251,045	*Total Current Liabilities*	264,127	253,848	269,813	283,491
	NON-CURRENT LIABILITIES				
856	Term Borrowings	827	856	838	10,754
19,411	Employee Entitlements	19,270	20,145	19,409	20,144
20,267	*Total Non-Current Liabilities*	20,097	21,001	20,247	30,898
271,312	**TOTAL LIABILITIES**	284,224	274,849	290,060	314,389
135,684	**NET ASSETS**	125,345	135,083	130,879	122,488
	EQUITY				
486,579	Contributed Capital	486,581	489,193	486,582	495,164
108,500	Property Revaluation Reserves	108,500	108,500	108,500	108,500
(459,395)	Accumulated Surplus/(Deficit)	(469,736)	(462,610)	(464,204)	(481,176)
135,684	*Total Equity*	125,345	135,083	130,879	122,488
	Statement of Changes in Equity				
165,991	Opening Balance	135,686	138,188	135,686	138,189
(30,933)	Operating Surplus/(Deficit)	(10,341)	(5,740)	(4,807)	(24,307)
1,333	Crown Capital Contributions	-	2,635	-	9,313
(707)	Return of Capital	-	-	-	(707)
135,684	Closing Balance	125,345	135,083	130,879	122,488

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 30 September 2021

	YTD Actual $000	YTD Budget $000	Variance $000	Full Year Budget $000	LY YTD Actual $000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash was provided from Operating Activities:					
Government & Crown Agency Revenue	311,157	307,052	4,105	1,240,738	286,341
Non-Government & Crown Agency Revenue	2,874	2,458	416	9,832	2,237
Interest Received	103	84	19	336	73
Cash was applied to:					
Payments to Suppliers	(192,905)	(185,723)	(7,182)	(719,719)	(182,803)
Payments to Employees	(119,566)	(129,086)	9,520	(498,453)	(112,906)
Capital Charge	-	-	-	(7,142)	-
Goods & Services Tax (net)	(1,291)	(2,582)	1,291	(2,604)	(625)
Net Cash Inflow / (Outflow) from Operations	372	(7,797)	8,169	22,988	(7,683)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	-	-	-	-	2
Cash was applied to:					
Capital Expenditure	(5,577)	(19,076)	13,499	(71,902)	(7,077)
Net Cash Inflow / (Outflow) from Investing Activity	(5,577)	(19,076)	13,499	(71,902)	(7,075)
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	(93)	(66)	(27)	(879)	(239)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	(93)	2,569	(2,662)	7,677	(239)
Total Increase / (Decrease) in Cash	(5,298)	(24,304)	19,006	(41,237)	(14,997)
Net Opening Cash & Cash Equivalents	7,582	7,582	0	7,582	31,011
Net Closing Cash & Cash Equivalents	2,284	(16,722)	19,006	(33,655)	16,014

Cash flow from Operating Activities is favourable to budget by $8.2m. Government revenue received is largely in line with the Statement of Financial Performance. Payments to Suppliers is unfavourable also in line with the Statement of Financial performance. Payments to Employees is favourable largely due to Employee Entitlements liabilities being $11.6m higher than budget.

Cash flow from Investing Activities is favourable to budget by $13.5m. The Capital Expenditure cash spend reflects project delays although this is expected to reduce as larger projects gain momentum. Cashflow from Financing Activities is $2.7m unfavourable with delays in Capital project drawdowns.

Overall, Cash flow is favourable to budget by $19.0m.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 30 September 2021

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	2,037	4,335	2,298	U	1,841
Clinical Equipment	2,219	5,576	3,357	U	2,839
Other Equipment	190	322	132	U	194
Information Technology	755	495	(260)	O	990
Motor Vehicles	-	-	-	O	-
Software	376	8,348	7,972	U	1,213
Total Expenditure	5,577	19,076	13,499	U	7,077

At 30 September 2021, our Financial Position on page 5 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $329.6m, which is $13.7m less than the budget of $343.3m.

The Land, Buildings & Plant, Clinical Equipment and Information Technology variances reflect expenditure on carry-over projects from 2020/21 and early expenditure on 2021/22 projects after approval of the capital plan in August 2021.

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

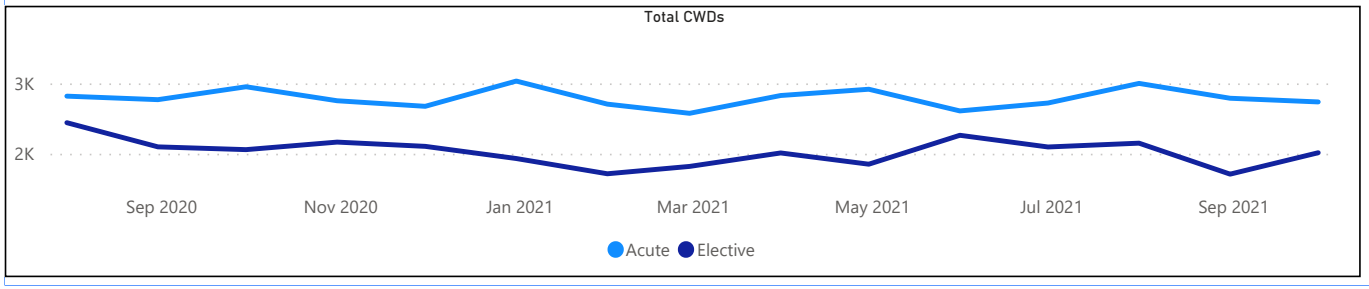
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year On Year YTD Variance
Surgical Caseweights												
Surgical Elective	1,360	1,472	-112	-8	1,392	-32	3,738	4,398	-660	-15	4,442	-704
Surgical Acute	1,179	1,231	-52	-4	1,318	-139	3,608	3,752	-144	-4	3,714	-107
Total	**2,539**	**2,704**	**-164**	**-6**	**2,710**	**-171**	**7,346**	**8,150**	**-804**	**-10**	**8,157**	**-811**
Medical Caseweights												
Medical Elective	318	312	6	2	341	-23	1,004	933	72	8	1,065	-60
Medical Acute	1,415	1,487	-72	-5	1,507	-92	4,530	4,575	-44	-1	4,494	37
Total	**1,733**	**1,799**	**-66**	**-4**	**1,848**	**-115**	**5,535**	**5,508**	**27**	**0**	**5,558**	**-24**
Maternity Caseweights												
Maternity Elective	336	365	-28	-8	325	11	1,132	1,125	7	1	1,090	41
Maternity Acute	142	94	48	51	127	15	388	286	101	35	332	56
Total	**478**	**459**	**19**	**4**	**452**	**26**	**1,519**	**1,411**	**108**	**8**	**1,422**	**97**
Total	**4,751**	**4,962**	**-211**	**-4**	**5,011**	**-260**	**14,400**	**15,069**	**-669**	**-4**	**15,137**	**-737**

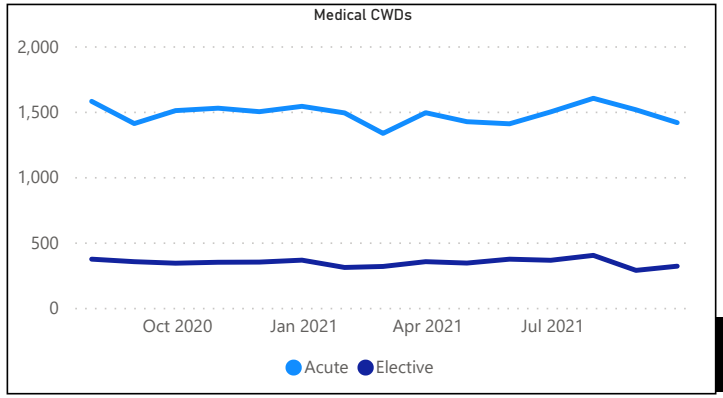
TOTALS

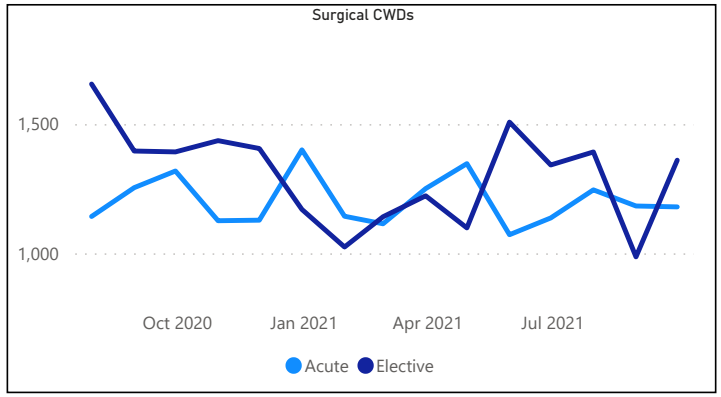
Acute	2,737	2,812	-76	-3	2,952	-216	8,526	8,613	-87	-1	8,540	-14
Elective	2,014	2,149	-135	-6	2,058	-44	5,874	6,456	-581	-9	6,597	-723
Total	**4,751**	**4,962**	**-211**	**-4**	**5,011**	**-260**	**14,400**	**15,069**	**-669**	**-4**	**15,137**	**-737**

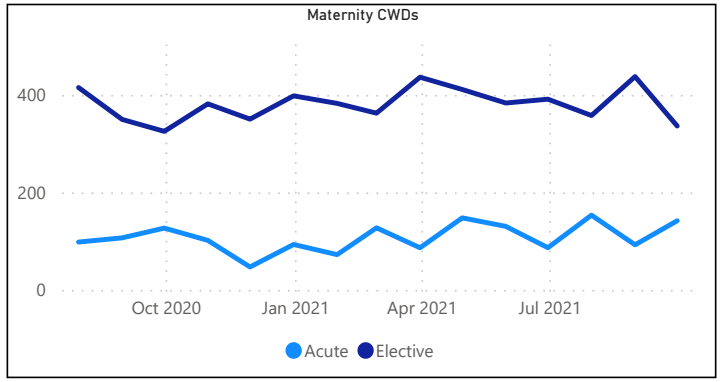
TOTALS excluding Maternity

Acute	2,595	2,718	-124	-5	2,825	-231	8,138	8,327	-189	-2	8,208	-70
Elective	1,678	1,785	-107	-6	1,733	-55	4,743	5,331	-588	-11	5,507	-764
Total	**4,273**	**4,503**	**-230**	**-5**	**4,558**	**-286**	**12,881**	**13,657**	**-777**	**-6**	**13,715**	**-835**









8.2

SERVICE PROVIDER RAW DISCHARGES

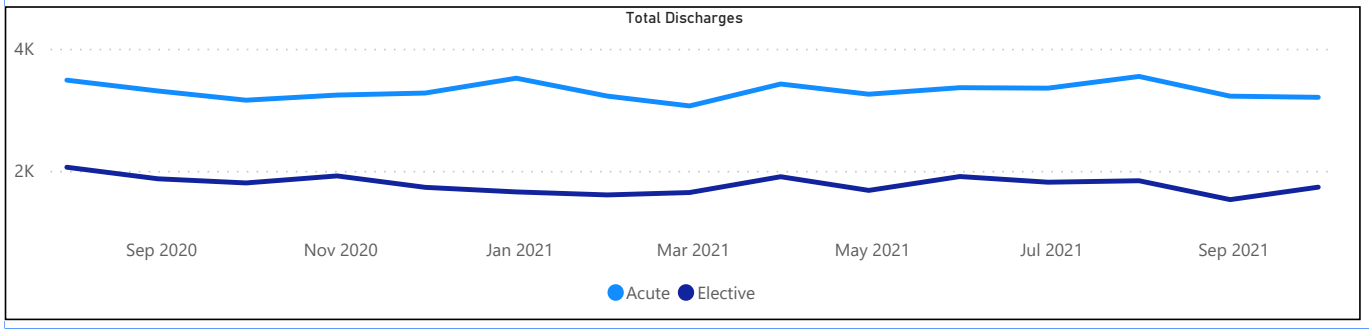
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Surgical Discharges												
Surgical Elective	868	1,036	-168	-16	967	-99	2,392	3,062	-670	-22	3,096	-704
Surgical Acute	787	799	-12	-1	834	-47	2,309	2,434	-125	-5	2,497	-188
Total	**1,655**	**1,834**	**-179**	**-10**	**1,801**	**-146**	**4,701**	**5,496**	**-795**	**-14**	**5,593**	**-892**
Medical Discharges												
Medical Elective	379	359	20	6	393	-14	1,169	1,075	94	9	1,192	-23
Medical Acute	2,332	2,374	-42	-2	2,219	113	7,368	7,321	47	1	7,131	237
Total	**2,711**	**2,732**	**-21**	**-1**	**2,612**	**99**	**8,537**	**8,396**	**141**	**2**	**8,323**	**214**
Maternity Discharges												
Maternity Elective	486	486	0	0	442	44	1,539	1,504	35	2	1,443	96
Maternity Acute	85	84	1	2	104	-19	296	255	41	16	322	-26
Total	**571**	**570**	**1**	**0**	**546**	**25**	**1,835**	**1,759**	**76**	**4**	**1,765**	**70**
Total	**4,937**	**5,137**	**-200**	**-4**	**4,959**	**-22**	**15,073**	**15,650**	**-577**	**-4**	**15,681**	**-608**

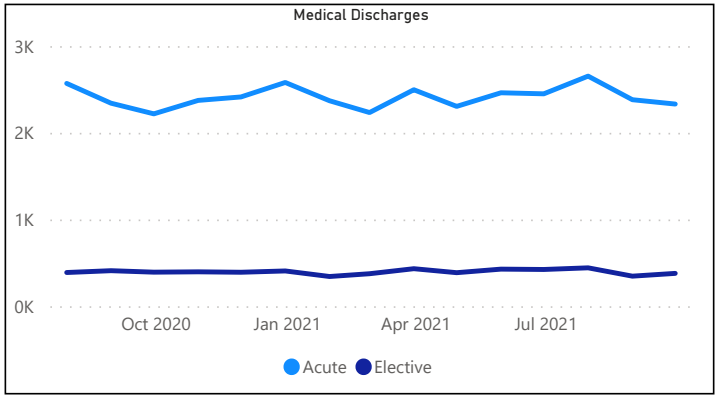
TOTALS

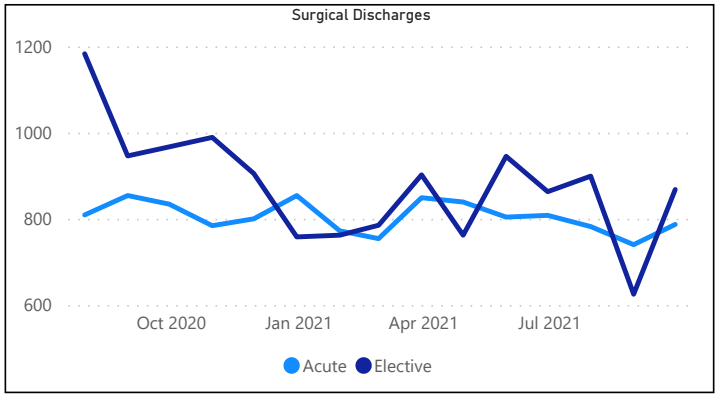
Acute	3,204	3,256	-52	-2	3,157	47	9,973	10,010	-37	0	9,950	23
Elective	1,733	1,881	-148	-8	1,802	-69	5,100	5,641	-541	-10	5,731	-631
Total	**4,937**	**5,137**	**-200**	**-4**	**4,959**	**-22**	**15,073**	**15,650**	**-577**	**-4**	**15,681**	**-608**

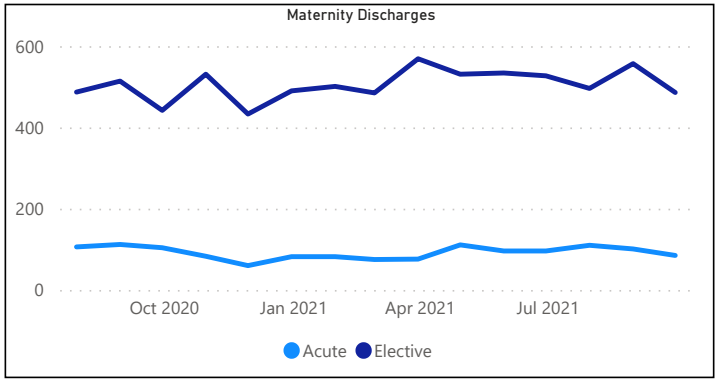
TOTALS excluding Maternity

Acute	3,119	3,173	-54	-2	3,053	66	9,677	9,754	-77	-1	9,628	49
Elective	1,247	1,394	-147	-11	1,360	-113	3,561	4,137	-576	-14	4,288	-727
Total	**4,366**	**4,567**	**-201**	**-4**	**4,413**	**-47**	**13,238**	**13,892**	**-654**	**-5**	**13,916**	**-678**



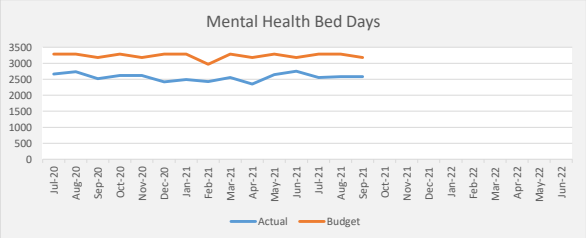




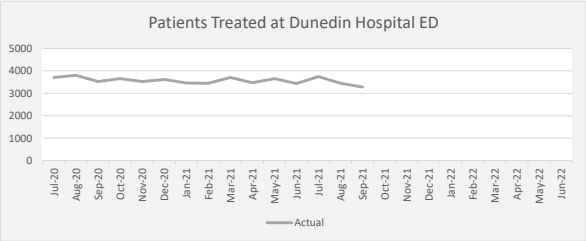


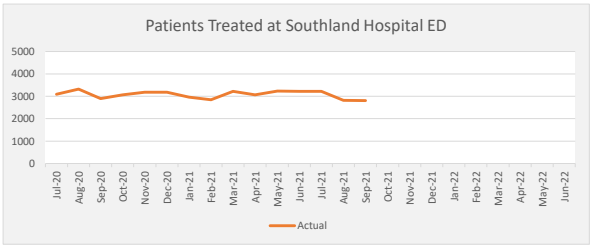
OTHER ACTIVITY

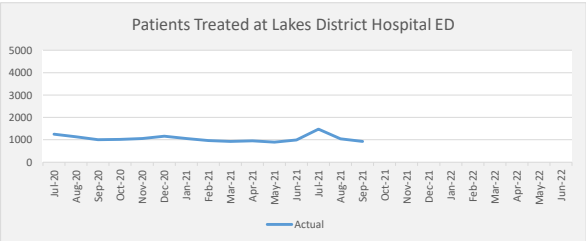
Sep-21				Sep-20	YEAR ON YEAR		YTD 2021/2022				YTD Sep-20	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,585	3,180	(595)	-19%	2,521	64	Mental Health bed days	7,723	9,752	(2,029)	-21%	7,914	(191)

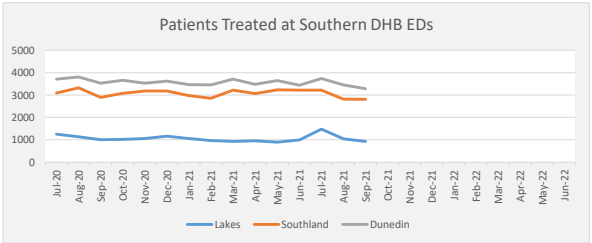


Sep-21	Sep-20	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2021/2022	YTD Sep-20	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,281	3,533	(252)	Dunedin	10,468	11,043	(575)
922	1,006	(84)	Lakes	3,444	3,392	52
2,809	2,893	(84)	Southland	8,849	9,303	(454)
7,012	7,432	(420)	**Total ED presentations**	22,761	23,738	(977)









FOR INFORMATION

Item: Quality Dashboard – September 2021

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

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – 2 November 2021

Recommendation

That the Board notes the attached quality dashboards and provides feedback on the proposed dashboard.

Purpose

The Executive Quality Dashboard presents key metrics for the Southern region across the dimensions of effectiveness, patient experience, efficiency and timeliness. It is intended to highlight clinical quality risks, issues and performance at a system wide level.

Specific Implications for Consideration

1. Financial
   - The cost of harm to patients is substantial and derived from additional diagnostics, interventions, treatments and additional length of stay.
2. Workforce
   - Sickness and absence reporting is currently being rolled out. We expect that to be available by the end of the first quarter.
3. Equity
   - No obvious issues with equity have been identified during April from the quality dashboard, but further analysis would be required to fully understand this.
4. Other
   - Please note comments in the discussion section

Background

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

Discussion

9. IT have changed the Dunedin Dashboard to a 36-month timeline. The Southern and Invercargill graphs will be moved to a 36-month timeline by the 12th of November

10. An analyst started in the IT department at the beginning of October whose exclusive focus is for equity measures. We will work with this analyst to include equity measures in the reporting. Unfortunately, different systems report equity in different data formats and structures. The variation and lack of uniformity will cause technical challenges to produce consistent equity reporting. Understanding disability is an issue for us and a clear definition is lacking. We expect to start including equity measures from January 22.

11. We have removed operationally focussed measures such as case-weights, ESPIs and theatre utilisation, which we understand are reported in other meetings, and will replace them with information relating to the quality of patient care such as hospital acquired complications (falls, pressure injuries etc) and other measures. This will mirror some of the content we provide to FARC and will commence next month (December).

12. Finding benchmarks for all measures continues to be challenging. We have benchmarks for patient care through the Health Round Table and will include these next month

13. You asked us to look at the graphs and information we are producing and appendix 2 contains a different approach to presenting the same data. Please note appendix 2 contains **illustrative data** only. It presents the data in a more succinct way. Measures are categorised as: Quality of care; staff related; Patient Experience; Operations. It shows the measure for the month vs benchmark or a target, how the measure rates compared to target and measure trend. We propose using this format moving forward

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Next Steps & Actions

14. **Southern and Invercargill graphs moved to 36-month timeline by 12 November**
15. **Equity measures to be included from January 2022**
16. **Implement proposed dashboard from November**

Appendices

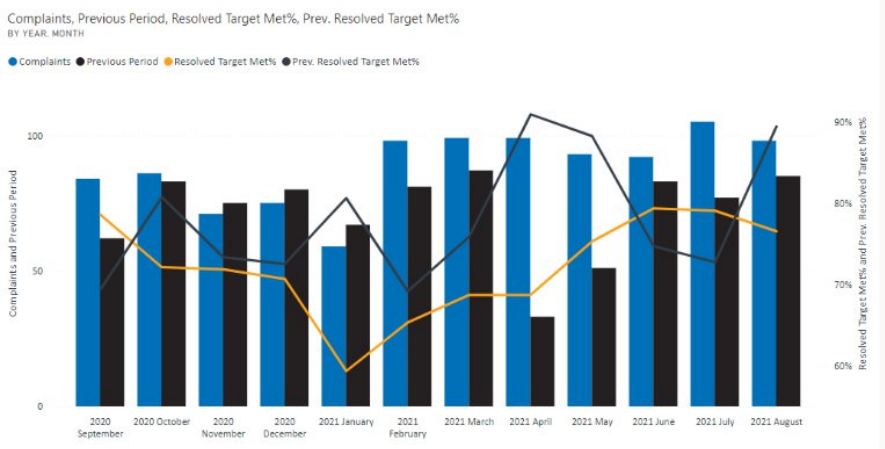
Appendix 1

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

Appendix 2

Proposed Executive Quality Dashboard – Southern Region, Dunedin and Invercargill Hospital and Māori

Executive Dashboard – Patient Experience (Southern)



Safety 1st data.

Complaints

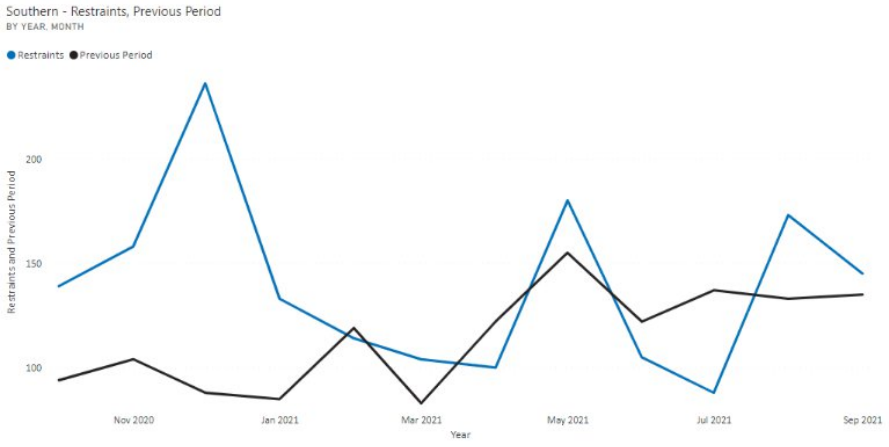
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

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.

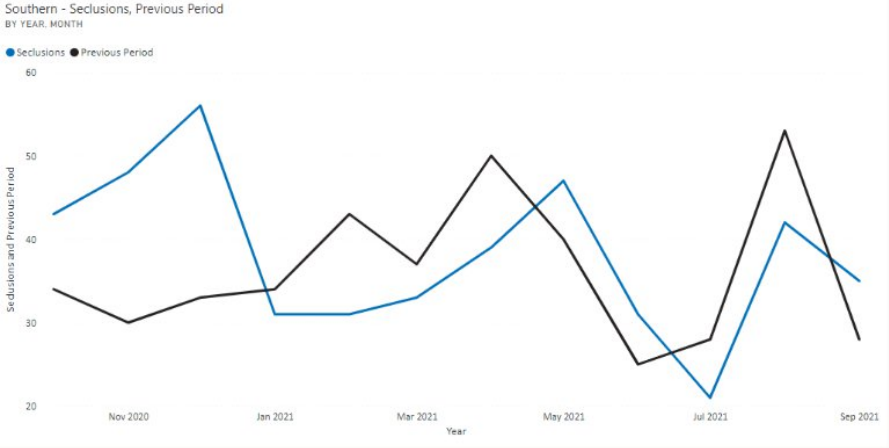
Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.

We have increased the number of complaints where we are responding to the consumer within target (20 days). It has increased from 60% in January to the high 70s in recent months.



Restraints

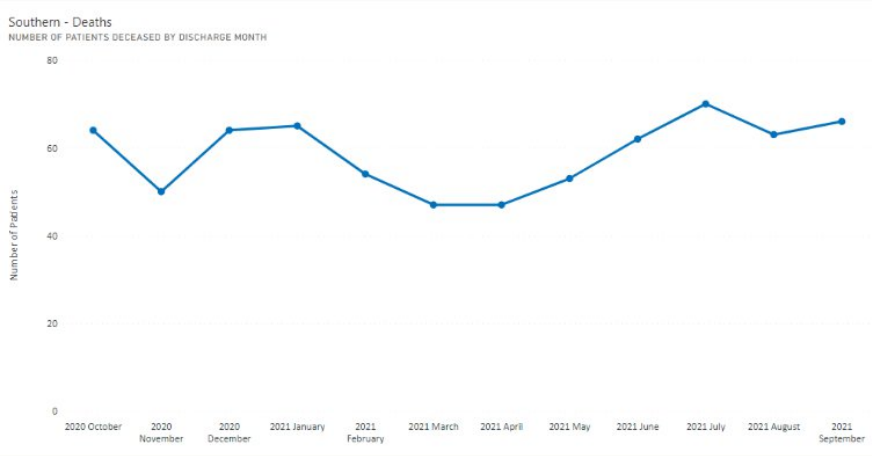
Safety 1st data. The number of restraint events per month. Restraints data includes Dunedin, Invercargill, Wakari and Lakes



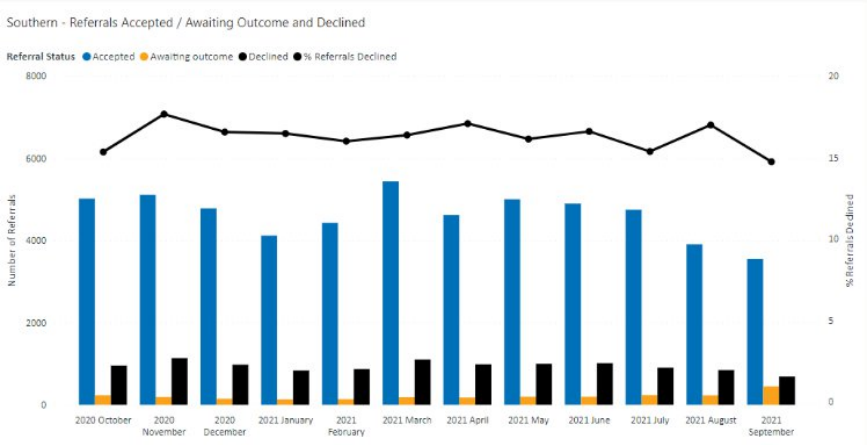
Seclusions

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

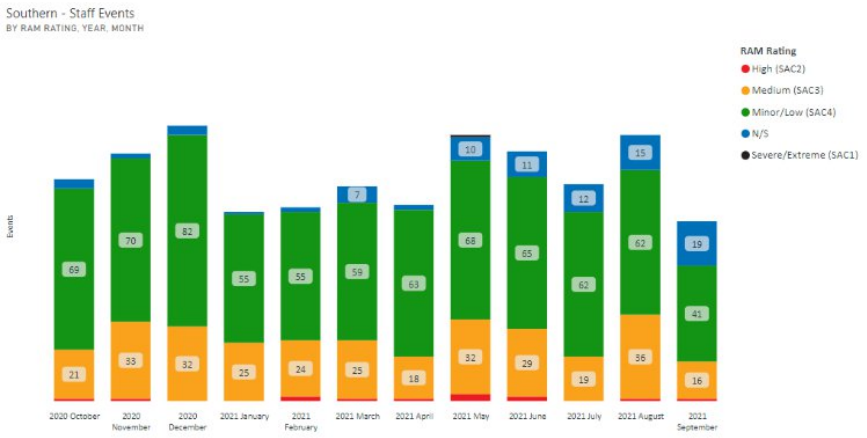
Executive Dashboard – Experience (Southern)



Deaths
Number of patients deceased by discharge month



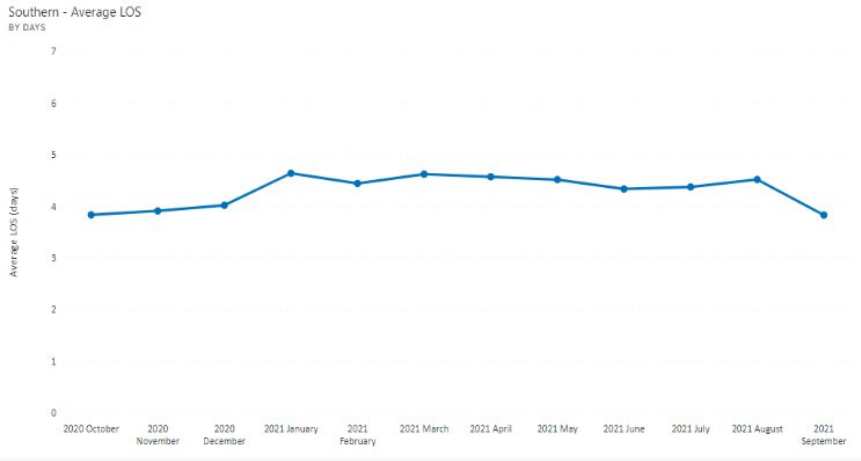
Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



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

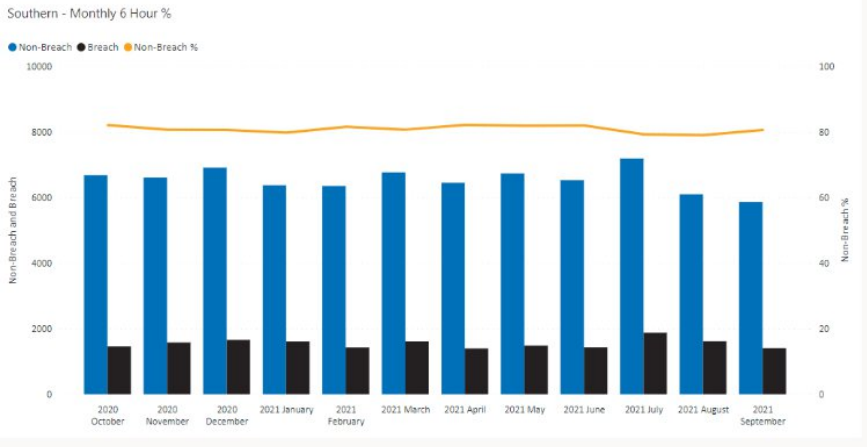
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls form (visitor falls) which were not associated with clinical practice. These events are not assessed in the same way as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

Executive Dashboard – Efficiency (Southern)



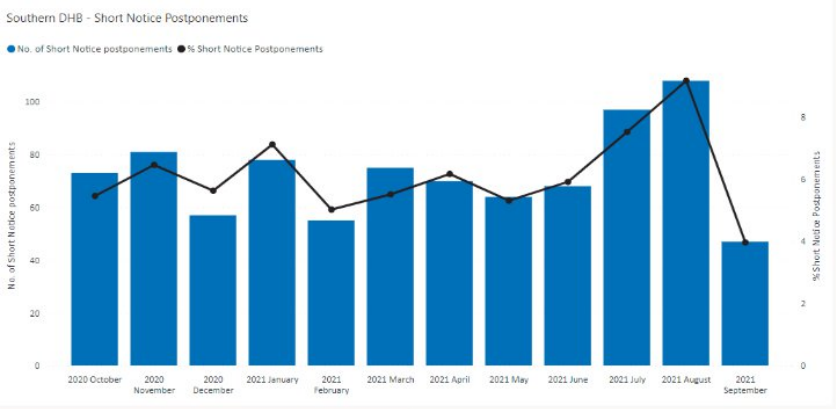
Average Length of Stay

Average length of stay by speciality of all patients present in the hospital at any point of time.



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.

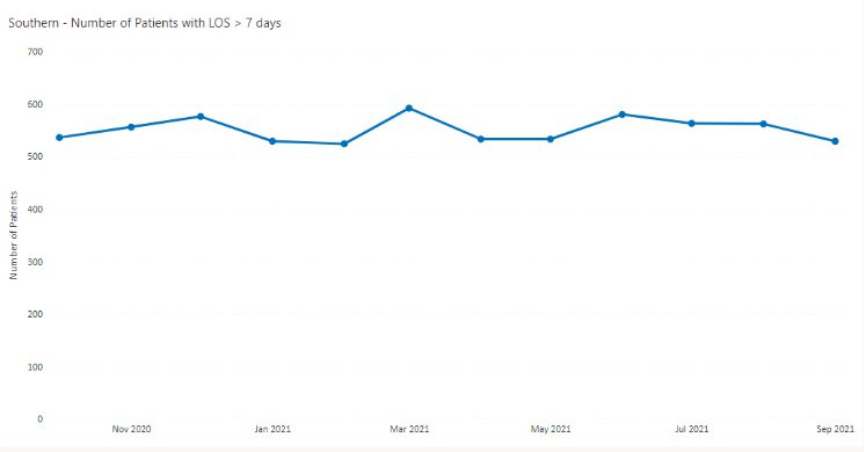


Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure.

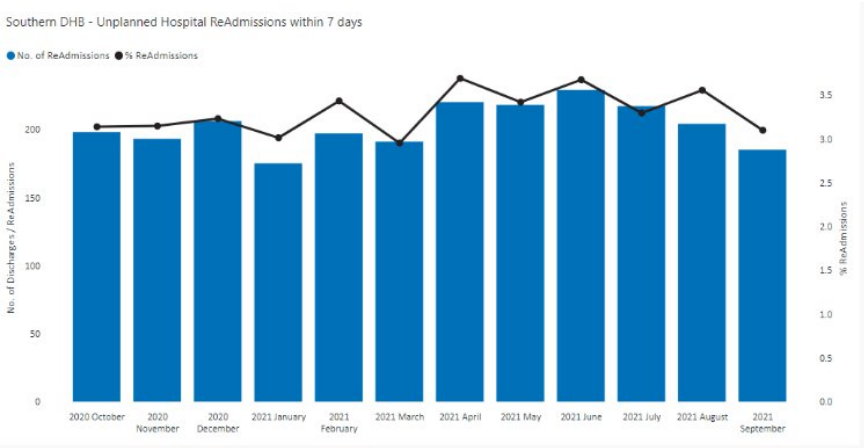
Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

Executive Dashboard – Timely (Southern)



Number of Patients with LOS > 7 days

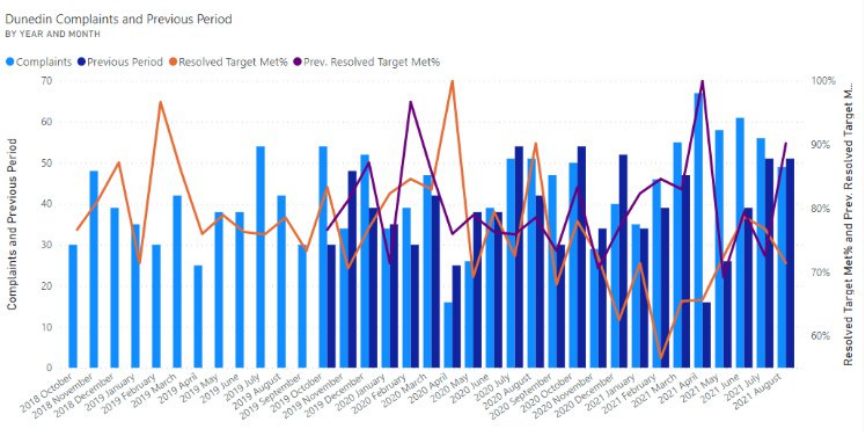
Number of patients in hospital at any point of time when they have exceeded 7 days since admission.



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.

Executive Dashboard – Patient Experience (Dunedin)



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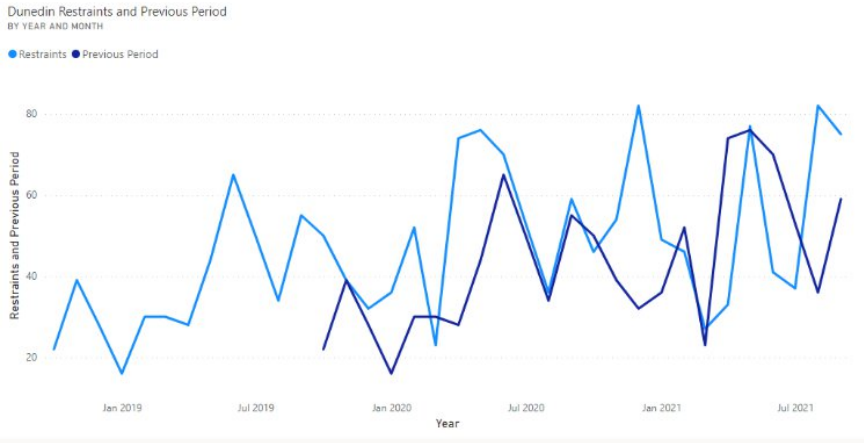
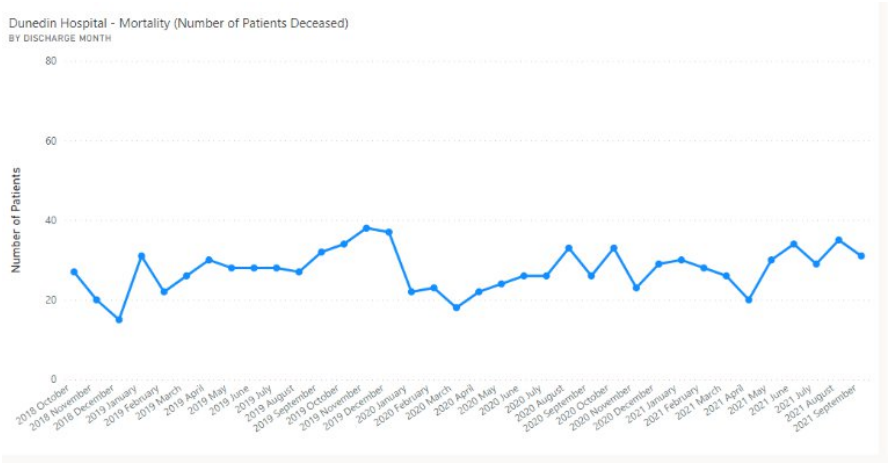


Restraints

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

Executive Dashboard – Effectiveness (Dunedin)



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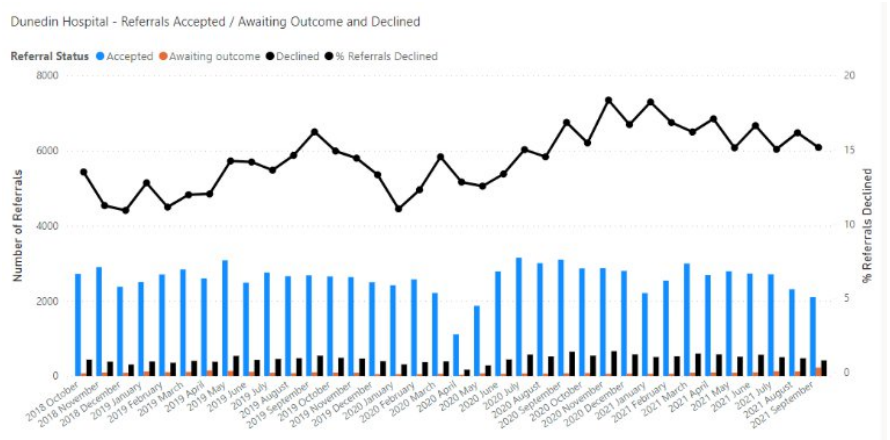

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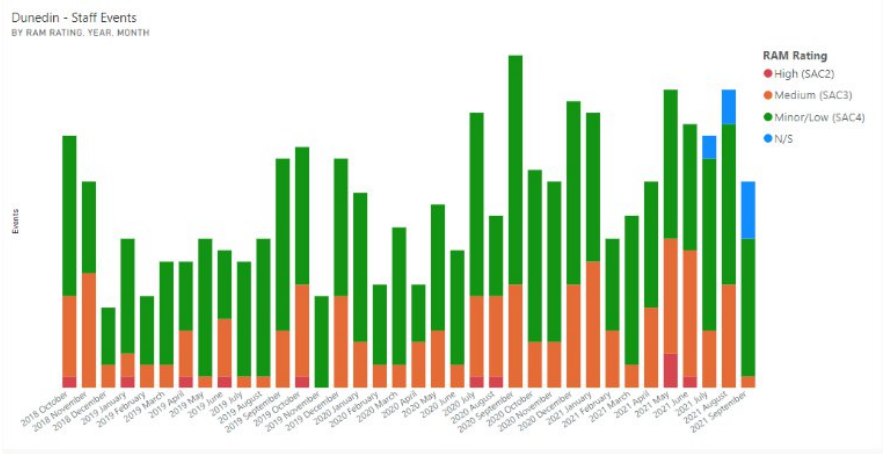

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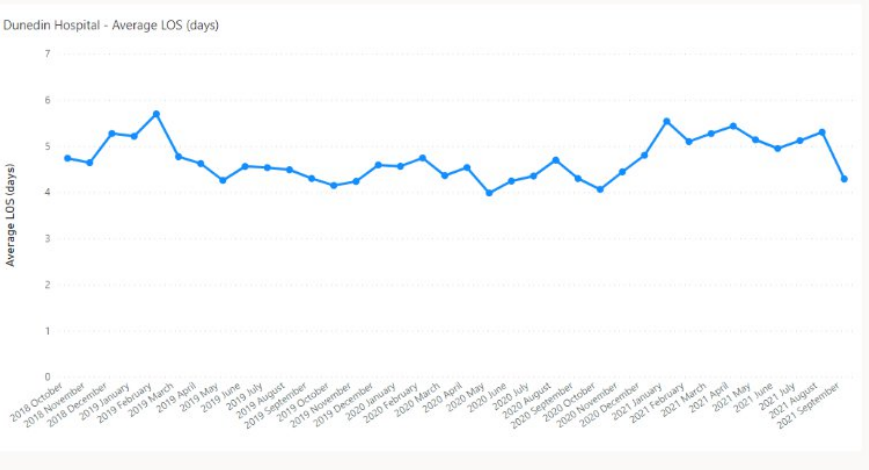
Executive Dashboard – Efficiency (Dunedin)



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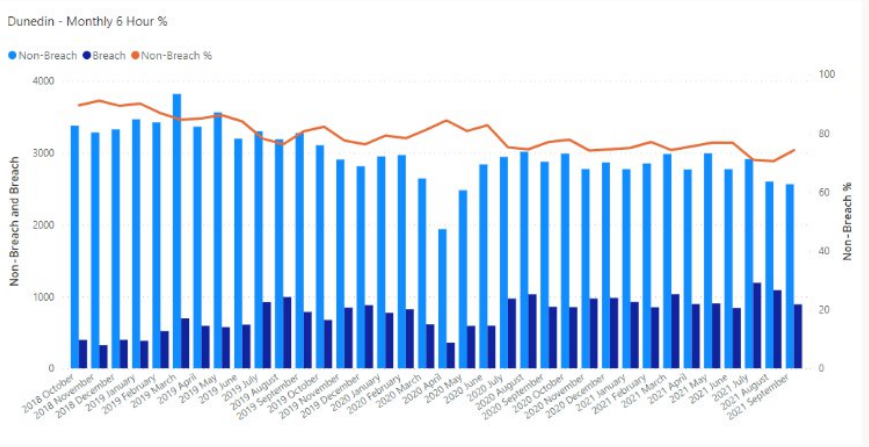

Monthly 6 Hour %

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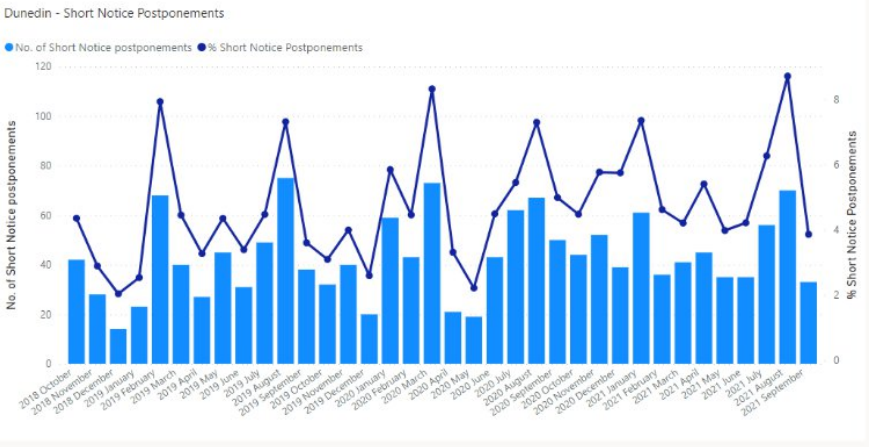


Short Notice Postponements

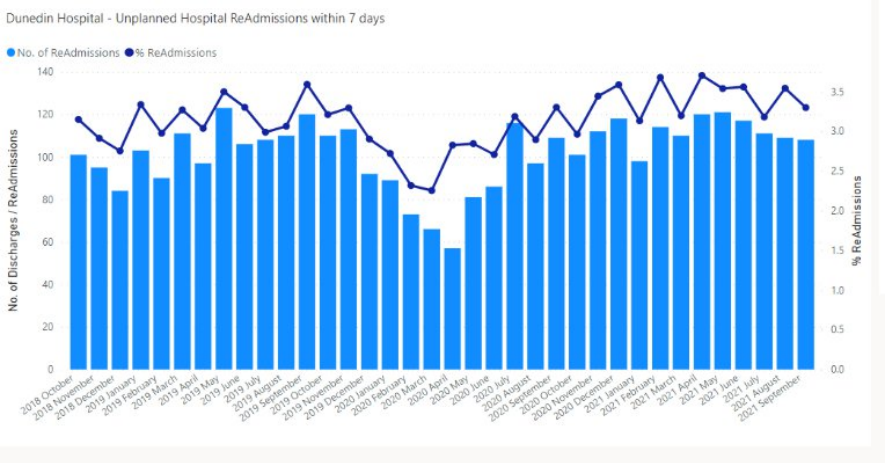
Theatre postponements within 24 hours of the scheduled procedure.

Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

Executive Dashboard – Timely (Dunedin)

Number of Patients with LOS > 7 days

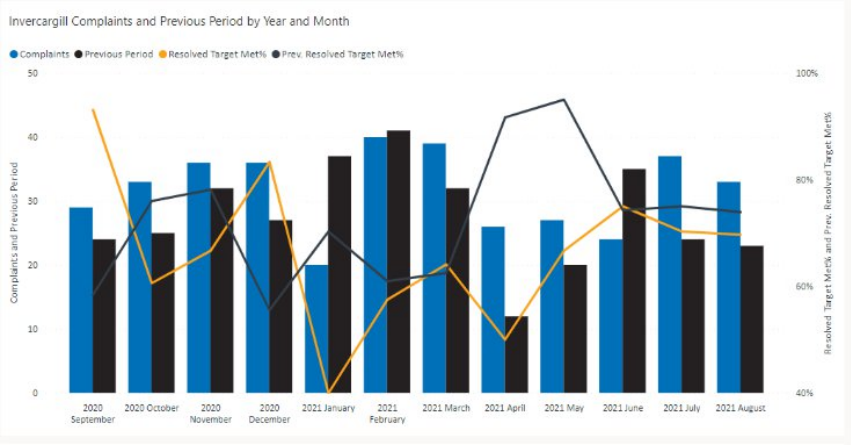
Number of patients per month who have a LOS > 7 days



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.

Executive Dashboard – Patient Experience (Invercargill)



Safety 1st data.

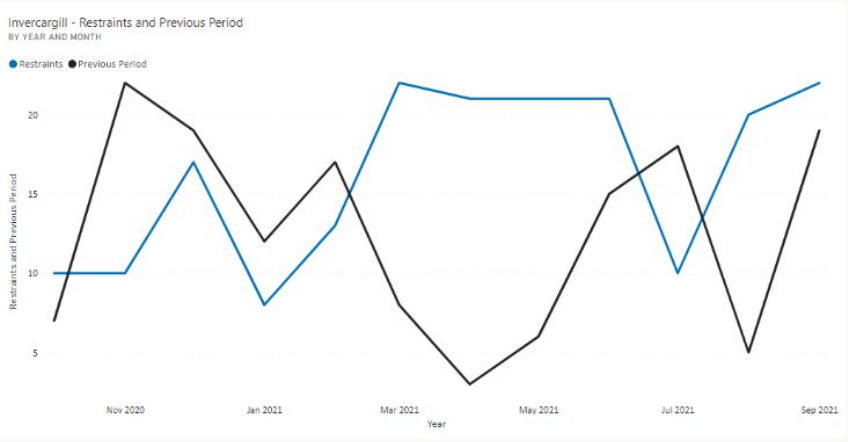
Complaints

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.

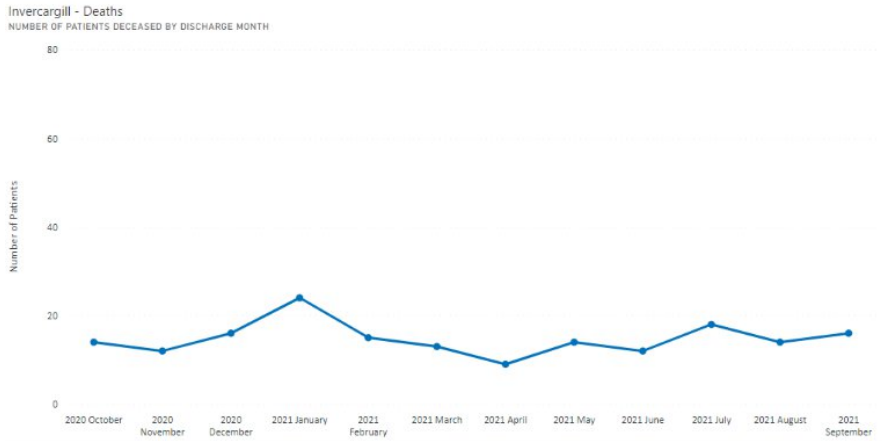
Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.



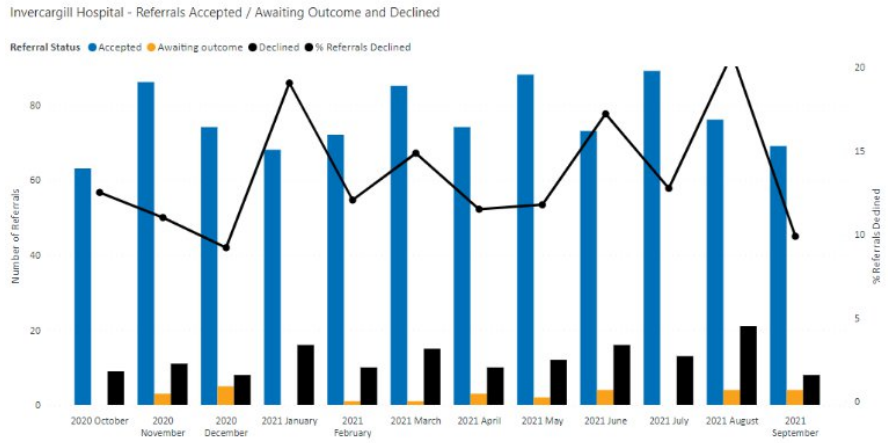
Restraints

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

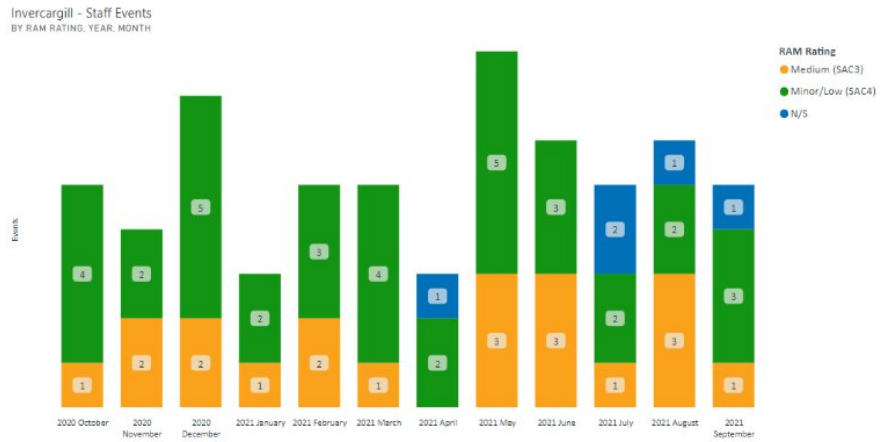
Executive Dashboard – Effectiveness (Invercargill)



Deaths
Number of patients deceased by discharge month.

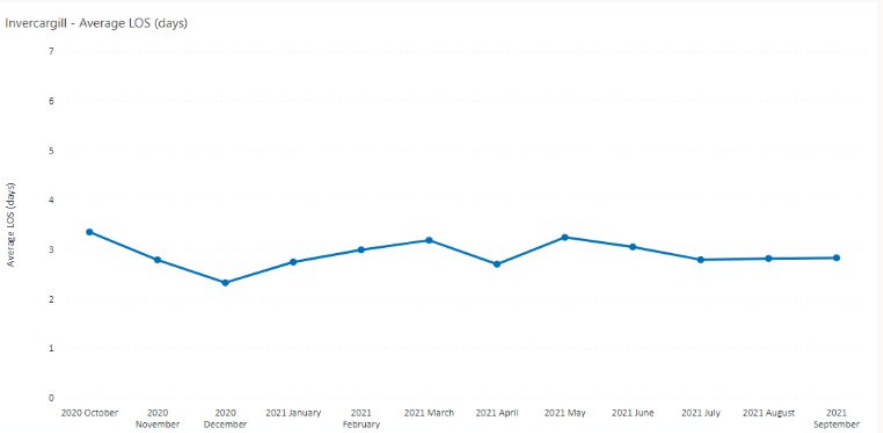


Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined.



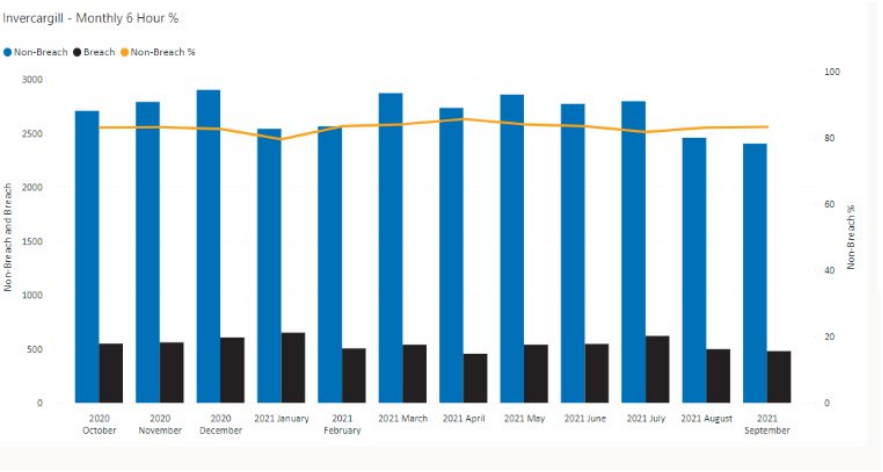
Safety 1st data.
The monthly number of reported
Staff adverse events.
Categorised by severity assessment Codes 1-4 and by 'N/S' (Not specified).

Executive Dashboard – Efficiency (Invercargill)



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 month's data.



Monthly 6 Hour %

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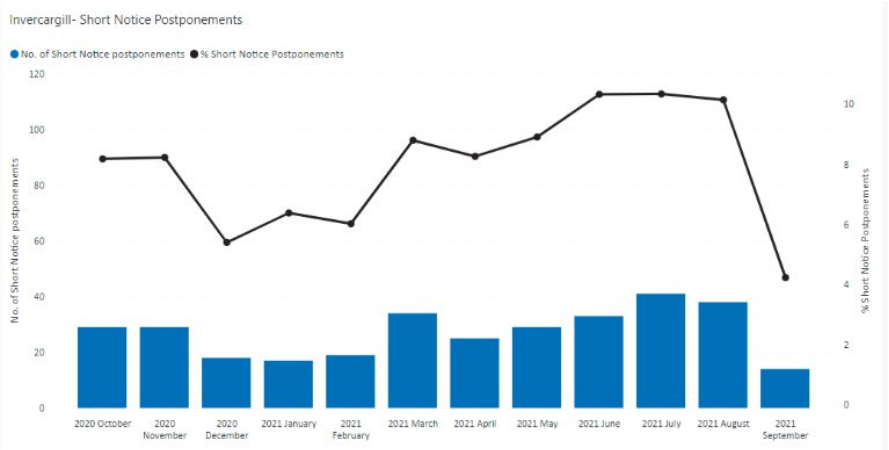
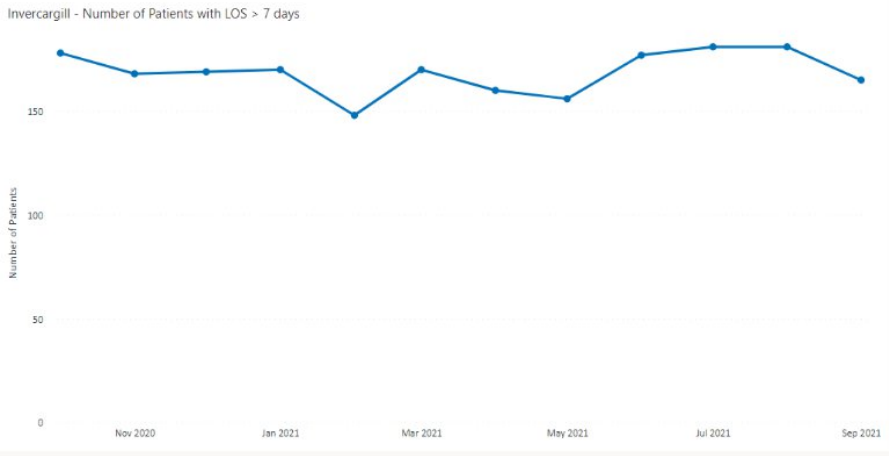


Short Notice Postponements

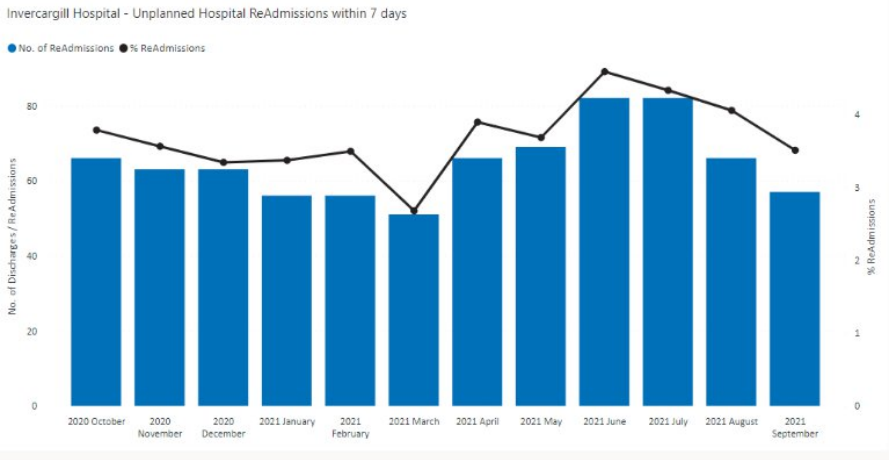
Theatre postponements
Within 24 hours of the scheduled procedure.

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 readmission within 7 days of the initial discharge from hospital organised on the basis of the month of discharge.

Appendix 2 : Proposed Exec Quality Dashboard

	Southern				Dunedin				Invercargill				Maori			
Quality of care	*Actual*	*Benchmark /Target*		*Trend*	*Actual*	*Benchmark /Target*		*Trend*	*Actual*	*Benchmark/Target*		*Trend*	*Actual*	*Benchmark/ Target*		*Trend*
1 Hospital Acquired Complications per 10k episodes of care					3.5	2.3			2.2	2.2			2.2	2.2		
2 Healthcare Associated Infections per 10k episodes of care					148	97			114	77			114	77		
3 Medication Complications per 10k episodes of care					40.1	25.2			20.2	19.3			20.2	19.3		
4 Readmissions within 7 days %					5.3	5.6			7.1	7.9			7.1	7.9		
5 Mental Health Seclusions no	35				tba				tba				tba			
6 Mental Health Restraints no	145	131			75	58			22	19			22	19		
7 Deaths no	66	60			31	30			16	14			16	14		
8 ED Wait Time %					74.17	80			83.31	80			83.31	80		
9 Vulnerable Patients in ED > 6 hours no					190	182			146	147			146	147		
Staff																
10 Staff Events - SAC 1 and 2 no					0	0			0	0			0	0		
11 Staff Events - SAC 3 and 4 no					16	20			4	4			4	4		
Patient Experience																
12 Complaints no	98	97			49	58			33	29			33	29		
13 Complaint response target met %	77	100			71	100			70	100			70	100		
14 Short Notice Postponments No					33	46			14	30			14	30		
15 Short Notice Postponments %					3.86	5			4.22	9			4.22	9		
Operations																
16 Referrals Declined %					14.61	16			9.88	14			9.88	14		
17 Length of stay days					4.28	5			2.83	3			2.83	3		
18 Patients with stay > 7 days no					367	385			164	170			164	170		
19 Patients with stay > 21 days no					70	84			40	41			40	41		

FOR INFORMATION

Item: Performance Dashboard Progress Update October 2021

Proposed by: Principal Advisor to CEO

Meeting of: Board, 2 November 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 we are on the home stretch now which is great. Feedback, suggestions, and questions are welcome.

Next Steps & Actions:

The final stages of the dashboard build are underway now which is focussed around bringing in the work that has been done in the Strategy, Planning and Funding team over into this project. This involves some background IT work but is progressing well.

Appendices

1. **Performance Dashboard Progress Update October 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	Complete
FSA's	Built/Complete
Average length of stay	In UAT
Worked vs Contracted FTE	Seeking specifications from business owners*
Hospital events as per Escalation Plan	Built/Complete
High cost Pharms	Built/handing over to IS
IDF's	Built/Handing over to IS
Measure (yet to build)	
Output per FTE	Not Started/Seeking clarification over what exactly is being counted
Community Pharms	Not Started/No dataset available to prepare this currently
Primary Care (Enrolled Pop)	Not Started/requires a MoH dataset and an investment from IS to be able to bring this in.
Mental Health Bed Days	Not Started/operational report does exist which is being investigated to bring across.

Discussion:

The monthly narrative is included below for the ESPI's, 6HR target and ED presentations as is the visual for Resourced Occupancy. A visual showing the hospital escalation trend data is also included below.

This past month the progress has slowed slightly given the competing demands on business owners with COVID endemic planning etc. We are essentially waiting to complete the HR focussed metrics, CCDM and bringing in of some primary and community measures.

Figure 1:

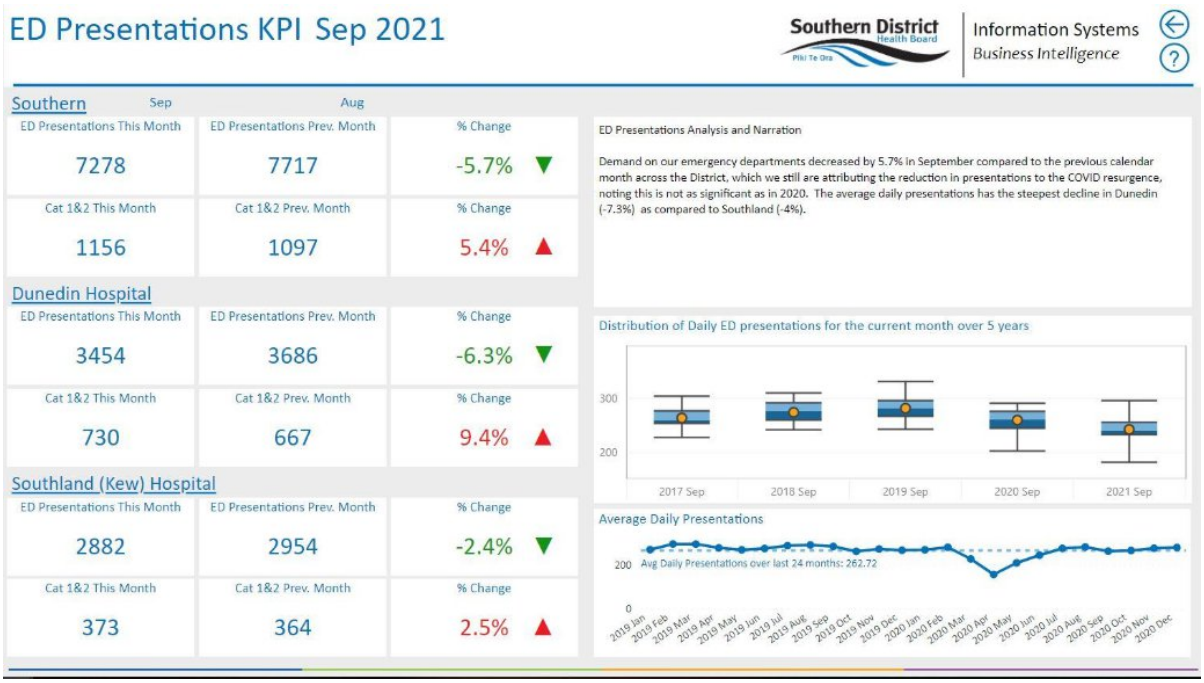


Figure 2:

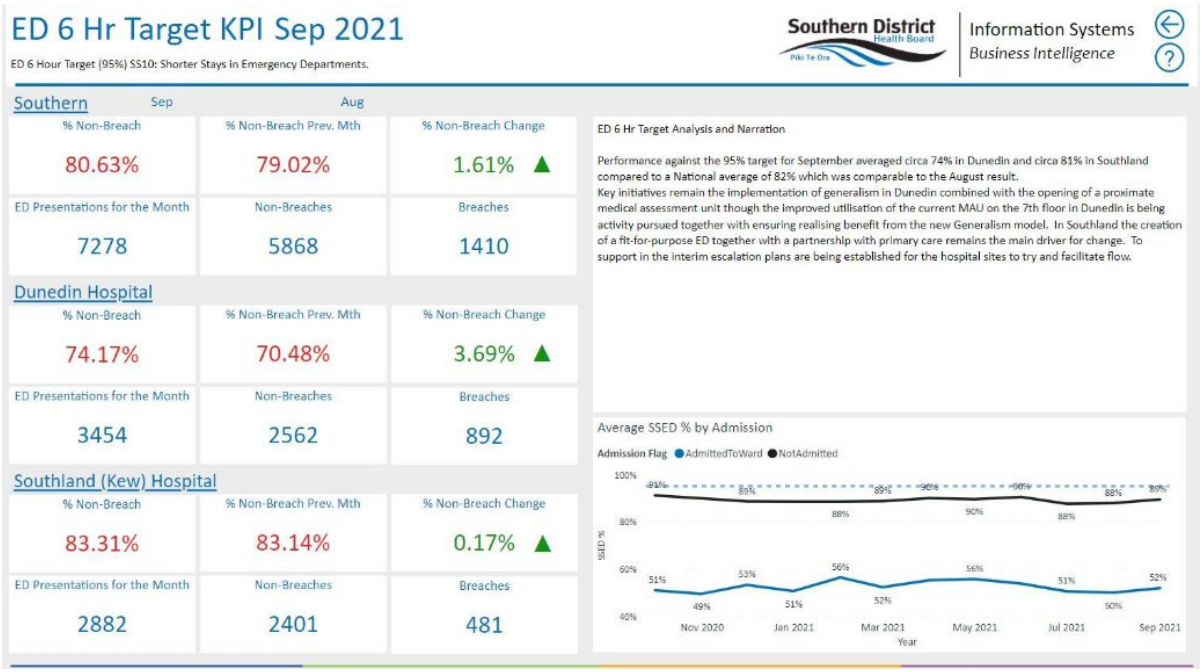


Figure 3:

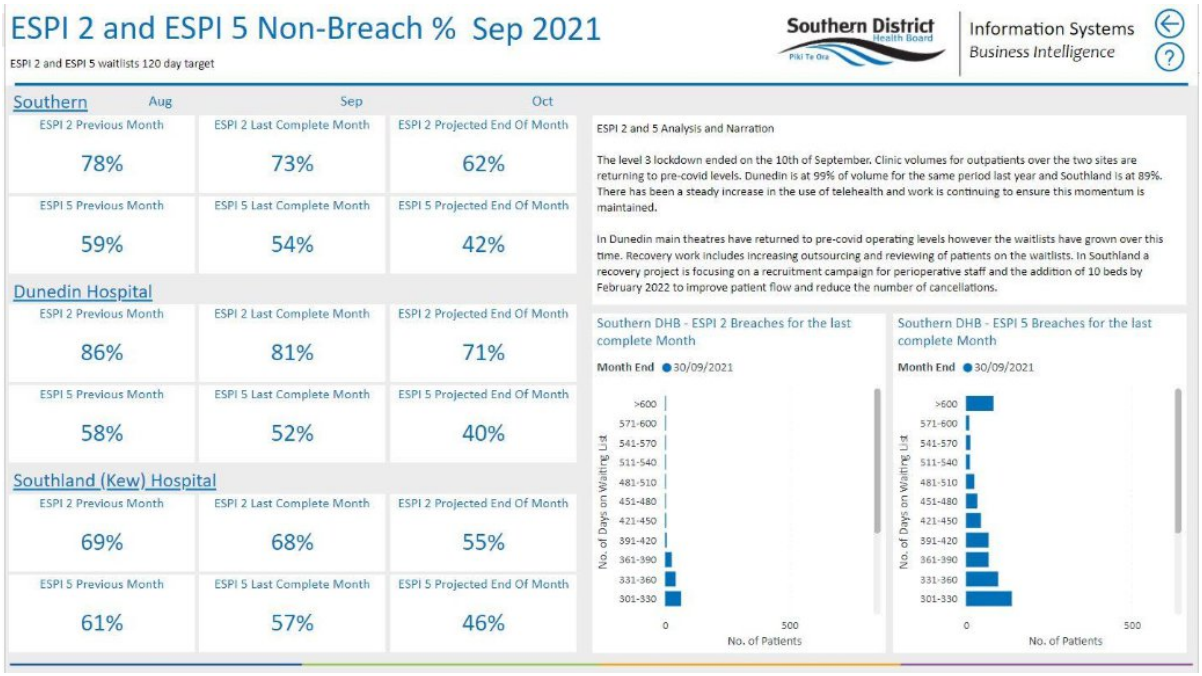


Figure 4:

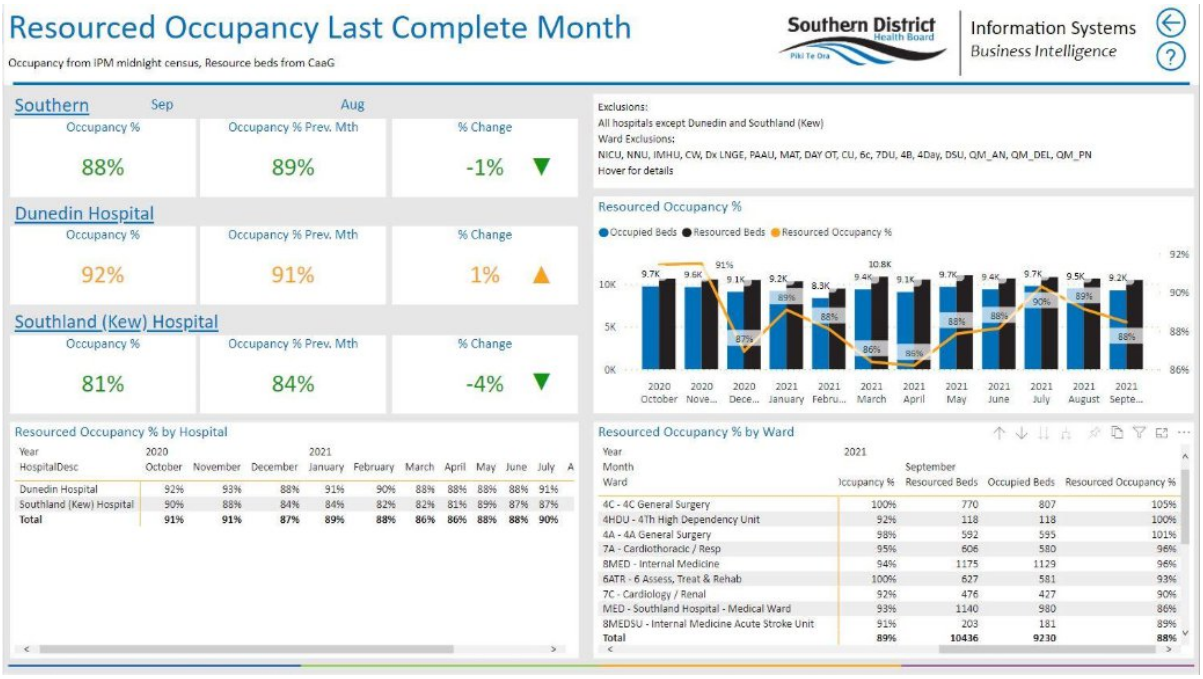


Figure 5.

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. *Same as last month and exacerbated by COVID endemic planning*.

- 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. *Same as last month and exacerbated by COVID endemic planning*.

FOR INFORMATION

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

Proposed by: Principal Advisor to CE

Meeting of: Board, 2 November 2021

Recommendation

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

Purpose

1. To demonstrate the style of reporting that the Cascade platform offers.
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 month's change programme update is the first iteration generated out of the Cascade platform. As a starter, this month's update is the subset of initiatives that have been tagged in the system as directly contributing to the new Dunedin Hospital. Cascade is a software online based tool that is centred around being able to link back to organisational strategic objectives which this style of report demonstrates well through its categorisation. Feedback and comments are welcomed.

Next Steps & Actions

- Continue uploading and refining content within Cascade and upskilling further users.
- In the next iteration the intention is to have the 'Risks' column showing and all the project risks appropriately documented which is critical governance information and we will also start to see historical completion rates and progress that is more meaningful.

Appendices

SDHB Change Programme (NDH Specific) Update October 2021.

PROJECTS CONTRIBUTING TO DUNEDIN'S NEW HOSPITAL (STRAT. CHANGE PORTFOLIO)

21/10/2021

20
GOALS

22%
GOAL COMPLETION

STRATEGIC CHANGE PORTFOLIO PLAN

POSITIONING PUBLIC HEALTH SERVICES FOR THE FUTURE

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
Health Needs Analysis: Development of Tō Tātou Pūkete/Our Health Profile presenting information about who lives in Southern, what keeps us healthy, how we get healthcare, and how healthy we are.	Rory Dowding	31/10/2021	33% ▲ 33% ahead	**Greer Harper:** Project is on track and progressing well despite resource being shared with COVID planning. *21/10/2021*	**Remaining indicators live on website** ☐ **Soft Launch of website 8/82 indicators** ☑ **Development of health Indicators** ☐	0% -

PRIMARY & COMMUNITY CARE

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
Health hubs Implementation	Rory Dowding	02/12/2021	17% ▲ 17% ahead	**Greer Harper:** Project is currently tracking well. *21/10/2021*	**Project Initiation, relationship agreement, preparation, RFP won** ☑ **"Go Live" opening date** ☐ **Initiate Co-Design Process (Te Kaika, MSD & SDHB)** ☐ **Property Frozen Floor Plan completed** ☐ **Heads of Agreement sign off** ☐ **Lease agreement sign off** ☐	0% -

Primary & Community Work Programme	Rory Dowding	01/01/2024	18% ahead	**Greer Harper:** Programme of work is extensive but very delayed due to resource being redeployed to the Vaccination programme and now COVID Endemic Planning. *21/10/2021*		0% -
Health Care Home Collaborative (WellSouth) Supporting the establishment and ongoing development of the health care home model across New Zealand	Rory Dowding	01/01/2023	50% ahead		**Roll out of tranche 5** ☐ **Tranche 1-4** ☑	0% -

CLINICAL SERVICE REDESIGN

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
Improving Patient Flow through the Implementation of the SAFER Bundle: A framework for improving patient flow	Jane Wilson	01/01/2022	25% ahead	**Greer Harper:** Overall behind on goal due to slower progress than hoped specifcally relating to engagement with the senior clinical staff. *04/10/2021*	**Discharge before Noon** ☐ **Flow from ED to inpatient wards** ☐ **Expected Date of Discharge & Clinical criteria for discharge** ☐ **Senior Review: Rapid Rounds & Red2Green** ☑	0% -
Embedding Virtual Health	Patrick Ng	31/10/2022	50% ahead	**Greer Harper:** Currently have 22 groups at various stages of implementing telehealth across the DHB which is great. Many groups are now seeing telehealth as being a valuable "business as usual" tool and engagement remains high. However, we have seen telehealth appointments drop off post lockdown - we really need services to keep using telehealth and for more to start. *20/10/2021*	**Continue to refine and resource developments** ☐ **Complete supported roll-out to services and support establishment of identified hubs in the community** ☐ **Identify potential hubs in the community for delivery** ☐ **Supported Rollout to services** ☑ **Development of Implementation Plan** ☑ **On-board Project Mgr & technical resource/support** ☑	0% -

Enhanced Generalism Model	Patrick Ng	02/01/2024	50% 50% ahead	**Greer Harper:** Work to progress the new model of care needed to be fully operating as the Generalism model represents is underway. There is some improvement and further change that is needed before we can say that the generalism model of care is fully operational. *21/10/2021*	**MAU Decant & Build** ☐ **MAU Design** ☐ **Recruitment: PM, SMO & Allied Health** ☐ **GAMA Implementation** ☑ **Communications Plan** ☑ **SLA/Referral Guidelines** ☑	0% -
TCU – Transit Care Units		02/01/2025	0% -			Not started

ENABLING OUR PEOPLE

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
Building our internal change capability to enact model of care changes	Tanya Basel	02/12/2023	50% 50% ahead	**Greer Harper:** Professional development in change capability (The Change Cycle Series) is an ongoing workshop offering for staff. *21/10/2021*	**Models of Care change management resourcing** ☐ **Org. Development Change Capability work** ☑	0% -
NDH Workforce Modelling	Tanya Basel	01/01/2025	50% 50% ahead	**Greer Harper:** Outpatients modelling was presented to ELT/CLG and work is now progressing on completing Inpatients modelling by December. *21/10/2021*	**Inpatients Modelling** ☐ **Outpatients Modelling** ☑	0% -

SYSTEMS FOR SUCCESS

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
Digital Transformation (detailed business case)	Nigel Trainor	02/07/2024	0% -	**Greer Harper:** On Board agenda for Nov 2nd. *21/10/2021*	**Board review of DBC** ☐ **Book DBC Clinic with Treasury** ☐ **Confirm & schedule interviewees for Gateway** ☐ **Gateway review** ☐ **Confirm TQA arrangements** ☐ **Confirm IQA of DBC** ☐ **Draft version of Detailed Business Case** ☐	0% -

Scanning Project: The digitisation of clinical records	Greer Harper	31/07/2022	0% − -	**Greer Harper:** The change management section of the Business case is in final stages of being drafted ahead of consultation starting but this is slightly behind the desired schedule. *21/10/2021*	**Clinical Engagement** ☐ **Bureau Service: Process Design** ☐ **Bureau Service: Transition & Training** ☐ **Management of Change: Consultation & Response** ☐ **Management of Change: Definition of roles & responsibilities** ☐	0% -
Establishment of an Integrated Operations Centre		01/06/2023	0% − -	**Greer Harper:** Initiative that has been identified by Patient Flow team and added to MoH Intensive Support programme. *21/10/2021*		Not started

SYSTEM IMPROVEMENTS

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
PICS implementation: New regional Patient Information System which replaces IPM in Otago & Southland	Nigel Trainor	31/05/2023	33% ▲ 33% ahead	**Greer Harper:** Whole project was delayed in kicking off as Programme Manager was redeployed to Vaccination programme. PICS has begun and is underway now. Steering group and operational steering group are in place and have had first meetings. *21/10/2021*	**Tranche 3 - Closure, Followup & GoLive** ☐ **Tranche 2 - Execution, Process Revew, Develop & Adapt** ☐ **Tranche 1 - Startup and Planning** ☑	0% -

FACILITIES FOR THE FUTURE

Goal	Owner	Due Date	Current Completion	Comment	Task	Historic Completion
Medical Assessment Unit (sub-initiative of broader Generalism Model implementation)	Nigel Trainor	02/08/2022	43% ▲ 43% ahead	**Greer Harper:** Contractor has been selected, decant process delayed slightly which will push build out. *21/10/2021*	**MAU Design** ☐ **MAU Build** ☐ **Decant Process: Physiology, Rheumatology** ☐	0% -
Dunedin Master Site Planning	Hamish Brown	01/01/2022	20% ▲ 20% ahead	**Greer Harper:** Initiative progressing well. *21/10/2021*	**Deliver & Document** ☐ **Refine Preferred Scenario** ☐ **Explore Spatial Options** ☐ **Define Vision & Principles** ☐ **Mobilisation/Lead-In** ☑	0% -

CETES – Clinical Engineering, Tech & Equipment Service	01/01/2027	0% − -		Not started
Seven-Day Hospital	02/01/2026	0% − -		Not started
Acute Assessment & Planning Units	02/01/2025	0% − -		Not started
23 Hour Unit	02/01/2025	0% − -		Not started

FOR INFORMATION

Item: Progress Report on Mental Health Review Implementation

Proposed by: Gilbert Taurua, Executive Director

Meeting of: Board, 2 November 2021

Recommendation

That the Board notes this is an update on the implementation of the recently released review of the mental health and addiction system 'Time for Change'.

Purpose

1. To update the Board on progress with the implementation of Time for Change, the review of the mental health and addiction system

Background

This update provides an overview of short-term activities as outlined in Section 5 from the report. Other activities outside the scope of the report are continuing to be advanced ie: MHAID key identified risks now on the risk register.

Next Steps & Actions

Two monthly updates to the Board

Appendices

Appendix 1 Mental Health and Addiction System Review Update

Southern DHB Board– 2nd November 2021

Mental Health and Addiction System Review Update

Introduction

This paper provides an update to the Board on the Mental Health and Addiction System Review. The Mental Health and Addiction System Review was completed by Synergia during January to June 2021 and signed off by the Board in August. This update provides an over of activity been undertaken to date.

Leadership

The Chief Executive through a proposal for change process is currently recruiting an Executive Director, Mental Health, Addiction and Intellectual Disability. This new role is the first Executive Director representing Mental Health, Addiction and Intellectual Disability at the executive leadership level. The role will impact the way that our Mental Health, Addiction and Intellectual Disability services are delivered across our region and lead development of more contemporary models of care within specialist mental health service and across the mental health and addiction system. We are planning to recruit a General Manager role provider arm services which has also come out of the proposal for change. Steve Bayne is currently acting in this GM role with the resignation of Louise Travers. We have engaged Toni Gutschlag in a .4 FTE service improvement role until April 2022 while still engaged with the Ministry of Health. Toni has identified that the MHAID directorate leadership team and three service managers have large operational and/or clinical workloads and responsibilities.

The Director of Nursing (DON) has been released to focus on the recommendations from the report and we are in the process of appointing an associate DON. We are in the process of appointing a project implementation manager to support the recommendations. We are still working on a proposed work programme for the Leadership Lab which will help build positivity and momentum and grow leadership.

Crisis Response Queenstown and Central Lakes and Waitaki Regions

We are in discussion with Jo Harry, looking at developing a crisis response for the Queenstown and Central Lakes. Jo is the ex-service manager of the Queenstown-Lakes mental health and addiction service, is a registered nurse and lives in Wanaka. Adell Cox and Heather Casey are supporting these discussions which at this stage will focus on the development of a plan to manage a crisis response for this locality. This will require the development of a respite supported accommodation facility and services able to be called upon 24/7. This will require additional investment. As this project develops, we are planning to follow a similar process for the development of a crisis service for the Waitaki. A more detailed plan for the Queenstown-Lakes crisis response will be tabled at the next meeting so we can agree to the scope of this project. There will be other outstanding issues across the Queenstown-Lakes services which will need to be resolved but I don't want these confused from the recommendation in the report which needs to focus on crisis response for these communities.

Closure of Ward 11

Chris Fleming and Gilbert Taurua have formally signalled the closure of Ward 11 on the Wakari site and have met separately with that team on the release of the Mental Health and Addiction System Review. Heather Casey has been providing support for this team after this announcement. An Expression of Interest has been undertaken to test the market for the transition of our long stay patients and the number and quality of responses have been impressive. We are presently working through these in order to be able to map out a pathway forward. The wider other facility issues for the Wakari site will be considered once the change manager is in place.

Network Leadership
The Network Leadership Group held its last meeting on 29 September. John McDonald has continued in the short term to support the four mental health locality groups and the inter sectorial government group until we have some direction from the transition office on the development of Locality Networks. The first meeting of the Southern Mental Health and Addiction Change Governance Group will be held in September under the Chairmanship of Dr Clive Bensemann. We are planning a series of groups which will need to be stood up to support the review recommendations including but not limited to an interagency government group, a service user group, a staffing group (as requested by the unions), an NGO group and an addictions specific group.

Organisational Development
We have engaged the Leadership Lab to support us with recommendation 4.3.7 from the Mental Health and Addiction System Review around organisational development and the role of culture. The Leadership Lab is an experienced organisational and leadership development group. They've worked with some of our local Southern communities on community development initiatives and have experience working with DHB specialist mental health services. We are looking for the Leadership Lab to lead us through an Appreciative Inquiry process to identify and highlight the strengths and views of staff of what is working well and where there is energy for change. We know there is a lot of passion and a real desire for things to be different within mental health services.

Quality and Patient Safety
Toni Gutschlag has identified that quality improvement, assurance, health and safety, informatics, education and development, serious and adverse event review processes are carved up into small and disjointed pieces and sit across many people. In her opinion it makes it difficult to have end to end visibility and coordination of core quality and patient safety functions. The distributed model of undertaking serious adverse event reviews is resulting in some delays, issues with quality and implementation of recommendations. We have arranged for up to 12 serious adverse event reports to be independently reviewed by a Specialist Mental Health Service quality and patient safety expert. This is to assess application to the Systems Analysis of Clinical Incidents (London Protocol) and alignment of recommendations with findings. It will also provide us with some insights into our organisational structure moving forward.

We are considering our internal quality resources within Specialist Mental Health Service (SMHS) and how this capacity can be increased, and the core quality and patient safety resources and functions are brought together into a single team. Toni has recommended that a dedicated role(s) to lead the serious and adverse event reviews are established. Other DHBs have called these roles Patient Safety Officers. This will ensure fidelity to the methodology is maintained, provide leadership and guidance to serious adverse events (SAE) team members, and reduce time taken to complete the reviews. At least one is required, and consideration should be given to more because of the volume of SAE's. Discussions have been had with the interim Executive Director, Quality and Clinical Governance Solutions.

Staff injury prevention weekly meetings have been reconvened, drilling down on each injury (using fishbone framework) to support staff and look at actions to prevent recurrence and leaning. This information is shared in team meetings and monthly summary provides update on issues and actions which are discussed at team meetings. Risk assessment tools have been further identified and are in place with training provided. Assessing dynamic and static risks and DASA used in all inpatient areas. (The Dynamic Appraisal of Situational Aggression (DASA) is a tool developed by Ogloff & Daffern (2006) to assess the likelihood that a patient or client will become aggressive within a psychiatric inpatient environment. The DASA is based on the Norwegian Brøset-Violence-Checklist.

Guidelines for assessment of pregnant staff has been completed and in now on Midas. This policy is only MHAID at this stage and needs to be rolled out by HSW to the rest of organisation.

Opportunities to partner with Canterbury DHB SMHS educator are being explored, Canterbury DHB has developed a talking therapies education framework and mandatory training programme.

National Asset Infrastructure Unit

We have had a site visit from the Ministry's Health Infrastructure Unit (HIU) the week of 20 September. The establishment of the Mental Health Infrastructure Programme (MHIP) is to support DHBs with the delivery of their Mental Health and Addiction (MHA) capital projects. The MHIP, in collaboration with the Ministry's Mental Health and Addiction Directorate also seeks to help DHBs who do not have capital projects underway but are in the 'identification' stage so that the need and relative priority for future investment in mental health and addictions infrastructure is determined. This work will help inform the DHB's intentions for capital investment and the HIU's prioritisation and pipeline of future projects. The team visited a number of clinical areas and met members of the Executive. The draft facilities safety survey has been undertaken:

1. Three DHB acute facilities agreed to pilot this survey which focused on facility design, specifically ability to separate patient cohorts, safety for patients and staff and Kaupapa Maori considerations
2. Ward 9b was identified as the priority area as draft findings may help inform capital expenditure and building work.
3. The opportunity was taken to include ward 10a due to need for capital work on the physical environment.
4. These draft reports have been received and we are currently reviewing this programme of work.

Gilbert Taurua

FOR INFORMATION

Item: Equity Update

Proposed by: Gilbert Taurua, CMHSIO

Meeting of: The Southern DHB Board – 2 November 2021 – Invercargill

Recommendation

That the Board notes this paper.

Purpose

1. The Board has requested monthly updates on equity actions aimed to improve Māori health systems responsiveness.

Specific Implications For Consideration

2. Financial

- As outlined in the previous board meeting there are significant financial implications as a result of the direction from the Board which includes savings to advance these directives.

3. Quality and Patient Safety

- This paper highlights opportunities to enhance quality and patient safety

4. Operational Efficiency

- The paper highlights operational efficiency and equity advancements.

5. Workforce

- Workforce issues are outlined in this paper.

6. Equity

- Complete equity focus to this update.

Background

7. The Southern DHB has requested monthly reporting to the Board on amendable mortality, positions to be appointed, the formation of the Māori clinical group, reorientation of district public health service and data sovereignty. This paper provides an update across these domains.

Next Steps & Actions

Monthly updates to be provided to the Board.

Appendices

Appendix 1 Māori Equity Board Paper

Appendix 1: Māori Equity Board Update

1. Introduction

- The Southern DHB has requested monthly reporting to the Board on amendable mortality, positions to be appointed, the formation of the Māori clinical group, reorientation of district public health service and data sovereignty. This paper provides an update across these domains.

2. Māori Amenable Mortality Update

- The Strategic Refresh project is developing 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.

- The Clinical Council is to 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 with the next meeting of this group to be held 28 October.

- As updated at the last Board meeting, 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.

3. Recruitment

- We have loaded an RFR for the recruitment of the Senior Manager Māori Workforce Development role. The Senior Manager Māori Health Workforce Development will be responsible for leading, in partnership with People and Culture, a Māori workforce development strategy for the organisation. This includes strategic planning responsibilities, the ongoing development and delivery of initiatives and the monitoring and evaluation of programmes focused on increasing and developing our Māori workforce.

- The CMHSIO and DON are looking at the roles of Clinical Nurse Specialist's (Kaiārahi Nāhi) to ensure care pathways mitigate avoidable, unjust or unnecessary barriers caused by the system of health care for our patients and their whānau/families. The primary function of these role include:

  <u>Te Ao Māori</u>
  - Ensure the provision of manaakitanga, pōwhiri, whanaungatanga, and tuku atu tuku mai throughout the patient's planned care journey.
  - Understand and fulfil the strategies that best support Māori peoples to stay on their planned pathway journey.
  - Advocacy, effective relationships management and community networks to ensure the culturally responsive care and treatment are accessed.

  <u>Te Ao Kawanatanga</u>
  - Connect PHO's, NGO's and Community based services and Pae Ora/Whānau Ora tools/processes/pathways along the journey in and out of hospital based care.

- Health system knowledge, health system networks, clinical experience and credibility are keys to success.

Te Ao Hou

- Produce educational resources aimed at building the capacity and capability of the system to embed equitable outcomes and drive positive change, based on the stories and evidence from real examples.

- The Māori health directorate have not been successful in making any appointments for the kaiawhina positions in Invercargill or Dunedin. We have received a further resignation from Invercargill so now have three kaiawhina vacancies and will need to readvertise.

4. Public Health

- The Southern DHB has made an appointment of Sarah Martin to the role of Public Health Pou Whakatere that will work with the Service Manager, 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.

5. Māori Health Equity Strategy Group

- The Southern DHB has approved the establishment of a Māori Health Equity Strategy Group that will provide oversight and advice on advancing equity strategies and plans across the Southern health system. Whakamaua, the Māori Health Action Plan 2021-2015 sets out a series of health priorities including Nga Kaiarahi Māori, Māori Leadership. Objectives in this Māori Health Action Plan included reducing health inequities and health loss for Māori. This Māori Equity Strategy Group will 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 equity in health outcomes for Māori. Dr Liza Edmonds, Neonatal Paediatrician and Clinical Senior Lecturer, Dunedin School of Medicine University of Otago, has agreed to chair this Group and we are now approaching the other group members identified.

6. Data Sharing Agreement and Māori Data Soverighty

- The Data sharing agreement has a history dating back to December 2018. The Southern Alliance was unable to resolve some of these challenges and recently there has been a greater willingness to proceed. The purpose of this agreement is to facilitate the safe, secure, and properly governed sharing of NHI-level data ('the

data') between Southern District Health Board (SDHB) and WellSouth Primary Health Network (WellSouth).

- Māori Data Sovereignty refers to the understanding that data is subject to the laws of the nation within which it is stored. Indigenous Data Sovereignty perceives data as subject to the laws of the nation from which it is collected. Māori Data Sovereignty recognises that Māori data should be subject to Māori governance. Māori Data Sovereignty supports tribal sovereignty and the realisation of Māori and Iwi aspirations. Recent direction from Donna Matahaere-Atariki in her role as WellSouth Board member and co-chair of the Iwi Governance Committee has recommended the removal of this clause from the Data sharing agreement. That this direction is based on the challenges in attempting to operationalise this approach, the observation that there are a few examples of Māori Data Sovereignty in place within the health sector and that Ngai Tahu have future aspirations to address this issue.

- The Data sharing protocol will be overseen by the Southern Health System Clinical Data Governance group which will comprise equal numbers of members from the WellSouth Clinical Governance Group and The SDHB Clinical Council, with Iwi and Consumer representation. Its role will be to govern the process of assessing and approving data sharing requests for clinical purposes between WellSouth and SDHB. Data requests will be made through the agreed Data Sharing Framework which acts as a P\process for the purpose for data sharing. As part of the Health Reforms the Ministry is working on a data and digital programme and the issue of Māori Data Sovereignty will need to be navigated at the national level.

WORKFORCE

2 November 2021 – Board Meeting

CONTENT

WORKFORCE DASHBOARD

PEOPLE STRATEGY

Data currently includes a mix of YTD as at end June 2021 (for DHB comparison) as well as data as at end September 2021 where it relates to specific data for Southern Only.

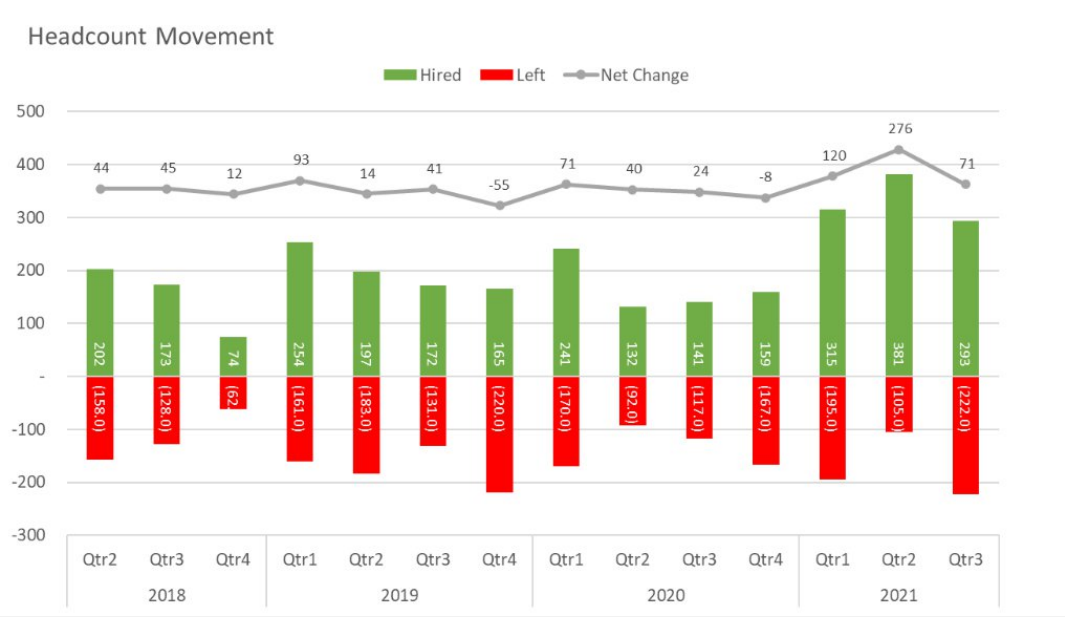
WORKFORCE DASHBOARD

EXECUTIVE DASHBOARD

	YTD data as at JUNE 2021	Nursing	Midwifery	SMO	RMO	AHST	Corporate & Other	Care & Support	Southern DHB	All DHBs
Headcount & FTE	Headcount	2,066.00	66.00	341.00	342.00	727.00	1,005.00	422.00	4,969.00	80,596.00
	Contracted FTE	1,637.60	43.60	300.10	330.40	620.80	893.40	316.40	4,142.30	68,772.00
	Average FTE	0.79	0.66	0.88	0.97	0.85	0.89	0.75	0.83	0.84
Diversity & Ethnicity	Age % 55+	29.0%	27.3%	37.2%	0.9%	21.2%	37.7%	41.2%	29.3%	29.1%
	Average Age	44.30	47.70	51.10	32.40	42.00	48.50	47.30	44.80	45.00
	% Females	87.8%	100.0%	40.2%	50.0%	80.6%	75.4%	83.4%	78.1%	78.4%
	Māori % of HC	4.70%	3.03%	1.50%	3.70%	5.00%	4.00%	5.70%	4.39%	8.19%
	Pacific % of HC	0.70%	No data	0.30%	2.00%	0.60%	0.70%	1.90%	0.80%	4.45%
Attraction & Retention	Time to Hire	51.70	No data	271.60	75.60	67.20	57.70	46.60	62.00	61.20
	Voluntary Turnover (%)	9.2%	10.9%	2.8%	N/A	11.4%	9.2%	0.0%	9.4%	10.9%
	Tenure (Years)	10.10	8.70	10.80	2.40	8.70	8.70	7.60	8.14	7.90
Leave / Absence	Average YTD Sick Leave per FTE (Hours)	83.70	89.90	31.40	48.40	73.10	58.00	97.80	71.20	74.50
	% Sick Leave hours per FTE	4.40%	5.80%	1.50%	2.30%	3.60%	3.20%	5.50%	3.50%	3.70%
	Average Annual Leave Entitlement per FTE	135.00	83.00	201.00	215.00	148.00	151.00	109.00	146.00	No Data
	Average Annual Leave balance per FTE (hours)	265.40	320.50	372.90	229.80	170.70	189.40	176.50	196.60	203.90
	Accrued >2 years	12.2%	No data	30.8%	5.3%	6.8%	7.1%	5.3%	11.1%	10.4%

TURNOVER

	2018	2019	2020	2021 (YTD)
Headcount Hired	449	788	673	989
Headcount Left	348	695	546	522



		2018	2019	2020	2021
Allied Health & Scientific Technical	Hired	68	109	124	261
	Left	- 59	- 107	- 77	- 204
	Net Change	**9**	**2**	**47**	**57**
Care & Support	Hired	58	89	91	161
	Left	- 34	- 68	- 78	- 65
	Net Change	**24**	**21**	**13**	**96**
Corporate & Other	Hired	78	155	115	169
	Left	- 67	- 144	- 94	- 58
	Net Change	**11**	**11**	**21**	**111**
Midwifery	Hired	12	19	9	5
	Left	- 4	- 15	- 15	- 2
	Net Change	**8**	**4**	**- 6**	**3**
Nursing	Hired	134	265	243	263
	Left	- 106	- 205	- 205	- 103
	Net Change	**28**	**60**	**38**	**160**
SMOs	Hired	19	40	23	30
	Left	- 18	- 31	- 18	- 9
	Net Change	**1**	**9**	**5**	**21**
Net Change for the year		**101**	**93**	**127**	**467**

Data is as per calendar year. Excludes RMO data due to PGY runs etc.
Increase in Q2 2021 relates to the COVAX workforce recruitment in March/April.

12.2

RETENTION

Turnover in PHYSIOTHERAPISTS, ANAESTHETIC TECHNICIANS and MIDWIVES is of concern.

PHYSIOTHERAPISTS in SOUTHLAND is of specific concern due to impact on service/patient flow

Also on the watch list is PHYSICISTS with a current turnover rate of 11.4%

WORKFORCE GROUP	METRIC	2020	2021	COMMENTS
PHYSIOTHERAPISTS	*Headcount*	69	72	• Turnover of Physiotherapists have increased. Specifically in Southland where the annual turnover rate has increased from 12.9% as at June 2020 to 37.5% as at June 2021. • Turnover rates in Dunedin has also increased from 4.1% end June 2020 to 11.1% June 2021. • Southland is at significant risk of not being able to provide services with the lack of Physiotherapists who play a key role in patient flow. • Engagements with staff regarding retention options are ongoing. • Recruitment has yielded some positive results, but immigration remains a barrier. • Anticipate that as of January 2022 Southland will be fully recruited if we manage to retain existing staff.
	Contracted FTE	58.3	60	
	Average FTE	0.85	0.83	
	% Females	79.7	76.4	
	% Turnover	6.1	18.2	
	Tenure	7	6.8	
	Average Age	37	39.4	
ANAESTHETIC TECHNICIANS	*Headcount*	36	38	• Southland ATs Turnover rate is 12.1% as at June 2021. • Dunedin ATs Turnover rate is 16.7% as at June 2021. • Recruitment constraints – Australian, UK, NZ qualifications are accepted. Very difficult to attract internationally – working holiday due to low paid role. • Pay levels does not provide for long term attraction of international recruits. • AT Trainees will become AUT graduate and will be in high demand around the country. There will be a gap between programs. DHB trained vs AUT trained program will not overlap creating a gap. • To address this anticipated gap, 12 Trainees currently in place to optimize our intake and ability to retain ATs. • A career framework is being developed to support further attraction including offering scholarships with bonding.
	Contracted FTE	34.4	36.1	
	Average FTE	0.95	0.95	
	% Females	55.6	57.9	
	%Turnover	3.5	15.2	
	Tenure	9.9	9.4	
	Average Age	43.7	43.7	
MIDWIVES	*Headcount*	75	66	• Dunedin reduced number of LMCs - Southern DHB has set up an Outreach Midwifery service in Dunedin to ensure those women who were unable to find an LMC could access a core midwife. • Changed our model of care to include the recruitment of Registered Nurses as part of the team. • Develop a plan to support Registered Nurses who wish to enter the midwifery pathway. • Additional support for Southland Hospital midwifery service created the Assistant Director of Midwifery role. • School of Midwifery at Otago Polytechnic - student placements across district to grow Midwifery pipeline. • Two new graduates in Dunedin this year and next year offering three placements in Southland and three in Dunedin • Midwifery scholarships for second and third year midwifery students. • Midwife Clinical Coach role being established to support new midwives, return to practise midwives and supervise newly registered internationally qualified midwives. • Midwifery recruitment campaigns internationally and within New Zealand, including the development of a local recruitment video. • Representation on the national Director of Midwifery leaders' group, who are working collectively on midwifery workforce strategies.
	Contracted FTE	51.9	43.6	
	Average FTE	0.69	0.66	
	% Females	100	100	
	% Turnover	10.7	10.9	
	Tenure	9	8.7	
	Average Age	47.5	47.7	

ATTRACTION

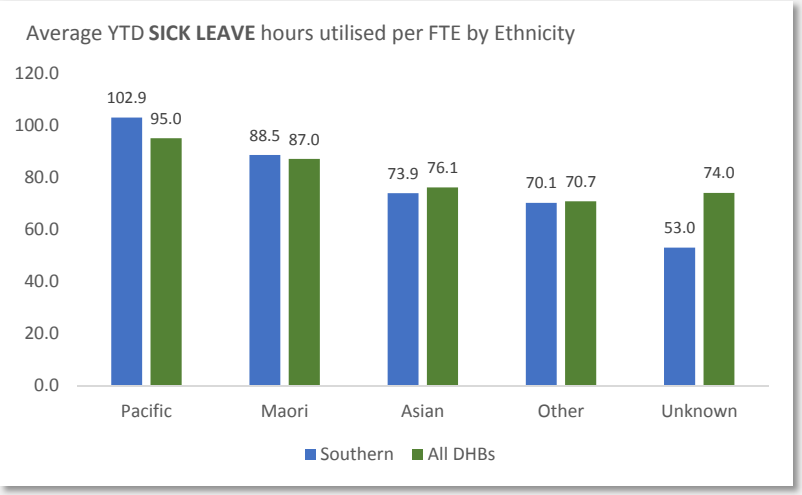
Challenges	Opportunities / Positives
• Small Team – limited resources • System challenges (EC at end of life) • Southland attraction remains difficult • Limited Talent Pool / Skills Shortages • Limited employment opportunities for partners • Immigration – changing goal post • MIQ – limited facilities/spaces • Turnover of recruitment staff • Increased turnover in leadership roles • IEA salary constraints – competing with private sector	• New Recruitment System – SuccessFactors • Knowledgeable Recruitment Team • Improve Relocation benefits • Strengthen Employee Value Proposition • Implement Employee Referral Program • Further develop workforce planning • Partner with tertiary institutions to match intake with long term demands

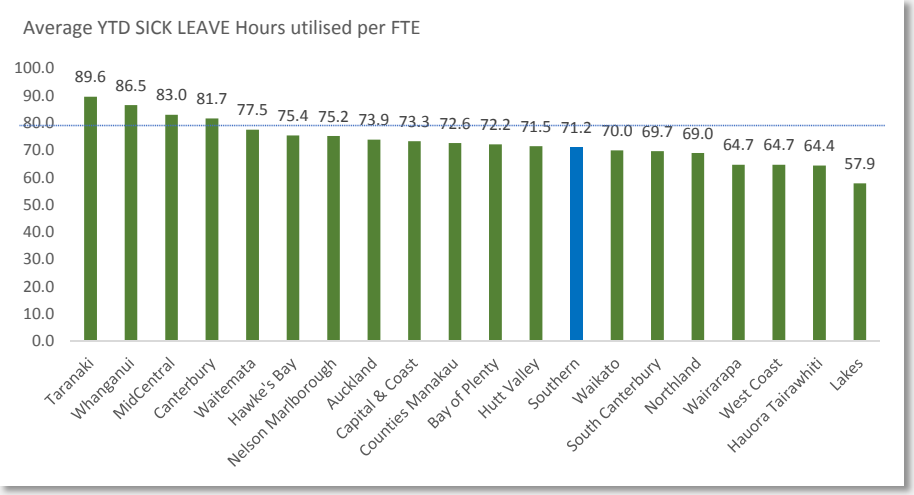
RETENTION

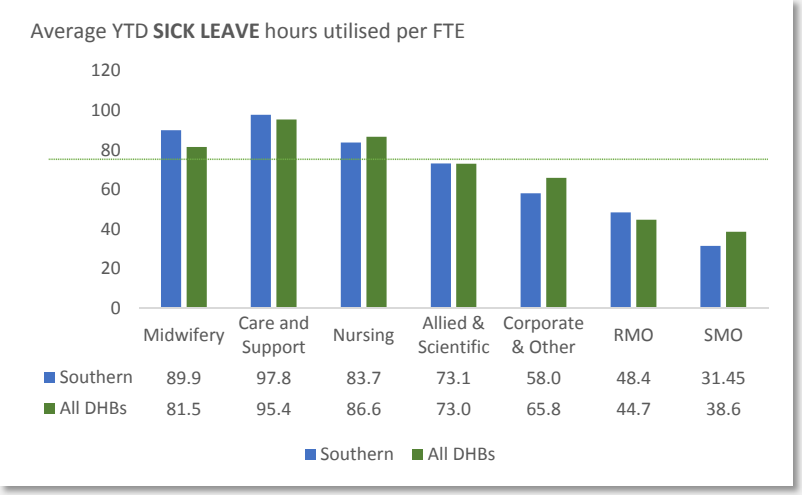
Challenges	Opportunities / Positives
• Inability to compete with private sector • Limited retention tools e.g. salary adjustment for IEAs • IEAs don't have the same benefits as MECAs • Demands on resources • Vacancies • Lack of service managers • Instability created by Health and Disability Review / Transformation • Salary freeze for IEAs • Visas / Immigration process • Higher turnover in management and corporate roles.	• Develop retention framework focussed on cultural pillars that impact on retention - learning, clarity, trust, purpose and inclusion. • Consider application of scarcity allowance • Strengthen Career Development • Strengthen Leadership Development • Prioritise Models of Care to support "top of scope" practice • Focus on Leadership and Professional Development

SICK LEAVE – JUNE 2021

	All DHBs	Southern
YTD Sick Leave utilised per FTE	74.5	71.2
% Sick leave	3.7	3.5

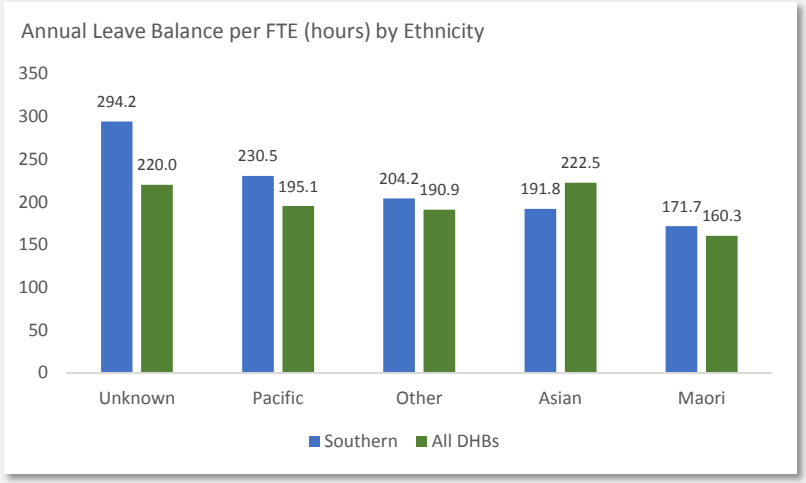


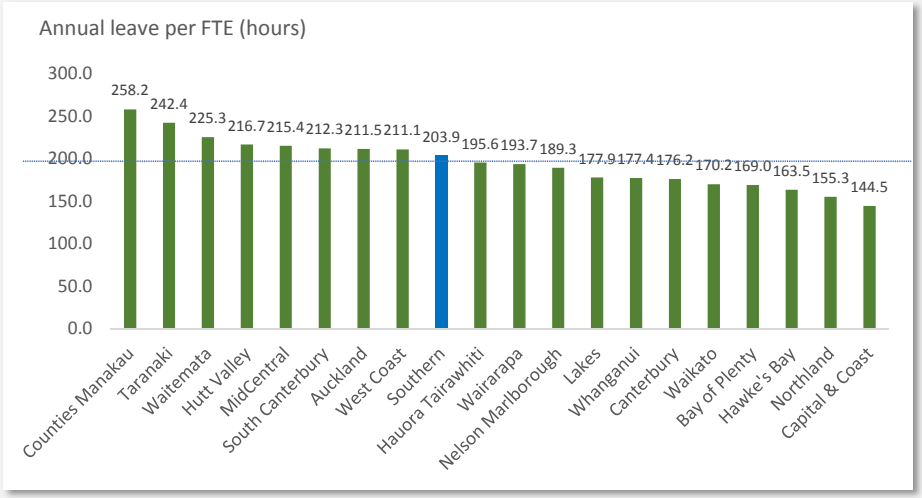


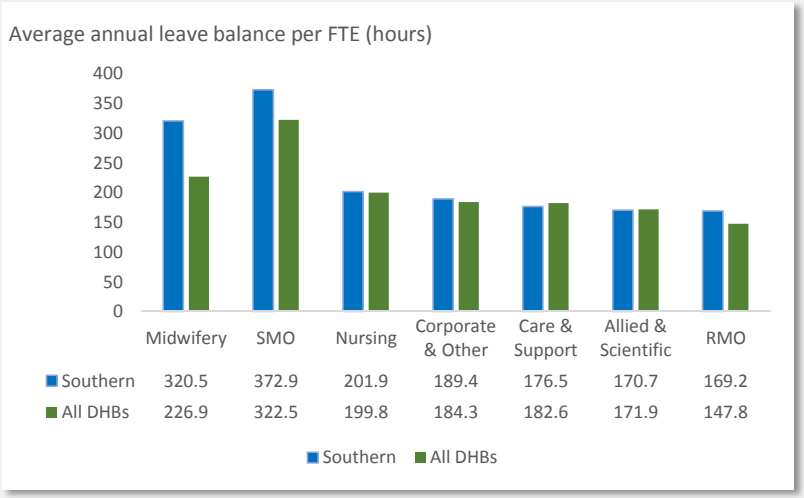


ANNUAL LEAVE – JUNE 2021

	All DHBs	Southern
Annual Leave balance per FTE	203.9	196.6
Accrued >2years (%)	10.4	**11.1**



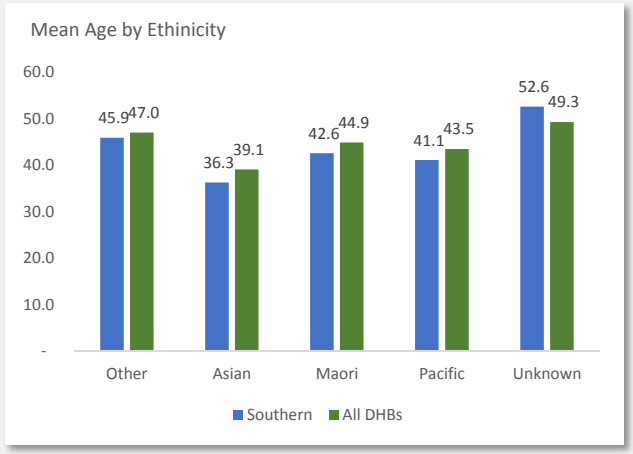


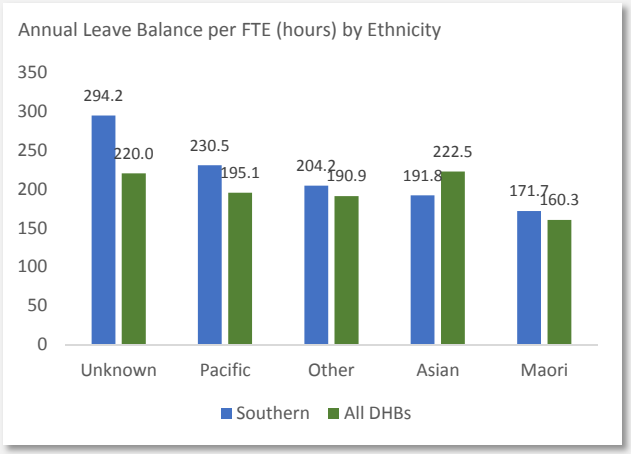


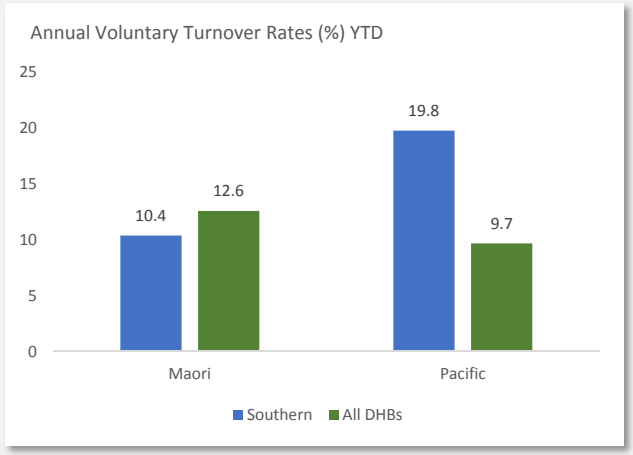
12.2

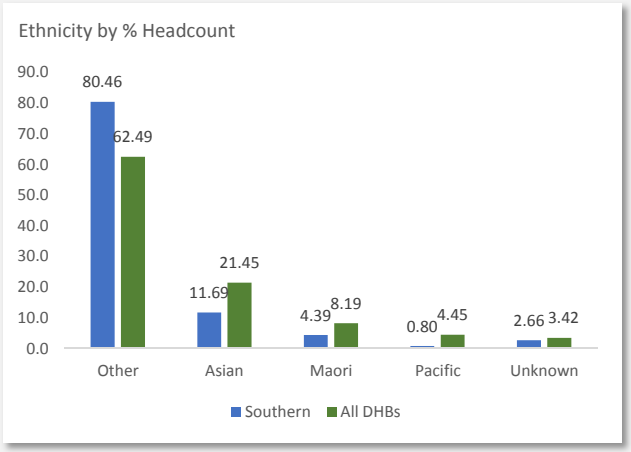
ETHNICITY / DIVERSITY

		All DHBs	Southern
Diversity (% HC)	Māori	8.19	**4.39**
	Pacific	4.45	**0.8**
Age	Māori	44.9	42.6
	Pacific	43.5	41.1
Annual Leave balance per FTE	Māori	160.3	**171.7**
	Pacific	195.1	**230.5**
Average YTD sick leave hours per FTE	Māori	88.5	87.0
	Pacific	95.0	**102.9**
Turnover (YTD %)		10.9	9.4
Māori		12.6	10.4
Pacific		9.7	**19.8**







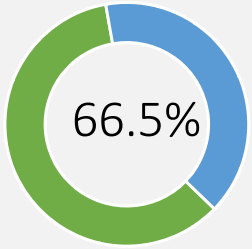


MANDATORY / ESSENTIAL TRAINING

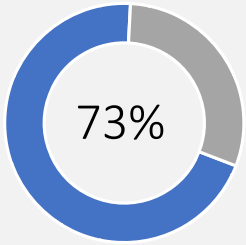
NURSING MANDATORY TRAINING (PDU)

- Māori Directorate Refresher
- Infection Prevention & Control
- Occupational Health & Safety
- Hazardous Substances
- Restraint Minimisation and Safe Practice
- Health & Disability Consumer Rights
- Safe Moving & Handling (Online)
- IV Blood & Blood Products
- Clinical Calculations
- Pressure Injury Prevention
- SDHB Fire Safety
- Immediate life Support Online
- Hand Hygiene
- Safe Moving & Handling Practical

	Dunedin	Southland
Total Compliance	**67%**	**66%**
Total Expired	**14%**	**18%**
Total No Data	**20%**	**16%**



66.5% of Nursing Staff are up to date with their mandatory training requirements



73% of all New Staff have completed mandatory online training and orientation modules

New Staff Mandatory Training July 2021 – September 2021

Non – Clinical Staff Module	# staff completed	# staff not completed
CEO Welcome Message	50	0
Code of Conduct & Integrity	46	4
Electrical Safety	44	6
Fire Safety	44	6
Fraud Awareness	44	6
Health Information and Privacy	44	6
Infection Control	44	6
Occupational Health and Safety	43	7
Smokefree	44	6

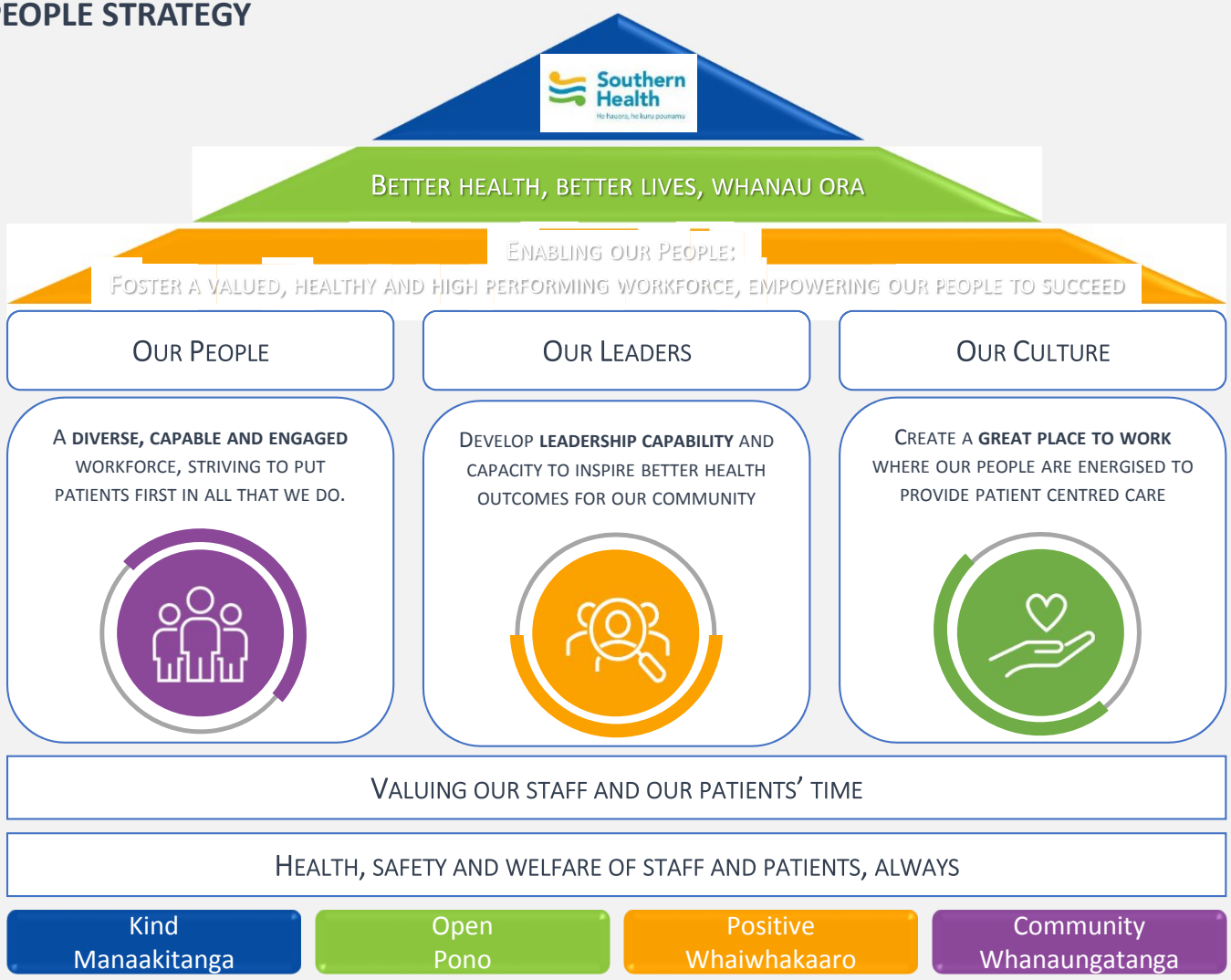
Clinical Staff Module	# staff completed	# staff not completed
CEO Message	108	0
Code of Conduct and Integrity for all Southern DHB Staff members	96	12
Disability Responsiveness	93	15
Reducing Harm from Falls	89	19
Lippincott	88	20
Early Warning Score	89	19
Electrical Safety for Clinical Staff	86	22
Fire Safety - Common modules (2018)	80	28
Fraud Awareness Training	84	24
Health Information and Privacy	81	27
Informed Consent	83	25
Infection Control	83	25
Occupational Health and Safety	82	26
Smokefree	82	26

PEOPLE STRATEGY

> “Tension, striving, and struggling for a WORTHWHILE GOAL are positive; trying to close the gap between what one is and what one should become.”
>
> - Viktor Frankl

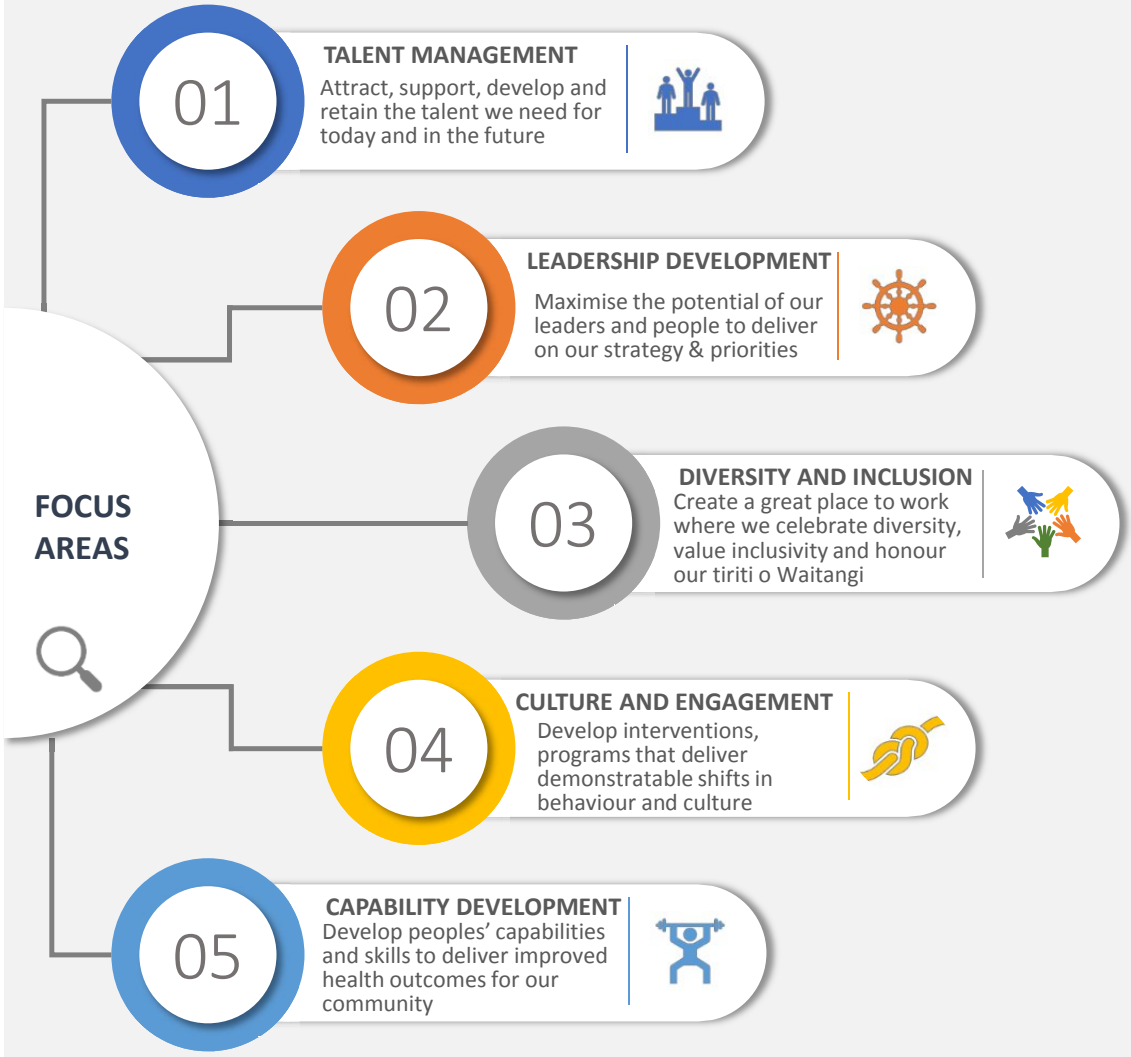
without vision, the people perish

A VISION FOR OUR PEOPLE STRATEGY



12.2

PEOPLE STRATEGY – FOCUS AREAS



2021/22	2022/23	Definition of Success
• Expand Workforce and Service Planning • Improve systems and processes • Talent Sourcing Plan for NDH • Identify Scarce and Critical skills and risk mitigation strategies • Focus on diversity in recruitment	• Align budget cycle with Workforce and Service Plans • Implement new HCM • Refine Workforce plan for NDH • Effective retention strategies for each workforce group/location	• Well executed workforce plan • Position management enables effective budgeting and workforce planning • Improved retention and attraction in all workforce groups
• *Ensure Leadership Development Program for all Leadership layers are fit for purpose* • *Establish Leadership Framework*	• *Align Leadership Development with Health NZ* • *Continue to focus on first line and middle managers development.*	• *Leaders perform appropriate tasks and responsibilities for their leadership layer* • *Capable and empowered leaders who lead engaged teams.*
• Give effect to the Workwell Plan – Aukaha Kia Kaha • Support Disability Strategy Establishing essential practices for Rainbow Tick • Support Māori Staff Experiences Survey • Pro-equity recruitment pilot in Allied Health focus on Māori.	• Implement Pro-Equity Recruitment across all areas • Align with Health NZ Disability Charter • Progress with Rainbow Tick if aligned with overarching strategy • Continue to build Māori and Pacific People representation.	• We leverage diverse backgrounds, experiences and perspectives to underpin our people strategy and to create a Great Place to Work. • Our workforce is representative of our population/communities
• *Refresh Speak Up* • *Establish recognition and retention frameworks, processes and policies/systems* • *Focus on shared values and values based leadership*	• *Give effect to Health NZ Health Charter* • *Support transformation and transition to Health NZ* • *Focus on wellbeing – appointment of Welfare Advisor*	• *A stable and resilient workforce* • *Well integrated into Health NZ* • *Clear vision and purpose established for all staff.*
• Define Functional and core competencies for workforce groups • Identify scarce skills • Change Cycle program to support response to change.	• Establish career programmes aligned with competency and core frameworks by workforce group.	• Workforce that works at top of scope • Learning and agile mindset. • Fit for purpose training programs that support the engagement and retention of staff

PEOPLE & CAPABILITY JOURNEY

FOR INFORMATION

Item: **Patient Flow Update Report October 2021**

Proposed by: Patient Flow Taskforce

Meeting of: Board, 2 November 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

As well as the 6 workstreams that are being monitored by the Patient flow taskforce there is also additional initiatives that are progressing in support of the SAFER bundle.

Next Steps & Actions

- Progress the discharge documentation pilot
- Further refinement and next round of patient surveys.

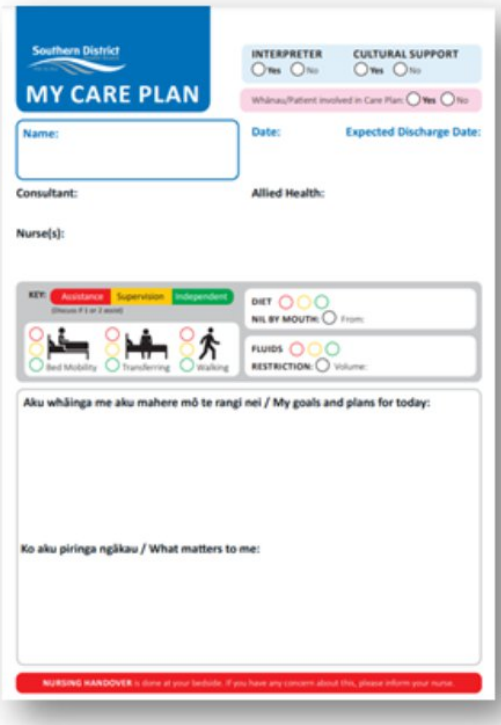
Appendices

1. Patient Flow Taskforce Progress Update

PATIENT FLOW IMPROVEMENT PROGRAMME

Activity over the past few weeks has still been constrained due to COVID endemic planning however the following activity has taken place:

The adult My Care Plan Board at the patient bedside has been revamped based on feedback from staff and patients.
They have been simplified making them easier to read and with more room to write. They serve the purpose to identify key patient safety concerns to enable staff to maintain safe care and are updated at each shift changeover or when indicated.
The bottom half of the page is for patients to add notes and information with headings in Te Reo and English.



Patient Experience Survey

As part of implementing the SAFER bundle to improve patient flow and measuring various quantitative metrics, it is important that we understand how we're doing from a qualitative perspective to improve the patient experience of care. There are four questions that have been identified internationally as part of the SAFER patient flow improvement work that every patient should know the answer to:

1. **What is wrong with me?** People need to know what is wrong with them but equally they need to understand that this may take some time to discover
2. **What is going to happen today?** It's important that patients know what their plan of care is and that decisions are made **with** the patient and whānau.
3. **What is needed to get me home?** Often this can be a barrier to timely and safe discharge – e.g., organising home or community-based care or help required, equipment, transport, prescriptions, discharge information and follow up care etc.
4. **When am I going home?** It's vital that the expected date of discharge is discussed with patients and whanau so that preparations can be made such as transport, home support arrangements etc.

To assess how we're doing from a patient perspective; we have developed a patient experience survey. We know that by asking for feedback we can improve our care, communication, systems, and processes based on what people tell us. On Monday 18 October members of the Community Health Council worked with the Patient Flow taskforce to undertake the first test survey on Ward 8Med. After some refinement, the survey will be repeated in several wards and results presented in December. We want to get feedback from patients who are soon to go home to see if there is room to improve our communication around this. The short survey takes no more than 2-3 minutes to complete, is entirely optional, results are anonymous and will be used to improve the experience for patients admitted in the future.

Further the taskforce joined the start of a rapid round on 8med this week to walk them through the patient flow dashboards. Up until this point the sharing of this has been self-service but we realise that time does not always permit these clinical teams to investigate and familiarise themselves with their own data. Overall, they were curious and engaged in the data and its existence, however the response was initially a little discouraging hearing first-hand the barriers offered up by the team in being able to move any of the metrics themselves. Once we worked through those and listened, there was also some good feedback about what we might like to look further into from a data perspective. We have identified a couple of really engaged doctors in that group who we are planning on talking too 1:1 to gain further buy-in.

Regarding the workstreams/projects previously identified:

ED Processes – Bed request to bed access & Parallel Processes: Work is progressing, and the team are working through the process changes currently. As the work is in its early stages a more detailed update with evaluative information will be provided later.

Model of care review for the MAU: The Internal Medicine team with the support of Cathy Orr project manager and an inter professional team have started conversations about model of care for MAU.

The first meeting of the group focused on mapping the current and future states and looking at the ideal patient flow. The next meeting will focus more on allied health engagement.

AT&R beds in Southland being commissioned: Conversations are continuing with SIT around staffing the additional beds utilising several nursing students that would come on board in February. This needs to be considered alongside the need for evening and night shift staffing with student holiday periods also needing to be covered. This is an initiative solution to challenges in staffing but will also facilitate high quality care. It is hoped other professional groups will enable several student placements to occur on this ward throughout the year enabling opportunities for interprofessional practice.

Discharge documentation project: The NMDHB example was on the agenda at the Clinical Leaders meeting scheduled this week with the intention of gaining buy-in for a pilot working group.

Set up of an Integrated Ops centre: Still in information gathering stages and awaiting the finalised re-structure occurring in Specialist Services before this initiative gets projectized.

Current Metrics **Spotlight on 8Med as well as all.*

Fig 1. Dunedin – Bed Request to admission time

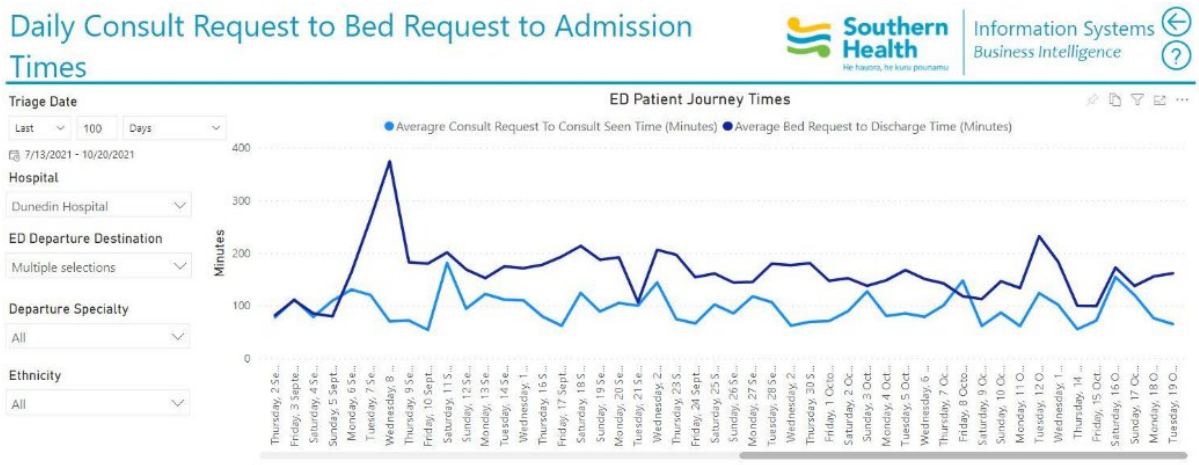


Fig. 1a Dunedin – Bed Request to admission time to 8Med

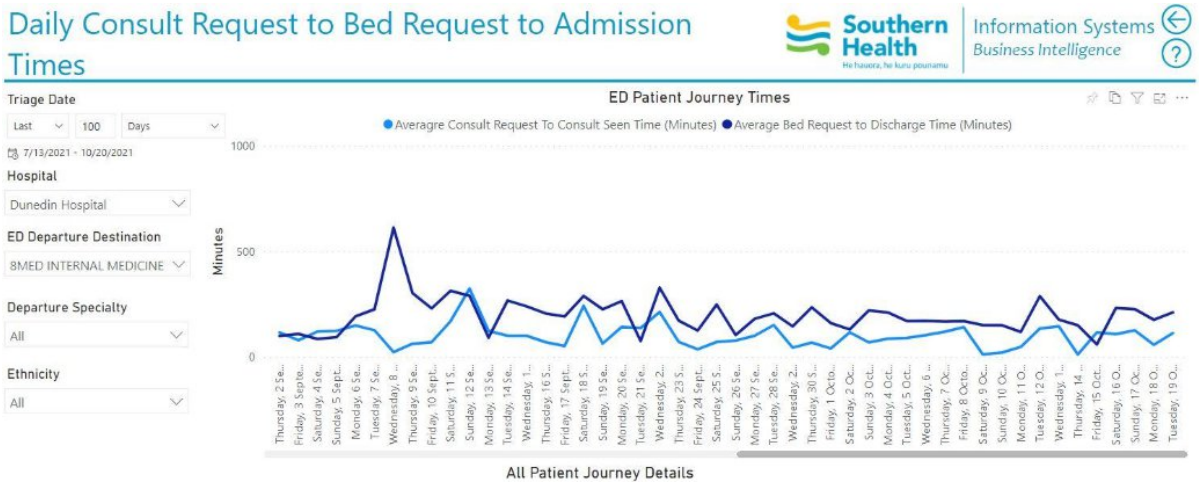


Fig. 2 Southland – Bed Request to admission time

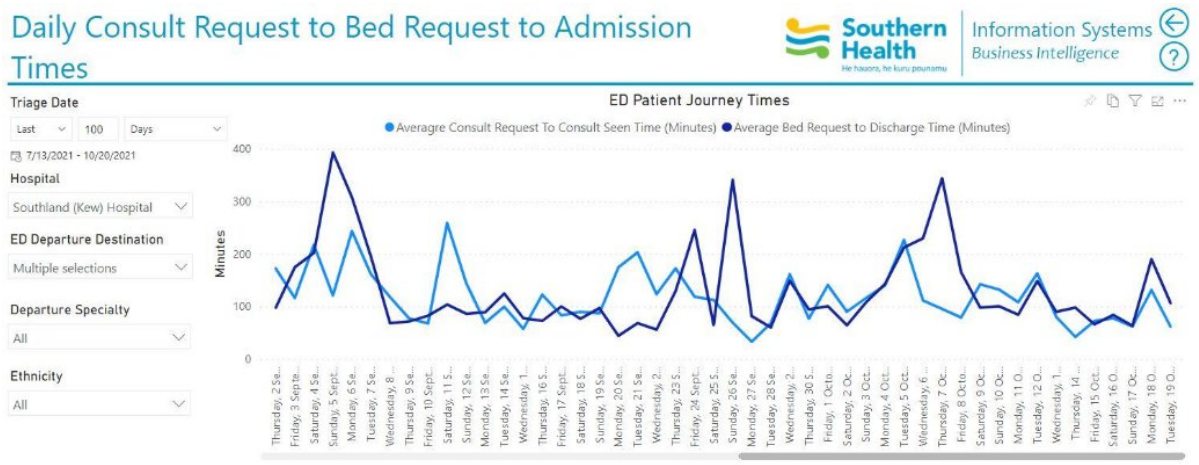


Fig. 3 Dunedin – Discharges before Noon

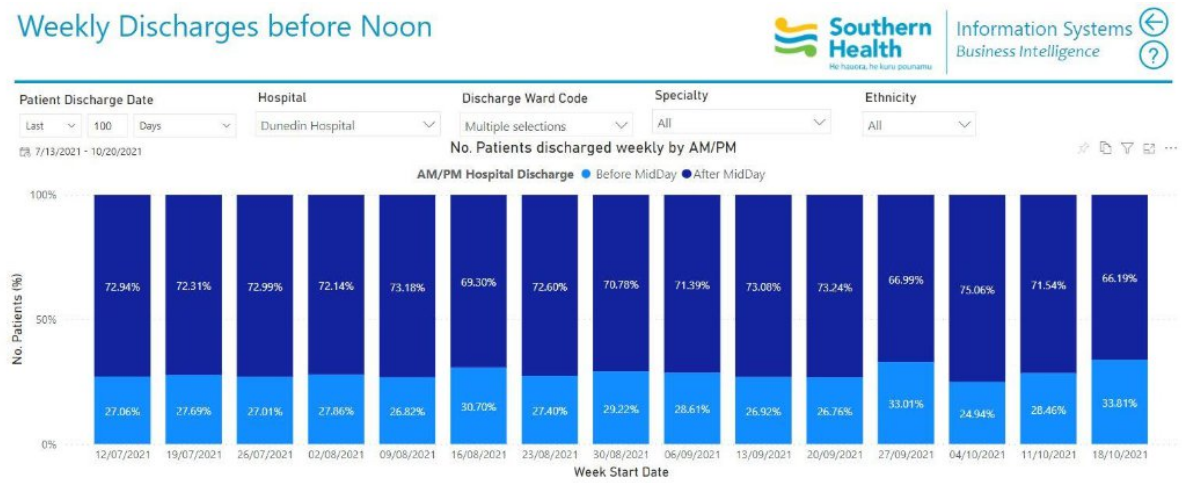


Fig. 3a Dunedin – Discharges before noon 8MED

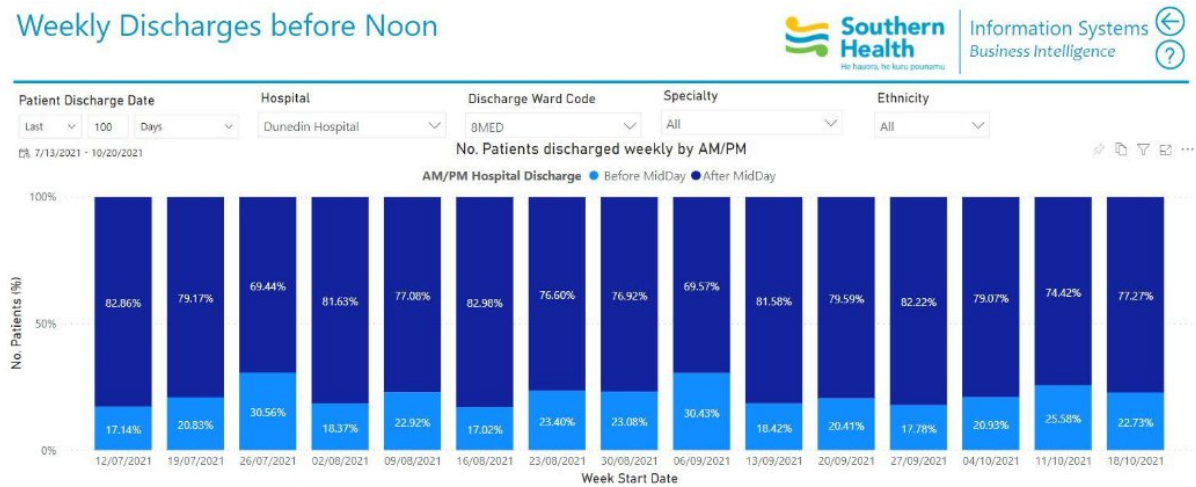


Fig. 4 Southland – Discharges before Noon

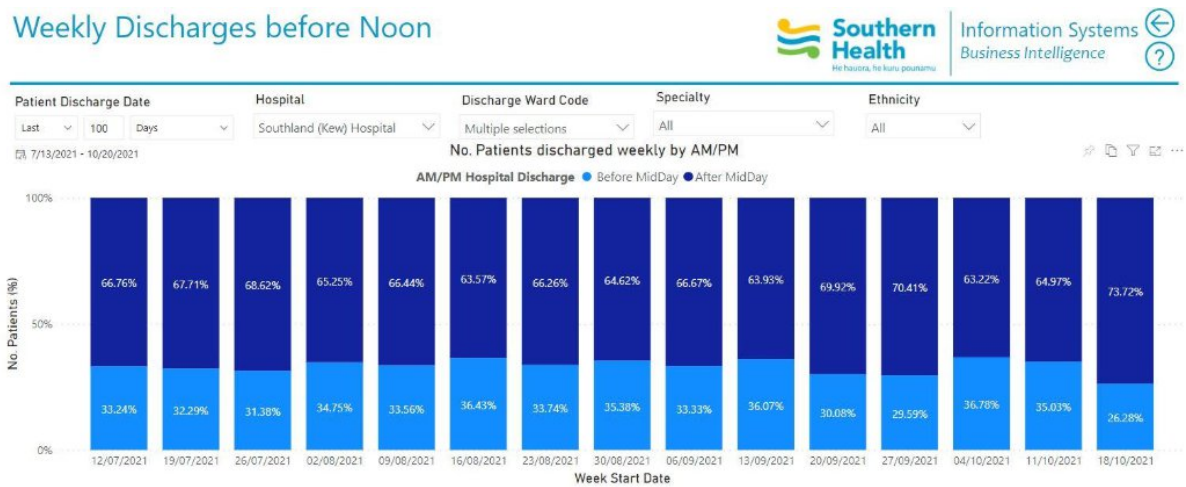


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Fig 5. Dunedin – Did not wait

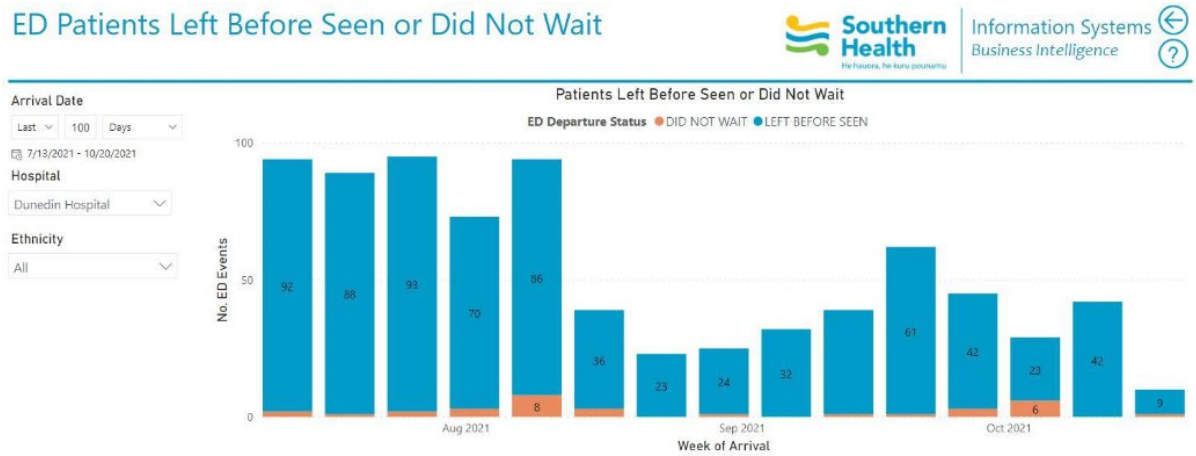

Fig. 6 Southland – Did not wait

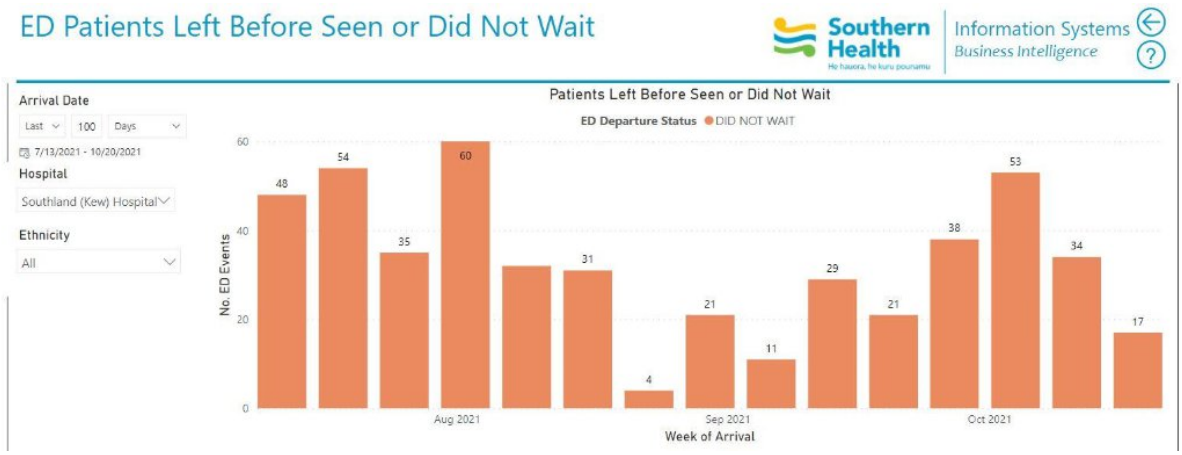

Fig. 7 Dunedin – Weekend vs weekday discharges

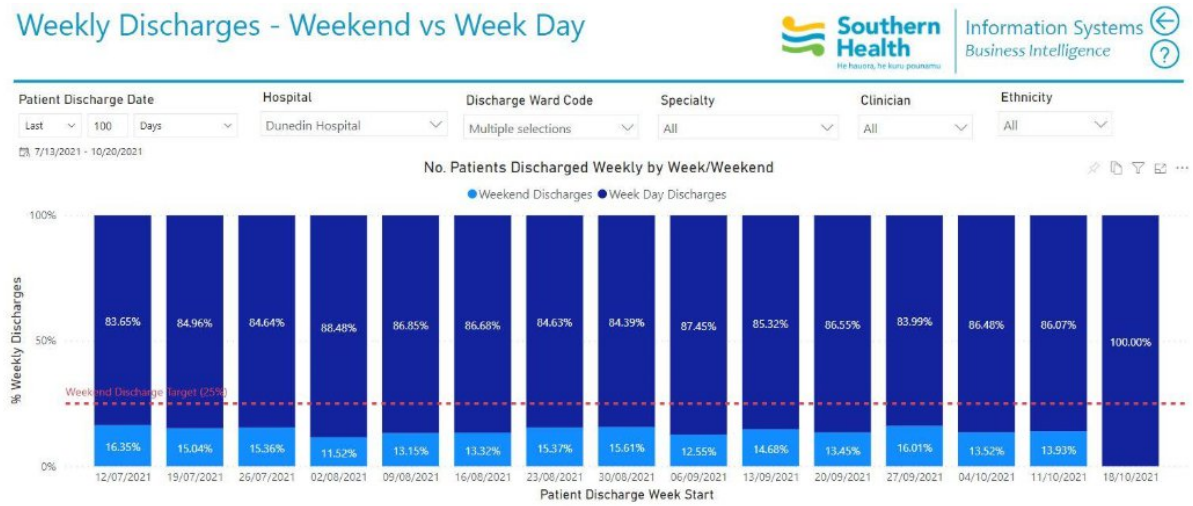

Fig. 7a Dunedin – Weekend vs weekday discharges 8MED

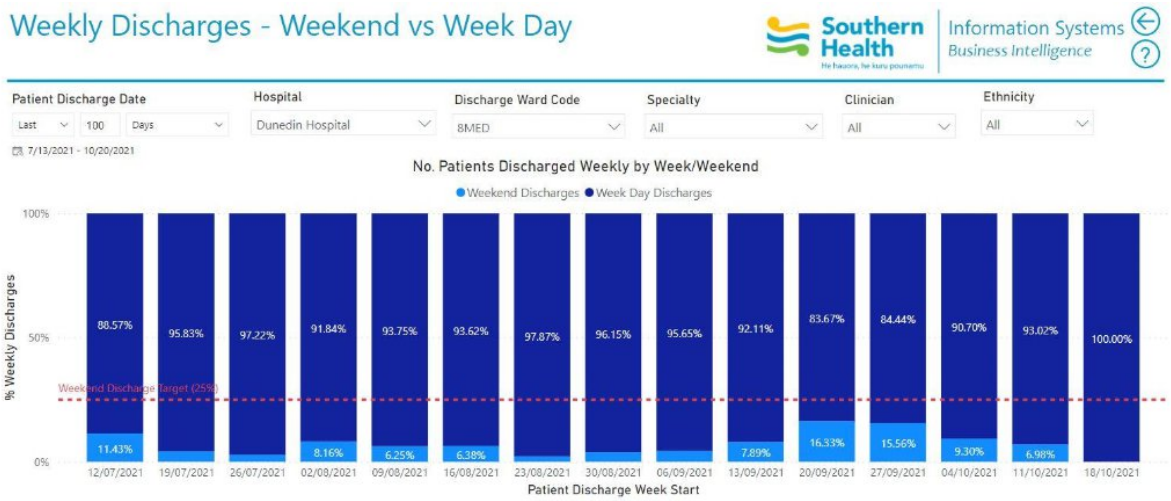

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Fig. 8 Southland – Weekend vs weekday discharges

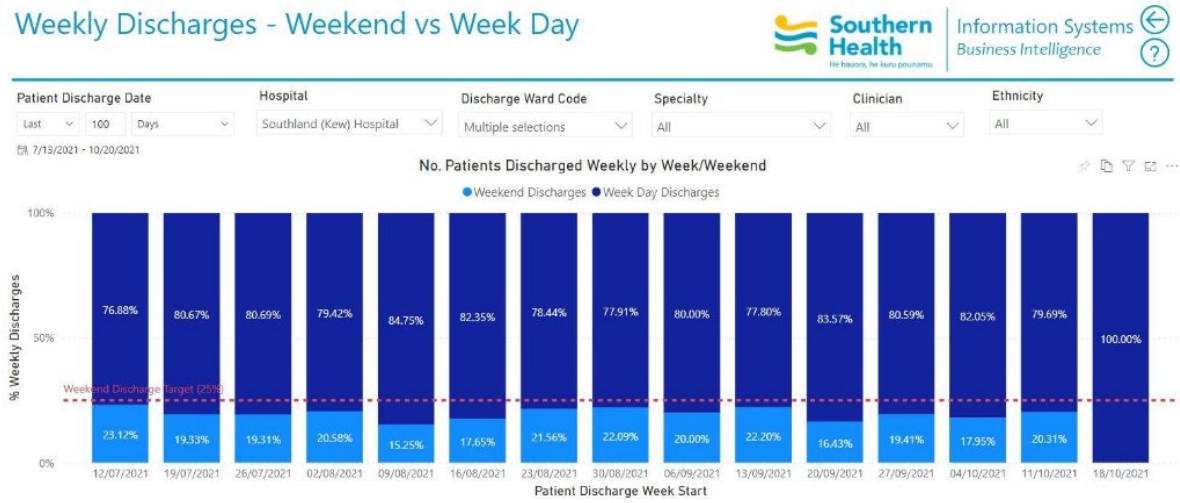


Fig. 9 Dunedin – LOS >21 Days

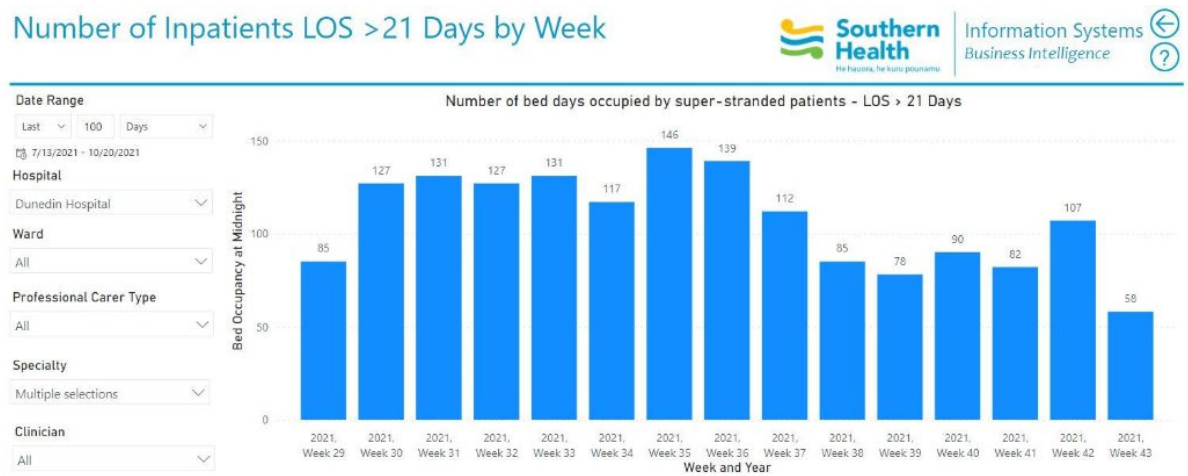


Fig. 9a Dunedin – LOS >21 Days 8MED

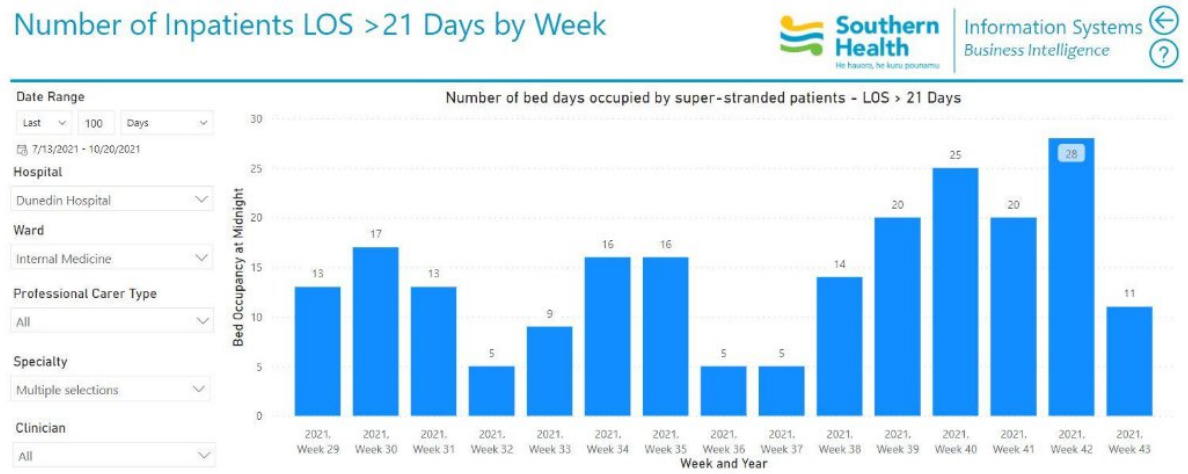
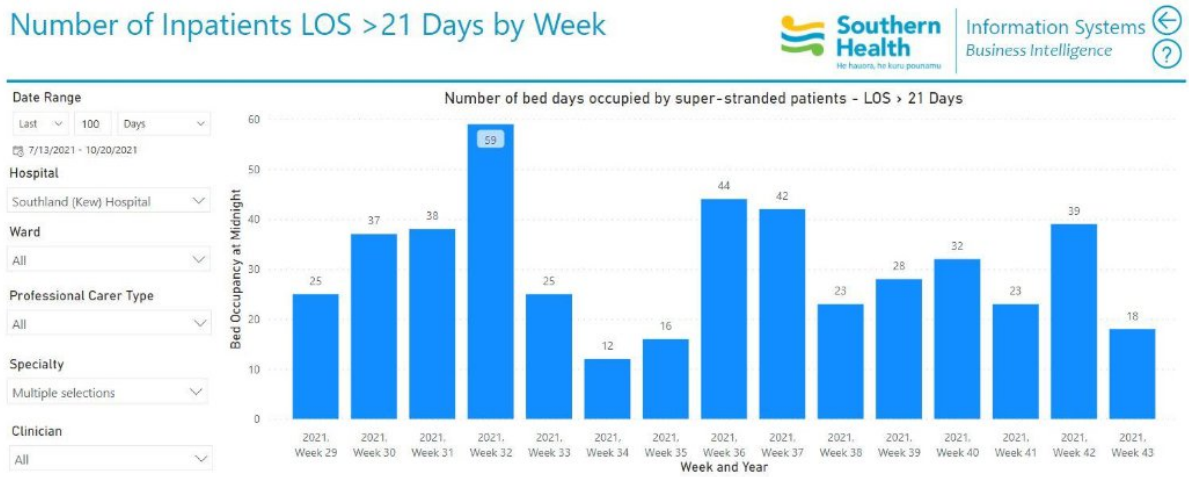


Fig. 10 Southland – LOS >21 Days



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 ▪ Unconfirmed minutes of 4 October 2021 meeting b) Hospital Advisory Committee Meeting ▪ Verbal report of 1 November 2021 meeting c) Finance, Audit & Risk Committee ▪ Verbal report of 1 November 2021 meeting d) Iwi Governance Committee ▪ Unconfirmed minutes 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 Briefing	To allow activities and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(i) of the Official Information Act.
Review of Māori Health Provider Contracts	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.
Capex Approvals ▪ Digital Business Case ▪ Neurosurgery Microscope ▪ COVID – Facility Upgrade	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
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.