# Southern DHB Board Meeting

By Zoom

02/03/2022 09:30 AM - 12:30 PM

| | | | |
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| 9. | Strategic Change Programme | CEO | 158 |
| 10. | Care Capacity Demand Management (CCDM) | CN&MO | 174 |
| 11. | Māori Health Actions to Address Amenable Mortality and Conditions (Verbal Update) | CMHS&IO | |
| 12. | Presentations: | | 178 |
| | 12.1 Midwifery | 11.00 am Karen Ferraccioli | |
| | 12.2 Clinical Council | 11.20 am David Gow | 178 |
| | 12.3 Patient Flow Taskforce | 11.40 am Patient Flow Taskforce | 194 |
| 13. | Late Papers | | 202 |
| | 13.1 Southland Clinical Needs Analysis | CEO/COO | 202 |
| 14. | Resolution to Exclude the Public | | 207 |

**APOLOGIES**

An apology has been received from Amy Adams, Board Member, Interim Health NZ.

**FOR INFORMATION/NOTING**

**Item:** **Interests Registers**

**Proposed by:** Jeanette Kloosterman, Board Secretary

**Meeting of:** Board, 2 March 2022

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## Recommendation

**That the Board receive and note the Interests Registers.**

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## Purpose

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

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## Changes to Interests Registers since the last Board meeting:

- Tuari Potiki – Re-elected permanent Chair of the Drug Foundation, Chair of the Needle Exchange Services Trust (NEST) and Board member, Mental Health and Wellbeing Commission, added
- Chris Fleming – Helix Enterprises Ltd added

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## 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).

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## 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)~~ | Removed 09.12.2021 | |
| | 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 | | |
| | 02.11.2021 | Wife, Alison Douglass, Barrister | Has had involvement with SDHB when representing patients. | |
| | 25.06.2021 | Director and Shareholder, Kiwood Limited | Nil (farm forestry plot). | |
| | 09.12.2021 | Member, Transition Unit's Funding Flows and Incentives Expert Panel (appointed December 2021) | | |
| | 09.12.2021 | Member: Transition Unit's Primary and Community Expert Panel (appointed October 2021) | | |
| | 09.12.2021 | Member: Transition Unit's Review of the Primary Care Capitation Formula Expert Panel (appointed October 2021) | | |
| **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 Updated 04.12.2021 | ~~Employed as Specialist, Radiation Oncology~~, Locum SMO, Southern DHB | 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~~ | Updated 29/10/2021 | |
| | 25.06.2021 | ~~Trustee, New Zealand Brain Tumour Trust~~ | Updated 29/10/2021 (Resigned as Trustee) | |
| | 04.12.2021 | Trustee, Healthcare Otago Charitable 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. | |

**SOUTHERN DISTRICT HEALTH BOARD**
**INTERESTS REGISTER**

| Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB | Management Approach |
|---|---|---|---|---|
| **Tuari Potiki** | 09.12.2019 | Employee, University of Otago | | |
| | 09.12.2019 | Chair, Te Rūnaka Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd) | Nil, does not contract in health. | Updated to include A3 Kaitiaki Limited on 19 October 2020. |
| | 09.12.2019 | Member, Independent Whānau Ora Reference Group | | |
| | 09.123.2019 | *Shareholder in Te Kaika | | |
| | 24.06.2021 | Te Rau Ora Directorship | | |
| | 24.06.2021 | Needle Exchange Services Trust (NEST) member | | |
| | 28.08.2021 (Updated 23.02.2022) | Chair, NZ Drug Foundation | | |
| | 23.02.2022 | Chair, Needle Exchange Services Trust (NEST) | | |
| | 23.02.2022 | Board Member, Mental Health and Wellbeing Commission | | |
| **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 | Employment: Associate Professor, University of Otago | Updated 08.12.2021 | |
| | 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)~~ | Removed 08.12.2021 | |
| | 17.08.2020 | Health Research Council Fellow | | |
| | 14.01.2022 | Sister-in-law, Charge Nurse Manager, Wakari, SDHB | | |
| **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 | | |

**SOUTHERN DISTRICT HEALTH BOARD**
**INTERESTS REGISTER**

| Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB | Management Approach |
|---|---|---|---|---|
| | 21.01.2020 | Member, NZ Association of General Surgeons | | |
| | 21.01.2020 | Member, ASMS | | |
| | 05.05.2020 | Member, Ministry of Health's Planned Care Advisory Group | Will be monitoring planned care recovery programmes. | |
| | 06.05.2020 | Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB | | |
| **Roger Jarrold** (Crown Monitor) | 16.01.2020 (Updated 28.01.2021) | Advisor to Fletcher Construction Company Limited | Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade. | |
| | 16.01.2020 (Updated 28.01.2021) | Chair, Audit and Risk Committee, Health Research Council | | |
| | 16.01.2020 | Trustee, Auckland District Health Board A+ Charitable Trust | | |
| | 16.01.2020 | Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board | | |
| | 23.01.2020 | Nephew - Partner, Deloitte, Christchurch | | |
| | 16.08.2020 | Son - Auditor, PwC, Auckland | PwC periodically undertake work for SDHB, eg valuations | |
| | 05.04.2021 | Financial Advisor, DHB Performance, Ministry of Health | | |
| | 18.06.2021 | Treasury: Health Reform Challenge Panel | | |
| | 26.08.2021 | Advisor to Health Transition Unit on Finance/Procurement | | |
| **Benjamin Pearson** (Crown Monitor) | 21.07.2021 | Consultant Paediatrician, South Canterbury DHB | | |
| | 13.01.2022 | Chief Medical Officer, 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 | |
| **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 Māori 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 |
| | 26.10.2017 | Nephew, Tax Advisor, Treasury | |

**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 |
|---|---|---|---|
| | 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) |
| | 19.02.2022 | Helix Enterprises Limited (Director and Shareholder) | Nil. Family owned investment entity. |
| **John EASTWOOD** | 19.01.2022 | Clinical Director Localities, Interim Health New Zealand | Conflict with matters related to establishment of Localities. Possible conflict with matters related to the Health Reforms and the establishment of Māori Health Authority and Health New Zealand |
| | 19.01.2022 | Clinical Professor Department of Preventative and Social Medicine, University of Otago | Conflict with matters related to Department of Preventative and Social Medicine, and possible conflict with matters related to the three UoO Clinical Schools and the University of Otago |
| | 19.01.2022 | Adjunct Professor University of New South Wales | Nil |
| | 19.01.2022 | Clinical Professor University of Sydney, Sydney, Australia | Nil |
| | 19.01.2022 | Executive Clinical Advisor Sydney Local Health District, Sydney, Australia | Nil |
| | 19.01.2022 | Director Early Years Research Group, Ingham Institute of Applied Medical Science, Liverpool, New South Wales, Australia | Nil |
| | 19.01.2022 | Director of Centre of Research Excellence for Health and Social Care Integration, Sydney, Australia | Nil |
| | 19.01.2022 | Co-Chair Sydney Institute for Women Children and their Families, Sydney Local Health District | Nil |
| | 19.01.2022 | Co-Chair International Foundation of Integrated Care - Australia | Nil |
| | 19.01.2022 | Co-Chair International Foundation of Integrated Care - Aotearoa Steering Committee | Nil |
| | 19.01.2022 | Member Royal Australasian College of Physicians Policy and Advocacy Committee (CPAC) | Nil |
| | 19.01.2022 | Executive Member of the International Society of Social Paediatrics and Child Health (ISSOP) | Nil |
| | 19.01.2022 | Consultant to the World Health Organization, Geneva | Nil |
| | 19.01.2022 | Fellow of the New Zealand College of Public Health Medicine | 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 |
|---|---|---|---|
| | 19.01.2022 | Fellow of the Australasian Faculty of Public Health Medicine | Nil |
| | 19.01.2022 | Fellow of the Royal Australasian College of Physicians | Nil |
| | 19.01.2022 | Fellow of the Royal Australasian College of Medical Administrators | Nil |
| | 19.01.2022 | Fellow and Certified Health Executive of the Australasian College of Health Services Managers | Nil |
| | 19.01.2022 | Wife - General Practitioner at Mosgiel Health Centre, Mosgiel | Possible conflict with any SDHB contract negotiations with the General Practice |
| | 19.01.2022 | Wife - Contracted medical educator for the Royal New Zealand College of General Practice | Nil |
| | 19.01.2022 | Member of the Medical Assurance Society (MAS) | Nil |
| **David GOW** | 07.12.2021 | Private Clinic, Mercy Hospital | |
| | 07.12.2021 | Wife employed by SDHB as Nurse Consultant for Quality Improvement | |
| **Andrew LESPERANCE** | 20.12.2021 | Son, employee, HR Department, Ministry of Health (working with IT team recruitment) | |
| | 20.12.2021 | Director, Secretan Family Trust | |
| | 20.12.2021 | Former Director, North Island PHO (resigned when appointed to SDHB) | |
| | 20.12.2021 | Daughter, Project Co-ordinator, Ministry of Education | |
| | 20.12.2021 | Son, student, University of Otago (accounting major) | |
| **Hywel LLOYD** | 16.06.2021 | GP, Mosgiel Health Centre | |
| | 16.0.2021 | Wife, Nurse, Paediatric Outpatients | |
| **Patrick NG** | 17.11.2017 | Member, SI IS SLA | Nil |
| | 27.01.2021 | Daughter, is a junior doctor in Auckland and is involved in orthopaedic and general surgery research and occasionally publishes papers | |
| | 23.07.2020 | Wife, Chief Data Architect, Inde Technology | 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. |

**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 |
|---|---|---|---|
| | 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 Māori illicit drug use to primary care and in Māori 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 |

# Minutes of the Southern District Health Board Meeting

## Wednesday, 2 February 2022, 9.30 am
## By Zoom

| | | |
|---|---|---|
| **Present:** | Mr Pete Hodgson | Chair |
| | Prof Peter Crampton | Deputy Chair |
| | Dr John Chambers | |
| | Mrs Kaye Crowther | |
| | Dr Lyndell Kelly | |
| | Mr Terry King | |
| | Mrs Jean O'Callaghan | |
| | Mr Tuari Potiki | |
| | Miss Lesley Soper | |
| | A/Prof Moana Theodore | |
| **In Attendance:** | Mr Roger Jarrold | Crown Monitor |
| | Dr Ben Pearson | Crown Monitor |
| | Mr Chris Fleming | Chief Executive Officer |
| | Ms Tanya Basel | Executive Director People and Culture |
| | Mr Hamish Brown | Acting Chief Operating Officer |
| | Ms Kaye Cheetham | Chief Allied Health, Scientific and Technical Officer |
| | Prof John Eastwood | Chief Medical Officer |
| | Dr David Gow | Chair, Clinical Council |
| | Mr Andrew Lesperance | Executive Director Planning, Funding and Population/Public Health |
| | Dr Hywel Lloyd | Director Quality and Clinical Governance Solutions |
| | 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 WELCOME AND KARAKIA

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

### 2.0 APOLOGIES

The Chair informed the meeting that a standing invitation had been extended to Prof Sue Crengle and Ms Fiona Pimm, members of the interim Māori Health Authority, and Ms Amy Adams, member of Interim Health NZ Board, to attend Board meetings until the end of the Board's term but they were unable to attend the February meeting.

Apologies for intermittent departures from the meeting to attend to other urgent business were received from Mr Tuari Potiki and members of the Executive Leadership Team.

## 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 December 2021 be approved and adopted as a true and correct record."**

M Theodore/J O'Callaghan

## 5.0 ACTION SHEET

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

- *Southland Site Planning* – An update would be provided at the next meeting, following the General Manager (GM) of Southland Hospital's return from leave.

  The Board requested that in the interim the GM Southland be asked to give Southland Board members an update.

- *District Head of Department (HoD) for Intensive Care* – The Intensive Care Unit (ICU) teams on both sites were working together and an offer for a district HoD was being progressed. The Clinical Director had identified that wider support was required from the nursing team to fully achieve the changes needed to strengthen ICU and HDU across the district.

  A digital solution capex had been allocated to the project and a group formed to collate the items.

- *Gynaecology Waiting List and Surgical Thresholds* – It was noted that this action had been transferred to the Hospital Advisory Committee.

- *Midwifery* – It was agreed that this issue should continue to be reported to Board.

- *Productivity* – This required further analysis (systems and numerical) and would be a standing item for the next two Hospital Advisory Committee meetings.

## 6.0 ADVISORY COMMITTEE REPORTS

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

The unconfirmed minutes of the Community and Public Health Advisory Committee (CPHAC) meeting held on 6 December 2021 (tab 6.1) were taken as read.

**Managing COVID-19 in the Community**

In response to a member's question, the Director of Quality and Clinical Governance Solutions reported that WellSouth had procured 600 pulse oximeters at the

beginning of the COVID outbreak and SDHB also had distribution chains for Ministry supplies of pulse oximeters into the community if WellSouth's supply was exceeded.

**Disability Support Advisory Committee**

The unconfirmed minutes of the Disability Support Advisory Committee (DSAC) meeting held on 6 December 2021 were taken as read (tab 6.2) and A/Prof Moana Theodore, DSAC Chair, thanked staff, Disability Working Group and Board Members for continuing to support the implementation of the Disability Strategy.

**Hospital Advisory Committee**

The Board received a verbal report from Mrs Jean O'Callaghan, Chair of the Hospital Advisory Committee (HAC), on the HAC meeting held on 1 February 2022, during which she advised the Committee:

- Was updated on discussions around the centralisation of RMO rosters and management;
- Received an update on the steps taken to address Southland Hospital gynaecology waiting times, noting that the recovery timeframe would be a minimum of 12 months;
- Received an excellent presentation on ED performance and discussed possible solutions, including a whole of system approach, preventing admissions, and pathways for discharge. A need for more resources was identified to improve productivity throughout the system.
- Ophthalmology issues were considered during a presentation from staff and the Committee would continue a watching brief on these.
- The Acting Chief Operating Officer (COO) presented an update on key activities and issues, and the financial position.

Mrs O'Callaghan commented that, while there was much to be done, it was pleasing to see progress in a number of areas.

In response to a question raised at the HAC meeting, the Acting COO reported that the team were working with a candidate for one of the Neurosurgeon vacancies, whose registration was being worked through with the Medical Council. Their start would be delayed by the arrival process into New Zealand, then orientating with the team in Christchurch.

## 7.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 7) was taken as read and the CEO commented on the following items.

**COVID-19 Endemic Planning**

The update on COVID-19 planning activity was taken as read and the CEO advised that his assessment of Southern DHB's readiness for a COVID outbreak in the district would only ever be a nervous confidence due to the potential scale and impact of an outbreak.

**Top Risks**

Overloading of the health system due to the emergence of a COVID endemic had been added to the top six risks facing Southern DHB.

**Southern Orthopaedic Outpatient Programme**

The Chief Allied Health, Scientific and Technical Officer (CAHS&TO) was pleased to report that the Southern Orthopaedic Outpatient Programme had commenced the previous week. The programme was a six month pilot to rehabilitate people in the community with knee and/or shoulder conditions and was a public/private partnership.

**Primary Maternity Unit Business Case – Central Otago/Wanaka**

The CEO reported that $7million had been approved for primary maternity units to be built on the land occupied by Central Otago Health Services Ltd (COHSL) and land to be acquired in Wanaka. A request for proposal (RfP) for the design of the facilities was under way.

**Care Capacity Demand Management (CCDM)**

An external evaluation of Southern DHB's CCDM efforts had assessed the process as being fully implemented. The CEO noted that this did not mean all the safe staffing requirements had been met and there were still some negative shift variances.

The CEO had asked the Chief Nursing and Midwifery Officer (CN&MO), Chief Medical Officer (CMO) and Executive Director Corporate Services (EDCS) to provide him and the Board with their collective assurance that Southern DHB was doing the right thing regarding CCDM in terms of their stewardship responsibility to ensure the appropriate use of resources.

The CN&MO reported that:

- 92 of the 96 requests for recruitment (RfRs) had been processed and 61 positions offered, with the majority of those starting that week as part of the new graduate programme.
- 103 new graduates were starting across the Southern Health system – 82 DHB employed and 21 in the community or aged residential care. 61 of the new graduates would be working on the Otago site and 21 on the Southland site, which was SDHB's largest ever recruitment of new nursing graduates.
- 60 Health Care Assistants had been appointed since October 2021.

During discussion, management responded to questions on long COVID, the hospitals' preparedness for the long Waitangi weekend, leadership team changes, the Orthopaedic Outpatient Programme and its impact on the First Specialist Appointment (FSA) waiting list, and Māori primary care enrolment.

**Omicron Update**

The Director of Quality and Clinical Governance Solutions presented an update on Omicron (tab 7). This included a high level summary of its characteristics, the expected new cases and hospitalisations per month in Southern DHB, and the implications of that for the health system. Management then responded to questions on community and inter-agency support, rapid antigen testing, paediatric vaccination rollout, and the role of connectors.

The Board extended its congratulations and best wishes to all those who had been involved in COVID endemic preparations.

## 8.0 FINANCE AND PERFORMANCE

### Financial Report

The Financial Report for the period ended 31 December 2021 (tab 8.1) was taken as read and the Executive Director Corporate Services (EDCS) outlined the main drivers of the result.

The EDCS reported that the year-end forecast deficit had increased by $10m, mainly driven by the increase in the PHARMAC forecast from $106m to $115m, and advised the Executive Leadership Team would be doing all it could to pull the result back to budget.

### Volumes Report

The EDCS presented and responded to questions on the volumes report for December 2021 (tab 8.2).

### Quality Dashboard

The Quality Dashboard (tab 8.3) was taken as read and the Director of Quality and Clinical Governance Solutions (DQ&CGS) informed the Board that:

- Falls and pressure injury reporting was still to be migrated into the new dashboard format. That had been delayed by pressure on the IT team.
- Hospital acquired complications and infections were still stubbornly red. The Clinical Council was looking at addressing this through the new local clinical governance framework.

Management then responded to questions on Health Roundtable data, complaints reporting, and hospital acquired complications and infections.

### Performance

The CEO presented a progress report on the development of the Performance Dashboard (tab 8.4).

### Quarter 1 2021/22 Performance Report

An overview of performance reporting to the Ministry of Health for quarter one 2021/22 (tab 8.5) was noted.

## 9.0 STRATEGIC CHANGE PROGRAMME

The CEO presented an update on the Strategic Change Programme, which included initiatives contributing directly to the new Dunedin Hospital (tab 9), then responded to questions.

## 10.0 MĀORI HEALTH – EQUITY

*Glenda Oben, Data Analyst Equity, joined the meeting for this item.*

An update from the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) on the actions to address the Māori amenable mortality rate (tab 10) was taken as read and the CMHS&IO provided the following updates.

- Expressions of interest for filling the Clinical Nurse Specialist roles were being progressed.
- The CMHS&IO was working with the Executive Director People and Capability (EDP&C) to recruit a Māori Workforce Development Specialist.
- The Māori Clinical Group would be meeting during February.

The CMHS&IO introduced Glenda Oben, Data Analyst Equity, and advised that she was currently working on the Digital Business Case and improving equity data.

Ms Oben outlined her work history, which included 15 years in Health analysis, and the work she was currently undertaking.

## 11.0 PRESENTATIONS

### Nga Kete Matauranga Pounamu Charitable Trust

*Mr King declared his interest as a Nga Kete Matauranga Pounamu Trust Board Member.*

Tracey Wright-Tawha, Tumu Whakarae, Nga Kete Matauranga Pounamu Charitable Trust, was welcomed to the meeting and gave a presentation on Nga Kete's work, in particular its COVID-19 related activity and the Mahana Southern Māori Mental Health and Addiction Services, and Nga Kete's focus for 2022 (tab 13.1).

### Awarua Whānau Services

Amy de Vries, Kaihautū/CEO, Awarua Whānau Services, was welcomed to the meeting and presented an overview of Awarua Whānau Services, its genesis, the range of health and social services it offered (nurse led clinics, Mama and Pepi, Mokopuna Ora, Tamariki Ora, Mauri Ora, Kaiarahi Tinana, Whānau Ora, Whānau Tautoko, counselling, supported bail, Tahuri Atu, youth transitions, and Community Connector), their COVID-19 pandemic support activity, and future plans, which included a men's parenting programme and development of a 1000 days pilot (tab 13.2).

Ms Wright-Tawha and Ms de Vries were thanked for their presentations and congratulated on their work and the support provided by their services.

## 12.0 PATIENT FLOW TASKFORCE

The Board received a verbal update on Patient Flow Taskforce activity from the Chief Allied Health, Scientific and Technical Officer (CAHS&TO), Chief Nursing and Midwifery Officer (CN&MO) and Chief Medical Officer (CMO), during which they reported:

- Two patient flow roles had been created, one each on the Dunedin and Invercargill sites. An appointment had been made to the Dunedin position and the Invercargill role was still being recruited to.

  The clinical chiefs, along with the Chief Operating Officer, would continue to sponsor the patient flow programme but the new roles would progress the operational aspects of it.

- The SAFER Bundle framework was being reinforced.

The CAHS&TO, CN&MO and CMO then gave an update on the Patient Flow Taskforce's workstreams, which included the weekend discharge pilot, 8MED pilot, reviewing the Medical Assessment Unit (MAU) model of care, discharge summaries, and setting up an integrated operations centre.

**PUBLIC EXCLUDED SESSION**

***At 12.17 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:**<br>a) Community and Public Health Advisory Committee<br>▪ Unconfirmed minutes of 6 December 2021 meeting<br>b) Iwi Governance Committee<br>▪ Unconfirmed minutes of 6 December 2021 meeting<br>▪ Verbal report of 31 January 2022 meeting<br>c) Finance, Audit & Risk Committee<br>▪ Verbal report of 1 February 2022 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. |
| **Mental Health Review Update** | To allow activities and negotiations to be carried on without prejudice or disadvantage | Sections 9(2)(i) and 9(2)(j) of the Official Information Act. |
| **Digital Transformation Business Case – Progress Update** | Commercial sensitivity | Sections 9(2)(i) of the Official Information Act. |
| **New Dunedin Hospital**<br>▪ Monthly Update<br>▪ Site Master Planning | 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**<br>▪ Primary Maternity Unit – Wanaka Land | 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**<br>▪ PACT Group<br>▪ 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. |

| *General subject:* | *Reason for passing this resolution:* | *Grounds for passing the resolution:* |
|---|---|---|
| **Budget 2022/23** | Subject to approval. | Sections 9(2)(f) and 9(2)(j) of the Official Information Act |

P Hodgson/L Kelly

The meeting closed with a karakia at 4.40 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

# Southern District Health Board
# BOARD MEETING ACTION SHEET

As at 23 February 2022

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| Feb 2021<br><br><br><br><br>Feb 2022 | **Southland Site Planning**<br>(Minute 9.0)<br><br>(Minute 5.0) | Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed.<br><br>GM Southland to provide Southland Board members with an update following his return from leave. | CEO<br><br>GM Southland | Data extract has been given to Sapere and analysis is in flight. A week long site visit by the Sapere team to Southland took place the week of Nov 29th. Targeted engagement with Clinical leads has also occurred. Project on track.<br><br>Sapere are still undertaking discovery work and engaging with appropriate stakeholders. | |
| March 2021 | **Māori Workforce**<br>(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.<br>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<br>Work is being undertaken to have staff update their personal information including ethnicity in Employee Connect. | March 2022 – In progress<br><br>Completed<br><br>In progress |
| May 2021 | **Quality Dashboard**<br>(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 | | |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| June 2021<br><br><br><br>Dec 2021 | (Minute 6.0)<br><br><br><br>(Minute 9.0) | Completion date to be supplied for adding calibration points.<br><br><br><br>Health Roundtable data to be added to routine reporting to benchmark Southern's performance, including the areas where it performs well. | DQCGS<br><br><br><br>DQCGS | Progress has been delayed due to other IT commitments. New timeline: To be added in March for the April meeting.<br><br><br><br>For HRT data on the quality Dashboard benchmarking will be added in March for the April meeting. | April 2022<br><br><br><br>April 2022 |
| 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.<br><br>Delay in reporting due to Health Order. | ~~December 2021~~ March 2022 |
| November 2021 | **Workforce Dashboard** (Minute 13.0) | ▪ Disability and diversity data by directorate to be included in the workforce dashboard.<br><br>▪ Median and mean figures to be reported. | EDP&C | Both items are WIP; due to the implementation of Health Order and endemic planning this was deprioritised. | March 2022 |
| 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. | |
| Sept 2021 | **Mental Health Review Implementation** (Minute 11.0) | Board to be provided with bi-monthly progress reports. | ED MHAID | | April 2022 |
| Oct 2021 | **ICU** (Minute 7.0) | Appointment of an HoD for ICU across Dunedin and Southland to be progressed. | COO/ CMO | The Clinical Director of ICU (Dunedin) identified that wider support (from nursing) was required to fully engage both units in the changes needed to strengthen the ICU and HDU services across the district. The team are working through this with the aim to | |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| | | | | confirm the staffing and programme of work at the end of the year.<br>Update 18/01/22 - A Professional Practice Facilitator has been appointed to facilitate a district wide approach to critical care as of 23 December 2021. | |
| Nov 2021 | (Minute 5.0) | Check to be made whether a digital solution to enable Intensive Care to operate as a single service was included in the capital plan. | COO | This has a capex that has been allocated within digital. This is part of a project led by the Digital Team. A group has been formed to collate the requirements. | |
| Oct 2021 | **Te Kaika Health and Wellness Hub**<br>(Minute 9.0) | Lease approval to be sought from the Minister. | CMHS&IO<br>CEO | Update provided in CEO Public Excluded report due to commercial sensitivities. | |
| Sept 2021 | **Māori Health – Actions to Address Amenable Mortality and Conditions**<br>(Minute 24.0) | Monthly reports to be submitted to Board. | CMHS&IO | Verbal update will be provided. | Ongoing |
| Dec 2021 | (Minute 16.0) | Suggested that the Māori Health Strategy Group's role include providing support and advice on equity across the organisation (incl. to Quality Directorate, Clinical and Community Health Councils). | CMHS&IO | | |
| Dec 2021 | **Performance and Accountability Framework**<br>(Minute 8.0) | Members to be provided with a high level view of the framework to give an understanding of how performance will be measured. | CEO | Included in agenda papers. | March 2022 |
| Dec 2021 | **Productivity**<br>(Minute 9.0) | Analysis to be submitted to the February Hospital Advisory Committee meeting. | EDCS<br>COO | | April meeting |
| Feb 2022 | (Minute 5.0) | To be a standing HAC agenda item. | | | |

| DATE | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| Feb 2022 | **Midwifery**<br>(Minute 5.0) | Midwifery issue to continue to be reported to Board (instead of CPHAC or HAC). | CN&MO | An update will be presented at the meeting. | |

## COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) MEETING, 1 MARCH 2022

- Verbal report from Tuari Potiki, CPHAC Chair

## DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC) MEETING, 1 MARCH 2022

- Verbal report from A/Prof Moana Theodore, DSAC Chair

# Southern District Health Board

## Minutes of the Hospital Advisory Committee Meeting held on Tuesday, 1 February 2022, commencing at 9.00am via zoom

| | | |
|---|---|---|
| **Present:** | Mrs Jean O'Callaghan | Chair |
| | Dr John Chambers | Committee Member |
| | Hon Pete Hodgson | Board Chair and Committee Member |
| | Dr Lyndell Kelly | Committee Member |
| | Miss Lesley Soper | Committee Member |
| | Assoc Prof Moana Theodore | Committee Member |
| **In Attendance:** | Mr Ben Pearson | Crown Monitor |
| | Mr Peter Crampton | Board Member |
| | Mrs Kaye Crowther | Board Member |
| | Mr Terry King | Board Member |
| | Mr Chris Fleming | Chief Executive Officer |
| | Mr Hamish Brown | Chief Operating Officer |
| | Professor John Eastwood | Chief Medical Officer |
| | Ms Kaye Cheetham | Chief Allied Health Scientific and Technical Officer |
| | Ms Tanya Basel | Executive Director People and Capability |
| | Mrs Jane Wilson | Chief Nursing and Midwifery Officer |
| | Mrs Joanne Fannin | Personal Assistant (Minute taker) |

### 1.0 WELCOME

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting and acknowledged the Chief Operating Officer, Hamish Brown, attending his first Hospital Advisory Committee (HAC) meeting as lead Executive for the Committee. She advised that Dr Justine Camp has resigned from the Committee.

### 2.0 APOLOGIES

An apology was received from Crown Monitor, Mr Roger Jarrold and an apology for lateness was recorded from the Board Chair and Committee Member, Mr Pete Hodgson and the Chief Nursing and Midwifery Officer, Mrs Jane Wilson. The CEO, Mr Chris Fleming noted an apology for early departure from the meeting.

### 3.0 DECLARATION OF INTERESTS

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

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

***It was resolved:***

**"That the Interests Registers be received and noted."**

### 4.0 PREVIOUS MINUTES (tab 3)

***It was resolved:***

**"That the minutes of the meeting held on 1 November 2021 be approved and adopted as a true and correct record of the meeting."**

## 5.0 MATTERS ARISING

There were no matters arising from the Minutes that were not covered in the Agenda.

## 6.0 REVIEW OF ACTION SHEET

The Committee considered the action sheet (tab 5) and attached information papers and the verbal update from the Chief Operating Officer (COO), Mr Hamish Brown.

***Performance Improvement Notice (PIN), Emergency Department (ED), Dunedin***

An update was attached to the action sheet, noting the progress made in relation to the PIN. Additional staffing has been provided to mitigate the immediate clinical risk and further work is required in relation to the benchmarking exercise that was undertaken. WorkSafe formally withdrew the PIN in December 2021, but has issued another notice, asking for further information on worker engagement to identify risks.

*Hon Pete Hodgson, Board Chair and Committee member joined the meeting at 9.10am.*

***Ministry of Health (MoH) Prioritisation Tool***

There are two prioritisation tools – one is a tool for Elective Services Patient Flow Indicator (ESPI) 2, First Specialist Assessment (FSA) for prioritising the first outpatient contact and the second is a tool for prioritising surgery. The prioritisation tool for surgery is well utilised, but not all services are using the prioritisation tool for FSA. It is very labour intensive to collect the information prior and some services will use clinical criteria to restrict the flow, which is also a common practice within other DHBs.

***Southern Cross Hospital, Queenstown***

Members noted the list of elective day cases that will be performed at Southern Cross Hospital in Queenstown. A meeting has been held with Southern Cross Hospital staff and the team at Lakes District Hospital working on care pathways and acknowledging that surgery is being undertaken in a rural location and considering the disposition of patients should they require a longer stay than anticipated and/or have complications.

*Dr Lyndell Kelly, Committee member, joined the meeting at 9.12am.*

Discussion was held on the need to refine the action sheet and to ensure that key issues continue to be captured and the Committee updated on an ongoing basis. Whilst the tasks may be completed as captured on the action sheet, the HAC require an update on the underlying issues. This relates particularly to the action points related to Ophthalmology, Gynaecology waiting lists and when centralisation of RMOs will happen. Further refinement of the actions may be required, noting that the RMO issue is just a proposal at the current time.

***Centralisation of Resident Medical Officer (RMO) Rosters***

Members requested that centralisation of RMO Rosters remain on the action sheet and that a report be included for the next HAC meeting to provide an update/outcome.

The Chair noted the merits and efficacy of districtwide services.

***Southland Gynaecology Outpatient Waiting List***

The COO highlighted the key issues within the report, including the recovery and sustainability actions and responded to members' questions. The Executive Director People and Capability, Ms Tanya Basel, advised that a full-time Gynaecologist was appointed at Southland Hospital in December 2021. Members requested that Southland Gynaecology Outpatient Waiting List remain on the action sheet and that an update be provided for the next HAC meeting.

*Mrs Jane Wilson, Chief Nursing and Midwifery Officer, joined the meeting at 9.27am.*

## 7.0 PRESENTATION – EMERGENCY DEPARTMENT, DUNEDIN HOSPITAL

The following staff joined the meeting at 9.30am:

- Dr Rich Stephenson, Clinical Director, Emergency Department (ED), Dunedin Hospital
- Janet Andrews, Charge Nurse Manager, ED, Dunedin Hospital
- Sarah Kalmakoff, Acting General Manager (GM), Medicine, Women's and Children (MWC), Dunedin Hospital

The Clinical Director, ED, Dunedin Hospital, Dr Rich Stephenson, spoke to the presentation (tab 6.1) highlighting key issues and proposed solutions and the following key points were noted in discussion following the presentation:

- Members commended the team on the quality of the presentation and data provided.
- Crown Monitor, Mr Ben Pearson, advised that a lot of the issues highlighted relate to preventable disease that should be managed in the community. Dr Stephenson agreed that the issues are across the health system and need to be addressed in parallel with primary care.
- Clarification was provided that 29% of attendances at ED are admitted to Dunedin Hospital. It is likely that the acuity has increased in line with the aging population.
- Members noted that the 71% of patients not admitted to ED could be cared for in General Practice and through the Dunedin Urgent Doctor After hours Care (DUDAC).
- Dr Stephenson concurred with the importance of accountability and the Health and Disability Commissioner's call for an audit of the adequacy of clinical documentation within Dunedin Hospital and advised the need for adequate administrative resource to facilitate that.
- The data provided in the report for Dunedin Hospital is readily accessible for Southland Hospital ED.
- Dr Stephenson concurred that General Medicine patients shouldn't need to be admitted and readmitted through the ED and agreed that the provision of Outpatient Clinics and providing a step between Inpatient and Primary Care would assist with the flow through ED, noting that this is a successful model in other EDs.
- Whilst it is too early to comment on whether the investment in additional staffing for the Medical Assessment Unit (MAU) has made a difference, Dr Stephenson advised that positive discussions are being held with the General Physicians and there is a shared view on the model of care. There is still a risk that the MAU could get access blocked and needs to be managed.
- The Acting GM MWC, Sarah Kalmakoff, provided an update, noting that there has been a culture change, Outpatient Clinics are being held and statistics are available that indicate an increase in the number of direct

admissions through the General Physicians. Conversations are being held at management and Executive level, exploring the opportunity to run a pilot for a pathway between the General Medicine patients in the Hospital who get admitted acutely and the General Medicine patients who come through to the MAU and looking at establishing a Community Team who can work with the less unwell patients in the community so they don't need to come through into the MAU or the Hospital.

- The Board Chair requested budget amounts for the resource suggested by the presenting team for discussion at the Finance Audit and Risk Committee (FARC) meeting to be held on the afternoon of 1 February 2022.
- The Board Chair highlighted the importance of patient flow.
- The Charge Nurse Manager, Janet Andrews, provided an update on the nursing resource in the Dunedin Hospital ED, noting the extra nursing resource that is required for Triage 1 and Triage 2 patients.
- The flow of the low acuity patients through the Dunedin Hospital ED is not an issue for the service. The wider issue of managing people's health better, intervening earlier and having better access to rapid diagnostics in primary care has significant scope for avoiding people becoming unwell and having to go to the ED.
- Discussion was held on the need to move quickly with the recruitment process, should the request for additional resource be approved. The additional resource would be a solution to business as usual as well as the Omicron threat.
- The Chair summarised the main issues as the role of primary care and flow through the Hospital system and commended the presenting team on coming with possible solutions to the challenges the team is facing.

*A brief five minute recess was held commencing at 10.23am.*

## 8.0 PRESENTATION – OPHTHALMOLOGY

The following staff joined the meeting at 10.28am:

- Janine Cochrane, General Manager, Dunedin Surgical Services and Radiology
- Brad Aitcheson, Service Manager, Surgical Services and Radiology
- Dr Casey Ung, Ophthalmology Specialist

The Service Manager, Brad Aitcheson; GM, Janine Cochrane and Ophthalmology Specialist, Dr Casey Ung, spoke to the presentation (tab 6.2), highlighting key issues and the following key points were noted in discussion following the presentation:

- Members thanked the team for their informative presentation.
- Whilst a Sequre contract has been signed, it was noted that this is to mitigate the risk. It is costly and is seen as a short term solution only.
- The Chair noted the need to mitigate the risk of people going blind.
- The Deputy Chair inquired whether data was available on the socio demographics of the patient population and matching service delivery to need, referring to data produced by Geoff Duff, Canterbury DHB. The GM, Janine Cochrane, advised that rudimentary data for intervention rates on cataracts across NZ is the only data available to the team at the current time. The team need to do more cataracts in Southland as the intervention rate is lower. The only data available currently is by district, standardised for ethnicity.
- Dr Casey Ung responded to a query on the intersection between private and public Ophthalmology services and advised that in Dunedin most Specialists work in the public system, resulting in there being very little scope for work to be picked up in the private sector, with only two Specialists in that area.

The CEO confirmed that there was no response to a request for proposal (RFP) for private capacity. Dr Ung advised there was also likely to be very little capacity through Optometrists, with known waiting lists in some areas.

- The GM advised that Southern DHB does have one of the highest thresholds for access to surgery, which is similar to other DHBs. The backlog with the waiting list is being worked through. Southern DHB sits about middle of the pack for intervention rates compared with other DHBs, in a very similar position to Canterbury DHB.
- Southern DHB currently has a recruitment process underway seeking two Ophthalmologists.
- The Chair thanked the presenting team and summarised the main points from the presentation, noting the need to monitor the waiting list and the importance of preventing harm.

## 9.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

### Chief Operating Officer's (COO) Report

The COO report (tab 7.1) was taken as read and the COO, Mr Hamish Brown, drew the Committee's attention to the following items:

- Equity - there is a continued focus on equity, particularly in the Outpatient space. This is hampered by poor access to data and a very manual process in place.
- Activity - the majority of services are managing and have recovered well post COVID lockdowns. There are four services under significant pressure and the report includes more detail on this and actions around their recovery.
- Both the Southland Hospital and Dunedin Hospital Emergency Departments have had significant pressure points and the issues were covered in the presentation at the meeting.
- Radiology - CT targets have improved following additional CT resource. There is a continued lag with MRI, with the new MRI still on target for installation in April 2022. The physical build work is currently underway for the installation.
- There are continued operational challenges with workforce and planning for COVID is ongoing. There have been numerous beds opened and closed across both sites as workforce and the management of vacancies continues. This has resulted in deferral and cancellation of surgery, which has been challenging for both staff and patients.
- Associate Professor, Moana Theodore, commended the COO on the continued work in relation to equity.
- The proposal to run additional acute operating theatre sessions for the Orthopaedic Group on a Saturday, noting these should commence within the next few months. A select team will come on board to provide support in this area. Access to acute lists has been a challenge for both sites for a long time, but particularly for Dunedin Hospital. A number of people have had a longer length of stay and there are mitigations around that with the proposal being that those who can will go home whilst they wait. The additional challenges with the outbreak of Norovirus on the Dunedin site were noted.
- Crown Monitor, Ben Pearson, queried whether the staff employed to assist in April are available to assist with the MRI backlog at the current time and the COO is to follow up on this.
- In reference to the Orthopaedic Outpatient Waitlist and ESPI 2 (FSA) breaches, the COO advised that there are no pending remedies to the capacity challenges with long term vacancies in key orthopaedic surgery roles. Tight acceptance criteria in lieu of the prioritisation tool continues. Work is being done on an advertising campaign with HainesAttract for the Southland Hospital vacancies. The closed borders are problematic from a workforce perspective.

- Neurosurgery recruitment is an ongoing challenge.

**Financial Performance Summary**

The COO presented the Specialist Services financial results (tab 7.2) for the period ended 31 December 2021, noting the adverse result of $3.3M for the month, primarily driven by nursing workforce costs related to pay equity and clinical supplies. A number of budget lines are over, particularly in the area of outsourcing. The following key points were discussed:

- Despite the operational challenges, the plan is only 28 elective CWD below plan.
- Whilst CWD is largely on track, the raw discharges are up. Due to the bed pressures, a lot more day cases have been prioritised to keep throughput up and the system flowing.
- The team has been innovative around utilising beds in the private Hospitals for recovery, etc.
- There are numerous vacancies across all workforce groups.
- Nursing overtime is up as management attempts to fill the vacant positions.
- There are a lot of complex patients requiring watches.
- SMOs are on budget for the month.
- Allied Health is below budget and recruitment is going well.
- A request was made for a report on the vacancies across the hospital system, for both Southland and Dunedin Hospitals. The report is to include information on recruitment efforts, the gaps and where services are failing because of the gaps. The Executive Director People and Capability, Tanya Basel, is to provide the report for the next HAC meeting.
- The Chair advised there will be further discussion on the areas of focus and prioritisation at the Finance Audit and Risk Committee. Decisions need to be made on where the money should be spent to get the best outcomes.

***It was resolved**:*

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

The meeting closed at 11.20am.

Confirmed as a true and correct record:

Chair: _____ Date: _____

**FOR INFORMATION**

**Item:** CEO Report to Board

**Proposed by:** Chris Fleming, Chief Executive

**Meeting of:** 2 March 2022

## Recommendation

That the Board:

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

## Purpose

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

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

## 1. Organisational Performance

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

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

Financial performance for the month of January continued to be adverse to plan as expected. The result was an operating surplus of $79k compared to a planned surplus of $2.545 million, so $2.466 million adverse to plan. The year to date deficit is now $16.779 million compared to a budgeted deficit of $8.558 million, a variance of $8.221 million.

The Business as Usual (BAU) budget (which excludes COVID related revenue and expenditure) is a year to date deficit of $15.786 million against a plan of $8.558 million, so $7.228 million adverse to plan.

At a material level the four major components of the BAU adverse result for the month are:

- Continued need to outsource activity above that planned which is $675k for the month
- Pharmaceuticals which relates to both the phasing and the underlying budget issue identified last month of $2.768 million
- Air Ambulance Services $490k
- ICT and Software exceeding budget $143k.

From a volumes perspective:

- Total case weighted discharges were virtually on plan at -8 or -0.2% for the month compared to the plan, but down 208 or 4.7% on the same month last year. Year to date case weighted discharges are up 120 or 0.4% year to date against plan but down 860 or 2.6% against last year
- Medical case weights are up 671 or 5.5% year to date on plan, and down 201 or 1.5% compared to last year
- Surgical case weights are down on plan 838 or 4.6% with acutes down 123 or 1.4% with electives being down 715 or 7.5%. Compared to last year, surgical acute case weights are down 143 or 1.7% and electives are down 657 or 6.9%
- Raw discharges (actual number of patients) are up 201 or 4.5% for the month against plan, which is down 178 or 3.7% compared to the same month last year. Year to date raw discharges are down 502 or 1.4% compared to last year
- Mental Health bed days are 874 or 26.6% below planned levels for the month (indicating an 73.4% bed occupancy) and 637 or 3.5% down on the same year to date period last year. This indicates overall bed occupancy is now only marginally lower than last year
- Emergency Department (ED) attendances are up 269 or 3.6% compared to January 2021, with Dunedin up 2.9%, Southland exactly the same as the previous year, and Lakes up 15.5%. On a year to date basis ED presentations are down 1.3% with only Lakes having a 2.7% increase.

The Performance Dashboard update has been included as a separate agenda item. 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

In the week of 7 February, the inevitable arrival of Omicron in the Southern District occurred. The situation is fast moving, we have our Emergency Coordination Centre (ECC) operating, and the exponential growth of cases is occurring as we speak. At the time of writing this report the formal case numbers are:

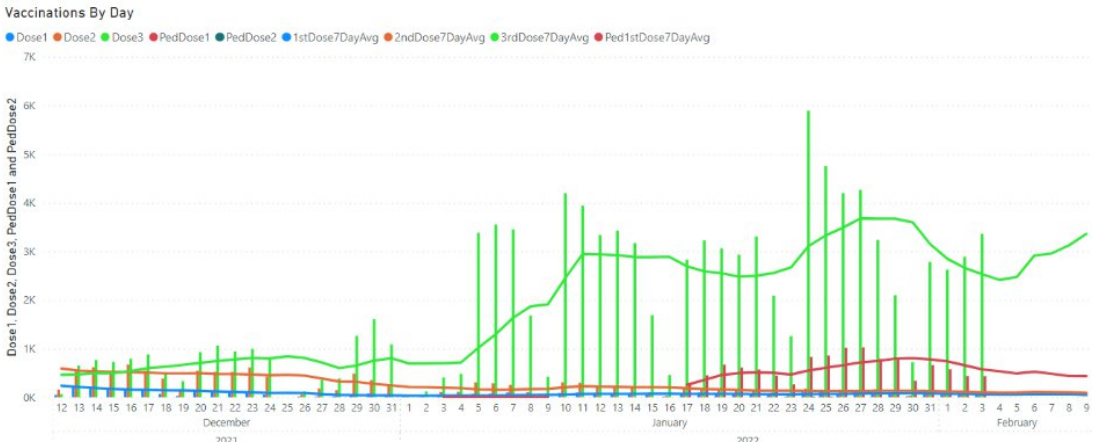
| Council | New cases as at 17 February 2022 | Total cases as at 17 February 2022 | Recovered |
|---|---|---|---|
| Central Otago | 0 | 1 | 0 |
| Clutha | 0 | 0 | 0 |
| Dunedin | 26 | 41 | 0 |
| Gore | 0 | 5 | 0 |
| Invercargill | 3 | 6 | 0 |
| Queenstown-Lakes | 37 | 160 | 0 |
| Southland | 1 | 6 | 0 |
| Waitaki | 2 | 3 | 0 |
| **TOTAL** | **69** | **222** | **0** |

It should be noted that even with these numbers there is a lag, and it is clear that there is now uncontrolled community transmission occurring across the District (as is the case across the entire country). It is expected that by the time the Board meets it is highly likely that the total cases will easily exceed 1,000. Whilst the majority of cases are in Queenstown, the situation in Dunedin is escalating with the return of students to University. The University of Otago are doing an outstanding job in terms of supporting a robust health response, all orientation events have been cancelled, however this has not stopped many unofficial events and the numbers of COVID positive students and potentially super spreader events are very concerning.

Rather than providing a lot of information in this report a brief presentation will be given at the Board meeting by Dr Hywel Lloyd who is acting as our ECC Controller.

## 3. COVID-19 Vaccination Programme

The month of January saw our booster demand significantly increase to numbers we have not seen since October. This with the complexity of adding an entirely new younger age cohort put significant pressures on our already stretched workforce.




### 5-11-year-old Vaccinations

We began preparing the rollout of vaccinations to the 5-11 year old cohort in December, although some vaccination providers have opted out of delivery at this stage. The phased rollout began in the Southern district on 17 January 2022, with 20 providers delivering 5-11 year old vaccinations in the first week, increasing to 61 providers by the end of January.

Specialist Paediatric COVID-19 Vaccination Clinics have been organised at Dunedin Hospital and Southland Hospital to assist tamariki unable to receive their COVID-19 vaccination through community clinics or home visits. This may be due to extreme needle phobia, neurodevelopmental needs such as intellectual disability/autism spectrum disorder or other complex health needs. Play Specialists, Paediatricians (for sedation where necessary) and Psychologists will be available for input alongside the COVID-19 vaccinators. General Practice can refer to these clinics via Electronic Referral Management System (ERMS).

### Māori and Pacific Population Rollout

Māori and Pacific Health Providers continue to deliver outstanding services for 5-11 years olds across the district. Māori Health Providers continue to undertake large drive through models that accommodate both the 5-11 year old and adult vaccinations, this is very effective and currently providing large numbers of vaccinations. This includes the Te Kaika Drive Through, Dunedin, 5 days a week 9am – 6pm; and Awarua Whānau Services Drive through in Invercargill, 7 days a week 11am – 7pm. He Puna Waiora, Invercargill, have 5 days a week clinics 9am-6pm and one late night.

Te Kāika Caversham have been working closely with the Dunedin City Council and Southern DHB to develop a schedule based on our postcode level data to target the highest number of outstanding populations, including outreach to Clutha district to provide workplace vaccinations, rural clinics, and school-based clinics.

Two Māori Health Providers have partnered to provide vaccination services across Rural Southland with a focus on 5-11 years and boosters. Māori Health Provider Outreach Services continue to provide vaccinations including Measles, Mumps and Rubella (MMR) and Human Papillomavirus Vaccination (HPV) in the home for 5–11 year olds and their whānau. Clinic

hours pivot to meet Māori community demands with drive through, onsite clinics and outreach clinics changing hours and venues across the district as needed.

We are planning for Whānau Days for Māori communities in each locality, led by local Rūnuka and Māori Health Providers.

Te Punaka Oraka Public Health Nursing Staff and Immunisation Coordinators have been working alongside Pacific Community Trust in the immunisation space. Looking to continue to strengthen relationship to embed outreach services, one Māori staff member has been released to external Māori Health Provider Te Kāika until end of 2022. This is to support a partnership model between SDHB and Te Kāika to support their growing workforce and skillset in immunisation cold chain processes. Feedback has been well received. The service is looking for further opportunities to partner across the region with other Māori and Pacific providers to increase positive Population health outcomes.

Southern DHB has engaged with Te Rūnanga o Ngāi Tahu (TRoNT) to obtain up to date data on the schools who have children aged 5-11 years old and 12-15 years who whakapapa to Ngāi Tahu. We have engaged with the Ministry of Education to obtain school ethnicity data to inform an effective rollout of the 5–11 year old vaccination programme for Southern. Our Māori and Pacific Providers have existing relationships with schools, particularly low decile and will continue to seek consent to offer vaccinations for schools in a delivery manner that would work for schools and their enrolled community.

**Aged Residential Care**

Booster doses in Aged Residential Care facilities began on 1 December 2021. We anticipate booster dose clinics to have been held at all 66 facilities in our district by 2 February 2022.

**Mental Health and Addictions**

Administration of booster doses in Mental Health and Addiction facilities began on 12 December. We anticipate booster dose clinics to have been held at all facilities we have worked with previously in February.

**Disability**

Administration of booster doses in partnership with Disability Support Services providers for their community and residential clients began on 17 December. Some providers have chosen to utilise clients' General Practitioners (GPs) who were not vaccinating initially. We anticipate booster dose clinics for this cohort to be complete at the end of February.

**COVID-19 Vaccination Outreach Service**

The COVID-19 Vaccination Outreach Service has recommenced following a break over Christmas. In 2021 the Outreach Service administered 4,773 vaccinations to hard-to-reach individuals and health care workers. An outstanding effort!

**Pharmacies and 5–11 year old Immunisations**

From 18 January 2022 pharmacy providers who had opted to deliver paediatric COVID-19 immunisations started vaccinating. The rollout occurred in a staggered approach due to Immunisation Coordination resource and provider timeliness in completing the training and necessary documents. As a result, 19 of 35 pharmacies now offer 5–11 year old immunisations in the Southern district.

**All-In Vaccinations**

Initial discussions were held with the newly appointed Measles Campaign Coordinator on consolidating vaccinations into both the Meridian and Victoria room clinics, including our in-home visits and rural outreach. This would involve bringing the COVID-19 Pfizer vaccine into Public Health nursing and the MMR, flu vaccine, and childhood immunisations into the COVID-19 vaccination providers. In addition, we expect COVID Immunisation Register (CIR)

to be linked into National Immunisation Register (NIR) through a new system in April 2022; it will be simpler to record multiple vaccinations at one time.

## 4. Endemic COVID Workforce Response and Planning

As part of our planning for the COVID response, the workforce plan is based on four pillars. The first pillar is focussed on mobilising the business and wider southern community to support the whole of the Southern Health System. Through collaboration with Business South, Firebrand, Volunteer South and the various business chambers across Otago and Southland, we have launched the Southern Heroes Support Crew. This is a good-will initiative and focussed on enable the Health System to keep functioning. The focus is predominantly on non-clinical support such as deliveries, supporting our service providers such as Compass and ISS to ensure we keep food, cleaning and other services going where appropriate.

**How it works:**

A platform has been established through which organisations can register their interest in being a Southern Hero. The various Emergency Operation Centres (EOCs) will be able to put up requests for assistance on the platform which will be pushed to the relevant supporting organisation who will, we hope, be able to respond to the request.

The program is in support of not only the DHB, but also the WellSouth and our Primary Health providers (including Māori and Pacific).

The second pillar is to support the internal movement of staff and redeployment within the health system for Southern. It also will also be looking at the redeployment of staff across regional boundaries (similar to our support of Auckland during the Delta outbreak). The work in this space is predominantly focussed on ensuring consistency in principles of movement of staff and ensuring that our workforce plans are workable and sustainable.

The third pillar is focussed on students and potential unregulated workforce that could assist with health care assistant activities so that we can pool skill workforce groups to where the needs are the greatest. We are proactively working with the tertiary and teaching institutions on how we on-board, remunerate and keep students safe.

The fourth pillar is to ensure that we are paying due attention to the wider Southern Health system. We will be looking at how we can leverage off telehealth to support rural practices. What would we need to mobilise to support remote and rural communities should medical centres need to shut due to isolating or affected staff.

Other aspects which are being covered and considered is ensuring our staff wellbeing and welfare:

- Meals for staff who are working long shifts or providing meal vouchers/afternoon teas for staff working long shifts
- Work in progress: Fatigue management, and supporting staff working long shifts potentially covering multiple shifts, to look after their own rest and recovery
- Currently available: Online resources to care for own (and others) mental well-being. This is accessed via a SharePoint site, and there are some good tools freely available. We are also about to launch a People and Capability newsletter for training programmes that are in support of staff wellbeing.

## 5. 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.<br><br>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<br><br>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<br><br>Southern has developed a track record of addressing significant issues, however, has not historically been utilising information effectively enough to ensure that they are forward looking to identify emerging issues in a more timely manner |
| Adverse health and safety event causing death, permanent disability or long term harm to staff, volunteer or contractor | Health and Safety Governance Group with agreed charter and work programme reporting regularly to the Finance, Audit and Risk Committee | Need to improve feedback loop and extend to near miss events |
| Critical failure of facilities, information technology (IT) or equipment resulting in disruption to service | Interim works programme being implemented to maintain facilities, asset management plan developed, 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 |

## 6. Health System Reforms

The disestablishment of District Health Boards and the formation of Health New Zealand will only be 82 working days at the time of this board meeting. While there are a lot of 'Day 1' groups established in Interim Health New Zealand there is remains very little detail in terms of transition planning.

The Interim Chief Executives of Health New Zealand and the Māori Health Authority commenced in their roles on Monday 14 February. Both Interim Chief Executives attended

the National Chairs' and Chief Executives' meetings on 16 and 17 February. We are expecting that Tier 2 structures for Health New Zealand will be released in late February / early March. The recruitment processes will then start. The reality is however clear that at the very least things are likely to be business as usual while systems, processes and structures are established. There will clearly need to be three stages:

- Legal Integration – which is the easiest part of the reforms as DHBs will be legally integrated into Health NZ with the passing of the legislation
- Function Amalgamation – which is where core functions are maintained and align using some form of matrix management process to align activities of DHBs to Health NZ operating structure
- Structural Amalgamation – where reporting lines evolve to structurally align functions into the Health NZ operating model.

These processes will take some time, so it is important that the Board and the Executive Leadership Team ensure stability is maintained and that we ensure we minimise any slippage in focus on key priorities.

## 7. Draft Expenditure Budget 2022/23

A draft expenditure budget was submitted to Health New Zealand on 11 February 2022. This budget was developed based on the core assumptions that the Transition Unit / Health New Zealand indicated. A number of the assumptions however are so far away from sector expectations (for example, cost uplift for funded providers of 2% when inflation is running at more than double this) that a significant amount of work will be required to ensure that it can move from being the draft budget to an achievable budget.

The draft budget included what we are calling business as usual investments, however there are a number of new investments that have been identified which we will discuss with Health NZ as the operating framework develops. The draft budget also excluded targeted savings which are presently being worked up by the Executive Team under the guidance of the Executive Director Corporate Services.

## 8. Key Appointments and Recruitment

### Executive

Toni Gutschlag commenced as Executive Director Mental Health, Addictions and Intellectual Disability on 21 February 2022.

Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer, will leave the DHB on 11 March 2022. I am in the final stages of agreeing with an external candidate to join Southern DHB in a fixed term position until the end of September 2022. This will provide time for clarity around the direction of travel with Health NZ and the Māori Health Authority.

The Executive Director Communications has been advertised and while there were a couple of outstanding candidates they both withdrew on offer based on the uncertainties associated with the health reforms and the potential impact on the role. The role has been readvertised and closes on late February.

### Chief Operating Officer Team

Most roles established following the restructure of Specialist Services last year have been filled:

- Deputy Chief Operating Officer / General Manager Southland – Simon Donlevy appointed and commenced in the role in December 2021
- General Manager Dunedin Surgical Services & Radiology – Janine Cochrane appointed and commenced in the role in December 2021

- General Manager Dunedin Medicine Women's & Children's Health – appointment made with Craig Ashton commencing on 16 March 2022
- Planned Care Manager – Nigel Copson appointed and commenced in the role in January 2022
- Patient Flow / Operations Manager Dunedin – Megan Boivin appointed and commenced in the role in December 2021
- Patient Flow / Operations Manager Invercargill – role readvertised
- Director of Nursing Southland – Linda Ryan appointed and commences in the role at the end of February 2022
- Director of Allied Health, Scientific and Technical Southland – Joline Wilson appointed and will commence in the role in April.
- Medical Director Southland – Adam McLeay appointed and commenced in the role at the end of January 2022
- Medical Director Surgical Services and Radiology – interviews held.

## 9. Dunedin Emergency Department (ED) Provisional Improvement Notice (PIN)

WorkSafe notified us on 24 December 2021 that the PIN issued on 30 July 2021 has been cancelled.

The cancellation was made under section 81 of the Act, for the following reason(s):

> "SDHB are taking steps to ensure that staffing shortages and the demand on nurses and capacity in the Emergency Department are being addressed so far as reasonably practicable"

Southern DHB is due to feedback on progress by the end of March 2022.

## 10. Southland Emergency Department

ED Southland staff have raised concerns regarding staffing levels. The Chief Operating Officer, General Manager Southland and Chief Nursing and Midwifery Officer met with ED staff pre-Christmas to discuss. Progress update: staff will be almost fully recruited to by March and the new Charge Nurse Manager has commenced.

A focus has to be given to the Primary Care / ED workstream as it remains abundantly clear that the number of presentations to ED which are primary care level persists. The initiative that Well South Primary Health Network and the Rūnaka are championing is excellent but after a number of months this has still not turned into reality due to difficulties attracting GPs to the service.

## 11. Midwifery

Midwifery remains concerning and services are fragile across the district. There has been considerable collaboration between the midwifery teams, lead maternity carers (LMCs), the Midwifery union (MERAS) and the Director of Midwifery to provide support and solutions to the current crisis.

## 12. Obstetrics and Gynaecology Southland

This service remains under considerable pressure and is vulnerable. Some advancement has been made in senior medical officer (SMO) recruitment, although a half time vacancy

remains and addition resource to support planned care is still being sourced. Additional nursing resources to support the service and redistribute workload continues.

## 13. Safe Staffing

Operational impacts have meant bed closures to maintain safe staffing – these impacts have been variable day to day and some control over both this and the nursing levels has been sought to reduce the daily churn and cancellations.

Additional nursing workforce (New Entry to Practice (NetP)) have commenced and in supernumerary phase with improvements by March in staff levels (albeit junior).

Intensive Care Unit (ICU) nursing staff numbers projected to stabilise from February.

## 14. Planned Care and Patient Flow

January saw high levels of acute surgery hours. However, with the planned reduction in planned care allowed additional acute lists to be scheduled and better throughput and flow within the hospital.

Ongoing elective cancellations have occurred due to availability of ICU/High Dependency Unit (HDU) beds – this is a significant impact on services such as cardiothoracic. Cardiothoracic waitlists have increased to maximum allowable and work with the Ministry of Health and tertiary/quaternary services group on this has occurred. A local recovery plan is in place however this remains tenuous.

Patient flow has been tenuous with the bed closures and the significant acute operating with numerous days in yellow/orange and significant delays for patients in Dunedin and Southland EDs.

Forecasts for January and February (especially nursing rosters) remain tight and moves have been made to consolidate medical and surgical footprints with some success.

The impact of this bed churn is booking less planned care cases requiring beds, however a significant shift to day cases has occurred.

Yet to reengage again with primary care (holiday period and omicron planning) on planned care however Planned Care manager will meet with Stuart Barson. Planned care managed to also meet with regional colleagues to discuss opportunities.

Working up forecasts for planned care recovery to input into national Chief Operating Officers' planning. Indications are three to five years to recover volumes with the addition of no new capacity.

## 15. EY Oncology Report

Oncology report has now been finalised by EY and recommendations agreed. The report has been endorsed by the Executive Leadership Team and is attached as an appendix to this report. It is to be noted that there is additional investment flagged, however these additional investments will need to be discussed and endorsed by Health New Zealand in the 2022/23 budget round.

## 16. Industrial Action

Industrial action by Medical Physicists has meant additional unbudgeted outsourcing has been required. This is partially offset financially by the under-utilised outsourcing budget. We are continuing to receive strong support from Te Aho o Te Kahu, Cancer Control Agency.

The Public Service Association (PSA) has issued a strike notice which applies to all Allied Health, Public Health, and Technical staff for a 24 hour period from 0600hrs on 4 March through to 0600hrs on 5 March. We are also expecting a second strike notice imminently. This is a significant risk as this covers staff who are involved directly in our current COVID Omicron response. This is a nationwide strike and as such we are working with TAS and our DHB partners. One of the significant issues is the pay equity claim which once the nurses one is settled will create a significant parity issue until the PSA one is resolved.

## 17. Ministry of Health / HealthCERT Certification Audit 2021

Following our Certification Audit in November 2021, the Ministry has advised that we have received Certification to Provide Certain Health Care Services for three years. The certification period takes effect on 16 February 2022 and expires on 16 February 2025.

We have received ten corrective action requests to progress improvement. These relate to Cultural, Informed Consent, Risk, Safe Staffing, Nursing Assessments, Nursing Care Plans, Medication Management, Food Fridges, Building Compliance, Infection Prevention and Control Patient Screening.

A new Health and Disability Services Standard – Ngā Paerewa Health and Disability Services Standard NZS8134:2021 – comes into effect at the end of February. Sector guidance is available on the Ministry of Health website.

Key, high-level changes to the new Standard include:

- strengthened infection prevention and antimicrobial stewardship, including learnings from New Zealand's experience of the COVID-19 pandemic
- an increased focus on supporting service providers to meet Te Tiriti O Waitangi obligations
- strengthened clinical governance, to ensure people's care and support needs are appropriately met.

## 18. Chief Operating Officer Team Key Projects Updates

### Generalism

The Medical Assessment Unit (MAU) remains on track for December 2022 Completion. The remaining decanting from the Fraser Building and Fraser Building works to commence imminently. MAU ground floor plans to commence in April 2022.

### Sterile Services Relocation

Final plans for sign off received by the clinical teams from the architect. Completion programme for October 2022.

### ICU Stage 2

Remediation plan accepted and instruction to proceed given by EDCS.

### Magnetic Resonance Imaging (MRI)

The building programme is about ten days behind, currently installation of the Farraday cage is occuring. Building/installation is scheduled to be completed by 29 April 2022. Applications training would commence on 2 May 2022.

The scanner arrives in NZ (Tauranga) the week of 28 February. It will then be shipped up to Auckland where it will be stored until it is to be delivered – this is planned to be 27 March 2022.

**Southland Fifth Operating Theatre/Emergency Department Expansion**

Awaiting pricing from the Quantity Surveyor. Need to determine sign off pathway as pricing for both business cases is linked to one structure (shared building elements and attribution may be complex).

**Integrated Operations Centre**

Project being scoped for commencement as soon as possible. Target implementation date June 2022.

## 19. Strategic Briefing for the Southern Health System

The full report was received by the Executive Team in November 2022 and reviewed by the Southern DHB Board. The Board requested there be opportunity for community and iwi feedback. In January 2022, preliminary work was commenced for a Strategic Briefing roadshow across the district. Given the COVID-19 situation now, this approach is not appropriate. Options are being reviewed on how to seek feedback that does not involve large gatherings yet encourages individual and group response. It is anticipated that during February and March 2022 a feedback process will be developed, with the Māori Health and the Communications teams, that is user friendly and available in different formats, both electronic and hard copy. Options to support feedback from people with disabilities will be included. The feedback will be collated, and recommendations put forward for Executive review. Once finalised, this will be presented to the transition unit as our longer term strategic refresh / plan.

## 20. Hauora Direct

The Southern DHB is working to award the Hauora Direct contract to a Southland based provider. This contract aims to improve health outcomes for Māori. In 2020 Nelson Marlborough DHB, funded a trial of the Hauora Direct programme (in conjunction with several community providers) as "pop-up" events at eight Nelson and Marlborough community locations. The initiative aligns with two of the eight Whakamaua priority areas and supports four of the actions. Hauora Direct assessments are to identify physical and mental health, and social and wellbeing concerns. The assessment is to identify whānau needs to be addressed, and health and social services they are eligible to receive. The assessment will include a risk-identification process for possible and probable health issues so whānau can access early support. The contract aims to support on the spot interventions to include immunisations for children and adults, blood tests for diabetes, cardiovascular screening, cervical smears, smoking cessation support and tamariki hearing and vision testing. Whānau will be referred to other services where issues cannot be dealt with immediately. The contract is being considered by the team currently with view to working with our Māori providers to support service delivery. The Southern DHB is working with Nelson Marlborough on IT solution to improve data collection quality and systems.

## 21. Updated Māori Enrolment Data

| | Feb-21 | Apr-21 | Jun-21 | Aug-21 | Nov-21 | Feb-22 |
|---|---|---|---|---|---|---|
| Central Otago | 1,877 | 1,893 | 1,881 | 1,918 | 1,939 | 1,954 |
| Clutha | 1,838 | 1,856 | 1,863 | 1,855 | 1,844 | 1,868 |
| Dunedin | 9,495 | 9,530 | 9,597 | 9,611 | 9,655 | 9,646 |
| Gore | 1,821 | 1,843 | 1,861 | 1,854 | 1,860 | 1,894 |
| Invercargill | 9,291 | 9,356 | 9,353 | 9,363 | 9,363 | 9,433 |
| Queenstown Lakes | 1,932 | 1,969 | 2,019 | 2,062 | 2,054 | 2,102 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Southland | 1,760 | 1,785 | 1,817 | 1,835 | 1,845 | 1,877 |
| Waitaki | 1,924 | 1,930 | 1,917 | 1,941 | 1,966 | 1,999 |
| **SDHB** | **29,938** | **30,162** | **30,308** | **30,439** | **30,526** | **30,773** |

*Source: NES file from the MoH*
*Ethnicity - Maori (21111)*
*Files used are dated 1st of the month following except February which is dated February*

## 22. Kaiārahi Nāhi, Māori Clinical Nurse Specialist Roles

The Chief Māori Health Strategy and Improvement Officer and Director of Nursing have ratified a request for recruitment (RFR) for two Kaiārahi Nāhi, Clinical Nurse Specialist roles. The RVR has adopted an expression of interest (EOI) approach to either appointing a Clinical Nurse Specialist (Kaiārahi Nāhi) role or Clinical Nurse Specialist trainee intern positions. The aim to this approach is based on our aspirations to reduce preventable deaths including a focus on cardiovascular, cancer and respiratory disease in Māori patients that are admitted into our hospitals. The EOI process has been initiated as we have no current Māori Clinical Nurse Specialist roles within the Southern DHB, therefore this approach aims to build our workforce capacity into the future.

## 23. Kaiawhina Positions

The Māori Health Directorate has been successful in making two appointments to the Kaiawhina positions in Invercargill and Dunedin after readvertising. This leaves only one Kaiawhina vacancy in Invercargill. The Māori Health Directorate welcomed Roger Fitzgerald and Lisa Whatuira by way of mihi whakatau at Te Taihoaho at Wakari on 18 January. This was also an opportunity to welcome Maryann Rangi who has taken up a Kaioranga Hauora as part of Te Korowai Hou Ora, whom no longer have any vacancies.

## 24. Māori Workforce Development Specialist Partner

We have loaded a request for recruitment (RFR) for a Māori Workforce Development Specialist role. The position 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.

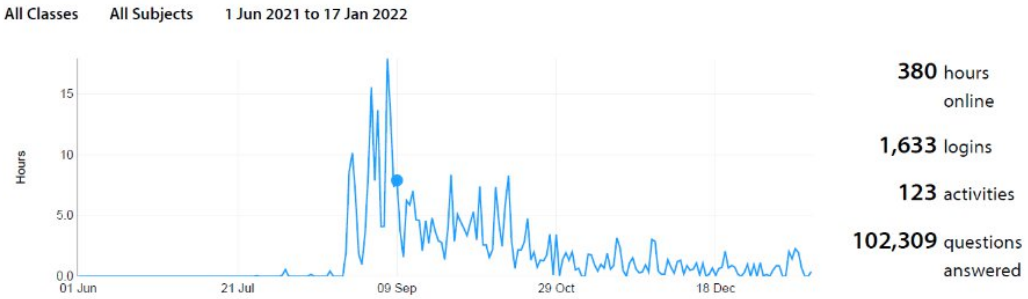
The role will report to the Executive Director People and Capability and the Chief Māori Health Strategy and Improvement Officer. The primary objectives of this role include:

- To lead, develop and implement strategy and programmes to improve the capacity and capability of Māori in the health workforce across the Southern district in line with a Māori workforce strategy.
- Ensure expert Māori leadership and advice is provided across workforce development planning for SDHB.
- Oversee all Māori workforce development reporting requirements from operations through to governance groups.
- Lead a continued focus on reducing inequalities and the integration of Māori values and worldview in across recruitment and retention processes in collaboration with the recruitment and HR teams.
- To build the Māori workforce pipeline from students in year 7 and 8's through to staff employed into the health sector.
- Develop processes and systems and provide support for hospital services to recruit more Māori into the workforce particularly in services where there is high utilisation by Māori.

- Work collaboratively to build the necessary relationships with tertiary education. institutions, the Māori Alliance Leadership Team, Iwi and Māori Health Providers and other key stakeholders to assist with the workforce pipeline development.
- To oversee the administration and contracting of the HWNZ Hauora Māori funding through the Ministry of Health.

## 25. Te Reo Māori Education

A collective response from WellSouth, Allied Health, Nursing and the Māori Health Directorate has provided 200 enrolments into an online platform, to support cultural education and address the need to persist with addressing equity and differential outcomes experienced by Māori. The training is being delivered in collaboration with Te Rau-o-te-Rangi Winterburn from Ōtaki. The training has a focus on cultural practices, NZ history, myths and legends, grammar and is a pipeline as well as higher level immersion. Each kete kōrero (learning module) contains vocabulary, comprehension, writing and speaking activities. They are broken into beginner and intermediate level learners. The platform is user friendly, flexible to meet the needs of busy staff, and has been reviewed by our Pou Taki and found to deliver a sound education program with good pedagogy and methodology. At stage we can report 380 online hours of engagement, learners have logged in 1,633 times, and answered more than 102,309 questions in Te Reo Māori successfully. Staff feedback and participation is providing confidence the platform is engaging learners well and supporting them on their reo journeys.




**Chris Fleming**
**Chief Executive Officer**

23 February 2022

# Southern Blood and Cancer Service Action Plan

EY

8 Feb 2022

Building a better working world

# Table of contents

# 1. Executive summary

Southern Blood and Cancer Service (SBCS) is a regional cancer centre in New Zealand, providing Medical Oncology, Radiation Oncology, and Haematology services - primarily for the population of Southern District Health Board (SDHB).

Recognising ongoing demand and capacity challenges, EY was commissioned by SDHB to provide advice on the development of a three-year action plan for SBCS – in the context of how these services compare with their peers in New Zealand's five other cancer centres. The objective of the work was to identify the most immediate gaps between SBCS and New Zealand's other cancer centres regarding workforce resourcing relative to service delivery, with recommendations for action between 2022-2024 to address any material gaps. The timeframe of three years for the action plan was chosen given uncertainties related to the Health & Disability System Reforms, and national service planning work underway by the CCA.

It was not part of EY's scope to review SBCS models of care or previously agreed resourcing changes within these services – noting the significant investment planned by the DHB for the 2021/22 year. While this is the case, this report provides further information, with which the DHB can consider the appropriate balance of investment made (but not yet incurred) and recommended. This includes benchmarking information that suggests the DHB's prior investment decisions will result in resourcing higher than many peers for some workforce roles – noting the caveats and limitations of the benchmarking information set out below, on pages 5 – 6, and in Appendix C.

To compare SBCS with the five other cancer centres in New Zealand, the CCA provided full-time equivalent (FTE) benchmarking data across all centres for key service roles. The CCA collected information from each centre, using a standard information specification. However, a range of caveats and limitations regarding the benchmarking data and analysis were noted by the CCA in its report (refer to Appendix C), in particular: varying definitions of FTE (e.g., number of hours per week), impact of private sector activity on demand and resourcing, and differences in workforce models (e.g., number and mix of specialist nursing staff). These limitations and caveats are provided in the body of this report as relevant, and in more detail in Appendix C.

The caveats and limitations of the CCA benchmarking exercise have impacted on the extent that differences in relative resourcing between cancer centres can be quantified, particularly for non-medical roles. As such, qualitative information from engagement with SDHB stakeholders, and those from other cancer centres, has been relied on in some situations to understand key differences, and their likely impact on service delivery and sustainability – and where possible and appropriate, SDHB data has been explored to understand current resourcing and delivery challenges and opportunities.

In preparation of this report, EY:

- Established a project Steering Group including SBCS clinical leaders, managerial leaders and the CCA;
- Reviewed the CCA's benchmarking data and analysis;
- Conducted scene-setting interviews with key SBCS clinical and operational leads at SDHB;
- Held interviews with representatives from each of the other five cancer centres;
- Conducted workshops with wider staff across various roles in the DHB's blood and cancer service;
- Met with the DHB's Executive Leadership Team twice. First to provide an update on current state findings, and the second to discuss the project's draft recommendations; and,

- Undertook a range of supplementary analyses to explore a range of key drivers of observed or reported differences between SBCS and other cancer centres.

The key observations from the CCA benchmarking exercise are summarised in Table 1 – with this information being discussed in several meetings with key clinical and operational leads.

| Table 1: Key findings from the CCA benchmarking exercise | |
|---|---|
| **Specialty** | **Key differences for SBCS (in comparison to other cancer centres)** |
| Across specialties | Low number of registrars |
| Medical Oncology | Greatest number of FSAs per SMO FTE |
| | Greatest number of treatments per SMO FTE |
| | Second lowest ratio of SMO FTE : population |
| Radiation Oncology | With actual FTE – lowest number of SMO FTE per LINAC[1]<br>With budgeted FTE this becomes third highest |
| | With actual FTE – highest FSAs per SMO FTE and highest courses per SMO FTE<br>With budgeted FTE – second lowest FSAs per SMO FTE and lowest courses per SMO FTE |
| | With actual FTE – third highest ratio of SMO FTE : population<br>With budgeted FTE this becomes the highest |
| | Low number of Medical Physicists and Radiation Therapists per LINAC |
| Haematology | Fewest FSAs per SMO FTE |
| | Greatest number of treatments per SMO FTE |
| | Third highest ratio of SMO FTE : population |

In considering the CCA's benchmarking information, feedback from stakeholders, and other supplementary analysis, key findings include *inter alia*:

- Accepting the caveats and limitations of the CCA's benchmarking exercise, the SBCS appears to have fewer FTE across clinical and technical positions relative to patient activity than most other cancer centres (see Table 1). While the DHB has agreed an uplift in FTE across a range of roles for SBCS in 2022, which reduces differences between SDHB and most other centres, it is important to note that other cancer centres have open positions being advertised across a range of clinical roles – i.e., FTE numbers compared to patient activity will continue to change;

- SBCS delivers a much higher proportion of patient care across rural or out-of-centre sites than other cancer centres, based on available information, which while promoting patient access across the DHB, impacts on travel time for centrally based SBCS staff that provide these clinics and care;

- SBCS has broadened and deepened the role of nurses in patient care, reportedly to an extent greater than other cancer centres, which is considered a strength of the service – noting that other centres also report ongoing efforts to strengthen the role of nursing in their models of care;

- The services have fewer medical registrars than many other centres, which impacts on the ability to 'grow' the future medical workforce. It also limits opportunities for some Senior

[1] Please note that actual FTE is currently 4.6 for Radiation Oncologists. There was a total of 7.695 FTE budgeted for in FY21, however 1.72 has been filled but roles are not starting until Feb/Dec, and 1.375 remains unfilled.

Medical Officer (SMO) patient care workload to be delivered by registrars, particularly advanced trainees;

- There are low numbers of reported administrative staff across all specialities. Reportedly there is a lack of both clinical and non-clinical administrative staff (such as service administrators). The lack of administrative staff is reported to exacerbate clinical workload as some tasks that could be performed by administrators is done by clinicians and/or technical roles – noting that this was reported as a DHB-wide challenge rather than specific to SBCS; and,

- Based on the CCA's benchmarking exercise, there are fewer Medical Physicists (MPs) and Radiation Therapists (RTs) per linear accelerator (LINAC) compared to other centres – noting that FTE per LINAC is a very high level resourcing capacity measure. The apparent small technical workforce may be exacerbating current issues with commissioning of LINACs, given that a split shift for MPs is used to maintain LINACs whilst maintaining maximal treatment delivery for patients – which is reported as reducing possible time spent on new LINAC commissioning.

Based on the information available to EY, and engagement with key stakeholders, it is obvious that SBCS aims to provide high quality holistic patient-centred cancer care, and has done continuous work in improving the service including recent steps to uplift workforce capacity. However, whilst having committed staff, and even leading in innovation in workforce model development for nurses and RTs, SBCS is still facing many challenges that have been long-standing, and require resolution.

After considering multiple information sources, our view of the immediate actions recommended in the next three years are focused on:

- Addressing immediate gaps to support current workload; and,

- Further investment across workforce roles to better align SDHB's SBCS resourcing with other cancer centres, in the context of the delivery challenges faced.

Our recommendations are provided below, including a sequenced three-year roadmap. Underpinning our recommendations are the following key matters:

1. SBCS has the vision of being a comprehensive cancer centre and is using an interdisciplinary workforce model which fosters holistic service delivery, taking into consideration the specific population served by the DHB. The service has benefited from the strengths that the interdisciplinary model has enabled, however, there are still points of vulnerability and limitations – particular attention should be drawn to the need for continuing to develop allied health and psychosocial support resourcing, to strengthen existing models of care – and broaden and deepen care models as appropriate.

2. Stakeholder engagement across both clinical and managerial leaders and staff suggest significant existing deficiencies in certain areas, particularly in administrative roles. Therefore, to make best use of senior clinical time and enable smoother patient flows, there is a need to bolster administrative FTE to meet existing service needs, and future requirements associated with the budgeted uplift to clinical roles in FY22 – noting additional administrative support is not factored in to the budgeted FY22 workforce capacity uplift.

3. Furthermore, as highlighted by reported issues with waiting times and CCA workforce benchmarking, there is prima facie evidence that increased workforce resourcing is needed to better align SBCS with other centres. While the budgeted uplifts in some roles in 2022 begins to achieve this, there remains some material differences, particularly when the service delivery context of the DHB is considered.

4. Consequently, appropriate growth in other workforce roles (e.g., non-clinical staff) to support the additional patient activity more clinical FTE resourcing will generate, will be needed.

5. There are wider changes on the horizon such as the prompt repatriation of stem cell transplant (SCT) patients to SBCS and standardisation of clinical protocols nationally, and therefore it will be necessary to ensure appropriate resourcing of medical, nursing, and other staff to enable these changes to be implemented. This is accommodated within the proposed further uplift in medical personnel beyond that already agreed with 2022.

6. All cancer centres have reported an imperative to focus on addressing longstanding inequities in access, experience, and outcomes of care. SBCS will need to continue to strengthen workforce roles to support populations with poorer access and experience such as Māori, including Community Māori Cancer Navigator roles, and for Pacific peoples and those with disabilities. Importantly, improved access, experience and outcomes are dependent on the success of primary health care and wider hospital and specialist services such as colonoscopy access. Therefore, it may be beneficial to support a role, particularly for Māori, that is enabled to support co-design of integrated models of care across and within primary, community and secondary care.

7. Many stakeholders reported the critical dependency of having sufficient and appropriate (e.g., patient dignity and confidentiality during consultations) physical space for service provision. While assessing the impact of current and future facility planning is out of our scope, we note that where space is insufficient or inappropriate for servicing current volumes (and staff), additional space will need to be made available as demand and workforce grows and this may be of urgent priority given the immediate planned uplifts in staffing within the service.

8. It is also noted that private laboratory arrangements do not provide Haematology registrar placement – which impacts on training and 'growing' the local workforce.

In considering the project's findings and recommendations, we note five further points:

1. SDHB has developed a model of care with apparently greater outreach across the district than most other cancer centres, which has impacts on workload and FTE. While this promotes access to services for DHB residents, and aligns with the direction of travel of the health system, and that of other centres, the organisation could review the cost-effectiveness of its outreach model of care to ensure that the relative investment requirements are delivering appropriate value.

2. All the data and analysis in the report needs to be considered in the context that Southern, unlike many other centres, does not have a large proportion of private sector service delivery (especially for Radiation Oncology) – for private paying patients. This means that the activity undertaken in the public system will be greater proportionally than elsewhere, including lower complexity care. The main measure of comparative workforce resourcing impacted will be population to FTE – although the average number of treatments will also be likely higher due to lower complexity work being undertaken. Given most other centres, and their catchment populations, have the potential to access private sector capacity, SDHB could explore the benefits of enabling this setting of care within the district – noting that this would be a longer-term strategy, and would create a different set of challenges such as local competition for workforce between public and private sectors, particularly technical and support roles.

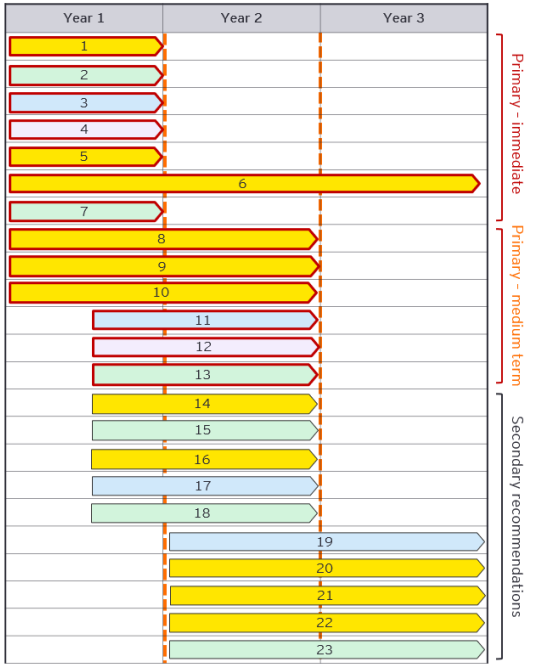
3. It is noted that the scope of this project did not include an assessment of the relative benefits of the scope and level of clinical interventions provided by the DHB's SBCS. It is further noted, that in some instances, there were identified issues with SDHB's coding and reporting of activity – as detailed in the CCA's benchmarking exercise. For example, Haematology treatment counts were sourced from SDHB's local data given reporting

issues, whereas for other centres this was from data submitted to the CCA as part of COVID-19 reporting. Local DHB data suggests much higher treatments in SDHB than elsewhere – both on a per capita basis, and per FTE. This is likely best considered a data issue – and was not directly included in the project's consideration of adding an additional 0.3 Haematology SMO FTE.

4. The DHB has already made a significant commitment to increasing FTE across SBCS in FY22 (and in FY21 for Radiation Oncology), including in new medical, nursing and technical roles. The benefits of these increases will not be fully known until new resources are recruited and in place in the service.

The increases in resourcing previously agreed for SBCS followed a process between DHB management and SBCS. In the main, the agreed FTE increases align with the implications of the available benchmarking information, noting caveats and limitations. Based on previously agreed increases in resourcing for the DHB's radiation oncology service, resourcing will be at the high end of peers for these roles based on the metrics used in the CCA benchmarking exercise - noting the relatively high course rate per capita, and the requirements for planning treatments and patient management. While noting the five points above, a three-year roadmap of actions is provided overleaf, which is intended to give a clear direction for addressing key workforce and related gaps for SBCS - as they relate to benchmarking, and what we heard from clinical and managerial stakeholders at SDHB. We believe that with renewed and sustained effort of the service together with the support of the organisation's leadership, SBCS can address immediate challenges and make good gains in achieving the overall aspirations of the DHB and its SBCSs.

**Figure 1: Three-year roadmap of recommendations for SBCS**




**Considerations and key dependencies for roadmap implementation:**

- Ensure sufficient physical space to allow current + future delivery of services (both inpatient and outpatient);
- Psychosocial and allied health currently have shared roles across medical service;
- Māori community cancer navigators are currently funded by the DHB;
- Haematology and medical oncology pool may be dependent on general medical registrar numbers;
- Nursing staff based at peripheral centres; and
- Private lab & implications for haematology registrar training.

| | |
|---|---|
| **Primary recommendations – immediate** | |
| 1 | Increase administration and nursing staffing to support budgeted uplift in clinical FTE, and current workload. Estimated to be 2 registered nursing FTE, and four administrative positions, across SBCS. Longer-term ensure the optimal use of digital technology and workflow tools to improve efficiency. |
| 2 | Increase 0.3 SMO FTE for Haematology to promote recruitment for this role and support imminent Day 1/Day 2 transfers for SCT as well as develop steps to manage the transfers |
| 3 | Prioritise recruitment of the remained budgeted FTE for FY21, especially the 1.375 Radiation Oncologist FTE and recruit for retiring SMO positions (*due to immediate succession planning needs*) |
| 4 | Consider a further 1.0 SMO FTE for Medical Oncology |
| 5 | Ensure adequate staffing levels to allow staff to use their designated proportion of non-clinical time |
| 6 | Continue support of current training pathways/programmes for medical staff, oncology nursing, and for advanced training (for CNSs, Nurse Practitioners, and RTs) |
| 7 | Purchase Plasmapheresis service from NZBS |
| **Primary recommendations – medium term** | |
| 8 | Continue support of existing roles to support access and outcomes for Māori + Pasifika such as Community Māori cancer navigator roles |
| 9 | There should be an uplift of allied health resourcing and psychosocial support to better deliver a multidisciplinary team model of care to improve patient experience and outcomes |
| 10 | Improved DHB Information Technology (IT)/Information systems (IS) engagement with SBCS to achieve enhanced integration and resiliency of service. Dedicated IT support capacity should be prioritised given the IT/IS needs of the service |
| 11 | Review workload of RTs and MPs in the context of agreed budget uplifts, and the CCA benchmarking exercise. With a focus on the comparative workload involved in planning of treatment courses |
| 12 | Gradually increase FTE for Medical Oncology registrars. Consider additional 1.0 FTE initially |
| 13 | As increased SMO supervision capacity becomes available as SMO FTE increases, gradually increase FTE for Haematology registrars |
| **Secondary recommendations** | |
| 14 | Consider the role of a telehealth coordinator (administrator role) to support better utilisation of telehealth at SBCS, that could be also used more widely across the organisation |
| 15 | Explore developing autologous SCT service at SBCS |
| 16 | Increase Māori + Pasifika workforce, and specific roles to address access to healthcare services and outcomes for these population groups, that may include co-design of healthcare services and models of care |
| 17 | Ongoing review of FTE for Radiation Oncology registrars as SMO workforce increases |
| 18 | Work with private laboratory to enable Haematology training |
| 19 | Consider some increased expansion of CNS scope of practice in RO, and concurrently continue to promote increased scope of practice for RTs |
| 20 | Develop ongoing L&D opportunities for clerical staff (e.g. MDM roles) + sufficient career progression pathways & opportunities within role to tailor depending on preferences |
| 21 | Consider trailing different leadership arrangements, e.g., non-medical leadership arrangements for some teams, or rotation of clinical governance |
| 22 | SDHB to work with commissioned NGO sites to ensure appropriate training and clinical development opportunities for relevant nursing roles and staff |
| 23 | Develop protocols for both malignant and non-malignant conditions, so can be managed by CNSs where possible and GPs in the community |

Key: SBCS overall – across service | Medical Oncology specific | Radiation Oncology specific | Haematology specific

## List of acronyms

| Table 2: List of acronyms | |
|---|---|
| **Acronyms** | **Definition** |
| CCA | Cancer Control Agency. |
| CNS | Clinical Nurse Specialist. |
| DHB | District Health Board. |
| ELT | Executive Leadership Team. |
| EY | Ernst & Young New Zealand. |
| FCT | Faster Cancer Treatment. |
| FSA | First Specialist Assessment. |
| FTE | Full-time equivalent. |
| GP | General Practitioner. |
| HDR | High dose-rate. |
| HO | House Officer. A doctor during their first two years of employment following their registration. Applies to graduates of Australian or New Zealand medical schools and graduates of NZREX clinical examination. |
| HWNZ | Health Workforce New Zealand. |
| IDF | Inter-District Flows. |
| IT | Information technology. |
| LINAC | Linear Accelerator. |
| MDT | Multidisciplinary team. A team of many health specialists such as medical oncologists, surgical oncologists, radiation oncologists, nurses, allied health, and pharmacists who work together to treat cancer patients. |
| MDM | Multidisciplinary meetings. |
| MDS | Myelodysplastic Syndrome. |
| MP | Medical Physicist. |
| NMDHB | Nelson Marlborough District Health Board. |
| NZBS | New Zealand Blood Service. |
| Pharmac | The Pharmaceutical Management Agency. |
| ROC | Radiation Oncology Collections. |
| RT | Radiation Therapist. |
| SBCS | Southern Blood and Cancer Service. |
| SDHB | Southern District Health Board. |
| SCDHB | South Canterbury District Health Board. |
| SCT | Stem cell transplant. |
| SMO | Senior Medical Officers. |
| TI | Trainee Intern. |
| WCDHB | West Coast District Health Board. |

# Glossary

| Table 3: Glossary | |
|---|---|
| **Terms** | **Definition** |
| Accreditation | Accreditation is the process used to approve the College recertification programmes that doctors participate in to ensure that they continue to be competent to practise within the scopes of practice in which they are registered. |
| Allied health | The allied health workforce is made up of health professionals who are not part of the medical, dental or nursing professions. Allied health professionals are qualified health practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. |
| Comorbidity | Co-occurrence of two or more conditions in the same individual. |
| Dietician | A healthcare professional who is trained in nutrition and diet, to help people make diet choices. |
| Lymphoma | Cancer of the lymph nodes. |
| Malignant | Cancerous, where the tumour grows uncontrollably and may spread. |
| Modality | A method of treatment. For example, surgery and chemotherapy are treatment modalities. |
| Model of care | Broadly defines the way health services are delivered. |
| MOSAIQ | A patient management information system. |
| Palliative care | Treatment to relieve symptoms, rather than cure. Palliative care can help people live more comfortably. |
| Registrar | A resident doctor who has been employed before their appointment as registrar, as a House Officer/Senior House Officer for at least 2 years. Depending on experience, a doctor may be eligible to work as a registrar in their third year post graduation. |
| Stereotactic radiotherapy | A type of radiation therapy that uses special equipment to position the patient and precisely deliver radiation to a tumour, commonly used to treat brain tumours and other brain disorders. |
| Telehealth | The use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location. |
| Waitlist | The number of patients waiting for treatment as calculated using the National Booking Reporting System. |
| Waiting time | The length of time any given individual is required to wait to receive the required treatment. |

# 2. Introduction

## 2.1 Background

Southern Blood and Cancer Service (SBCS) is one of the six cancer centres in New Zealand, providing Medical Oncology, Radiation Oncology and Haematology specialist inpatient and outpatient services. SBCS primarily provides care for the resident population of Southern District Health Board (SDHB). This makes it relatively unique, as most other cancer centres service residents of other DHBs within their Region, and are generally supported by companion services within these referring DHBs – which provide less complex care for their resident populations, and may manage patient follow-up when a patient is discharged from the care of a cancer centre.

SBCS aspires to provide high quality, leading practice oncology and haematology services, where patients receive appropriate treatments within appropriate timeframes, and staff are provided with a suitable working environment. There have been some ongoing issues with high numbers on waiting lists and prolonged waiting times at SBCS, and therefore, SDHB and Te Aho o Te Kahu | the Cancer Control Agency (CCA) have sought to develop an action plan for SBCS – with the action plan based on an assessment of the current state of SDHB's oncology and haematology services and the immediate actions required to better align the DHB's oncology and haematology workforce resourcing relative to service delivery with that of the other five cancer centres in New Zealand.

Establishing a clear understanding of the current state of oncology and haematology services at SDHB, in comparison with New Zealand's five other cancer centres, is intended to be informative for SDHB's current Board, the CCA and the future Health New Zealand entity in determining immediate actions and investment for these services.

As such, SDHB commissioned EY to develop an action plan for SBCS informed by:

- Resourcing patterns at New Zealand's five other cancer centres, cognisant of differences in service scope and mix;
- Future demand growth, epidemiological and model of care changes which could influence resourcing and service delivery patterns at the DHB, and more broadly, oncology and haematology services across New Zealand; and,
- A documented understanding of current resource constraints at the DHB and their impact on service delivery.

This document includes:

- A current state assessment of the oncology and haematology services at SDHB, in comparison with the other five cancer centres in New Zealand;
- Clarifies the most immediate gaps and the priority investment that is required to close those gaps; and,
- The actions that need to be taken over the next three years in order to align resourcing and service delivery so that it is on par with national comparisons. Both in terms of investment but also in terms of any practice change.

## 2.2 Purpose and scope

The purpose of this report is to provide an action plan for SDHB's oncology and haematology services for the next three years.

The scope of this report providing recommendations for addressing immediate workforce resourcing gaps between 2022 and 2024, largely in the context of how SBCS resourcing compares

with that of the other five New Zealand cancer centres. In estimating immediate gaps, the report considers the unique context that these services operate in, as well as the key dependencies for the services.

Out of scope of this report are:

- Long-term planning beyond the proposed three-year time horizon including the workforce resourcing necessary to align with international and local best practice;
- Assessment of efficiency and workflows – which are being considered through other SDHB work;
- Quality assurance of data supplied by SDHB and CCA;
- Detailed operational model of care, workforce and capacity planning and design;
- Financial, economic and affordability analysis;
- Consideration of surgical services and workforce that are involved in cancer service delivery; and
- Consideration of other services including palliative care, and laboratory and diagnostic services that create dependencies for cancer service delivery.
- Reviewing previously agreed investment choices related to workforce resourcing in SBCS.

## 2.3 Methodology

In preparing this report, the following approach has been taken:

- **Steering Group formation and engagement.** The Steering Group was established to bring together knowledge and expertise required from various clinical roles across specialities in addition to operational leads, from both SDHB and CCA, to provide guidance during the project. Three one-hour meetings were held over the course of the project for members to provide feedback on the project progress. Refer to Appendix B for the Steering Group Terms of Reference with more detailed responsibilities and membership composition.
- **CCA benchmarking exercise.** CCA requested data from across New Zealand's six cancer centres to provide a high-level snapshot of the current full-time equivalent (FTE) allocation. The aim of the exercise was to better understand current staffing levels and service delivery at SDHB, compared to other centres, to identify immediate gaps. Please refer to Appendix C for the full report.
- **Supplementary data analysis.** There was further quantitative exploration of drivers of differences for SBCS such as operating context (e.g., rurality) and demographics of population served. More specifically these analyses used National Collections (National Minimum Dataset, National Non-Admitted Patient Collection, New Zealand Cancer Registry) datasets to understand:
    - Patterns across the patient cohort receiving Blood and/or Cancer services;
    - Delivery sites within the scope of each cancer centre; and,
    - Benchmarking data was recalculated using proposed uplifts in FTE for 2022 and proposed additional FTE as per recommendations in this report; and

- Current ratios of administrative and nursing staff per SMO at SBCS based on SDHB data, and the implied increases required to maintain relative workloads given planned and recommended uplifts in SMO FTE.

- There was extensive stakeholder engagement with various groups at SDHB including clinical and operational leads in SBCS, in addition to other SBCS staff members across a variety of roles (more than 50 staff in total). There was also engagement with key clinical and operational leads at the other five cancer centres, and members from CCA:

  - **Scene-setting interviews with key clinical and operational stakeholders.** This included 10 interviews with Clinical Leads of three services (Medical Oncology, Radiation Oncology, and Clinical Haematology), Radiation Therapist Lead, Head of Medical Physics, Service Manager, Associate Director of Nursing, General Manager, Executive Director for Specialist Services, and CCA's Regional Hub Manager for Southern.

  - **Interviews with the other five cancer centres in New Zealand.** Interviews were held with representatives from other five centres including both clinical and operational leads (or other Senior Medical Officers (SMOs) from each specialty if leads were not available). Most interviews were conducted as a group with multiple participants except for Wellington where three 30-minute individual interviews were held. Please note that not all specialties were represented across all interviews due to difficulties with coordinating availability, with Haematology being least represented across centres.

    The purpose of these interviews was to discuss the CCA's benchmarking exercise findings, identify factors that may explain differences between SDHB and the other cancer centres, and key learnings that may be relevant for Southern.

  - **Stakeholder workshops with both clinical and operational leads for SBCS, in addition to other staff members.**

    The first round of stakeholder workshops included a wide range of SDHB staff across different roles to validate and understand observed differences, including key drivers, between SBCS and other cancer centres, and potential responses around workforce and service delivery. Four workshops were held with stakeholders from each specialty/group (Medical Oncology, Radiation Oncology, Clinical Haematology, and staff from peripheral centres), respectively. Each of the workshops had 10-20 participants.

    Following this there was a second stakeholder workshop with the clinical and operational leads, in which there was discussion of proposed recommendations, their validity, and their prioritisation and sequencing.

Caveats and limitations related to the project's methodology include:

- We acknowledge limitations around the benchmarking exercise given comparability challenges with the data provided to CCA. CCA requested data for budgeted FTE, but it was not confirmed whether FTE provided by other centres represented budgeted or actual FTE, and this was not extensively or formally validated with the centres. The FTE also did not represent 'job-sizing' or what other cancer centres thought is required for efficient, effective, and sustainable service delivery. Limited description of other roles e.g., administration provided by other centres, made comparability of roles and resourcing between centres impossible.

- Other data issues were related to the use of National Collections data for supplementary data analysis. According to the feedback we received, National Collection data may not accurately reflect current operational practice, although this appears to be at the margin.

- Given the acknowledged limitations identified for the quantitative analyses, recommendations were formed based on a holistic and synthesized view of all the information received, including extensive qualitative feedback from SBCS staff and from other cancer centres taken at multiple points alongside quantitative analyses.

- It is also acknowledged that many cancer centres are facing challenges regarding workforce resourcing. FTEs reported by other cancer centres may not reflect optimal staff resourcing, and therefore the current state assessment and the report's recommendations were provided with the aim of informing any immediate gaps between SBCS and the other centres and the priority investment needed to address these gaps, taking into consideration the already approved uplift in FTE budgeted for FY22, rather than what the best practice looks like.

# 3. Key findings and observations

## 3.1 Southern Blood and Cancer Service Overall

This section summarises the key themes from engaging with SBCS stakeholders and representatives from the five other cancer centres – which are relevant for each of the specialties within SBCS (Medical Oncology, Radiation Oncology, and Haematology). Recommendations spanning SBCS based on these themes, the implications of the CCA benchmarking report, and supplementary data analysis are provided at the end of the section.

### 3.1.1 Overview of the service

SBCS provides Medical Oncology, Radiation Oncology, and Haematology services for the entire Southern district. Different services are provided across six sites – Dunedin (centre), Invercargill, Oamaru, Balclutha, Dunstan, and Queenstown.

SBCS directly employs a wide range of medical, technical, and non-clinical staff, who work either specifically for each of the three specialties or across the whole service. In addition, there are roles that do not directly report to SBCS but are crucial to, and interrelated with the delivery of cancer services, such as pharmacists, allied health including dieticians and physiotherapists (which are shared with other medical specialities), and psychosocial support staff including psychologists, district nurses who perform community work for oncology, and staff at peripheral centre who deliver oncology services including Clinical Nurse Specialists (CNSs) and chemotherapy trained nurses.

### 3.1.2 What we heard from stakeholders

Key clinical and operational leads at SBCS as well as other SDHB staff members across various roles provided insights around the service – mainly on the service's key strengths, challenges, and opportunities. *Please note that this section (Section 3.1) is focused on the findings that are applicable to the whole service; findings and recommendations specific to a specialty are detailed in the succeeding sections.*

What we heard from stakeholders was:

- The services are academically grounded and innovative, with successful pathways for training of oncology nurses and CNSs, and for Radiation Therapists (RTs). These pathways facilitate capacity building and promote retention, and facilitate workforce models of care that utilise maximal scope of practice for clinical staff, in the context of capacity pressures.

- Staff described a supportive environment, where there is usually good integration between specialities; and committed, dedicated, patient-orientated staff.

However, many key challenges were also reported to exist for SBCS across all specialties which included:

- The challenges of a growing and ageing population with more complex needs, together with increasing new techniques and treatments available;

- That the Southern district is a large geographic area, with many small communities, and therefore it is challenging to enable dispersed, local access to patients. This also varies depending on the amount of care delivered rurally among specialties, with increased burden for specialities with larger amounts of rural service provision;

- High workloads in comparison to existing workforce capacity. This was reported as exacerbated by insufficient availability of staff in key roles, such as administration/clerical staff and registrars, that could potentially decrease workload for SMOs and other clinical

staff; difficulties with staff recruitment and retention for some roles e.g. SMOs and service managers; insufficient physical space for services particularly in the context of increasing demand; difficulties with cross-coverage given the small workforce to maintain steady throughput when staff (particularly SMOs) go on leave; and more frequent on-call in comparison to other DHBs across all three specialties because of smaller headcounts.

These issues were reported as contributing to long patient waiting times (relative to national averages), and a lack of non-clinical contact time which may decrease opportunities for clinicians to perform other key tasks such as quality and safety activities, research, and future service planning. This also provides less resiliency to the service for cross-covering those on leave, as there is little flexibility in clinical workload and scheduling. Impacts of the high frequency of on-call work may contribute to increased job stress and poorer quality of life for staff.

- Communication difficulties between some roles within services, and upwards to those at higher levels of management was reported;
- Attention to immediate issues leading to less opportunity for long-term planning, with interventions often making short-term improvements, but not addressing chronic problems (eg. use of locums for reducing wait lists); and,
- There was felt to be a high burden associated with teaching commitments given the relationship of the service to the medical school and university, as well as an active research unit.

Reported key opportunities for SBCS across all specialties include:

- Increasing support capacity including:
    - Information systems (IS) and processes need to better serve cancer services through enhanced integration and resiliency. Improved DHB Information Technology (IT)/IS engagement with the SBCS is required to achieve this. Dedicated IT support capacity should be prioritised given the IT/IS needs of the service;
    - Promoting the site as a training centre by increasing number of registrars (at all levels, but particularly advanced trainees);
    - Developing the Māori and Pasifika workforce to aid efforts to improve access and equity;
    - Further development and expansion of roles in service including educators, cancer care nurse coordinators, and CNSs, and greater access to allied health staff for haematology & oncology services, particularly dedicated dietician support; and
    - Greater recognition of importance of psychosocial support and associated staff including psycologists, counsellors, and social workers.
- Future strategic planning & processes including:
    - Exploring alignment of some treatment protocols with other cancer centres *(in the context of this currently being undertaken nationally by CCA, and with similar processes having been undertaken for Radiation Oncology for major cancers);*
    - Increasing the ability for SMOs to use non-clinical time for other important activities such as planning and research;

- Opportunities for further regional collaboration, noting that regional planning may be enhanced in context of health reforms; and

- Improving visibility on external data reporting (around the information reported to external agencies) to ensure associated data coding is up-to-date with the increasingly complex treatments.

Important dependencies with other services were alerted as needing consideration:

- Oncology district nurses perform community work for oncology. This is managed by district nursing, rather than SBCS;

- Roles including multidisciplinary meetings (MDM), Fast Cancer Treatment (FCT), Cancer Nurse Coordinators, palliative care CNSs (see below also), and psychosocial roles that contribute to the function of the service but also interface more broadly;

- Surgical workloads and referrals (e.g., impacts of absent flows on public holidays or COVID-19 on surgery, causing fluctuations in oncology services workload);

- The importance of the palliative care services for oncology and haematology patients, which is shared amongst medical and surgical services but frequently required by oncology and haematology patients due to the nature of their conditions. It is important to ensure patients have sufficient access to palliative care services with any workload changes within SBCS.

- Access to diagnostic services (including complex radiology and pathology) is critical to blood and cancer services, and the interdependency of the availability of these services was noted for SBCS; and

- Physician workload and capacity from other medical specialties, eg. Referrals from respiratory physicians for lung cancer, as fluctuations in respiratory physician workload / availability may impact diagnostic speed and/or patient flows for oncology referrals.

### 3.1.3 Key themes from other cancer centres

The following key themes emerged from the interviews with other five cancer centres and are applicable to all specialties. Importantly, these findings were subjective as reported by the other cancer centres and were based on interviews that had varying representation of some specialities, particularly noting the lack of Haematology representation generally. The key themes were:

- There was acknowledgement that an ageing population and increasing possible scope of technologies and treatments create a challenging environment for blood and cancer services nationally;

- All centres reported some rural service delivery and associated subsequent strains on staffing and services depending on extent of this. It should be noted that volumes and workload associated with regional service delivery varies across centres, with some delivering services across large geographic areas and/or supporting service delivery in peripheral centres;

- Training and extended scope of practice was seen as beneficial, but there was acknowledgement of difficulties associated with SMO supervision required for these roles;

- Many centres have found large benefits from tumour streaming, that extend beyond patient care, but acknowledge challenges for this in smaller centres in terms of cross cover (i.e. need sufficient volumes within tumor streams to organise team based delivery, and subspecialty leads). Trends for subspecialisation can impact on patient flow and resourcing

patterns within services, with critical mass (of both patients and workforce) important to enable increasing subspecialisation;

- Benefits for regionalisation may include increased consistency of services (data collected and shared, care protocols), but this should not be considered a solution for underinvestment in workforce resourcing;

- Team structure and collaboration – there was reflection on the impact and value that different leadership structures and roles can have on the service, with some centres reported it was useful to have leadership roles seperate to clinical leads for individual services, and to have structures that promote collaboration through flattening of traditional medical hierachies, including non-doctor led groups. They also discussed that the rotation of clinical leadership roles can be beneficial; and

- Most centres discussed that 'growing their own' for medical workforce was critical for recruitment and retention.

### 3.1.4 Key findings from CCA benchmarking exercise

The table below lists the key findings based on CCA's benchmarking exercise, both across SBCS and for specific specialities. According to the analysis, SBCS appears to have fewer FTE across clinical and technical positions relative to patient activity in comparison to most other cancer centres, which aligns with the feedback from key stakeholders from both SBCS and other centres. Please note that this exercise did not include job sizing. Furthermore, to manage increasing workload and referrals over recent years, SBCS SMOs renumerated hours are now almost all used for direct clinical tasks (30% of non-clinical time was reported as standard in other centres).

Please note that two calculations were performed as part of the original benchmarking exercise for Radiation Oncology, as for this speciality the entire budgeted FTE for FY21 was yet to be recruited for at the time of the report - with the **actual FTE** standing at 4.6 for Radiation Oncologists, with a further 1.72 filled but with roles not starting until Feb/Dec 2022, and 1.375 remaining unfilled, making up a total of 7.695 FTE **budgeted** for in FY21.

Caveats and limitations have been acknowledged and taken into considerations when reviewing the benchmarking information. Refer to Section 2.3 – Methodology for more details.

| Table 4: Key findings from the CCA benchmarking exercise | |
|---|---|
| **Specialty** | **Key differences for SBCS (in comparison to other cancer centres)** |
| Across specialties | Low number of registrars |
| Medical Oncology | Greatest number of FSAs per SMO FTE |
| | Greatest number of treatments per SMO FTE |
| | Second lowest ratio of SMO FTE : population |
| Radiation Oncology | With actual FTE – lowest number of SMO FTE per LINAC[2]<br>With budgeted FTE this becomes third highest |
| | With actual FTE – highest FSAs per SMO FTE and highest courses per SMO FTE<br>With budgeted FTE – second to lowest FSAs per SMO FTE and lowest courses per SMO FTE |
| | With actual FTE – third highest ratio of SMO FTE : population<br>With budgeted FTE this becomes the highest |
| | Low number of MPs and RTs per LINAC |

[2] Please note that actual FTE is currently 4.6 for Radiation Oncologists. There was a total of 7.695 FTE budgeted for in FY21, however 1.72 has been filled but roles are not starting until Feb/Dec, and 1.375 remains unfilled.

| | |
|---|---|
| Haematology | Fewest FSAs per SMO FTE |
| | Greatest number of treatments per SMO FTE |
| | Third highest ratio of SMO FTE : population |

### 3.1.5 Key findings from supplementary analyses – ratios of administrative and nursing FTE to SMO FTE

A strong theme that came through engagement with SBCS stakeholders, and discussions with other cancer centres, was the importance of administrative and nursing support for efficient and effective service delivery.

Unfortunately the CCA benchmarking exercise was unable to assess the relative resourcing of administration and nursing between centres given wide variation in how these areas are arranged and resourced. Furthermore there are no clear quntifiable standards and guidelines that provide indications of appropriate or optimal arrangements or resourcing for these roles in oncology and hematology services.

Given the importance and priority placed on addressing reported deficiencies in these areas, we conducted assumptions based analysis using SBCS workforce data. We were also advised by the service that the following additional resourcing should be considered: 2 additional booking clerks, an additional non-clinical administration role, and a typist, to be shared across SBCS.

The assumptions that underpinned our analysis were:

- As new medical staffing are brought on, only some of their time will be for direct clinical work that generates additional patient activity – given the objective of sharing clinical workload, and enabling senior staff to have non-clinical time.
- While there are reported deficiencies in existing resourcing, a start point to inform modelling is the current ratio of administrative and nursing staff per SMO.
- The services should retain some flexibility in determining the optimal mix of roles in discussion with operational and executive management.

Our assumptions based analysis suggests that 2.0 FTE for nursing staff (in addition to the FY22 uplift of 2 nursing staff) and an increase of four administrative positions will be required to support the proposed uplift in medical FTE (inclusive of both the already approved FY22 uplift, and those recommended in addition in this report). This is on the assumption that senior medical staff will be progressively enabled to have at least 20% non-clinical time, and patient workload is shared across SMOs.

### 3.1.6 Summary of our perspective based on key findings

The insights from both SBCS stakeholders and from representatives of the other five cancer centres highlighted the key characteristics of SBCS's workforce resourcing and service delivery, and the most immediate gaps between Southern and the other cancer centres. This information was reviewed in conjunction with the CCA's benchmarking findings and a range of supplementary analysis, to provide both qualitative and quantitative perspectives to inform this current state assessment:

1. There are a high number of clinics delivered at rural centres by SBCS which are associated with additional workload burdens across both SMOs and other roles in the service, as rural clinic delivery requires: prolonged driving times (1-4hrs depending on peripheral centre) or plane journeys with reported safety concerns for SMOs, and support for CNSs and oncology trained nurses at these centres. This also has significant workload implications for other

clinical/allied health works including members of the psychosocial team, who deliver home visits at these peripheral centres.

One of the differences for SBCS compared to other cancer centres is that there are no oncology SMOs at these peripheral centres (unlike some other cancer centres that service large regions that have own their SMOs e.g. Nelson Marlborough DHB (NMDHB), South Canterbury DHB (SCDHB)) for Medical Oncology and Haematology.

2. There are a fewer registrars across all specialities at SBCS compared to other centres which likely exacerbates current workload for all clinical and technical roles, but also creates difficulties for future recruitment and retention of SMOs, as registrar training (according to other cancer centres) is the most successful recruitment strategy for senior medical staff.

   However, it should be noted that a benefit of fewer registrars is that it has led to increased innovation around workforce models for other clinical staff. For example, CNS pathways for nurses in oncology and haematology, and extended scope of practice for RTs. This approach should be retained, but it is also important to recognise that these roles require adequate supervision by SMOs (which also creates workload), and also for CNS roles there is a need to recognise that they use a nursing model of care and should not be thought of as replacing the need for adequate medical staffing.

3. There are low numbers of reported administration staff across all specialities in SBCS (noting this was reported as a DHB-wide challenge). Note it was not possible to compare the level of resourcing at SBCS with other cancer centres due to data limitations.

   An overwhelming theme from all stakeholder interviews, including from administrative staff themselves was a lack of both clinical and non-clinical administrative staff (such as service administrators). The lack of administrative staff was reported as exacerbating clinical workload as some tasks that could be performed by less a expensive workforce may be performed by clinicians and/or technical roles.

4. There were a low number of Medical Physicists (MPs) and RTs per LINAC compared to other centres – acknowledging that FTE per LINAC is a high level measure, which does not account for factors such as patient complexiety and time spent on course planning.

   This small technical workforce may be exacerbating current issues with commissioning of LINACs, given that currently this is requiring a split shift for MPs to maintain LINACs and ensure maximal treatment delivery to patients, but this may reduce possible time spent on commissioning.

### 3.1.7 Recommendations that apply across SBCS

To address the immediate gaps for SBCS regarding workforce resourcing, our recommendations for actions are provided around the following four categories:

| | |
|---|---|
| Workforce (recruitment & retention) | Workforce model |
| Workforce structure and organisation | Other activities e.g., production planning |

Based on a synthesized view of all key findings, our recommended approach is:

1. Bolster administrative staff that support current service delivery, as administrative gaps will likely be preventing services being delivered as efficiently as possible (noting wider DHB

work on efficiency and workflows). There may be opportunities to better use workflow tools and digital approaches to support more efficient administration – these are out of scope of this report but should be considered more broadly by the organisation.

2. As reported by other cancer centres, to provide a service that aligns with contemporary models of care for oncology patients, a multi-disciplinary approach is required to enhance patient outcomes and experience, and therefore we would recommend bolstering allied health and psychosocial roles to allow sufficient availability and support of these roles for patients. In particular, priority would be for increased access (which may be dedicated FTE attached to the service) for dietician support, and additional FTE for psychosocial support.

3. Given reported issues with waiting list numbers and times, and benchmarking information from the CCA, there is prima facie evidence to increase clinical FTE, which for Medical Oncology and Haematology include SMOs and nurses delivering chemotherapy, and for Radiation Oncology includes SMOs and RTs. Details of recommendations regarding further potential uplifts in FTE are provided specifically for each speciality in their respective sections, however the intention would be that for SMOs, job size may potentially decrease as the size of this workforce is increased – balanced with the need to provide sufficient non-clinical time.

4. Once there is sufficient workforce across all roles in the service to support increased workloads to address waiting lists issues, there should be further increases in registrar FTE to promote recruitment of future SMO workforce, given issues depending on locums, and challenges with hiring in the current environment for these sorts of specialised medical roles.

SDHB should also consider critical dependencies identified related to workforce including issues with current lack of space for service provision in both inpatient and outpatient settings, which has been raised as a significant barrier to patient care by staff and private laboratory arrangements that do not provide Haematology registrar placement.

Specific recommendations are given below (not given in order of importance):

| Table 5: Recommendations that apply across SBCS | | |
|---|---|---|
| **Category** | **Recommendations** | |
| Workforce (recruitment & retention) | Primary - immediate | 1. Add two Booking Clerks, one non-clinical administration staff and one typist for SBCS, to ensure there is sufficient administrative support for the increased medical FTE planned for FY22 and corresponding increases in workload, given the following considerations:<br>▸ This investment should go alongside opportunities to consider the use of new digital technology and workflow tools in the longer-term. |
| | | 2. Increase nursing staff FTE by an additional 2.0 to ensure there is sufficient corresponding nursing to match the increased medical FTE planned for FY22 and corresponding increases in workload.<br>▸ Based on considerations similarly to increased administrative FTEs, an uplift of 4.0 FTE total in Registered Nurses appears to be sensible, as the midpoint between 1.1 and 8.8 additional Nursing FTE calculated from the ratio modelling. This considers that the service has already planned to increase 2 FTE nursing staff in the FY22 uplift.<br>▸ Distribution of this Nursing FTE in terms of speciality and location should be further discussed with the service. |
| | | 3. There needs to be prioritisation of recruitment of the remained budgeted FTE for FY21 (e.g., 1.375 Radiation Oncologists) and succession planning, particularly in Radiation Oncology, with recruitment efforts started in the short-term given the imminent retirement of three out of five Radiation Oncologists. |
| | Primary – medium term | 4. There should be an uplift of allied health resourcing and psychosocial support to better deliver a multidisciplinary team (MDT) model of care to improve patient experience and outcomes. |
| | | 5. Information systems (IS) and processes need to better serve cancer services through enhanced integration and resiliency. Improved DHB Information Technology (IT)/IS engagement with the SBCS is required to achieve this. Dedicated IT support capacity should be prioritised given the IT/IS needs of the service |
| | | 6. Continuing support of existing roles to support access and outcomes for Māori and Pasifika such as community Māori cancer navigator roles. |
| | Secondary | 1. Increased emphasis on increasing Māori and Pasifika workforce, and specific roles to address access to healthcare services (which may be broader than SBCS) and outcomes for these population groups, that may include co-design of healthcare services and models of care. |
| | | 2. Consider the role of a telehealth coordinator (administrator role) to support better utilisation of telehealth at SBCS, that could be also used more widely across the organisation (*although it would be important that this position was able to successfully support SBCS as a priority*).<br>▸ This may have the added benefit of freeing up time of other administrative staff.<br>This is in addition to current SDHB-wide plans for increased telehealth coordinator support in FY22. |

| | | |
|---|---|---|
| | *Dependencies* | *Consideration actions to maximise benefits within key dependencies that allow expansion of workforce including:*<br>▸ *Private laboratory that does not provide placements for Haematology trainees;*<br>▸ *General medical registrar numbers at SDHB, which is the pool from which Medical Oncology and Haematology registrars may be taken from; and*<br>▸ *Nursing at peripheral centres on whom the service is dependent for administration of chemotherapy, and CNS practice at these peripheral centres, and subsequent requirement for increased workforce centrally (in Dunedin) to adequately supervise and support this workforce delivering services rurally.* |
| Workforce structure and organisation | Secondary | 1. We heard from other cancer centres about the success of different leadership arrangements, for example, having non-medical leadership arrangements for some teams and rotating clinical governance. There should be consideration of trialling alternative forms of leadership, in discussion and agreement with SBCS staff. |
| Workforce model | Primary – immediate | 1. There needs to be adequate staffing to allow staff to use their designated proportion of non-clinical time, as utilisation of this requires appropriate levels of staffing to balance clinical workload commitments.<br>▸ As staffing increases, consideration of the size of an FTE, and the balance between clinical and non-clinical time should be revisited, with the aim for 70% clinical time on average. |
| | | 2. There should be continued support of current training programmes/pathways for medical staff, oncology nursing, and for advanced training (e.g., for CNSs and Nurse Practitioners).<br>▸ However, we recommend that SBCS should endeavour to ensure that staff engaging in advanced training programmes will be provided employment in these roles at the end of training. |
| | Secondary | 1. There should also be continued support for opportunities for increased scope of practice for RTs. |
| | | 2. There was some feedback that nurses at rural centres may face unequal opportunities for professional development and career progression compared to nurses placed centrally, and SDHB should work with commissioned NGO sites to ensure appropriate training and clinical development opportunities for rural staff where possible – noting that staff in these centres are employed by DHB commissioned providers. |
| | *Dependencies* | *Consideration of key dependencies: Psychosocial and allied health currently have shared roles across medical specialities, and some more designated FTE specifically for oncology should be considered, as currently they are not dedicated to this service.* |
| Other activities | Secondary | 1. Additional focus should be given to ongoing learning & development opportunities for clerical staff (e.g., MDM roles) and sufficient career progression pathways and opportunities within roles to tailor responsibilities depending on preferences. |
| | *Dependencies* | *Consideration of key dependencies to allow expansion of service delivery includes ensuring sufficient physical space to allow current and future delivery of services (both inpatient and outpatient). This was highlighted as a critical area during all staff engagement, and one immediately impacting patient care due to lack of private areas for consultation with patients, and this issue will be exacerbated by increased workload associated with workforce expansion.* |
| Strategic | Primary – immediate | 1. It is critical that there is adequate space for service delivery in both inpatient and outpatient settings, as described above. |

## 3.2 Medical Oncology

### 3.2.1 Service overview

Medical Oncology manages drug treatments for people with solid tumours, providing treatments including chemotherapy, targeted therapy, biologic therapy, and hormonal therapies. Clinical roles within the Medical Oncology service include Medical Oncologists, registrars, and nursing staff (including CNSs and one nurse practitioner), in addition to psychosocial support roles, and other allied health workers and associated clinical and non-clinical administrators.

The current FTEs for SBCS's Medical Oncology service are listed in the table below:

| Table 6: Current FTEs for SBCS's Medical Oncology service | |
|---|---|
| **Position** | **Number (FTE)** |
| Medical Oncologists | 4.76 |
| Medical Oncology Registrars | 2 |
| Nurse Practitioners | 0.9 |
| Nurse Specialists | 1.5 (1.0 Otago, 0.5 Southland) |
| Booking Clerks | 1 |
| Shared across all specialities | |
| Senior Nurses | 3.8 (Otago), 1.5 (Southland) |
| Registered Nurses | 13.42 (Otago), 3.37 (Southland) |
| Medical Secretaries | 3.5 (Otago), 0.6 (Southland) |
| Receptionists | 2.7 (Otago), 1.5 (Southland) |

Medical Oncology mainly delivers outpatient services with some inpatient care for acutely unwell patients. According to National Collections data, SDHB delivers Medical Oncology services to six sites in total, and provide outpatient appointments at three rural sites, accounting for 13.0% of the service's total outpatient appointments, which is much higher than Waikato, where 5.2% of the outpatient appointments are delivered at rural sites. SDHB also provides 16.0% of its chemotherapy appointments at rural sites, which is nearly twice the proportion that Waikato delivers at rural sites (8.2%). Note all centres have been considered in the analysis, however, the data reported to the National Collections does not appear to be capturing all activities delivered by each centre within their catchment, therefore, the table only shows the data for Southern and Waikato and limitations with this data should be noted.

| Table 7: Medical Oncology service delivery locations by DHB | | | | | | | |
|---|---|---|---|---|---|---|---|
| **DHB of Service** | **Centre** | **Sites in same DHB as centre** | **Sites in centre catchment (including tertiary provision)** | **Rural sites where outpatient appts are provided by centre** | **% share of outpatient appts** | **Rural sites where chemo is provided by centre** | **% share of chemo appts** |
| Waikato | Waikato Hospital | 2 | 7 | 1 | 5.2% | 1 | 8.2% |
| Southern | Dunedin Hospital | 6 | 6 | 3 | 13.0% | 3 | 16.0% |

### 3.2.2 What we heard from stakeholders

Most of the feedback from stakeholders for Medical Oncology applied to most other specialties across SBCS. Please refer to Section 3.1.2 for further details. However, a few key challenges were emphasized specifically for Medical Oncology, around the increasing number of complex funded treatments, and a co-morbid population.

The key opportunities highlighted for Medical Oncology were:

- Increasing advanced medical trainees;
- Future planning for treatments that are listed to be funded by PHARMAC in the future, in order to allow time and resources for Business Case development for delivery of these treatments;
- The need for ongoing support and adequate supervision for advanced nurses, operating with an increased scope of practice such as CNSs; and
- More consideration and recognition of the importance of psychosocial service and allied health in general – the benefits of having a dedicated dietician and physiotherapist in the service were emphasised. Please note however, that the theme of increased psychosocial and allied health access was also mentioned across all specialities in SBCS.

An additional key dependency for Medical Oncology (and Haematology) is that there are oncology trained nurses at peripheral centres (Invercargill & rural hospitals) who are not employed directly by SBCS.

### 3.2.3 CCA benchmarking

There are some key limitations for Medical Oncology noted in the benchmarking exercise conducted by CCA:

- Access to private centre Medical Oncology treatments was not accounted for.
- Population served, FSA and treatment data reflects the site of the cancer centre and smaller peripheral sites as some of the larger regions have Medical Oncologist and registrar FTE serving their local populations that were not quantified in this analysis e.g., NMDHB and SCDHB employ Medical Oncologists, and therefore they have not been included in Canterbury data.
- FTE data requested was budgeted FTE, and therefore this may not reflect actual FTE; and FTE data has not been validated with the centres.

With these limitations acknowledged, the key findings for Southern compared to other centres include:

- For Southern, the SMO FTE : population ratio is the second lowest of all cancer centres, meaning the average population served by each SMO FTE at Southern is larger than most of the other centres. The population per Medical Oncologist is the second highest of all cancer centres.
- Southern sees the highest number of FSAs per Medical Oncologist over a 12-month period.
- Southern delivers the highest number of treatments per Medical Oncologist over a 12-month period.
- For Southern, the Registrar FTE : population ratio is the lowest among all centres, meaning each Registrar on average covers the largest population.

These findings were discussed with SDHB staff in the first round of workshops and were generally felt to be fair. Other additional discussion points from this workshop for Medical Oncology staff included that SBCS currently does some tumour streaming, though the current level of SMO FTE created difficulties for further development of this.

Additional analysis was done on the CCA benchmarking exercise to include impact of planned service investments for FY22. The following tables provide this update (with recalculations for this uplift highlighted in yellow). The tables also illustrate the new benchmarking comparison result incorporating our recommendations around proposed increases in FTEs (described in next section).

Table 8: Benchmarking update, Medical Oncology FSAs per FTE

| Centre | Catchment population | Medical Oncology treatments | Medical Oncology FSAs | Medical Oncologist FTE | Population per FTE (000's) | Treatments per FTE | FSAs per FTE |
|---|---|---|---|---|---|---|---|
| Auckland / Counties / Waitemata | 1,701,410 | 20,390 | 2,338 | 19.15 | 88.8 | 1,064.8 | 122.1 |
| Waikato | 435,690 | 6,707 | 859 | 7.00 | 62.2 | 958.1 | 122.7 |
| MidCentral / Whanganui | 303,065 | 7,770 | 1,095 | 8.39 | 36.1 | 926.1 | 130.5 |
| Capital and Coast / Hutt | 477,430 | 6,497 | 883 | 10.45 | 45.7 | 621.7 | 84.5 |
| Canterbury / West Coast | 610,840 | 6,440 | 1,211 | 13.90 | 43.9 | 463.3 | 87.1 |
| Southern | 344,900 | 6,853 | 659 | 4.76 | 72.5 | 1,439.7 | 138.4 |
| Peer group (excl Southern) | 3,528,435 | 47,804 | 6,386 | 58.89 | 59.9 | 811.8 | 108.4 |
| Southern (with uplift) | 344,900 | 6,853 | 659 | 6.56 | 52.6 | 1,044.7 | 100.5 |
| Comments | | | | Remains smallest centre in terms of FTE | Becomes third highest for population per FTE | Remains high, on par with Auckland for treatments per FTE | Becomes below peer average (known FSA limitations) |
| Southern (based on recommendation further 1.0 FTE for Medical Oncologist) | 344,900 | 6,853 | 659 | 7.56 | 45.6 | 906.5 | 87.2 |
| Comments | | | | Becomes second smallest centre in terms of FTE | Becomes third highest for population per FTE | Remains high, on par with Waikato / MidCentral for treatments per FTE | Becomes below peer average (known FSA limitations)* |

| Table 8: Benchmarking update, Medical Oncology FSAs per FTE | | | | | | | |
|---|---|---|---|---|---|---|---|
| Centre | Catchment population | Medical Oncology treatments | Medical Oncology FSAs | Medical Oncologist FTE | Population per FTE (000's) | Treatments per FTE | FSAs per FTE |
| *Noting that FSAs may increase in response to increased FTE (as based on FSAs associated with existing FTE) | | | | | | | |

| Table 9: Benchmarking update, Medical Oncology Registrars | | | | | |
|---|---|---|---|---|---|
| Centre | Catchment population | Medical Oncology treatments | Medical Oncology FSAs | Registrar FTE | Population per Registrar FTE (thousandths) |
| Auckland / Counties / Waitemata | 1,701,410 | 20,390 | 2,338 | 10.20 | 166.8 |
| Waikato | 435,690 | 6,707 | 859 | 6.00 | 72.6 |
| MidCentral / Whanganui | 303,065 | 7,770 | 1,095 | 5.51 | 55.0 |
| Capital and Coast / Hutt | 477,430 | 6,497 | 883 | 8.34 | 57.2 |
| Canterbury / West Coast | 610,840 | 6,440 | 1,211 | 7.00 | 87.3 |
| Southern | 344,900 | 6,853 | 659 | 2.00 | 172.5 |
| Peer group (excl. Southern) | **3,528,435** | **47,804** | **6,386** | **37.05** | **95.2** |
| Southern (with uplift) | **344,900** | **6,853** | **659** | **3.00** | **115.0** |
| Comments | | | | **Remains smallest Registrar workforce in terms of FTE** | **Second fewest Registrars per population after uplift** |
| Southern (based on recommendation additional 1.0 FTE) | **344,900** | **6,853** | **659** | **4.00** | **86.2** |
| | | | | **Remains smallest Registrar workforce in terms of FTE** | **Second fewest Registrars per population after uplift** |

### 3.2.4 Recommendations for Medical Oncology

Based on the key findings from SDHB stakeholders, other cancer centres, the CCA benchmarking exercise and supplementary analyses, the following recommendations are proposed specially for Medical Oncology.

*Please note these are not listed in order of priority*

| Table 10: Recommendations for Medical Oncology | | |
|---|---|---|
| **Category** | **Recommendations** | |
| Workforce | Primary – immediate | 1. Consider a further 1.0 FTE for Medical Oncologist (additional to planned uplift FY22).<br>▸ Benchmarking showed that the SMO FTE : population ratio is the second lowest of all cancer centres, meaning the average population served by each SMO FTE at Southern is larger than most of the other centres.<br>▸ There is also a high proportion of service delivery rurally by SMOs, and additional workload requirements associated with support for rural staff such as CNSs.<br>▸ Increasing the headcount of SMOs will also increase the resiliency of the service by ensuring better ability to cross-cover, decreased frequency of on-call that may improve quality of life for staff, and may promote increased ability to tumour stream that may increase efficiency of the service.<br>▸ It will also promote increased ability of SMOs to use non-clinical time for other important activities that may contribute to the service such as planning and quality and safety activities. |
| | Primary – medium term | 2. Gradually increase FTE for Medical Oncology registrars. Consider additional 1.0 FTE initially.<br>This is recommended as some SMO tasks may be able to be performed or supported by registrars (depending on their level of experience/training), and therefore this may decrease SMO workload, in addition to potentially decreasing the workload of other clinical staff such as CNSs.<br>▸ Needs to reflect gradual increase in SMO FTE for supervision<br>▸ Includes dependency of general medical registrar pool |
| | | 3. Increase nursing and administrative support as per general recommendations (see Section 3.1.7). |
| | *Dependencies* | *Oncology trained nurses at peripheral centres (Invercargill & rural hospitals), who are not employed directly by SBCS.* |
| Strategic | Secondary | 1. The service should ensure appropriate early pharmacy involvement in business case development for treatment delivery. |

## 3.3 Radiation Oncology

### 3.3.1 Service overview

Radiation Oncology requires a highly specialised, multi-disciplinary workforce, with key roles for service delivery including Radiation Oncologists, RTs, and MPs. The wider team consists of nursing including CNSs, administrative staff, psychosocial and allied health.

The current FTEs for SBCS's Radiation Oncology service are listed in the table below. Please note the data reflects budgeted FTE, as per CCA's request from all centres. However, it has been acknowledged that there are existing vacancies yet to be filled for FY21 for Radiation Oncologists, hence why both actual FTE which is currently 4.6 FTE has been presented alongside the total budgeted FTE 7.695[3].

[3] Of total FTE budgeted for Radiation Oncologists in FY21 (7.695), 1.72 has been filled but roles are not starting until Feb/Dec 2022, and 1.375 remains unfilled.

| Table 11: Current FTEs for SBCS's Radiation Oncology service | |
|---|---|
| **Position** | **Number (FTE)** |
| Radiation Oncologists | |
| Budgeted FY21 | 7.695 |
| Actual FY21 | 4.6 |
| Radiation Oncology Registrars | 2 |
| Radiation Therapists | 28.62 |
| Medical Physicists | 7.05 |
| Nurse Specialists | 1 |
| Booking Clerks | 1 (0.5 RO only + 0.5 SCBS Booking Coordinator) |
| Shared across all specialities | |
| Senior Nurses | 3.8 (Otago), 1.5 (Southland) |
| Registered Nurses | 13.42 (Otago), 3.37 (Southland) |
| Medical Secretaries | 3.5 (Otago), 0.6 (Southland) |
| Receptionists | 2.7 (Otago), 1.5 (Southland) |

Radiation Oncology commonly provides services for patients with malignant conditions, but also provides a reasonable proportion of services for benign diseases, with common types of cancer treated by radiation therapy including breast, lung, prostate and colorectal cancer.

Radiation Oncology may provide differing treatment modalities that varies by centre in New Zealand. Southern DHB offers radiation therapy delivered externally using a linear accelerator (LINAC). However, it does not offer superficial radiation therapy which is commonly used for skin cancers, or brachytherapy that can be used to treat some prostate cancers and certain types of gynaecological malignancies, with the closest centre offering brachytherapy being Christchurch. SDHB also holds the national stereotactic radiotherapy contract with the Ministry of Health and provides this service for New Zealand nationally.

Radiation Oncology services are usually delivered on an outpatient basis, but LINAC treatment is centralised in Dunedin due to the technology required and associated roles. Therefore, at SBCS all patients are treated in Dunedin, but there are outpatient clinics for FSAs or follow-up provided in rural areas to improve access for patients.

The following table shows the service delivery locations for Radiation Oncology. According to National Collections data, there are four sites in SBCS's catchment, with outpatient appointments being provided at two rural sites, accounting for 6.4% of the service's total outpatient appointments, with was higher than the 2$^{nd}$ highest proportion of total outpatient appointments which was Waikato. Note all centres have been considered in the analysis, however, the data reported to the National Collections does not appear to be capturing all activities delivered by each centre within their catchment, therefore, the table only shows the data for Southern and Waikato and limitations with this data should be noted. It has been reported by the service that Radiation Oncology delivers outpatient appointments in six sites (Timaru, Oamaru, Dunedin, Balclutha, Dunstan, and Invercargill), different from what was reported in the National Collections.

| Table 12: Radiation Oncology service delivery sites by DHB | | | | | |
|---|---|---|---|---|---|
| **DHB of Service** | **Centre** | **Sites in same DHB as centre** | **Sites in centre catchment (including tertiary provision)** | **Rural sites where outpatient appts are provided by centre** | **% share of outpatient appts** |
| Waikato | Waikato Hospital | 2 | 5 | 1 | 1.4% |
| Southern | Dunedin Hospital | 4 | 4 | 2 | 6.4% |

### 3.3.2 What we heard from stakeholders

The key challenges raised by stakeholders that are specific to Radiation Oncology are:

- Historically there have been some challenges with communication and working relationships between different roles given the complex, multi-disciplinary workforce;
- The service has yet to apply for accreditation for advanced training since there are insufficient numbers of registrars (as they are only able to apply with more than two registrars), which has implications for recruiting trainees. However, this will change next year with the uplift in Radiation Oncology registrars;
- There can be recruitment challenges particularly for SMOs and MPs given there is better renumeration overseas;
- Succession planning is becoming increasingly critical as three of the five current radiation oncologists are retiring shortly;
- For medical physics, it is currently difficult to balance time between commissioning equipment and treatment of patients, particularly as the third LINAC is being replaced, and therefore MPs have been split into two shifts for performing their work, in order to ensure that maximum volumes of treatments can still be delivered amongst the two functioning machines;
- Stereotactic contract is associated with increased workforce reources which is challenging at the current time given constraints on RTs and MPs; and
- There is reported psychological impact to the radiation oncology workforce because of ongoing strains associated with high workload, and their concerns around potential harm for patients presented by long waiting times.

The key opportunities for Radiation Oncology were continued support of advanced practice opportunities for RTs, expansion of CNS and RT service, and continued development of telehealth service (where appropriate).

The service has some key dependencies that need to be considered such as equipment commissioning/implementation, as one LINAC is being replaced and anticipated to be back in service in Feb 2022, and another LINAC has some commissioning issues that are being resolved but is still able to treat patients. The service is also waiting for an expert from overseas to set up new software for stereotactic radiotherapy. Lastly, and the service is reliant on IT systems integration for treatment, and this requires specific knowledge to ensure the correct set-up and integration.

### 3.3.3 CCA benchmarking

Assumptions and limitations for Radiation Oncology noted in the benchmarking exercise conducted by CCA include:

- For the purposes of this analysis in the South Island, NMDHB, SCDHB, West Coast District Health Board (WCDHB) Radiation Oncology FSAs and treatment counts were incorporated into Canterbury DHB/Christchurch Hospital counts, though a proportion of NMDHB Radiation Oncology patients are treated in Capital Coast DHB and a proportion of South Canterbury patients are also treated in SDHB. This centralised approach to delivery of Radiation Oncology services was also applied to North Island centres.

- Some Radiation Oncology centres provide specialised treatment techniques on behalf of other DHBs such as high dose-rate (HDR) brachytherapy and stereotactic treatments.

- LINAC counts do not reflect 100% operational time, therefore the number of LINACs listed in the tables below do not reflect actual machine operating time. The level of LINAC machine utilisation and shift work to manage increasing demand is not accounted for.

- SDHB does not have any local access to private Radiation Oncology facility capacity. Auckland, Waikato, Wellington and Canterbury all have access to private facility capacity.

- Auckland and Christchurch Hospital FSA and treatment counts may include a proportion of outsourcing to a private facility.

- FTE data requested was budgeted FTE, and therefore this may not reflect actual FTE, and FTE data has not been validated with the centres.

- Non-cancer FSA and treatment counts are included in the data.

- Re-treatment counts are included in the data.

- Noting that hospital level data has been used for FSA and Treatment course counts (Radiation Oncology Collections (ROC)), and that recently IT have discovered that the output of LA3 (the service's newest accelerator) has not been accounted for in existing data, that reportedly makes up 30-40% of workload.

Currently there is 4.6 Radiation Oncologist FTE at SDHB. Based on this the findings of the benchmarking were:

- Compared to other centres, Southern has the lowest number of Radiation Oncologist FTE per LINAC.

- Sees the highest number of FSAs per Radiation Oncologist FTE over a 12-month period.

- Delivers the highest number of courses per Radiation Oncologist FTE over a 12-month period.

- Southern sees the third highest ratio of SMO FTE : population.

**SBCS if full budgeted FTE for FY21 is filled (7.695) then[4]:**

- Shares the third highest number of Radiation Oncologist FTE per LINAC.

- Sees the second to lowest number of FSAs per Radiation Oncologist FTE over a 12-month period.

- Delivers the lowest number of treatment courses per Radiation Oncologist FTE over a 12-month period.

[4] Of total FTE budgeted for in FY21 (7.695), 1.72 has been filled but roles are not starting until Feb/Dec 2022, and 1.375 remains unfilled. There is no additional recruitment scheduled for investment for Radiation Oncologist FTE for FY22.

- Southern sees the highest ratio of SMO FTE : population.

For Radiation Oncology registrars, MPs, and RTs, the benchmarking found:

- Southern has the lowest number of Registrars per LINAC.
- Southern has the lowest number of MPs per LINAC.
- Southern has the second to lowest number of RTs per LINAC.
- Southern has the second to lowest number of courses per RT over a 12 month period.

These findings were discussed with Southern's staff in the workshops, where staff considered the data presented as generally fair, with the exception of the FTE number for MPs which was felt to be slightly high. The importance of considering the implications of current vs. budgeted FTE was also emphasized.

It should be noted that the number of MPs and/or RTs per LINAC is not being used as an indicator to determine specific numbers for these roles, instead it is being provided as one reference point for benchmarking, and these benchmarking findings have been considered alongside qualitative information and findings from supplementary data analyses.

Additional analysis was done on the CCA benchmarking exercise to include impact of planned service investments. The following tables provide this update. It is shown that with the budgeted FTE, SBCS becomes much more in line with the other cancer centres.

Table 13: Benchmarking update, Radiation Oncology FSAs per FTE

| Centre | Catchment population | Radiation Oncology courses | Radiation Oncology FSAs | Radiation Oncologist FTE | Population per FTE | Treatments per FTE | FSAs per FTE |
|---|---|---|---|---|---|---|---|
| Auckland DHB | 1,894,580 | 3,221 | 3,528 | 15.60 | 121.4 | 206.5 | 226.2 |
| Waikato DHB | 860,905 | 1,651 | 1,535 | 8.00 | 107.6 | 206.4 | 191.9 |
| MidCentral DHB | 603,555 | 1,559 | 1,742 | 9.06 | 66.6 | 172.1 | 192.3 |
| Capital and Coast / Hutt DHBs | 477,430 | 1,717 | 1,345 | 10.37 | 46.0 | 165.6 | 129.7 |
| Canterbury DHB | 832,155 | 2,034 | 1,987 | 11.00 | 75.7 | 184.9 | 180.6 |
| Southern DHB** | 344,900 | 1,198 | 1,070 | 4.60 | 75.0 | 260.4 | 232.6 |
| Peer group (excl. Southern) | 4,668,625 | 10,182 | 10,137 | 54.03 | 86.4 | 188.5 | 187.6 |
| Southern DHB (budgeted)** | 344,900 | 1,198 | 1,070 | 7.695 | 44.8 | 155.7 | 139.1 |
| Comments | | | | | Becomes lowest rate, similar to Capital and Coast / Hutt | Becomes the lowest treatment per FTE rate | Changes from highest rate to second lowest, similar to Capital & Coast |

**Note: Of total FTE budgeted for Radiation Oncologists in FY21 (7.695), 1.72 has been filled but roles are not starting until Feb/Dec 2022, and 1.375 remains unfilled, resulting in the actual FTE of 4.60.

| Table 14: Benchmarking update, Radiation Oncology Registrars / Radiation Therapists / Medical Physicists | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Centre** | **Catchment population** | **Radiation Oncology courses** | **LINACs** | **Registrar FTE** | **Registrar FTE per LINAC** | **RT FTE** | **Radiation Oncology courses per RT FTE** | **RT FTE per LINAC** | **MP FTE** | **MP FTE per LINAC** |
| Auckland DHB | 1,894,580 | 3,221 | 6 | 8.00 | 1.33 | 74.8 | 43.1 | 12.47 | 19.88 | 3.31 |
| Waikato DHB | 860,905 | 1,651 | 4 | 5.00 | 1.25 | 41.0 | 40.3 | 10.25 | 11 | 2.75 |
| MidCentral DHB | 603,555 | 1,559 | 4 | 4.48 | 1.12 | 37.1 | 42.1 | 9.26 | 11.71 | 2.93 |
| Capital and Coast / Hutt DHBs | 477,430 | 1,717 | 3 | 7.14 | 2.38 | 35.6 | 48.2 | 11.87 | 9.1 | 3.03 |
| Canterbury DHB | 832,155 | 2,034 | 4 | 7.00 | 1.75 | 40.8 | 49.9 | 10.19 | 11.6 | 2.90 |
| Southern DHB | 344,900 | 1,198 | 3 | 2.00 | 0.67 | 28.6 | 41.9 | 9.54 | 7.05 | 2.35 |
| Peer group (excl. Southern) | 4,668,625 | 10,182 | 21 | 31.62 | 1.51 | 229.2 | 44.4 | 10.91 | 63.29 | 3.01 |
| Southern DHB (with uplift) | 344,900 | 1,198 | 3 | 5.00 | 1.67 | 29.6 | 40.5 | 9.87 | 10.05 | 3.35 |
| Comments | | | | Becomes more in line with other centres, though lower than average | Changes from lowest rate to third lowest, similar to Canterbury | Smallest centre, remains smallest after uplift | Remains second lowest courses per FTE, similar to Waikato | Increases with uplift, but remains slightly below peer average | Smallest centre, increases to second smallest | Changes from lowest rate to highest rate |

### 3.3.4 Our recommendations for Radiation Oncology

*Please note these are not listed in order of priority*

| Table 15: Recommendations for Radiation Oncology | | |
|---|---|---|
| **Category** | **Recommendations** | |
| Workforce | Primary – immediate | 1. We would recommend that the focus is given to the recruitment of the additional 1.375 Radiation Oncologist FTE, which is the remaining unfilled portion of the budgeted FTE for Radiation Oncologists for FY21 (total 7.695[5]) and recruitment for retiring RO positions. However, we would strongly emphasize the need for **annual reviews** for further permanent uplifts in FTE. Further considerations and rationale for this recommendation are as follows:<br>▸ The FY21 uplift in Radiation Oncologist FTEs is being actively recruited to, and once complete, will bring SBCS much closer in-line with the other cancer centres.<br>▸ Given the need for immediate succession planning with three out of the five Radiation Oncologists retiring shortly and in the context of existing recruitment challenges, the focus should be on recruiting to FY21 uplift and to retiring Radiation Oncologist positions.<br>▸ Consideration should be given to time-limited uplifts in FTE to enable smooth transition between retiring SMOs and new replacements i.e., overlaps in departing SMOs and incoming SMOs.<br>▸ It is expected that this transition process will occur over a 2-3 year period.<br>▸ Given these transitional arrangements, and the connection with national planning and the Health & Disability System Reforms, it would be prudent to adopt a wait and see approach to further permanent uplifts in FTE that should be reviewed **annually** through each year of the action plan, taking into consideration the stability of workload for staff when SMOs go on leave and the resiliency of the service in the long-term. |
| | Primary – medium term | 2. Review the workload and capacity of Radiation Therapists and Medical Physicists in the context of agreed budget uplifts, and the CCA benchmarking exercise. With a focus on the comparative workload involved in planning of treatment courses. |
| | Secondary | 1. There should be ongoing review of FTE for Radiation Oncology Registrars.<br>▸ In FY22 this will be 4.0 FTE, which is likely the maximum currently given supervision requirements, but depending on recruitment of SMOs in the future should be reviewed. |
| | | 2. Consider some increased expansion of CNS scope of practice with the intention that this is increasing access to nursing model of care (instead of a substitute for medical FTE), and concurrently continue to promote increased scope of practice for Radiation Therapists. |

## 3.4 Clinical Haematology

### 3.4.1 Service overview

Clinical Haematology is concerned with diagnosing and treating disorders of the blood and blood-forming organs, treating both malignant conditions such as leukaemia and lymphoma and non-malignant conditions such as clotting and other bleeding disorders.

SBCS's Clinical Haematology service consists of the team below:

[5] Of total FTE budgeted for Radiation Oncologists in FY21 (7.695), 1.72 has been filled but roles are not starting until Feb/Dec 2022, and 1.375 remains unfilled.

| Table 16: SBCS's Clinical Haematology service | |
|---|---|
| **Position** | **Number (FTE)** |
| Clinical Haematologists | 4.75 |
| Haematology registrars | 1 |
| Nurse Specialists | 1.7 (0.8 FTE Otago, 0.6 FTE Southland, 0.3 FTE Haemophilia CNS) |
| Booking Clerks | 0.5 (shared with RO 0.5 FTE) |
| Shared across all specialities | |
| Senior Nurses | 3.8 (Otago), 1.5 (Southland) |
| Registered Nurses | 13.42 (Otago), 3.37 (Southland) |
| Medical Secretaries | 3.5 (Otago), 0.6 (Southland) |
| Receptionists | 2.7 (Otago), 1.5 (Southland) |

It should be noted that SBCS is slightly unique in that all lymphomas are treated under Haematology, as opposed to these being treated by Medical Oncology in many other centres. Haematology services at SDHB do not provide the following: Autologous and allogenic SCT (all patients get treated by Canterbury cancer centre), initial acute lymphoblastic leukaemia for youth, and a thrombosis service as this is treated by other medical specialities).

Lab Haematology is provided by a private lab in Dunedin (Southern Community Laboratory) which purchases 0.8 FTE from SDHB Clinical Haematologists.

SBCS provides outpatient Haematology services in Dunedin and Invercargill. There is also a CNS clinic in Dunstan, and there are chemotherapy trained nurses placed at Dunstan, Balclutha, Oamaru and Balclutha.

Importantly compared to Medical Oncology, Haematology delivers more inpatient activity as a proportion of events and this may cause increased workload for clinical staff (see Appendix D).

### 3.4.2 What we heard from stakeholders

The key challenges for Clinical Haematology were generally applicable across all services (please refer to Section 3.1.2), but the lack of administrative support was emphasized, and this was seen to have significant impacts on workload and cause inefficiencies within the service. However, one specific challenge for the service was that the private laboratory does not provider registrar placements, which limits the opportunity for advanced training.

Opportunities raised that were specific for Clinical Haematology:

- Developing protocols for Haematology (both malignant and non-malignant conditions) and encourage these to be managed where possible by CNSs and by GPs in the community (especially for long-term conditions), to increase SMO capacity to address Haematolgical malignancies and more acute/serious non-cancerous Haematology conditions;
- Ensuring ongoing support for advanced practice nursing roles once established;
- Expansion of treatments for Haematology within the DHB including autologous stem cell transplant (SCT) and plasmapheresis service;
- Increasing clinical trial access for rural residents; and

- Scope for further training for medical staff (registrars).

Important key dependencies for the service that needed to be take into considerations were:

- Laboratory side of Haematology: Some SMO FTE is required for the lab. The private laboratory does not provide training positions which reduces opportunity for advanced trainee training and retention; and
- Clinical workload associated with non-cancerous Haematologyatological conditions.

### 3.4.3 CCA benchmarking

Specific considerations for Clinical Haematology noted in the benchmarking exercise conducted by CCA:

- Access to private centre treatments has not been accounted for.
- SBCS treatment counts have been taken from local data provided instead of the COVID-19 DHB Data Monthly report (which was the data source used for the other specialties' benchmarking, due to error identified in the COVID report.
- There is variation in FTE allocation across Haematology service delivery compared to laboratory/New Zealand Blood Service (NZBS) duties across cancer centres, and this has not been accounted for in the analysis, although cancer centres were asked to provide FTE that excluded this FTE allocation.
- FTE data requested was budgeted FTE, and therefore this may not reflect actual FTE, and FTE data has not been validated with the centres.
- There is variation in the cancer types and other non-cancer conditions treated by Haematologists which has not been accounted for in the analysis. For example in some centres patients with Lymphoma are treated by Medical Oncologists.
- Allogeneic SCTs are performed in only three centres (Auckland, Wellington and Christchurch). Autologous SCTs are performed in Auckland, Wellington, Christchurch, Palmerston North and Waikato. Dunedin does not currently do autologous transplants and SDHB patients go to Christchurch (currently about 1-2 patients per month). However, there is a large national waiting list for transplants, and Christchurch is actively asking SDHB to help with capacity by doing its own autologous transplants and to start taking their patients back as soon as possible.
- Population served, FSA and treatment data has been limited to the site of the cancer centre and smaller peripheral sites, as the larger regions have Haematologist and Registrar FTE serving their local population and we have not quantified these FTEs in this exercise i.e. we have removed the Haematology FSA, treatment counts and populations for Bay of Plenty, Northland, Counties, Waitemata and Nelson Marlborough DHBs.
- The proportion of cancer and non-cancer conditions with associated treatments has not been accounted for in this analysis.

Findings for SBCS compared to other centres:

- Southern has the third highest ratio of SMO FTE : population, meaning at Southern, the population each SMO FTE covers is the third smallest.
- Southern delivers the highest number of treatments per Haematologist over a 12-month period.

- Southern sees the lowest number of FSA's per Haematologist FTE over 12-month period.
- Southern has the lowest ratio of Registrar FTE : population.

These findings were discussed in workshops with SDHB staff who felt the number of FSAs per SMO FTE and the amount of treatment courses did not reflect the current workload. It was also raised that regional demographics should be more strongly considered when benchmarking workload, as Southern may have a higher proportion of elderly population and related Myelodysplastic Syndrome (MDS) conditions.

Additional analysis was done on the CCA benchmarking exercise to include impact of planned service investments, The following tables provide this update with recalculations to account for planned service investments in FY22 highlighted in yellow. The tables also illustrate the new benchmarking comparison result incorporating our recommendations around proposed increases in FTEs:

| Table 17: Benchmarking updates, Haematology FSAs per FTE | | | | | | | |
|---|---|---|---|---|---|---|---|
| Centre | Catchment population | Haematology treatments | FSAs | SMO FTE | Population per FTE (000's) | Treatments per FTE | FSAs per FTE |
| Auckland DHB | 493,990 | 3,395 | 768 | 7.60 | 65.0 | 446.7 | 101.1 |
| Waikato DHB | 601,815 | 4,282 | 1,149 | 8.00 | 75.2 | 535.3 | 143.6 |
| MidCentral DHB | 603,555 | 2,383 | 727 | 6.45 | 93.6 | 369.5 | 112.7 |
| Capital and Coast / Hutt DHBs | 477,430 | 3,390 | 756 | 8.72 | 54.8 | 388.8 | 86.7 |
| Canterbury DHB | 672,795 | 2,804 | 541 | 7.43 | 90.6 | 377.4 | 72.8 |
| Southern DHB | 344,900 | 3,453 | 333 | 4.75 | 72.6 | 726.9 | 70.1 |
| Peer group (excl. Southern) | 2,849,585 | 16,254 | 3,941 | 38.20 | 74.6 | 425.5 | 103.2 |
| Southern DHB (with uplift) | 344,900 | 3,453 | 333 | 5.75 | 60.0 | 600.5 | 57.9 |
| Comments | | | | Remains smallest centre in terms of total FTE | Becomes second lowest for population per FTE | Remains highest for treatments per FTE | Remains low (known FSA limitations) |
| Southern DHB (based on recommendation of 0.3 FTE) | 344,900 | 3,453 | 333 | 6.05 | 57.0 | 570.7 | 55.0 |
| Comments | | | | Remains smallest centre in terms of total FTE, though closer to MidCentral | Becomes second lowest for population per FTE | Remains highest for treatments per FTE | Remains low (known FSA limitations) |

| Table 18: Benchmarking updates, Haematology Registrars | | | | | |
|---|---|---|---|---|---|
| **Centre** | **Catchment population** | **Haematology treatments** | **Haematology FSAs** | **Registrar FTE** | **Population per Registrar FTE 000's)** |
| Auckland DHB | 493,990 | 3,395 | 768 | 4.00 | 123.5 |
| Waikato DHB | 601,815 | 4,282 | 1,149 | 6.00 | 100.3 |
| MidCentral DHB | 603,555 | 2,383 | 727 | 3.21 | 188.0 |
| Capital and Coast / Hutt DHBs | 477,430 | 3,390 | 756 | 7.82 | 61.1 |
| Canterbury DHB | 672,795 | 2,804 | 541 | 7.81 | 86.1 |
| Southern DHB | 344,900 | 3,453 | 333 | 1.00 | 344.9 |
| Peer group (excl. Southern) | 2,849,585 | 16,254 | 3,941 | 28.84 | 98.8 |
| Southern DHB (with uplift) | 344,900 | 3,453 | 333 | 2.00 | 172.5 |
| Comments | | | | Becomes more in line with other centres, though lower than average | Changes from highest rate so second highest, similar to MidCentral |

### 3.4.4 Our recommendations for Clinical Haematology

*Please note these are not listed in order of priority*

| Table 19: Recommendations for Clinical Haematology | | |
|---|---|---|
| **Category** | **Recommendations** | |
| Workforce (recruitment & retention) | Primary – immediate | 1. Increase recommended SMO FTE by 0.3 for FY22 (in addition to planned uplift already proposed)<br>▸ Given the current vacancy of 0.5 FTE and the difficulties associated with its recruitment, a greater FTE loading will increase the attractiveness and support the recruitment process; and<br>▸ This additional FTE may also serve to cover additional workload related to care (repatriation) of transplant patients from other centres, which has become an immediate need, and these FTE costs may be offset by reducing costs currently associated with Inter-District Flow (IDF) outflows related to these patients. |
| | Primary – medium term | 2. Gradually increase FTE for Haematology registrars when SMO FTE increases, and this should be reviewed on an ongoing basis so that this increase is considered once SMO FTE is filled and therefore increased support may be provided to incoming registrars<br>▸ Need to align with SMO FTE for supervision (SMOs will be rate limiting factor, in addition to other training requirements eg., laboratory);<br>▸ Needs to consider staffing requirements in terms of balance of basic vs advanced trainees in service;<br>▸ There may also need to be advocacy for increased number of medical registrars generally (as Haematology registrars may come from this pool); |
| | Secondary | 1. Consider arrangements with the private lab to provide laboratory placements for Haematology registrars to encourage recruitment and retention of medical workforce. |
| | *Dependencies* | *Like for Medical Oncology, an additional key dependency for Haematology is that there are oncology trained nurses at peripheral centres (Invercargill & rural hospitals), who are not employed directly by SBCS.* |
| Workforce model | Secondary | 1. Protocols for both malignant and non-malignant conditions should be developed, so these conditions can be managed by CNSs and GPs where possible. |
| Strategic | Primary – immediate | 1. Imminent steps needed to manage transferred Day 1/2 (repatriated) autologous SCT patients for SBCS.<br>▸ This may reduce costs currently associated with IDF outflows related to these patients, that may offset the costs associated with establishing this at SBCS |
| | | 2. Purchase plasmapheresis service from NZBS as a priority, particularly given this is required for multiple medical specialities including neurology and renal, and not just blood and cancer services.<br>▸ This may have an additional benefit that NZBS may provide some FTE with the provision of this plasmapheresis machine, which may increase FTE available for other Haematologists.<br>▸ Also cost of purchase may be offset by current costs associated with IDF outflows, and better manage local and regional demand given pressure on this service |
| | Secondary | 1. Aim that autologous SCTs will be performed at SBCS (and associated planning around this) in approximately one year.<br>▸ Benefits of allowing increased medical training at site, and pathway for advanced nursing role. |

| Table 19: Recommendations for Clinical Haematology | | |
|---|---|---|
| **Category** | **Recommendations** | |
| | | ▸ This will require increased psychosocial support, more intensive and specialised nursing support, dietetic support, registrar input for management as inpatients, and will have corresponding increases in workload for the day unit. |
| | | 2. Need to pursue mechanisms to allow increased training time for Haematology registrars through laboratory placements (as above). |

## 3.5 Summary of all recommendations

We have received different channels of evidence which have suggested that there needs to be increased capacity for SBCS's workforce to support currently service delivery.

1. SBCS has the vision of being a comprehensive cancer centre and is using an interdisciplinary workforce model which fosters holistic service delivery, taking into consideration the specific population served by the DHB. The service has benefited from the strengths that the interdisciplinary model has enabled, however, there are still points of vulnerability and limitations – particular attention should be drawn to the need for continuing to develop allied health and psychosocial support resourcing, to strengthen existing models of care – and broaden and deepen care models as appropriate.

2. Stakeholder engagement across both clinical and managerial leaders and staff suggest significant existing deficiencies in certain areas, particularly in administrative roles. Therefore, to make best use of senior clinical time and enable smoother patient flows, there is a need to bolster administrative FTE to meet existing service needs, and future requirements associated with the budgeted uplift to clinical roles in FY22.

3. Furthermore, as highlighted by issues with waiting times and CCA workforce benchmarking, there is prima facie evidence that increased workforce resourcing is needed to better align SBCS with other centres. While the budgeted uplifts in some roles in 2022 begins to achieve this, there remains some material differences, particularly when the service delivery context of the DHB is considered.

4. As a consequence, appropriate growth in other workforce roles (e.g., non-clinical staff) to support the additional patient activity more clinical FTE resourcing will generate, will be needed.

5. There are wider changes on the horizon such as the prompt repatriation of stem cell transplant (SCT) patients to SBCS and standardisation of clinical protocols nationally, and therefore it will be necessary to ensure appropriate resourcing of medical, nursing, and other staff to enable these changes to be implemented. This is accommodated within the proposed further uplift in medical personnel beyond that already agreed with 2022.

6. All cancer centres have reported an imperative to focus on addressing longstanding inequities in access, experience, and outcomes of care. SBCS will need to continue to strengthen workforce roles to support populations with poorer access and experience such as Māori, including Community Māori Cancer Navigator roles, and also for Pacific peoples and those with disabilities. Importantly, improved access, experience and outcomes are dependent on the success of primary health care and wider hospital and specialist services such as colonoscopy access. Therefore, it may be beneficial to support a role, particularly for Māori, that is enabled to support co-design of integrated models of care across and within primary, community and secondary care.

7. Many stakeholders reported the critical dependency of having sufficient and appropriate (e.g., patient dignity and confidentiality during consultations) physical space for service provision. While assessing the impact of current and future facility planning is out of our scope, we note that where space is insufficient or inappropriate for servicing current volumes (and staff), additional space will need to be made available as demand and workforce grows and this may be of urgent priority given the immediate planned uplifts in staffing within the service.

8. It is also noted that private laboratory arrangements do not provide Haematology registrar placement – which impacts on training and 'growing' the local workforce.

The following table provides an integrated list of all recommendations for SBCS, both for the overall service and for each specialty. These form the basis of the three-year roadmap with sequenced actions in the next section.

Table 21: List of all recommendations for SBCS, both for the overall service and specific for each specialty (*not listed by priority*)

| | | SBCS Overall | Medical Oncology | Radiation Oncology | Haematology |
|---|---|---|---|---|---|
| Workforce | Workforce (recruitment & retention) | Primary recommendations – immediate:<br>1. Add two Booking Clerks, one non-clinical administration staff and one typist for SBCS, to ensure there is sufficient administrative support for the increased medical FTE planned for FY22 and corresponding increases in workload.<br>▸ This investment should go alongside opportunities to consider the use of new digital technology and workflow tools.<br>2. Increase nursing staff FTE by an additional 2.0 to ensure there is sufficient corresponding nursing to match the increased medical FTE planned for FY22 and corresponding increases in workload.<br>▸ Based on considerations similarly to increased administrative FTEs, an uplift of 4.0 FTE total in Registered Nurses appears to be sensible, as the midpoint between 1.1 and 8.8 additional Nursing FTE calculated from the ratio modelling. This takes into account that the service has already planned to increase 2 FTE nursing staff in the FY22 uplift.<br>▸ Distribution of this Nursing FTE in terms of speciality and location should be further discussed with the service.<br>3. There needs to be prioritisation of recruitment of the remained budgeted FTE for FY21 (e.g., 1.375 Radiation Oncologists) and succession planning, particularly in Radiation Oncology, with recruitment efforts started in the short-term given the imminent retirement of three out of five Radiation Oncologists. | Primary recommendations – immediate:<br>1. Consider a further 1.0 SMO FTE for Medical Oncology (additional to planned uplift FY22) based on evidence from benchmarking and high proportion of rural service delivery.<br>2. Increase nursing and administrative support as per general recommendations. | Primary recommendations – immediate:<br>1. It is recommended that the focus is given to the recruitment of the additional 1.375 Radiation Oncologist FTE, which is the remaining unfilled portion of the budgeted FTE for Radiation Oncologists for FY21 (total 7.695) and recruitment for retiring SMO positions (given the imminent retirement of three out of five Radiation Oncologists). However, we would strongly emphasize the need for annual reviews for further permanent uplifts in FTE. Further considerations and rationale for this recommendation are as follows:<br>▸ The 2022 uplift in Radiation Oncologist FTEs is being actively recruited to, and once complete, will bring SBCS much closer in-line with the other cancer centres.<br>▸ Given the need for immediate succession planning with three out of the five Radiation Oncologists retiring shortly and in the context of existing recruitment challenges, the focus should be on recruiting to FY21 uplift and to retiring Radiation Oncologist positions.<br>▸ Consideration should be given to time-limited uplifts in FTE to enable smooth transition between retiring SMOs and new replacements.<br>▸ It is expected that this process will occur over a 2-3 year period.<br>Given these transitional arrangements, and the connection with national planning and the Health & Disability System Reforms, it would be prudent to adopt a wait and see approach to further permanent uplifts in FTE that should be | Primary recommendations – immediate:<br>1. Increase recommended SMO FTE by 0.3 for FY22 (in addition to planned uplift already proposed)<br>▸ Given the current vacancy of 0.5 FTE and the difficulties associated with its recruitment, a greater FTE loading will increase the attractiveness and support the recruitment process; and<br>▸ This additional FTE may also serve to cover additional workload related to care (repatriation) of transplant patients from other centres, which has become an immediate need, and these FTE costs may be offset by reducing costs currently associated with IDF outflows related to these patients. |

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| | | | | reviewed annually through each year of the action plan, taking into consideration the stability of workload for staff when SMOs go on leave and the resiliency of the service in the long-term. | |
| | | Primary – medium term:<br>4. There should be an uplift of allied health resourcing and psychosocial support to better deliver a multidisciplinary team (MDT) model of care to improve patient experience and outcomes.<br>5. Information systems (IS) and processes need to better serve cancer services through enhanced integration and resiliency. Improved DHB Information Technology (IT)/IS engagement with the SBCS is required to achieve this. Dedicated IT support capacity should be prioritised given the IT/IS needs of the service<br>6. Continuing support of existing roles to support access and outcomes for Māori and Pasifika such as community Māori cancer navigator roles. | Primary – medium term:<br>3. Gradually increase FTE for Medical Oncology registrars. Consider additional 1.0 FTE initially.<br>▸ Needs to reflect gradual increase in SMO FTE for supervision<br>*Includes dependency of general medical registrar pool.* | Primary – medium term:<br>2. Review the workload for Radiation Therapists and Medical Physicists in the context of agreed budget uplifts, and the CCA benchmarking exercise. With a focus on the comparative workload involved in planning of treatment courses. | Primary – medium term:<br>3. Gradually increase FTE for Haematology registrars when SMO FTE increases, and this should be reviewed on an ongoing basis so that this increase is considered once SMO FTE is filled and therefore increased support may be provided to incoming registrars<br>▸ Need to align with SMO FTE for supervision (SMOs will be rate limiting factor, in addition to other training requirements e.g., laboratory);<br>▸ Needs to consider staffing requirements in terms of balance of basic vs advanced trainees in service;<br>▸ There may also need to be advocacy for increased number of medical registrars generally (as Haematology registrars may come from this pool); |
| | | Secondary recommendations:<br>1. Increased emphasis on increasing Māori and Pasifika workforce, and specific roles to address access to healthcare services (which may be broader than SBCS) and outcomes for these population groups, that may include co-design of healthcare services and models of care.<br>2. Consider the role of a telehealth coordinator (administrator role) to support better utilisation of telehealth at SBCS, that could be also used more widely across the organisation (although it would be important that this | | Secondary recommendations:<br>1. Ongoing review of FTE for Radiation Oncology registrars.<br>▸ 2022 will be 4.0 FTE, which is likely maximum given supervision requirements, but depending on recruitment of SMOs in the future should be reviewed regularly<br>2. Consider increased expansion of CNS role, and concurrently continue to promote increased scope of practice for Radiation Therapists. | Secondary recommendations:<br>1. Work with the private lab to enable Haematology training for Haematology registrars to encourage recruitment and retention of medical workforce. |

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| | | position was able to successfully support SBCS as a priority).<br>▸ This may have the added benefit of freeing up time of other administrative staff.<br>▸ This is in addition to current SDHB-wide plans for increased telehealth coordinator support in FY22. | | | |
| | | *Consideration of key dependencies to allow expansion of workforce including:*<br>*1. Adequate space for service delivery;*<br>*2. Private laboratory for Haematology, which does not provide placements for these trainees;*<br>*3. General medical registrar numbers at SDHB; and*<br>4. *Nursing at peripheral centres.* | *Dependency:*<br>1. *Oncology trained nurses at peripheral centres (Invercargill & rural hospitals), who are not employed directly by SBCS.* | | *Dependency:*<br>1. *Oncology trained nurses (can deliver chemotherapy) at peripheral centres (Invercargill & rural hospitals), who are not employed directly by SBCS.* |
| | Structure | Secondary:<br>1. Could explore and trial different leadership arrangements, eg. non-medical leadership arrangements for some teams, or rotation of clinical governance. | | | |
| | Workforce model | Primary – immediate:<br>1. Adequate staffing levels to allow staff to use their designated proportion of non-clinical time<br>2. There should be continued support of current training programmes/pathways for medical staff, oncology nursing, and for advanced training (e.g., for CNSs. Nurse Practitioners, and RTs).<br>▸ However, we recommend that SBCS should endeavour to ensure that staff engaging in these programmes will be provided employment in these roles at the end of training. | | | |

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| | | Secondary:<br>1. SDHB should work with commissioned NGO sites to ensure appropriate training and clinical development opportunities for relevant nursing roles and staff. | | | Secondary:<br>1. Protocols for both malignant and non-malignant conditions should be developed, so these conditions can be managed by CNSs and GPs where possible. |
| | Other activities | Secondary<br>1. Need ongoing learning & development opportunities for clerical staff (e.g. MDM roles) + sufficient career progression pathways and opportunities within roles to tailor responsibilities depending on preferences | | | |
| | | *Consideration of key dependencies to allow expansion of service delivery:*<br>1. *Sufficient physical space* | | | |
| Strategic | | Primary – immediate:<br>1. It is critical that there is adequate space for service delivery in both inpatient and outpatient settings, and this is sufficient to support patient dignity and confidentiality during consultations and procedures. This has been flagged as a critical issue to be addressed | | | Primary – immediate:<br>1. Imminent steps required to manage transferred Day 1/2 (repatriated) autologous SCT patients for SBCS<br>▸ This may reduce costs currently associated with IDF outflows related to these patients, that may offset the costs associated with establishing this at SBCS<br>2. Purchase plasmapheresis service from NZBS as a priority, as required for multiple medical specialities including neurology and renal, and not just blood and cancer services.<br>▸ This may have an additional benefit that NZBS may provide some FTE with the provision of this plasmapheresis machine, which may increase FTE available for other Haematologists. |

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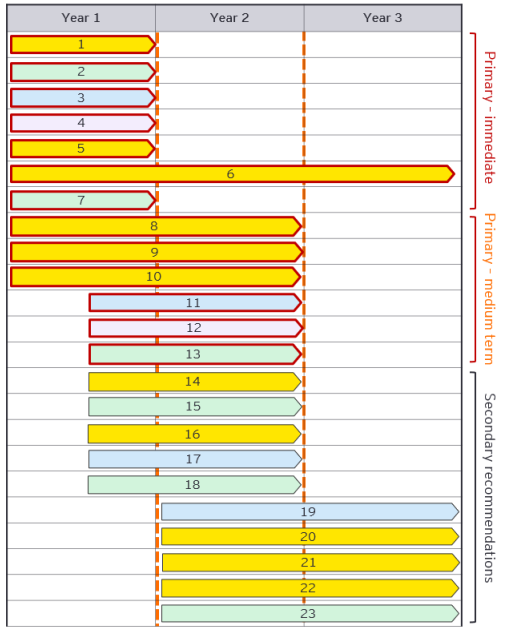
| | | Secondary:<br>1. Increased pharmacy involvement in business case development for treatment delivery from the start of the planning process | | Secondary:<br>1. Aim that autologous SCTs will be performed at SBCS (and associated planning around this) in approximately one year.<br>▸ Benefits of allowing increased medical training at site, and pathway for advanced nursing role<br>▸ This will require increased psychosocial support, more intensive and specialised nursing support, dietetic support, registrar input for management as inpatients, and will have corresponding increases in workload for the day unit.<br>2. Need to pursue mechanisms to allow increased training time for Haematology registrars through laboratory placements (as above). |

## 3.6 Roadmap of recommendations for SBCS

Based on all the findings above, a three-year roadmap for SBCS has been developed with recommended immediate actions and investment to address the gaps between SBCS and the other cancer centres in New Zealand. Of note, there needs to be annual review of workforce issues and requirements for the service.

**Figure 2: Three-year roadmap of recommendations for SBCS**




**Considerations and key dependencies for roadmap implementation:**

- Ensure sufficient physical space to allow current + future delivery of services (both inpatient and outpatient);
- Psychosocial and allied health currently have shared roles across medical service;
- Māori community cancer navigators are currently funded by the DHB;
- Haematology and medical oncology pool may be dependent on general medical registrar numbers;
- Nursing staff based at peripheral centres; and
- Private lab & implications for haematology registrar training.

| | |
|---|---|
| **Primary recommendations – immediate** | |
| 1 | Increase administration and nursing staffing to support budgeted uplift in clinical FTE, and current workload. Estimated to be 2 registered nursing FTE, and four administrative positions, across SBCS. Longer-term ensure the optimal use of digital technology and workflow tools to improve efficiency. |
| 2 | Increase 0.3 SMO FTE for Haematology to promote recruitment for this role and support imminent Day 1/Day 2 transfers for SCT as well as develop steps to manage the transfers |
| 3 | Prioritise recruitment of the remained budgeted FTE for FY21, especially the 1.375 Radiation Oncologist FTE and recruit for retiring SMO positions (*due to immediate succession planning needs*) |
| 4 | Consider a further 1.0 SMO FTE for Medical Oncology |
| 5 | Ensure adequate staffing levels to allow staff to use their designated proportion of non-clinical time |
| 6 | Continue support of current training pathways/programmes for medical staff, oncology nursing, and for advanced training (for CNSs, Nurse Practitioners, and RTs) |
| 7 | Purchase Plasmapheresis service from NZBS |
| **Primary recommendations – medium term** | |
| 8 | Continue support of existing roles to support access and outcomes for Māori + Pasifika such as Community Māori cancer navigator roles |
| 9 | There should be an uplift of allied health resourcing and psychosocial support to better deliver a multidisciplinary team model of care to improve patient experience and outcomes |
| 10 | Improved DHB Information Technology (IT)/Information systems (IS) engagement with SBCS to achieve enhanced integration and resiliency of service. Dedicated IT support capacity should be prioritised given the IT/IS needs of the service |
| 11 | Review workload of RTs and MPs in the context of agreed budget uplifts, and the CCA benchmarking exercise. With a focus on the comparative workload involved in planning of treatment courses |
| 12 | Gradually increase FTE for Medical Oncology registrars. Consider additional 1.0 FTE initially |
| 13 | As increased SMO supervision capacity becomes available as SMO FTE increases, gradually increase FTE for Haematology registrars |
| **Secondary recommendations** | |
| 14 | Consider the role of a telehealth coordinator (administrator role) to support better utilisation of telehealth at SBCS, that could be also used more widely across the organisation |
| 15 | Explore developing autologous SCT service at SBCS |
| 16 | Increase Māori + Pasifika workforce, and specific roles to address access to healthcare services and outcomes for these population groups, that may include co-design of healthcare services and models of care |
| 17 | Ongoing review of FTE for Radiation Oncology registrars as SMO workforce increases |
| 18 | Work with private laboratory to enable Haematology training |
| 19 | Consider some increased expansion of CNS scope of practice in RO, and concurrently continue to promote increased scope of practice for RTs |
| 20 | Develop ongoing L&D opportunities for clerical staff (e.g. MDM roles) + sufficient career progression pathways & opportunities within role to tailor depending on preferences |
| 21 | Consider trailing different leadership arrangements, e.g., non-medical leadership arrangements for some teams, or rotation of clinical governance |
| 22 | SDHB to work with commissioned NGO sites to ensure appropriate training and clinical development opportunities for relevant nursing roles and staff |
| 23 | Develop protocols for both malignant and non-malignant conditions, so can be managed by CNSs where possible and GPs in the community |

Key: SBCS overall – across service | Medical Oncology specific | Radiation Oncology specific | Haematology specific

# 4. Concluding remarks

SBCS aims to provide high quality holistic patient-centred cancer care, and has done continuous work in improving the service including recent steps to uplift the workforce capacity. However, whilst having committed staff, and even leading in innovation in workforce model development for nurses and RTs, SBCS is still facing many challenges that have been long-standing, calling for further actions to address.

After considering the findings from multiple approaches, our view of the immediate actions and investment recommended in the next three years are focused on:

- Immediate gaps to support current workload; and
- Further investment across workforce roles to better align SDHB's SBCS resourcing with other cancer centres, in the context of the particular delivery challenges they face.

A three-year roadmap of recommendations is provided overleaf, which is intended to give a clear direction for addressing key gaps for SBCS around workforce resourcing. We believe that with renewed and sustained effort of the service together with the support of the organisation's leadership, SBCS can address immediate challenges and make good gains in achieving these overall aspirations of the DHB and its SBCSs.

# Appendix A Detailed scope of works

The detailed work undertaken throughout this project is set out below, across three stages.

**Stage 1: Discovery, scoping and establishment**

The first stage was about understanding existing information and data sources, and engaging with key stakeholders to determine critical aspects that need to be considered during the project. This stage included:

- Conducting 10 scene-setting interviews with key stakeholders at SDHB and CCA to get an early perspective on key issues, and best approach for undertaking the project;
- Reviewing existing data and information to identify points of clarification and areas of supplementary analyasis required; and
- Establishing a Steering Group, detailed project plan and engagement schedule.

**Stage 2: Current state assessment and identifying opportunities for improvement**

The second stage involved developing the current state assessment of oncology and haematology services at SDHB, and formulating recommendations for action planning. This included:

- Exploring the FTE benchmarking exercise conducted by CCA, understanding its considerations and limitations, and exploring the key findings around points of difference between SBCS and the other five cancer centres;
- Interviewing key clinical and operational leads at the other five cancer centres, with the aim of understanding key differences between centres around workforce resourcing and service delivery, main drivers, and any learnings that may be applicable for SBCS;
- Testing and further understanding the benchmarking findings with key stakeholders, through both workshops with SDHB staff and key leads in other centres;
- Conducting four workshops (Medical Oncology, Radiation Oncology, Haematology, and staff at peripheral centres) with SDHB staff across a wide range of roles, presenting key work so far to:
    - Test and further understand the key differences identified between SBCS and other cancer centres through scene-setting interviews, benchmarking exercises, and interviews with other centres, gather feedback and identify drivers as well as implications of any key differences agreed
    - Identify any other areas of critical need and opportunities for improvement that have not been revealed but should be considered
- Summarising the above into a current state assessment of SBCS, and draft recommendations to be taken forward for roadmap development.

**Stage 3: Prioritising and sequencing actions, roadmap forming**

This final stage involved gaining feedback on the draft recommendations, and prioritising and sequencing actions identified in Stage 2 through one stakeholder workshop with key clinical and operational leads at SDHB and members of CCA. This formed the basis of the three-year roadmap.

# Appendix B Steering Group Terms of Reference

## 1. Context

SDHB and CCA are collaborating to develop a three-year action plan for SDHB's oncology services.

The purpose of the action plan is to inform and support SDHB's current Board, the CCA, and the future Health New Zealand entity in determining immediate actions and investment for the DHB's oncology services, to better align the DHB's oncology resourcing and service delivery with that of the other five cancer centres in New Zealand.

The action plan will be based on a current state assessment of SDHB's oncology services in comparison with New Zealand's five other cancer centres. In particular, the action plan will be informed by:

- Resourcing patterns at New Zealand's five other cancer centres, cognisant of differences in service scope and mix;
- Future demand growth, epidemiological and model of care changes which could influence resourcing and service delivery patterns at the DHB, and more broadly, oncology services across New Zealand; and
- A documented understanding of current resource constraints at the DHB and their impact on service delivery.

**Key deliverables of the project**

A document that:

- Clarifies how SDHB's oncology services compare with services at the other five cancer centres, the most immediate gaps, and the priority investment required to close the gaps; and
- Outlines the actions needed over the next three years (in terms of both investment and any practice change) to align resourcing and service delivery.

Figure 3 below illustrates the project stages and key activities as well as milestones.

Figure 3: Project stages and key deliverables/milestones

| | Stage | Key deliverables/milestones |
|---|---|---|
| Sep 2021 | **Stage 1:** **Discovery, scoping and establishment** | ► Agreement of the project plan and engagement schedule; establishment of Steering Group<br>► Scene-setting interviews completed<br>► Review existing data |
| Sep-Oct 2021 | **Stage 2:** **Current state assessment and evidence-based planning** | ► Receive benchmarking analysis done by CCA<br>► Interviews with other cancer centres completed<br>► First round of stakeholder workshops conducted<br>► Current state assessment submitted to Steering Group |
| Oct-Nov 2021 | **Stage 3:** **Plan road mapping and project closure** | ► Prioritising and sequencing actions identified in stage 2<br>► Second round of stakeholder workshops conducted (prioritisation of actions)<br>► Defining key milestones for basis of three-year roadmap<br>► Action Plan finalised and submitted to Steering Group |

# 2. The Steering Group

## 2.1 Roles and functions of the Steering Group

The Steering Group will bring together knowledge and expertise required in each functional area to help the project move at pace.

As a group it is responsible for:

- Oversight of project plan, and sign-off of terms of reference (TOR)
- Ensuring linkages are being made across all relevant areas of organisational work, and that relevant information and resourcing is made available to the project team
- Providing guidance and feedback on recommendations made by the project team, and lead engagement with Executive Leadership Team (ELT) / Board
- Meeting on a cycle of 2-3 weeks dependent on programme stage
- Providing collective expertise to support and guide the project
- Providing recommendations to the Project Sponsor to support decision making
- Ensuring work is achieved within agreed timeframes
- Monitoring the project's risks
- Facilitating engagement of key stakeholders.

As individual members, they will:

- Promote and provide relevant linkages for the project within their areas of expertise
- Assist with identifying relevant expertise, skills, and resources, and advise on appropriate communication/consultation mechanisms
- Provide input and feedback relevant to their specialist area of expertise
- Promote and champion the project within their own organisation and amongst their colleagues and area of expertise.

In addition, the Project Sponsor provides guidance and overall direction for the project including:

- Controlling changes to the project's scope
- Providing guidance on approach and overall direction for the project
- Controlling changes to project scope and methodology
- Assisting with identifying and working with key stakeholder groups, and advising on appropriate communication / engagement mechanisms.

## 2.2 Membership

Table 22: Steering Group membership

| Name | Organisation | Name | Organisation |
|---|---|---|---|
| Patrick Ng (Chairperson/Project Sponsor) | SDHB | Therese Duncan | SDHB |
| Simon Donlevy | SDHB | Daniel DeBono | SDHB |
| Shaun Costello | SDHB | Kelsey Chisholm | SDHB |
| Blair McLaren | SDHB | Sara Joice | SDHB |
| Lucy Pemberton | SDHB | Nicholas Glubb | CCA |
| Alison Aumata | SDHB | Janfrey Doak | CCA |

## 2.3 Meeting agenda, minutes, and actions

An agenda and associated meeting items will be circulated at least two working days in advance of Group meetings.

The meeting will be minuted by EY, with actions arising from the meeting agreed by Group members. Each action arising will have an agreed owner and timeframe for resolution.

## 2.4 Frequency and focus of meetings

The Group will meet four times over the course of the project. Group meetings are expected to be one hour in duration but may be extended at different stages of the project. The provisional timing and expected focus of Group meetings is provided in Table 2 below.

If any member is unavailable to attend a meeting, detailed notes and a progress update will be sent out for review/comment.

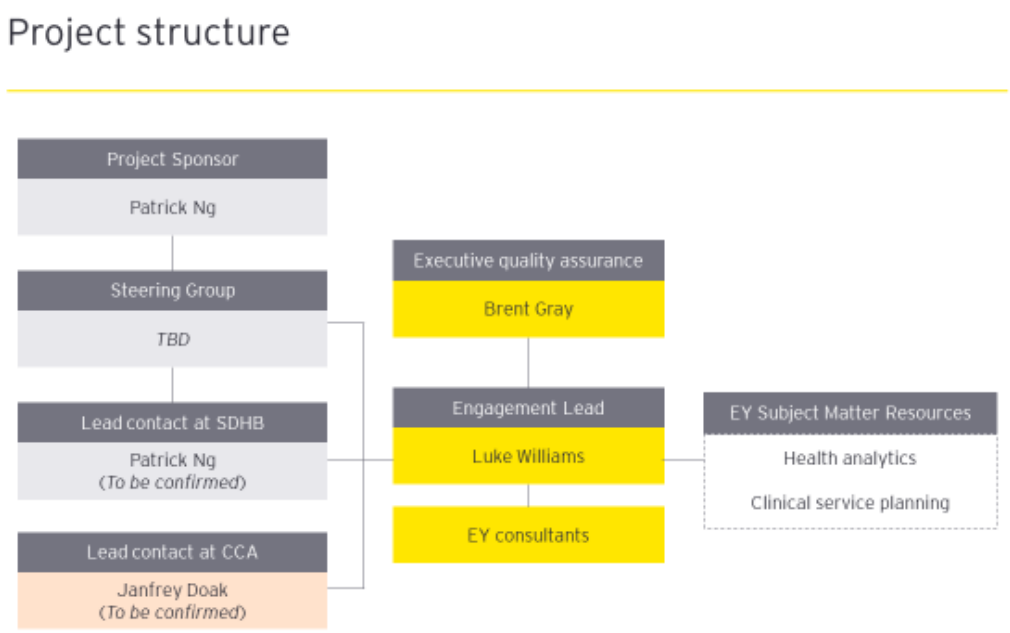
Table 23: Meeting schedule and focus

| Meeting | Date scheduled | Main agenda |
|---|---|---|
| 1 | Thursday, 23 Sep 2021 | ► To confirm approach and present initial findings to-date based on scene-setting interviews and benchmarking analysis. |
| 2 | Thursday, 14 Oct 2021 | ► To present findings on key differences from benchmarking data analysis and interviews with other cancer centres to test prior to first stakeholder workshops.<br>► Outline upcoming workshops (held in the following week 18-22 Oct). |
| 3 | Thursday, 28 Oct 2021 | ► To present and discuss the current state assessment and suggested actions based on first stakeholder workshops.<br>► Outline upcoming workshops to sequence and prioritise actions (held in the following week 1-5 Nov). |
| 4 | Thursday, 18 Nov 2021 | ► To present and discuss the draft Action Plan. |

# 3. Other relevant information

## 3.1 Project structure

Figure 4: Project structure diagram



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# Appendix C CCA benchmarking report

## Southern Blood and Cancer Service (SBCS) FTE Benchmarking exercise

## 1. Purpose

The purpose of this exercise is to provide a high-level snapshot view of the current state of FTE allocation across New Zealand's six cancer centres, to support SDHB's short term investment in the SBCS. The aim is to better understand the relationship between current staffing levels and service delivery at Southern DHB, using the other five cancer centres as points of reference. It is important to note that the other five cancer centres are not viewed as being optimally staffed and resourced. This is not intended to be used to model future demand.

## 2. Limitation in this analysis

There are a number of key limitations and areas subject to variation in the interpretation of the data. Therefore its utility beyond this exercise should be carefully considered in consultation with the SBCS clinical leads.

- Radiation Oncology private providers of treatment influence the public treatment course and FSA counts used below, due to outsourcing arrangements which have not been quantified in this exercise.
- Registrar training impacts on FSA counts. Some centres have a high number of advanced trainees who see patients for their FSA, however other centres do not have this capability such as in the SBCS. Therefore the FSA counts per Oncologist are not a direct and accurate reflection of workload in this analysis.
- We have not validated the data received from the centres in this exercise. This includes the level of non-contact clinical time (some centres have up to 30%) or other portions of FTE that may allocated as part of contractual arrangements, to support roles such as clinical lead duties.
- Complexities associated with full budgeted FTE's given and actual current state FTE, does not support a robust analysis.
- Existing staff vacancies have not been considered in this analysis.

### 2.1 Status in SDHB

- SDHB is unique in that it is responsible for delivery of oncology and haematology services for its own largely rural, geographically dispersed population, which includes servicing peripheral clinics. Dunedin based clinics and clinician workload are impacted to accommodate servicing geographically distant rural clinics. SDHB does not have the benefits of scale that larger centres have to undertake this nor do all cancer centres provide rural clinics.
- To manage increasing workload and referrals over recent years, SBCS SMOs renumerated hours are now almost all used for direct clinical tasks (30% of non-clinical time is considered standard).

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- Their high clinical workload results in a reduced level of redundancy in the system to support planned and unplanned leave, fluctuations in referrals to the service, undertaking quality improvement activities, participation in local/regional/national work, leadership and other professional development opportunities etc.

- SDHB is one of only two cancer centres in NZ that has no direct access to local private Radiation Oncology facilities. There is also only limited private Medical Oncology care and no private Haematology care.

- SBCS has one of the highest training, teaching and supervision workloads which is not accounted for.

- Capacity to see new patients (FSA's) is influenced and can be significantly limited by the number of follow up appointments available in clinic.

## 2.2 Key considerations

- The six tertiary cancer centres were asked to provide total 20/21 or 21/22 calendar year budgeted number of FTEs for the roles within each craft group (including Base, Overtime, Cover, CME, other allowances), reflective of ambulatory patients only. Centres were asked to exclude inpatient resources.

- Individual "full time" positions for SMOs are likely to be in excess of 40 hours – therefore annual overall budgeted FTE has been used as a high level measure.

- FTE is made up of both non-clinical and clinical hours. Larger centres have the benefits of scale and ability to support other activities such as CME, meeting participation, clinical leadership activities, project and service improvement work, commitments to regional work etc.

- Oncologists work across both public and private to service the regional population in five of the six cancer centres (see locations of private facilities in table below).

- There are potential inaccuracies in counting FSAs due to general coding variations from DHBs which are not validated in this exercise, this includes variation in coding for the range of approaches to undertaking FSA such as Telehealth, peripheral clinics, phone, and cancer centre clinic visits.

- There is significant variation in the utilisation of private facilities and outsourcing will influence FSA and treatment data counts, this could not be accounted for in this analysis.

- Treatment delivery for regional services such as sarcoma, gynae-oncology and paediatric oncology are undertaken by a small number of tertiary centres and cover multiple DHBs.

- Population 'catchments' for the purposes of this analysis have Tairawhiti allocated to Waikato.

- Data reflects MidCentral provision of cancer services for Taranaki.

- Re-treatment rates for Medical and Haematology services and follow up data for each centre has not been considered.

- Treatment complexity has not been considered in this analysis.

- Levels of service support are not included in this exercise e.g., PAs or administrative support which play a key role in managing the service including staff workloads.

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- On call/ inpatient workload is not included but on call frequency would be expected to be greater for smaller centres.
- Nursing FTE has not been included in this analysis due to the high level of variability of their work across the different oncology services and models of care, making their workforce numbers difficult to compare.

# 3. Data Sources

- Radiation Oncology collections (ROC) dataset (treatment course counts by Hospital supplied by TAoTK DMR team).
- COVID -19 DHB Data Monthly report - 24 Nov 2020 0.1v (supplied by TAoTK DMR team) – FSA and Medical/Haematology course and treatment counts.
- https://www.health.govt.nz/new-zealand-health-system/my-dhb/ population served counts 20/21.
- Health Partners Consulting Group. 2014. Radiation Oncology National Linear Accelerator and Workforce Plan. Health Partners Consulting Group.
- DHBs provided FTE data in tables below and where given, associated budgets.

# 4. Supporting data

| Measure | Southern | MidCentral | Waikato | Auckland | Canterbury | Capital Coast |
|---|---|---|---|---|---|---|
| Population by DHB | 344,900 | 603,555 | 860,905 | 1,894,580 | 832,155 | 477,430 |
| Cancer registrations 2018 (NZCR) | 1,933 | 3,729 | 4,929 | 8,607 | 4,562 | 2,340 |
| Cancer registrations per 100,000 population | 560 | 618 | 573 | 454 | 548 | 490 |
| Access to private providers | Mercy (Med onc only and only for limited cancers) | None | KKC (Rad onc only), Braemar Hospital (Medical Oncology and Haematology) | ARO, Canopy, Harbour cancer centre | St Georges cancer care | ICON |

# 5. Findings by service

## 5.1 Radiation Oncology service

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- For the purposes of this analysis in the South Island, NMDHB, SCDHB, WCDHB Radiation Oncology FSAs and treatment counts are incorporated into Canterbury DHB/Christchurch Hospital counts, though a proportion of NMDHB Radiation Oncology patients are treated in Capital Coast DHB and a proportion of South Canterbury patients are also treated in Southern DHB. This centralised approach to delivery of Radiation Oncology services was also applied to North Island centres.

- Some Radiation Oncology centres provide specialised treatment techniques on behalf of other DHBs such as HDR brachytherapy and stereotactic treatments.

- Linear accelerator counts (LINACs) do not reflect 100% operational time, therefore the number of LINACs listed in the tables below do not reflect actual machine operating time. The level of LINAC machine utilisation and shift work to manage increasing demand is not accounted for.

- Southern DHB does not have any local access to private RO facility capacity. Auckland, Waikato, Wellington and Canterbury all have access to private facility capacity.

- Auckland and Christchurch Hospital FSA and treatment counts may include a proportion of outsourcing to a private facility.

- FTE data has not been validated with the centres.

- Non-cancer FSA and treatment counts are included in the data.

- Re-treatment counts are included in the data.

**SDHB current state Radiation Oncologist (RO) FTE at 4.6[6]:**

**Note, Hospital level data has been used for FSA and Treatment course counts (ROC collection).**

- ► Has the lowest number of Radiation oncologist FTE per LINAC.
- ► Sees the highest number of FSAs per Radiation oncologist FTE over a 12-month period.
- ► Delivers the highest number of courses per Radiation oncologist FTE over a 12-month period.
- ► The population per Radiation oncologist is the fourth highest.

| Centre | Number of linacs 2021 | Catchment population MoH DHB counts | Population per linac | Intervention rates 2020 ROC Data *2018 used | Rad onc courses 2020 ROC Data/TAoTK | Rad onc FSAs 19/20 COVD data | Radiation oncologists (RO) FTE | FSAs in 19/2020 per RO* 12 month period | Courses per RO | ROs per '000 population | ROs per linac |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Auckland City Hospital | 6 | 1,894,580 | 315,763 | *32.5 | 3,221 | 3,528 | 15.6 | 226.15 | 206.47 | 121 | 2.6 |
| Waikato Hospital | 4 | 860,905 | 215,226 | 31.7 | 1,651 | 1,535 | 8 | 191.88 | 206.38 | 108 | 2.0 |
| Palmerston North Hospital | 4 | 603,555 | 150,889 | 35.5 | 1,559 | 1,742 | 9.06 | 192.27 | 172.08 | 67 | 2.3 |
| Wellington Hospital | 3 | 477,430 | 159,143 | 42.7 | 1,717 | 1,345 | 10.37 | 129.70 | 165.57 | 46 | 3.5 |
| Christchurch Hospital | 4 | 832,155 | 208,039 | 37 | 2,034 | 1,987 | 11 | 180.64 | 184.91 | 76 | 2.8 |
| Dunedin Hospital | 3 | 344,900 | 114,967 | 34.8 | 1,198 | 1,070 | 4.6 | 232.61 | 260.43 | 75 | 1.5 |
| **New Zealand** | **24** | **5,013,525** | | **30.28** | **11,380** | **11,207** | **58.63** | | | | |

**SDHB if full budgeted FTE is filled (7.695) then:**

**Note, Hospital level data has been used for FSA and Treatment course counts (ROC collection).**

- ► Shares the third highest number of Radiation oncologist FTE per LINAC.

[6] Of total FTE budgeted for Radiation Oncologists in FY21 (7.695), 1.72 has been filled but roles are not starting until Feb/Dec 2022, and 1.375 remains unfilled, resulting in the current actual RO FTE of 4.6.

TE AHO O TE KAHU CANCER CONTROL AGENCY

- Sees the second to lowest number of FSAs per Radiation oncologist FTE over a 12-month period.
- Delivers the lowest number of treatment courses per Radiation oncologist FTE over a 12-month period.
- The population per Radiation oncologist is the lowest.

| Centre | Number of linacs 2021 | Catchment population MoH DHB counts | Population per linac | Intervention rates 2020 ROC Data *2018 used | Rad onc courses 2020 ROC Data/TAoTK | Rad onc FSAs 19/20 COVD data | Radiation oncologists (RO) FTE | FSAs in 19/2020 per RO* 12 month period | Courses per RO | ROs per '000 population | ROs per linac |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Auckland City Hospital | 6 | 1,894,580 | 315,763 | *32.5 | 3,221 | 3,528 | 15.6 | 226.15 | 206.47 | 121 | 2.6 |
| Waikato Hospital | 4 | 860,905 | 215,226 | 31.7 | 1,651 | 1,535 | 8 | 191.88 | 206.38 | 108 | 2.0 |
| Palmerston North Hospital | 4 | 603,555 | 150,889 | 35.5 | 1,559 | 1,742 | 9.06 | 192.27 | 172.08 | 67 | 2.3 |
| Wellington Hospital | 3 | 477,430 | 159,143 | 42.7 | 1,717 | 1,345 | 10.37 | 129.70 | 165.57 | 46 | 3.5 |
| Christchurch Hospital | 4 | 832,155 | 208,039 | 37 | 2,034 | 1,987 | 11 | 180.64 | 184.91 | 76 | 2.8 |
| Dunedin Hospital | 3 | 344,900 | 114,967 | 34.8 | 1,198 | 1,070 | 7.659 | 139.70 | 156.42 | 45 | 2.6 |
| **New Zealand** | **24** | **5,013,525** | | **30.28** | **11,380** | **11,207** | **61.689** | | | | |

## 5.2 Registrars, Physicists and Radiation Therapists

- SDHB has the lowest number of Registrars per LINAC.
- SDHB has the lowest number of Physicists per LINAC
- SDHB has the second to lowest number of Radiation Therapists per LINAC.
- SDHB has the second to lowest number of courses per Radiation Therapist over a 12month period.

| Centre | Number of linacs 2021 | Catchment population MoH DHB counts | Intervention rates 2020 ROC Data *2018 used | Rad onc courses 2020 ROC Data/TAoTK | Registrars FTE | Registrars per linac | RTs FTE | courses per RT | RTs per linac | Physcisits FTE | Physicists per linac |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Auckland City Hospital | 6 | 1,894,580 | *32.5 | 3,221 | 8.00 | 1.33 | 74.8 | 43 | 12.47 | 19.88 | 3.31 |
| Waikato Hospital | 4 | 860,905 | 31.7 | 1,651 | 5.00 | 1.25 | 41 | 40 | 10.25 | 11 | 2.75 |
| Palmerston North Hospital | 4 | 603,555 | 35.5 | 1,559 | 4.48 | 1.12 | 37.05 | 42 | 9.26 | 11.71 | 2.93 |
| Wellington Hospital | 3 | 477,430 | 42.7 | 1,717 | 7.14 | 2.38 | 35.62 | 48 | 11.87 | 9.1 | 3.03 |
| Christchurch Hospital | 4 | 832,155 | 37 | 2,034 | 7 | 1.75 | 40.77 | 50 | 10.19 | 11.6 | 2.9 |
| Dunedin Hospital | 3 | 344,900 | 34.8 | 1,198 | 2 | 0.67 | 28.62 | 42 | 9.54 | 7.05 | 2.35 |
| **New Zealand** | **24** | **5,013,525** | **30.28** | **11,380** | **33.62** | | **257.86** | | | **70.34** | |

# 6. Medical Oncology service

- Access to private centre Medical Oncology treatments has not been accounted for.
- Population served, FSA and treatment data reflects the site of the cancer centre and smaller peripheral sites as the larger regions have Medical Oncologist and Registrar FTE serving their local populations that we have not quantified in this analysis e.g., NMDHB and SCDHB employ Medical Oncologists therefore they have not been included in Canterbury data.
- FTE has not been validated by the centres.

Findings:

- The population per Medical Oncologist is the second highest.
- SDHB sees the highest number of FSAs per Medical Oncologist over a 12-month period.

TE AHO O TE KAHU CANCER CONTROL AGENCY

- SDHB delivers the highest number of treatments per Medical Oncologist over a 12-month period.
- The population per Registrar is the highest.

**Medical oncology**

*does not account for number and location of Advanced trainees undertaking FSAs

| Centre (DHB)s for Medical oncology services | Catchment population | Medical oncology treatments | Medical oncology FSAs | Medical oncolgoists | Medical Oncologist | Treatments per Medical oncologist | FSAs per medical oncologist* | Registrars | Registrar |
|---|---|---|---|---|---|---|---|---|---|
| | MoH DHB counts | COVID data (12 months Nov 19-Oct 20) | COVID data (12 months Nov 19-Oct 20) | FTE | per '000 population | | | FTE | per '000 population |
| Auckland / Counties /Waitem | 1,701,410 | 20,390 | 2,338 | 19.15 | 89 | 1065 | 122 | 10.2 | 167 |
| Waikato | 435,690 | 6,707 | 859 | 7 | 62 | 958 | 123 | 6 | 73 |
| MidCentral /Whanganui | 303,065 | 7,770 | 1,095 | 8.39 | 36 | 926 | 131 | 5.51 | 55 |
| Capital and Coast / Hutt | 477,430 | 6,497 | 883 | 10.45 | 46 | 622 | 84 | 8.34 | 57 |
| Canterbury/West Coast | 610,840 | 6,440 | 1,211 | 13.90 | 44 | 463 | 87 | 7 | 87 |
| Southern | 344,900 | 6,853 | 659 | 4.76 | 72 | 1,440 | 138 | 2 | 172 |
| New Zealand | **3873335** | **54657** | **7,045** | **63.65** | | | | | |

# 7. Haematology Service

- Access to private centre treatments has not been accounted for
- SBCS treatment counts have been taken from local data provided due to error identified in COVID report.
- There is variation in FTE allocation across Haematology service delivery vs laboratory/NZBS duties, this has not been accounted for in the analysis. FTE has not been validated by the centres.
- There is variation in the cancer types and other non-cancer conditions treated by Haematologists which has not been accounted for in the analysis. For example in some centres patients with Lymphoma are treated by Medical Oncologists.
- Allogeneic SCTs are performed in only three centres (Auckland, Wellington and Christchurch). Autologous SCTs are performed in Auckland, Wellington, Christchurch, Palmerston North and Waikato. Dunedin does not currently do autologous transplants and SDHB patients go to Christchurch (currently about 1-2 patients per month). However, there is a national waiting list crisis for transplants, and Christchurch is actively asking SDHB to help with capacity by doing its own autologous transplants and to start taking their patients back as soon as possible.
- Population served, FSA and treatment data has been limited to the site of the cancer centre and smaller peripheral sites as the larger regions have Haematologist and Registrar FTE serving their local population and we have not quantified these FTEs in this exercise i.e. we have removed the Haematology FSA, treatment counts and populations for Bay of Plenty, Northland, Counties, Waitemata and Nelson Marlborough DHBs.
- The proportion of cancer and non-cancer conditions with associated treatments has not been accounted for in this analysis.

Findings:

- The population per Haematologist is the fourth lowest.
- SDHB delivers the highest number of treatments per Haematologist over a 12-month period.
- SDHB sees the lowest number of FSA's per Haematologist FTE over 12-month period.

TE AHO O TE KAHU CANCER CONTROL AGENCY

- The population per Registrar is the highest.

## 8. Financials (reflects those centres who provided this data)

| | Southern DHB | Midcentral | Canterbury |
|---|---|---|---|
| Radiation Oncology | $7,000,734 | $9,292,961 | $12,296,260 |
| Medical Oncology | $2,040,026 | $3,546,764 | $7,621,788 |
| Haematology | $2,543,549 | $2,867,738 | $4,549,844 |
| Otago and Southland Nursing | $2,209,761 | - | - |
| Otago and Southland Admin | $562,398 | - | - |
| **Total for service** | **$14,356,468** | **$15,707,463** | **$24,467,892** |

# Appendix D Supplementary analysis report

Based on the findings to-date from scene-settings interviews and workshops, the key differences highlighted in Southern's service for consideration for workforce resourcing were:

- Age of population served, and other demographic and disease burden factors;
- Geographic distribution of population served, and rural service delivery; and
- Decreased private provider availability.

To further explore this, a supplementary analysis was conducted to explore some of these areas further.

The supplementary analysis included:

- An update to the benchmarking exercise using Southern's proposed additional FTE for 2022 (not included in previous report), as well as an update to show what the benchmarking outcomes will look like with the proposed additional FTEs recommended.

The following table provides the 2022 recruitment plan of new positions approved by SBCS.

Table 24: 2022 recruitment plan of new positions approved by SBCS

| Position | Number (FTE) |
|---|---|
| Radiation Oncology Registrars | 3 |
| Medical Physics | 3 |
| Nursing | 2 |
| Specialist Nurses | 1.6 |
| Radiation Therapist | 1 |
| Medical Oncologist | 1.8 |
| Oncology Registrar | 1 |
| Haematologist | 1 |
| Haematology Registrar | 1 |

**Caveats and limitations for the supplementary analysis:**

- Administrative data provided by centres were difficult to interpret as roles may not be comparable, for example, Southern provided administration staff and Booking Clerks separately while it was unclear whether the FTEs provided by other centres included Booking Clerks;
- This was not included in benchmarking data originally, and therefore not validated with staff;
- Other caveats and limitations related to the benchmarking exercise in general are listed in Appendix C;
- Based on the feedback we received on the supplementary analysis, National Collections data used for these may not accurately reflect current operational practice for SCBS.

However, the issues do not appear to have significant impact on our findings and subsequent recommendations.

# Medical Oncology

## Location of service delivery

IDF data also indicates that almost all of SDHB's population are served locally for Medical Oncology services, the third highest nationally.

Table 25: Proportion of DHB population served locally for Medical Oncology services

| DHB | % served locally |
|---|---|
| Auckland | 100% |
| Bay of Plenty | 98% |
| Canterbury | 100% |
| Capital and Coast | 99% |
| Counties Manukau | 0% |
| Hawkes Bay | 0% |
| Hutt Valley | 0% |
| Lakes | 87% |
| MidCentral | 96% |
| Missing | 0% |
| Nelson Marlborough | 97% |
| Northland | 91% |
| South Canterbury | 64% |
| Southern | 99% |
| Tairawhiti | 96% |
| Taranaki | 68% |
| Waikato | 98% |
| Wairarapa | 0% |
| Waitemata | 0% |
| West Coast | 54% |
| Whanganui | 0% |

## Age of patients seen at FSA by SDHB

Considering the population characteristics of patients seen for FSAs by Southern's Medical Oncology services, Southern has slightly fewer younger cases, nearly 5-percentage-points higher than other centres for patients aged 60-74 years. For Māori specifically, there is nearly a negative 10-percentage-point difference at 30-44 years, meaning the proportion seen in this age group for Māori was lower than other centres, and a positive 10-percentage-points for 75+ years (higher than other centres). Māori made up 5.4% of Medical Oncology FSAs at Southern, compared to 13.3% across other centres.

**Figure 5: Proportion of FSAs by age, Medical Oncology, SBCS compared to other cancer centres**

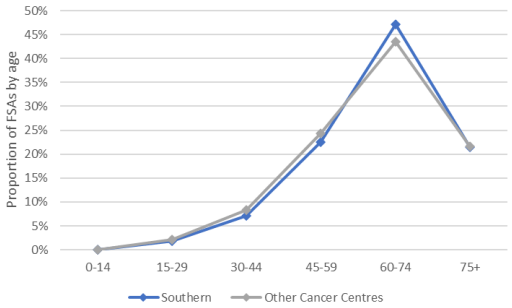
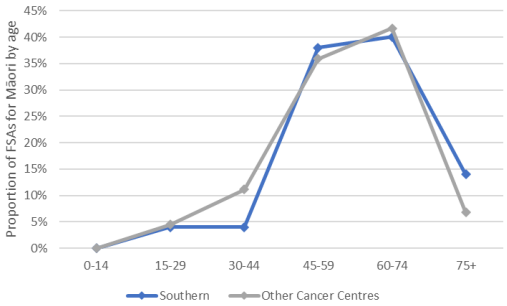



**Figure 6: Proportion of FSAs for Māori by age, Medical Oncology, SBCS compared to other cancer centres**




# Radiation Oncology

## Location of service delivery

IDF data also shows that almost all of SDHB's population are served locally for Radiation Oncology services, the fourth highest nationally.

| Table 26: Proportion of DHB population served locally for Radiation Oncology services | |
|---|---|
| **DHB** | **% served locally** |
| Auckland | 100% |
| Bay of Plenty | 96% |
| Canterbury | 100% |
| Capital and Coast | 99% |
| Counties Manukau | 0% |
| Hawkes Bay | 0% |
| Hutt Valley | 0% |
| Lakes | 6% |
| MidCentral | 96% |
| Missing | 0% |
| Nelson Marlborough | 18% |
| Northland | 46% |
| South Canterbury | 0% |
| Southern | 98% |
| Tairawhiti | 38% |
| Taranaki | 0% |
| Waikato | 96% |
| Wairarapa | 0% |
| Waitemata | 0% |
| West Coast | 18% |
| Whanganui | 0% |

## Age of patients seen at FSA by SDHB

Considering the population characteristics of patients seen for FSA by Southern's Radiation Oncology service, there is approximately 5-percentage-point more patients seen in the 75+ year age-group for Southern compared to other centres. For Māori, the proportion of patients seen at FSA in Southern is lower than at other centres for younger ages and higher most notably for 60-74 years. Māori made up 6.8% of Radiation Oncology FSAs, compared to 12.4% across other centres.

**Figure 7: Proportion of FSAs by age, Radiation Oncology, SBCS compared to other cancer centres**

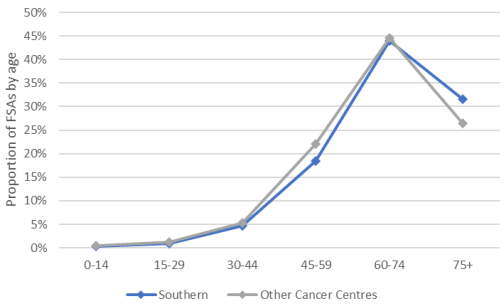
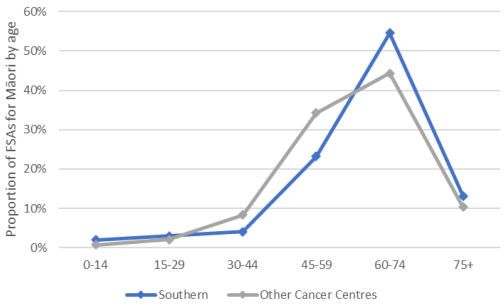



**Figure 8: Proportion of FSAs for Māori by age, Radiation Oncology, SBCS compared to other cancer centres**




# Haematology

## Location of service delivery

IDF data shows that a high proportion of SDHB's population are served locally for Haematology services, the fourth highest nationally.

| Table 27: Proportion of DHB population served locally for Haematology service | |
|---|---|
| **DHB** | **% served locally** |
| Auckland | 96% |
| Bay of Plenty | 88% |
| Canterbury | 99% |
| Capital and Coast | 100% |
| Counties Manukau | 84% |
| Hawkes Bay | 0% |
| Hutt Valley | 0% |
| Lakes | 65% |
| MidCentral | 89% |
| Missing | 0% |
| Nelson Marlborough | 84% |
| Northland | 87% |
| South Canterbury | 0% |
| Southern | 94% |
| Tairawhiti | 90% |
| Taranaki | 52% |

| | |
|---|---|
| Waikato | 92% |
| Wairarapa | 0% |
| Waitemata | 78% |
| West Coast | 70% |
| Whanganui | 0% |

The following table provides an illustrative view of inpatient and outpatient activity for the 2020/21 financial year based on National Collections data for Haematology and Medical Oncology.[7] Compared to Medical Oncology, Haematology delivers more inpatient activity as a proportion of events and this may cause increased workload for clinical staff.

Table 28: Haematology / Medical Oncology service delivery by type

| | Haematology | | Medical Oncology | |
|---|---|---|---|---|
| Type of service | Number of events | % share of events | Number of events | % share of events |
| Overnight inpatient | 596 | 8.8% | 382 | 4.0% |
| Bed-nights | 3,170 | | 1,704 | |
| Day case inpatient | 578 | 8.5% | 797 | 8.3% |
| Outpatient FSA | 401 | 5.9% | 589 | 6.1% |
| Outpatient FU | 3,596 | 53.0% | 3,511 | 36.4% |
| IV Chemotherapy - (non paediatric) | 1,620 | 23.9% | 4,367 | 45.3% |

## Age of patients seen at FSA by SDHB

Considering the population characteristics of patients seen for FSA by SDHB's Haematology services, a larger proportion of the patients seen at FSA are older. The proportion aged between 60-74 years was five percentage point higher, and slightly higher again for 75+ years for Southern compared to other cancer centres. For Māori the FSAs were at low volumes, but over 10 percentage points higher for 60-74 years compared to other centres. Māori made up 6.8% of Haematology FSAs, compared to 12.1% across other centres.

**Figure 9: Proportion of FSAs by age, Haematology, SBCS compared to other cancer centres**

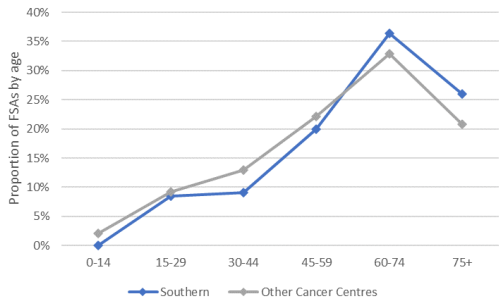
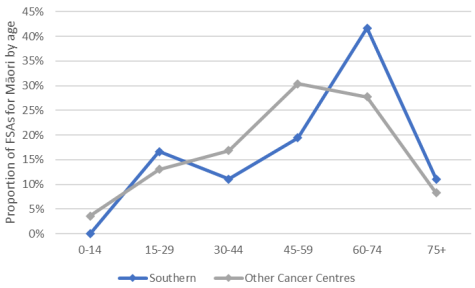



**Figure 10: Proportion of FSAs for Māori by age, Haematology, SBCS compared to other cancer centres**




[7] Inpatient activity based on the following DRGs: A07A, A07B, A07Z, A08A, A08B, Q60A, Q60B, Q60C, Q61A, Q61B, Q61C, Q62A, Q62B, Q62Z, R03A, R03B, R03C, R60A, R60B, R60C, R61A, R61B, R61C

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**FOR APPROVAL**

**Item:** Financial Report for the period ended 31 January 2022

**Proposed by:** Nigel Trainor, Executive Director Corporate Services

**Meeting of:** Board Meeting, 2 March 2022

## Recommendation

**That the Board approves the Financial Report for the period ended 31 January 2022.**

## Purpose

1. To provide the Board with the financial performance of the DHB for the month and year to date ended 31 January 2022.

## Specific Implications for Consideration

2. **Financial**

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

## Next Steps & Action

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

## Appendices

Appendix 1 Financial Report for the Board

Appendix 1: Financial Report for the Board

# Southern DHB Financial Report

| | |
|---|---|
| Financial Report for: | 31 January 2022 |
| Report Prepared by: | Finance |
| Date: | 16 February 2022 |

## *Report to Board*

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the period ending 31 January 2022.

January 2022 result was a small surplus of $0.1m, being $2.5m unfavourable to budget.
The year to date result is a deficit of $16.7m which is $8.2m unfavourable to budget.

### 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. Each of these unbudgeted activities are mostly covered by additional MoH funding.

The Nursing MECA pay equity component for the settlement is shown separately as a key driver for both funding and expenditure while the ongoing post-settlement funding and workforce payments are included in BAU.

**SOUTHERN DISTRICT HEALTH BOARD**
**Summary of Monthly Results - By Key Drivers**
For the month of January 2022

| | Month Actual Total $000 | Month Nursing MECA Settlement $000 | Month COVID-19 Vaccination $000 | Month COVID-19 Resurgance $000 | Month Transtasman Border $000 | Month BAU $000 | Month Budget Total $000 | Month BAU Variance $000 | | Month Actual COVID-19 Testing $000 | Month Budget COVID-19 Testing $000 | Month Variance $000 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | | | | | | | | |
| Government & Crown Agency | 107,236 | | 3,134 | 330 | 5 | 103,055 | 101,947 | 1,108 | F | 712 | 500 | 212 | F |
| Non-Government & Crown Agency | 900 | | - | - | - | 900 | 847 | 53 | F | - | - | - | |
| *Total Revenue* | 108,136 | - | 3,134 | 330 | 5 | 103,955 | 102,794 | 1,161 | F | 712 | 500 | 212 | |
| **EXPENSES** | | | | | | | | | | | | | |
| Workforce Costs | 41,967 | | 590 | 195 | - | 41,182 | 41,059 | (123) | U | - | - | - | |
| Outsourced Services | 3,963 | | 20 | - | - | 3,943 | 3,268 | (675) | U | - | - | - | |
| Clinical Supplies | 8,402 | | 20 | 70 | - | 8,312 | 5,822 | (2,490) | U | - | - | - | |
| Infrastructure & Non-Clinical Supplies | 5,404 | | 124 | 82 | 5 | 5,193 | 5,191 | (2) | U | - | - | - | |
| Provider Payments | 45,152 | | 2,380 | - | - | 42,060 | 41,460 | (600) | U | 712 | 500 | (212) | U |
| Non-Operating Expenses | 3,169 | | - | - | - | 3,169 | 3,449 | 280 | F | - | - | - | |
| *Total Expenses* | 108,057 | - | 3,134 | 347 | 5 | 103,859 | 100,249 | (3,610) | U | 712 | 500 | (212) | |
| **NET SURPLUS / (DEFICIT)** | 79 | - | - | (17) | - | 96 | 2,545 | (2,449) | U | - | - | - | |

**SOUTHERN DISTRICT HEALTH BOARD**
**Summary of YTD Results - By Key Drivers**
For the period ending 31 January 2022

| | YTD Actual Total $000 | YTD Nursing MECA Pay Equity Settlement $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 $000 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | | | | | | | | |
| Government & Crown Agency | 772,650 | 15,103 | 26,341 | 2,749 | 95 | 721,836 | 716,082 | 5,754 | F | 6,526 | 3,500 | 3,026 | F |
| Non-Government & Crown Agency | 5,869 | | - | - | - | 5,869 | 5,931 | (62) | U | - | - | - | |
| *Total Revenue* | 778,519 | 15,103 | 26,341 | 2,749 | 95 | 727,705 | 722,013 | 5,692 | F | 6,526 | 3,500 | 3,026 | |
| **EXPENSES** | | | | | | | | | | | | | |
| Workforce Costs | 309,463 | 16,096 | 5,656 | 2,446 | 76 | 285,189 | 287,646 | 2,457 | F | - | - | - | |
| Outsourced Services | 30,168 | | 489 | - | - | 29,679 | 26,865 | (2,814) | U | - | - | - | |
| Clinical Supplies | 68,343 | | 87 | 108 | - | 68,148 | 61,897 | (6,251) | U | - | - | - | |
| Infrastructure & Non-Clinical Supplies | 42,153 | | 1,142 | 195 | 19 | 40,797 | 37,623 | (3,174) | U | - | - | - | |
| Provider Payments | 322,761 | | 18,967 | - | - | 297,268 | 293,917 | (3,351) | U | 6,526 | 3,500 | (3,026) | U |
| Non-Operating Expenses | 22,410 | | - | - | - | 22,410 | 22,623 | 213 | F | - | - | - | |
| *Total Expenses* | 795,298 | 16,096 | 26,341 | 2,749 | 95 | 743,491 | 730,571 | (12,920) | U | 6,526 | 3,500 | (3,026) | |
| **NET SURPLUS / (DEFICIT)** | (16,779) | (993) | - | - | - | (15,786) | (8,558) | (7,228) | U | - | - | - | |

**Drivers of the result:**

The main drivers of the unfavourable BAU result is as follows:

| Driver variance > $1.0m | Month Variance 000's | YTD Variance 000's |
|---|---|---|
| Pharmaceuticals – Budget lower than Pharmac forecast, plus incorrect phasing of budget (both Fund $2.3m and Provider $3.2m) | (2,768) | (5,568) |
| Outsourced clinical services – related to Surgical services | (675) | (3,092) |
| Air Ambulance mix usage and 10% price increase | (490) | (1,713) |
| ICT & Software | (143) | (1,645) |
| **Sub Total** | **(4,076)** | **(12,018)** |
| **Offset by** | | |
| Other Government Revenue – ACC back pay & price increase | 265 | 1,875 |
| Workforce costs – BAU – refer below | (123) | 2,161 |
| **Total Variance** | **(3,934)** | **(7,982)** |

**Pharmaceuticals:**

| 000's | 2021/22 SDHB Budget | Oct 2020 Pharmac Forecast | Feb 2021 Pharmac Forecast | Dec 2021 Pharmac Forecast |
|---|---|---|---|---|
| Total Pharms Budget – per Pharmac Forecast | $108,347 | $108,347 | $113,572 | $115,000 |
| Savings Target | $2,000 | | | |
| **SDHB Net Budget** | **$106,347** | | | |

The SDHB Pharms budget was set using the Oct 20 forecast, however since then the forecast has increased significantly, in hindsight the budget should have been set using the Feb 2021 Pharmac forecast. Even if we had used the Feb 2021 forecast the budget variance would still be $1.5m.

The YTD cost of the Pharms is $68.7m ($48.7m Community and $20m Provider), a crude extrapolation would give a full year spend of $118m. There are two unknowns that is the level of rebate and the additional revenue to offset cost increases.

**Month detail:**

Consolidated Revenue was $4.8m favourable to budget.

| Variance area | Variance |
|---|---|
| Covid related | |
| Unbudgeted COVID-19 Vaccination Revenue | $3.13m |
| Unbudgeted COVID-19 Incremental Costs funding | $0.33m |
| COVID-19 Surveillance & Testing funding | $0.21m |
| | |
| Nursing Pay Equity funding | $0.82m |
| Reduction PBF – Pharms COVID-19 revenue | $(0.43)m |
| **Total** | **$4.06m** |

Expenses were $7.3m unfavourable to budget.

Workforce costs were $0.9m unfavourable including $0.6m for unbudgeted Vaccination programme costs.

| Variance area | Variance |
|---|---|
| SMOs – 0.75 FTE favourable with continued vacancies, offset by additional overtime and outsourced in a number of areas for cover, $0.2m indirect costs being mostly professional memberships (budget phasing) | $(0.23)m |
| RMOs – remain unfavourable with low rates of leave being taken plus overtime, over budget by 14.8 FTE | $(0.24)m |
| Nursing - reflecting $0.3m unbudgeted Vaccination activity. Net MECA settlement cost to SDHB (net of MoH funding) estimated at $0.7m to date. | $(0.87)m |
| Allied Health - remains favourable in a number of areas including Dental Therapists, Occupational Therapists, Physiotherapists, Psychologists & Technicians, 55 FTE overall, largely driven by continued unfilled vacancies. | $0.24m |
| Management/Admin - favourable including $0.3m unbudgeted Vaccination programme costs. | $0.19m |

Outsourced Services is $0.70m unfavourable with additional surgical activity including Medical Imaging, Ophthalmology, Orthopaedics and Rural Hospital ACC payments.

Clinical Supplies are $2.6m unfavourable. This includes higher than budgeted costs in Treatment Disposables, Air Ambulance and Pharmaceuticals, offset by an underspend in Implants & Prostheses (Cardiac, Hips, Knees and Shunts/Stents).

Provider Payments were $3.2m unfavourable, reflecting $2.4m COVID-19 Vaccination expenses (offset by additional revenue) and other costs unfavourable to budget including Community Pharmaceuticals $0.4m, Primary Health and Dental Care $0.1m and Residential Care $0.2m.

**Year To Date**

Revenue is $53.0m favourable to budget. This is made up as follows:

| Variance area | Variance |
|---|---|
| Nursing Pay Equity | $15.93m |
| Unbudgeted COVID-19 Vaccination Revenue (incl Māori) | $26.34m |
| Unbudgeted COVID-19 Incremental Costs funding | $2.75m |
| | $4.71m |
| COVID-19 Surveillance & Testing funding | |
| Unbudgeted Public Health core contract uplift | $3.03m |
| ACC Contract increase | $2.17m |
| Mental Health, Public Health | $1.73m |
| Primary Care | $1.17m |
| Reduction PBF – Pharms COVID-19 revenue net | ($2.16)m |
| IDFs | ($0.93)m |
| Ineligible Patients | ($0.66)m |
| **Total** | **$54.08m** |

Expenses are $61.2m unfavourable to budget.

Workforce costs are $21.8m unfavourable including $5.7m unbudgeted Vaccination programme costs.

| Variance area | Variance |
|---|---|
| SMO – indirect costs $1.7m unfavourable being mostly CME, outsourced remains $0.5m higher than budget in a number of areas due to vacancies. FTE are 10.13 under budget but is offset by increased overtime payments of $2.5m against a budget of $0.2m | $(1.80)m |
| RMOs – remain unfavourable with low rates of leave being taken plus overtime and relocation costs, FTE's over budget by 8.6. | $(0.82)m |
| Nursing – this has become complex as there are three main areas that need separating, these are:<br>• Nursing Meca settlement – pay equity partial settlement cost $16m and was offset by revenue of $15.1<br>• Unbudgeted Nursing FTE of 56.9 YTD at a cost $3.1m for Covid response covered by unbudgeted revenue<br>• BAU Nursing FTE for the YTD is exactly on budget at 1,934, due to a number of reasons the BAU Nursing costs is under budget by $3.2m. The budget has higher costs per nurse this is related to the mix of employees classified as nursing. | $(17.77)m |

| | |
|---|---|
| Allied Health – remains favourable in a number of areas including Occupational Therapists, Physiotherapists, Psychologists & Technicians, 48 FTE overall, largely driven by continued unfilled vacancies. | $1.37m |
| Management/Admin - unfavourable driven by:<br>• Unbudgeted Vaccination programme costs $2.7m and 72FTE | $(2.54)m |

Outsourced Services is $3.1m unfavourable with additional surgical activity including ENT, Plastic Surgery, Urology and Ophthalmology. Included in the unfavourable variance is $0.4m Vaccination programme costs for delivery to Rural areas and $0.5m for Rural Hospital ACC payments related to the increased revenue above. Offsetting is $0.7m favourable in Radiation Oncology with lower than budgeted volumes through St Georges.

Clinical Supplies are $6.4m unfavourable. This includes higher than budgeted costs in Treatment Disposables, Instruments & Equipment, Air Ambulance and Pharmaceuticals.

Infrastructure and Non-Clinical Supplies are $4.5m unfavourable in a range of areas, including COVID-19 expenses $1.1m, Patient Meals, Cleaning, Facilities, Transport & Travel, IT Services and Microsoft Licenses.

Provider Payments are $25.3m unfavourable, reflecting $0.4m ARRC back-payments, $2.3m Community Pharmaceuticals, $2.3m Primary Care and $19.0m COVID-19 Vaccination expenses (offset by additional revenue).

# Financial Summary Reports

## *Financial Performance Summary*

**SOUTHERN DISTRICT HEALTH BOARD**
**Statement of Financial Performance**
For the period ending 31 January 2022

| 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** | | | | | | |
| 107,236 | 102,447 | 4,789 | F | Government & Crown Agency | 772,650 | 719,582 | 53,068 | F | 1,187,928 | 1,233,735 |
| 900 | 847 | 53 | F | Non-Government & Crown Agency | 5,869 | 5,931 | (62) | U | 12,489 | 10,168 |
| 108,136 | 103,294 | 4,842 | F | *Total Revenue* | 778,519 | 725,513 | 53,006 | F | 1,200,417 | 1,243,903 |
| | | | | **EXPENSES** | | | | | | |
| 41,967 | 41,059 | (908) | U | Workforce Costs | 309,463 | 287,646 | (21,817) | U | 481,291 | 502,352 |
| 3,963 | 3,268 | (695) | U | Outsourced Services | 30,168 | 26,865 | (3,303) | U | 47,821 | 46,095 |
| 8,402 | 5,822 | (2,580) | U | Clinical Supplies | 68,343 | 61,897 | (6,446) | U | 111,249 | 107,947 |
| 5,404 | 5,191 | (213) | U | Infrastructure & Non-Clinical Supplies | 42,153 | 37,623 | (4,530) | U | 62,476 | 64,693 |
| 45,152 | 41,960 | (3,192) | U | Provider Payments | 322,761 | 297,417 | (25,344) | U | 489,958 | 506,799 |
| 3,169 | 3,449 | 280 | F | Non-Operating Expenses | 22,410 | 22,623 | 213 | F | 37,059 | 40,324 |
| 108,057 | 100,749 | (7,308) | U | *Total Expenses* | 795,298 | 734,071 | (61,227) | U | 1,229,854 | 1,268,210 |
| 79 | 2,545 | (2,466) | U | **NET SURPLUS / (DEFICIT)** | (16,779) | (8,558) | (8,221) | U | (29,437) | (24,307) |

## *Financial Position Summary*

**SOUTHERN DISTRICT HEALTH BOARD**
**Statement of Financial Position**
As at 31 January 2022

| Actual 30 June 2021 $000 | | Actual 31 January 2022 $000 | Budget 31 January 2022 $000 | Actual 31 December 2021 $000 | Budget 30 June 2022 $000 |
|---|---|---|---|---|---|
| | **CURRENT ASSETS** | | | | |
| 7,582 | Cash & Cash Equivalents | 10,855 | 7 | 129,166 | 7 |
| 61,439 | Trade & Other Receivables | 65,516 | 54,503 | 66,313 | 48,474 |
| 6,159 | Inventories | 6,370 | 5,525 | 6,446 | 5,235 |
| 75,180 | *Total Current Assets* | 82,741 | 60,035 | 201,925 | 53,716 |
| | **NON-CURRENT ASSETS** | | | | |
| 325,558 | Property, Plant & Equipment | 326,211 | 340,086 | 324,903 | 358,043 |
| 6,258 | Intangible Assets | 10,559 | 20,067 | 10,756 | 25,118 |
| 331,816 | *Total Non-Current Assets* | 336,770 | 360,153 | 335,659 | 383,161 |
| 406,996 | **TOTAL ASSETS** | 419,511 | 420,188 | 537,584 | 436,877 |
| | **CURRENT LIABILITIES** | | | | |
| - | Cash & Cash Equivalents | - | 21,566 | - | 33,663 |
| 72,840 | Payables & Deferred Revenue | 90,659 | 65,202 | 208,466 | 69,492 |
| 235 | Short Term Borrowings | 108 | 908 | 107 | 1,979 |
| 82,596 | Holidays Act 2003 | 86,786 | 86,971 | 86,191 | 90,146 |
| 95,374 | Employee Entitlements | 101,993 | 87,280 | 103,912 | 88,211 |
| 251,045 | *Total Current Liabilities* | 279,546 | 261,927 | 398,676 | 283,491 |
| | **NON-CURRENT LIABILITIES** | | | | |
| 856 | Term Borrowings | 792 | 4,884 | 801 | 10,754 |
| 19,411 | Employee Entitlements | 18,706 | 20,173 | 18,706 | 20,144 |
| 20,267 | *Total Non-Current Liabilities* | 19,498 | 25,057 | 19,507 | 30,898 |
| 271,312 | **TOTAL LIABILITIES** | 299,044 | 286,984 | 418,183 | 314,389 |
| 135,684 | **NET ASSETS** | 120,467 | 133,204 | 119,401 | 122,488 |
| | **EQUITY** | | | | |
| 486,579 | Contributed Capital | 488,141 | 490,131 | 487,156 | 495,164 |
| 108,500 | Property Revaluation Reserves | 108,500 | 108,500 | 108,500 | 108,500 |
| (459,395) | Accumulated Surplus/(Deficit) | (476,174) | (465,427) | (476,255) | (481,176) |
| 135,684 | *Total Equity* | 120,467 | 133,204 | 119,401 | 122,488 |
| | **Statement of Changes in Equity** | | | | |
| 165,991 | Opening Balance | 135,684 | 138,188 | 135,684 | 138,189 |
| (30,933) | Operating Surplus/(Deficit) | (16,779) | (8,558) | (16,857) | (24,307) |
| 1,333 | Crown Capital Contributions | 1,562 | 3,574 | 575 | 9,313 |
| (707) | Return of Capital | - | - | - | (707) |
| 135,684 | Closing Balance | 120,467 | 133,204 | 119,401 | 122,488 |

## *Cash Flow Summary*

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

| | YTD Actual $000 | YTD Budget $000 | Variance $000 | Full Year Budget $000 | LY YTD Actual $000 |
|---|---|---|---|---|---|
| **CASH FLOW FROM OPERATING ACTIVITIES** | | | | | |
| *Cash was provided from Operating Activities:* | | | | | |
| Government & Crown Agency Revenue | 771,909 | 724,679 | 47,230 | 1,240,738 | 691,397 |
| Non-Government & Crown Agency Revenue | 5,572 | 5,735 | (163) | 9,832 | 6,212 |
| Interest Received | 297 | 196 | 101 | 336 | 180 |
| *Cash was applied to:* | | | | | |
| Payments to Suppliers | (454,967) | (425,247) | (29,720) | (719,719) | (422,876) |
| Payments to Employees | (296,664) | (291,327) | (5,337) | (498,453) | (264,425) |
| Capital Charge | (3,368) | (3,507) | 139 | (7,142) | - |
| Goods & Services Tax (net) | 2,655 | (1,149) | 3,804 | (2,604) | 929 |
| **Net Cash Inflow / (Outflow) from Operations** | 25,434 | 9,380 | 16,054 | 22,988 | 11,417 |
| **CASH FLOW FROM INVESTING ACTIVITIES** | | | | | |
| *Cash was provided from Investing Activities:* | | | | | |
| Sale of Fixed Assets | - | - | - | - | 3 |
| *Cash was applied to:* | | | | | |
| Capital Expenditure | (23,532) | (41,786) | 18,254 | (71,902) | (17,959) |
| **Net Cash Inflow / (Outflow) from Investing Activity** | (23,532) | (41,786) | 18,254 | (71,902) | (17,956) |
| **CASH FLOW FROM FINANCING ACTIVITIES** | | | | | |
| *Cash was provided from Financing Activities:* | | | | | |
| Crown Capital Contributions | 1,562 | 3,574 | (2,013) | 8,556 | 1,145 |
| *Cash was applied to:* | | | | | |
| Repayment of Borrowings | (191) | (308) | 117 | (879) | (552) |
| Repayment of Capital | - | | - | | |
| **Net Cash Inflow / (Outflow) from Financing Activity** | 1,371 | 3,266 | (1,896) | 7,677 | 593 |
| **Total Increase / (Decrease) in Cash** | 3,273 | (29,140) | 32,412 | (41,237) | (5,946) |
| **Net Opening Cash & Cash Equivalents** | 7,582 | 7,582 | 0 | 7,582 | 31,011 |
| **Net Closing Cash & Cash Equivalents** | 10,855 | (21,558) | 32,412 | (33,655) | 25,065 |

Cash flow from Operating Activities is favourable to budget by $16.1m. Government revenue received includes the Nursing Pay Equity funding receipt in December and ongoing unbudgeted COVID-19 funding. Payments to Suppliers is unfavourable in line with the Statement of Financial Performance, adjusted for movements in working capital. Payments to Employees is unfavourable by $5.3m with the unbudgeted Nursing Settlement payments of $17.6m being mostly offset by the budgeted expected pay out for Employee Entitlements $12.7m.

Cash flow from Investing Activities is favourable to budget by $18.3m. The Capital Expenditure cash spend reflects project delays although this will reduce as larger projects gain momentum.
Cashflow from Financing Activities is $1.9m unfavourable with delays in Capital project drawdowns.
Overall, Cash flow is favourable to budget by $32.4m.

*Capital Expenditure Summary*

**SOUTHERN DISTRICT HEALTH BOARD**
**Capital Expenditure - Cash Flow**
For the period ending 31 January 2022

| Description | YTD Actual $000 | YTD Budget $000 | Variance $000 | Over Under Spend | LY YTD Actual $000 |
|---|---|---|---|---|---|
| Land, Buildings & Plant | 6,537 | 15,227 | 8,690 | U | 3,923 |
| Clinical Equipment | 13,446 | 13,167 | (279) | O | 9,660 |
| Other Equipment | 529 | 1,020 | 491 | U | 317 |
| Information Technology | 1,752 | 1,684 | (68) | O | 1,920 |
| Motor Vehicles | - | 30 | 30 | U | 14 |
| Software | 1,267 | 10,657 | 9,390 | U | 2,125 |
| **Total Expenditure** | 23,531 | 41,785 | 18,254 | U | 17,959 |

At 31 January 2022, our Financial Position on page 6 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $336.8m, which is $23.4m less than the budget of $360.2m.

The Land, Buildings & Plant, Clinical Equipment and Software variances reflect both expenditure on carry-over projects from 2020/21 and expenditure to date on 2021/22 projects.

# SERVICE PROVIDER CASEWEIGHTED DISCHARGES

As at: 08/02/2022 05:31:44

01/07/2021 31/01/2022

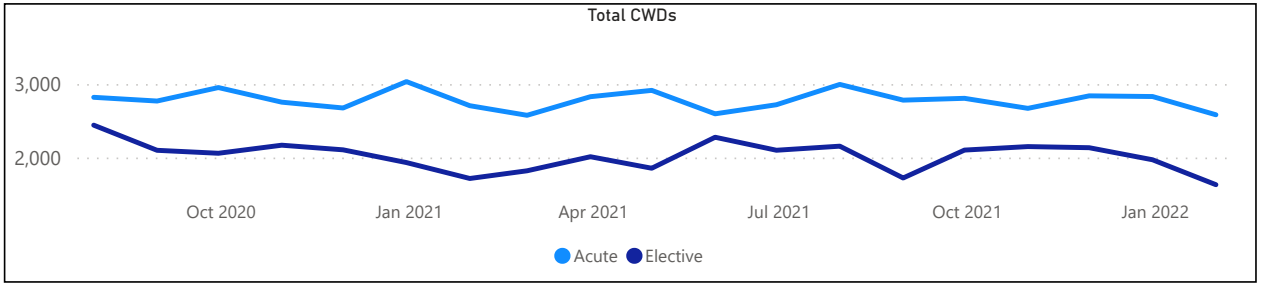
| Caseweights | MTD Actual | MTD Target | MTD Variance | % Variance (MTD) | MTD LY Actual | Year on Year Monthly Variance | YTD Actual | YTD Target | YTD Variance | % Variance (YTD) | YTD LY Actual | Year on Year YTD Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medical Caseweights** | | | | | | | | | | | | |
| Medical Acute | 1,432 | 1,344 | 88 | 7% | 1,490 | -58 | 10,412 | 10,083 | 329 | 3% | 10,549 | -137 |
| Medical Elective | 255 | 248 | 7 | 3% | 308 | -53 | 2,370 | 2,028 | 341 | 17% | 2,434 | -64 |
| **Total** | **1,687** | **1,592** | **95** | **6%** | **1,798** | **-111** | **12,782** | **12,111** | **671** | **6%** | **12,983** | **-201** |
| **Surgical Caseweights** | | | | | | | | | | | | |
| Surgical Acute | 1,077 | 1,141 | -64 | -6% | 1,143 | -66 | 8,369 | 8,492 | -123 | -1% | 8,512 | -143 |
| Surgical Elective | 994 | 1,074 | -80 | -7% | 1,024 | -31 | 8,823 | 9,538 | -715 | -8% | 9,480 | -657 |
| **Total** | **2,071** | **2,215** | **-144** | **-7%** | **2,167** | **-97** | **17,192** | **18,030** | **-838** | **-5%** | **17,992** | **-800** |
| **Maternity Caseweights** | | | | | | | | | | | | |
| Maternity Acute | 73 | 82 | -9 | -12% | 72 | 0 | 721 | 627 | 95 | 15% | 647 | 75 |
| Maternity Elective | 382 | 331 | 51 | 15% | 383 | -1 | 2,668 | 2,476 | 192 | 8% | 2,603 | 66 |
| **Total** | **454** | **413** | **41** | **10%** | **455** | **-1** | **3,390** | **3,103** | **287** | **9%** | **3,249** | **140** |
| **Total** | **4,212** | **4,220** | **-8** | **-0%** | **4,420** | **-208** | **33,364** | **33,244** | **120** | **0%** | **34,224** | **-860** |

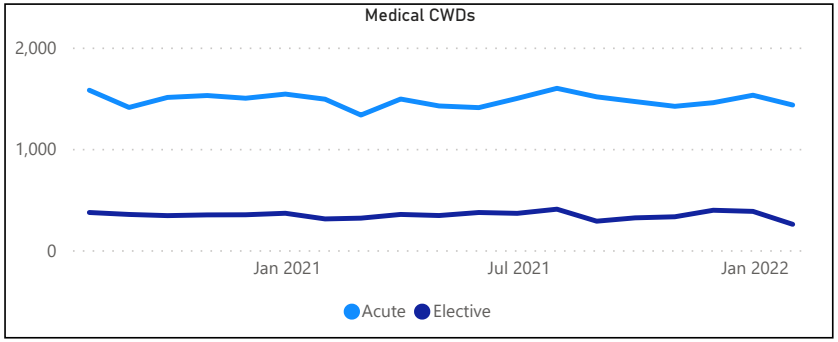
TOTALS

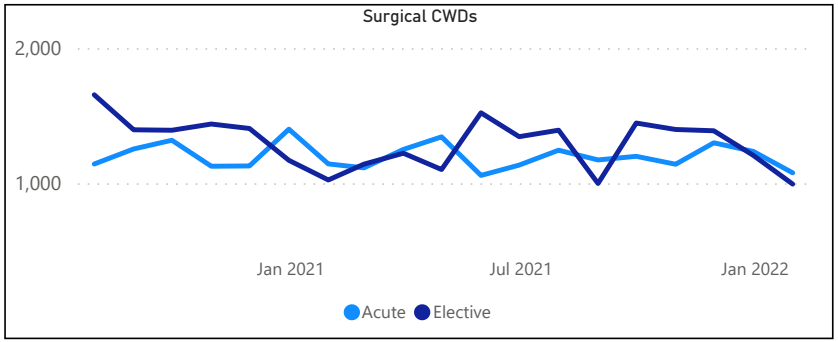
| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 2,582 | 2,568 | 14 | 1% | 2,705 | -123 | 19,502 | 19,201 | 301 | 2% | 19,707 | -205 |
| Elective | 1,631 | 1,653 | -22 | -1% | 1,715 | -85 | 13,861 | 14,043 | -182 | -1% | 14,517 | -655 |
| **Total** | **4,212** | **4,220** | **-8** | **-0%** | **4,420** | **-208** | **33,364** | **33,244** | **120** | **0%** | **34,224** | **-860** |

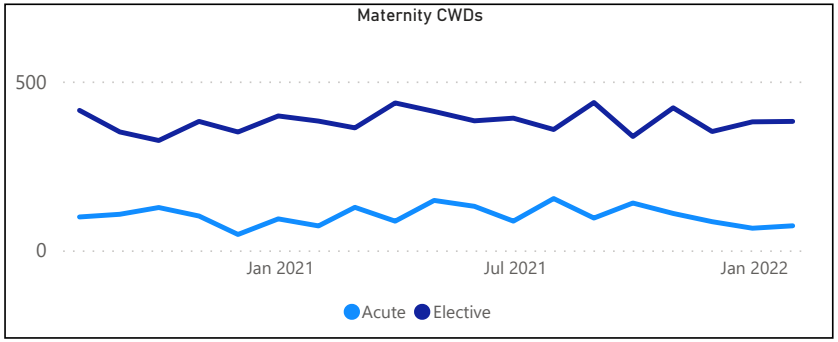
TOTALS excluding Maternity

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 2,509 | 2,485 | 24 | 1% | 2,633 | -124 | 18,781 | 18,574 | 207 | 1% | 19,060 | -280 |
| Elective | 1,249 | 1,322 | -73 | -6% | 1,332 | -84 | 11,193 | 11,567 | -374 | -3% | 11,914 | -721 |
| **Total** | **3,758** | **3,807** | **-49** | **-1%** | **3,965** | **-207** | **29,974** | **30,141** | **-167** | **-1%** | **30,974** | **-1,001** |



# SERVICE PROVIDER RAW DISCHARGES

As at: 08/02/2022 05:31:44

01/07/2021 31/01/2022

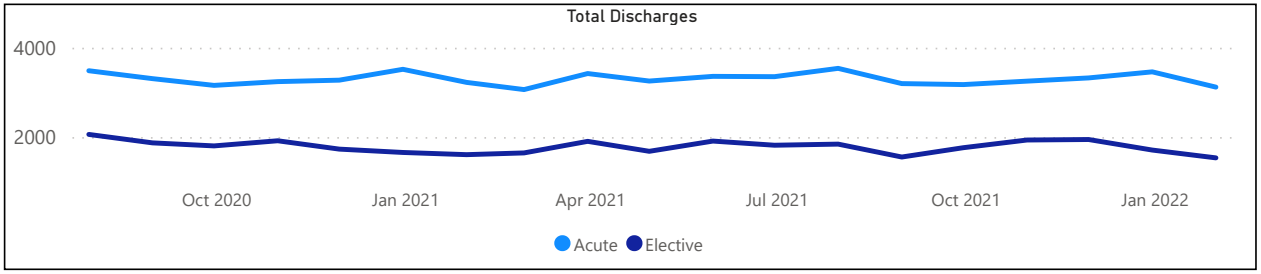
| Discharges | MTD Actual | MTD Target | MTD Variance | % Variance (MTD) | MTD LY Actual | Year on Year Monthly Variance | YTD Actual | YTD Target | YTD Variance | % Variance (YTD) | YTD LY Actual | Year on Year YTD Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medical Discharges** | | | | | | | | | | | | |
| Medical Acute | 2,378 | 2,156 | 222 | 10% | 2,370 | 8 | 17,160 | 16,128 | 1,032 | 6% | 16,870 | 290 |
| Medical Elective | 337 | 297 | 40 | 14% | 343 | -6 | 2,774 | 2,348 | 426 | 18% | 2,731 | 43 |
| **Total** | **2,715** | **2,452** | **263** | **11%** | **2,713** | **2** | **19,934** | **18,476** | **1,458** | **8%** | **19,601** | **333** |
| **Surgical Discharges** | | | | | | | | | | | | |
| Surgical Acute | 676 | 739 | -63 | -8% | 772 | -96 | 5,314 | 5,502 | -188 | -3% | 5,707 | -393 |
| Surgical Elective | 691 | 742 | -51 | -7% | 762 | -71 | 5,792 | 6,654 | -862 | -13% | 6,510 | -718 |
| **Total** | **1,367** | **1,481** | **-114** | **-8%** | **1,534** | **-167** | **11,106** | **12,156** | **-1,050** | **-9%** | **12,217** | **-1,111** |
| **Maternity Discharges** | | | | | | | | | | | | |
| Maternity Acute | 64 | 73 | -9 | -13% | 82 | -18 | 590 | 559 | 31 | 6% | 629 | -39 |
| Maternity Elective | 506 | 444 | 62 | 14% | 501 | 5 | 3,713 | 3,313 | 400 | 12% | 3,398 | 315 |
| **Total** | **570** | **518** | **52** | **10%** | **583** | **-13** | **4,303** | **3,872** | **431** | **11%** | **4,027** | **276** |
| **Total** | **4,652** | **4,451** | **201** | **5%** | **4,830** | **-178** | **35,343** | **34,503** | **840** | **2%** | **35,845** | **-502** |

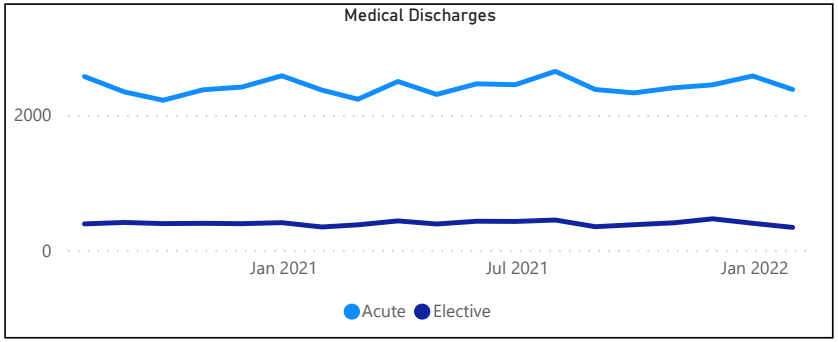
TOTALS

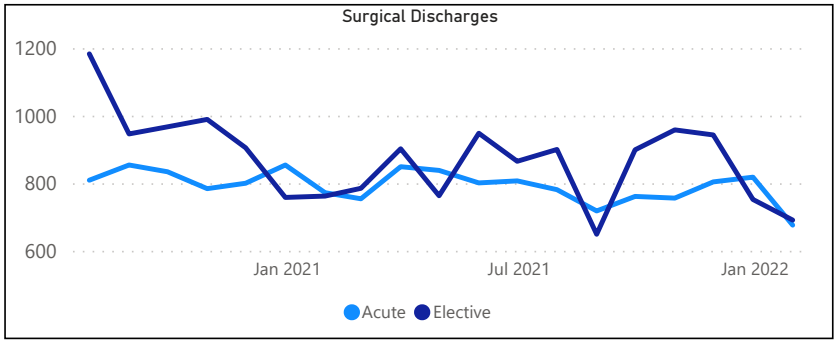
| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elective | 1,534 | 1,483 | 51 | 3% | 1,606 | -72 | 12,279 | 12,314 | -35 | -0% | 12,639 | -360 |
| Acute | 3,118 | 2,968 | 150 | 5% | 3,224 | -106 | 23,064 | 22,189 | 875 | 4% | 23,206 | -142 |
| **Total** | **4,652** | **4,451** | **201** | **5%** | **4,830** | **-178** | **35,343** | **34,503** | **840** | **2%** | **35,845** | **-502** |

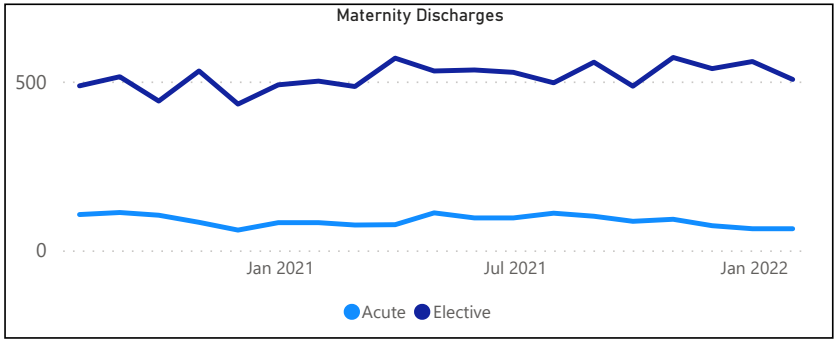
TOTALS excluding Maternity

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elective | 1,028 | 1,039 | -11 | -1% | 1,105 | -77 | 8,566 | 9,001 | -435 | -5% | 9,241 | -675 |
| Acute | 3,054 | 2,894 | 160 | 6% | 3,142 | -88 | 22,474 | 21,630 | 844 | 4% | 22,577 | -103 |
| **Total** | **4,082** | **3,933** | **149** | **4%** | **4,247** | **-165** | **31,040** | **30,631** | **409** | **1%** | **31,818** | **-778** |



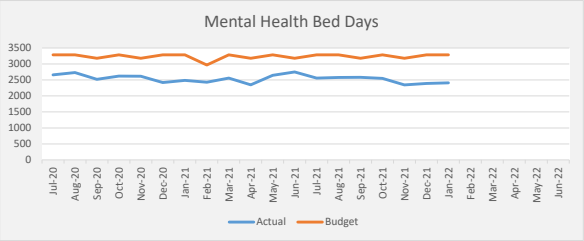



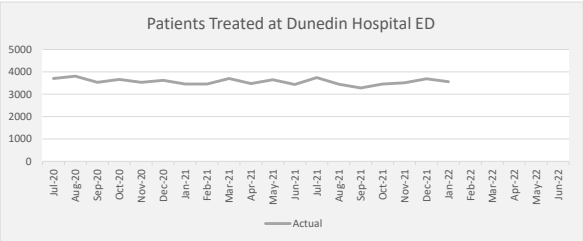



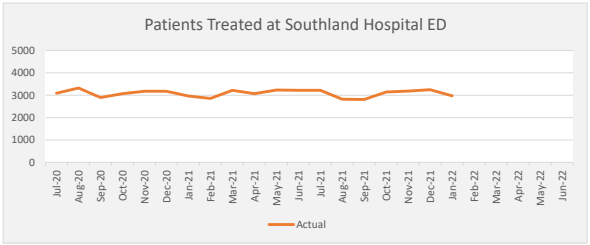
## OTHER ACTIVITY

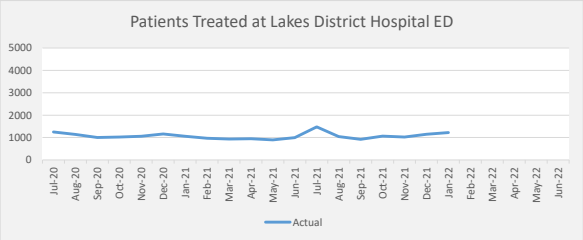
| Jan-22 | | | | Jan-21 | YEAR ON YEAR | | YTD 2021/2022 | | | | YTD Jan-21 | YEAR ON YEAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | % Variance | Actual | Monthly Variance | | Actual | Budget | Variance | % Variance | Actual | YTD Variance |
| 2,412 | 3,286 | (874) | -27% | 2,487 | (75) | Mental Health bed days | 17,423 | 22,790 | (5,367) | -24% | 18,060 | (637) |

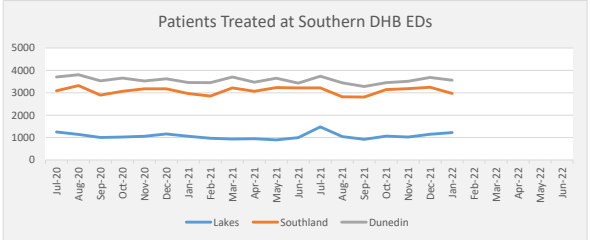



| Jan-22 | Jan-21 | YEAR ON YEAR | Treated Patients (excludes DNW and left before seen) | YTD 2021/2022 | YTD Jan-21 | YEAR ON YEAR |
|---|---|---|---|---|---|---|
| Actual | Actual | Monthly Variance | | Actual | Actual | YTD Variance |
| | | | **Emergency department presentations** | | | |
| 3,561 | 3,459 | 102 | Dunedin | 24,680 | 25,313 | (633) |
| 1,224 | 1,060 | 164 | Lakes | 7,902 | 7,695 | 207 |
| 2,970 | 2,967 | 3 | Southland | 21,388 | 21,692 | (304) |
| 7,755 | 7,486 | 269 | **Total ED presentations** | 53,970 | 54,700 | (730) |



**FOR INFORMATION**

**Item:** Quality Dashboard – January 2021

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

Patrick O'Connor, Quality Improvement Manager

**Meeting of:** Board – March 2022

## Recommendation

**That the Board notes the attached quality dashboards.**

## Purpose

The Executive Quality Dashboard presents key quality metrics for the Southern region relating to quality of care, staff, patient experience and operations. 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
   - Better quality provides a better working environment for staff with less time and effort spent on incidents and remediating care issues.
3. Equity
   - Equity reporting will be included in the report and is expected to be included from 2022.
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.
7. Changes to dashboards and/or creation of new indicators or charts take one full time IT/reporting analyst a minimum of two weeks to complete.
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. Falls and Pressure Injuries have been added this month.

10. Māori measures have been added this month. Not all measures are available with the MOH ethnicity guidelines, and these have been excluded this month as require further verification. We expect these to be included, if possible, in the next two months resource permitting. Please note that for several measures (HACs, Deaths, Vulnerable patients) the numbers are very low and often in the low single

digits. This makes it difficult to draw meaningful insights from the data unless there is an unexpected spike.

11. Not included in the report but for noting: In January 99% (77 of 78) of complaints were acknowledged within five working days, which is the HDC Code of Rights standard. This a great result, which has been improving steadily over the last three months.

12. Please see commentary for further details on measures.

---

Next Steps & Actions

Equity reporting to be reviewed with the new equity analyst in IT and included in reporting. We should be able to give an update to timing in the first quarter of the year.

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**Appendices**

| | |
|---|---|
| **Appendix 1** | **Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital** |
| **Appendix 2** | **Executive Quality Dashboard - Māori** |
| **Appendix 3** | **Guide to interpreting the dashboard** |
| **Appendix 4** | **Commentary and data definitions** |
| **Appendix 5** | **Updated graphs** |

## Appendix 1

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

| | | | Benchmark /3 year average | | | | Benchmark /3 year average | | | | Benchmark/ 3 year average | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Quality of care** | *Actual* | | | *Trend* | *Actual* | | | *Trend* | *Actual* | | | *Trend* |
| 1 | Hospital Acquired Complications per 10k episodes of care | | | | | 3.5 | 2.9 | | | 2.2 | 2.2 | | |
| 2 | Healthcare Associated Infections per 10k episodes of care | | | | | 148 | 97 | | | 114 | 77 | | |
| 3 | Medication Complications per 10k episodes of care | | | | | 40.1 | 25.2 | | | 20.2 | 19.3 | | |
| 4 | Readmissions within 7 days % | | | | | 2.7 | 3.4 | | | 2.7 | 3.2 | | |
| 5 | Mental Health Seclusions no | 22 | 32 | | | | | | | | | | |
| 6 | Mental Health Restraints no | 247 | 131 | | | 103 | 48 | | | 14 | 14 | | |
| 7 | Deaths no | 45 | 58 | | | 21 | 28 | | | 10 | 15 | | |
| 8 | ED Wait Time - % patients discharged within 6 hours | | | | | 72 | 95 | | | 80 | 95 | | |
| 9 | Vulnerable Patients (Aged 70 and over; Triage Category 1 2 3) in ED > 6 hours | | | | | 202 | 162 | | | 148 | 146 | | |
| 10 | Falls resulting in fracture or intracranial injury per 10k of episodes of care | | | | | 0.09 | 0.03 | | | 0.05 | 0.04 | | |
| 11 | Pressure Injuries no | 20 | 22 | | | | | | | | | | |
| | **Staff** | | | | | | | | | | | | |
| 12 | Staff Events - SAC 1 and 2 no | | | | | 1 | 0 | | | 0 | 0 | | |
| 13 | Staff Events - SAC 3 and 4 no | | | | | 11 | 20 | | | 5 | 4 | | |
| | **Patient Experience** | | | | | | | | | | | | |
| 14 | Complaints no | 102 | 81 | | | 57 | 42 | | | 31 | 30 | | |
| 15 | Complaint response target met % | 66 | 100 | | | 67 | 100 | | | 61 | 100 | | |
| 16 | Short Notice Postponments No | | | | | 42 | 44 | | | 9 | 28 | | |
| 17 | Short Notice Postponments % | | | | | 8.6 | 4.5 | | | 10.4 | 6.7 | | |
| | **Operations** | | | | | | | | | | | | |
| 18 | Referrals Declined % | | | | | 12 | 15 | | | 10 | 14 | | |
| 19 | Length of stay days | | | | | 3.5 | 4.6 | | | 3.3 | 3.4 | | |
| 20 | Patients with stay > 7 days no | | | | | 299 | 385 | | | 129 | 168 | | |
| 21 | Patients with stay > 21 days no | | | | | 77 | 87 | | | 27 | 42 | | |

## Appendix 2

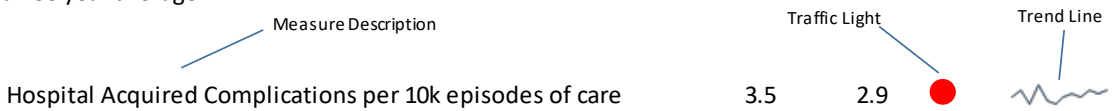
### Executive Quality Dashboard – Māori

| | | | 3 year | | | | 3 year | | | | 3 year | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Quality of care** | *Actual* | *average* | | *Trend* | *Actual* | *average* | | *Trend* | *Actual* | *average* | | *Trend* |
| 1 | Hospital Acquired Complications per 10k episodes of care | | | | | 2.6 | 3.4 | | | 1.49 | 2.2 | | |
| 2 | Healthcare Associated Infections per 10k episodes of care | | | | | 57 | 139 | | | 92 | 93 | | |
| 3 | Medication Complications per 10k episodes of care | | | | | 10 | 46 | | | 17 | 18 | | |
| 4 | Readmissions within 7 days % | 3.5 | 3.3 | | | | | | | | | | |
| 5 | Mental Health Seclusions no (not available) | | | | | | | | | | | | |
| 6 | Mental Health Restraints no (not available) | | | | | | | | | | | | |
| 7 | Deaths no | 1 | 3 | | | | | | | | | | |
| 8 | ED Wait Time - % patients discharged within 6 hours (not available) | | | | | | | | | | | | |
| 9 | Vulnerable Patients (Aged 70 and over; Triage Category 1 2 3) in ED > 6 hours | 13 | 11 | | | | | | | | | | |
| 10 | Falls (not available) | | | | | | | | | | | | |
| 11 | Pressure Injuries (not available) | | | | | | | | | | | | |
| | **Staff** | | | | | | | | | | | | |
| 12 | Staff Events - SAC 1 and 2 no (not available) | | | | | | | | | | | | |
| 13 | Staff Events - SAC 3 and 4 no (not available) | | | | | | | | | | | | |
| | **Patient Experience** | | | | | | | | | | | | |
| 14 | Complaints no | | | | | | | | | | | | |
| 15 | Complaint response target met % | | | | | | | | | | | | |
| 16 | Short Notice Postponments No | 6 | 7 | | | | | | | | | | |
| 17 | Short Notice Postponments % | 7 | 7 | | | | | | | | | | |
| | **Operations** | | | | | | | | | | | | |
| 18 | Referrals Declined % | 18 | 19 | | | | | | | | | | |
| 19 | Length of stay days | | | | | | | | | | | | |
| 20 | Patients with stay > 7 days no | 33 | 38 | | | | | | | | | | |
| 21 | Patients with stay > 21 days no | 12 | 10 | | | | | | | | | | |

**Appendix 3** **Guide to Interpreting the Executive Quality Dashboard**

**Traffic Lights**

For each measure a traffic light indicates how the quality measure rates either against a benchmark, target or where there are no benchmark or target against the three year average.




**Traffic light colours**

| Traffic light | Traffic light criteria | Interpretation |
|---|---|---|
|  | In top 25% of Health Round Table peer comparison or:<br>On or better than target or:<br>In line with 3 year average | Performing well and/or stable process |
|  | In the middle 50% of Health Round Table peer comparison or:<br>Within 10% of target or:<br>Last 3 data points show worsening trend compared to long term average | Rates with majority of peers, close to reaching target, or shows slightly worsening trend. Requires watching |
|  | In the bottom 25% of Health Round Table peer comparison or:<br>Great than 10% away from target or:<br>Last 6 data points show worsening trend compared to long term average | Rates lowly against peers, not reaching target, or shows worsening trend. Requires action |

**Trend Line**
The trend line shows the last 36 months or, for Health Round Table measures the last 8 quarters

**Comparators**
Health Round Table Benchmarking: Hospital Acquired Complications, Care Associated Infections, Medication Complications
MOH Targets: ED Wait Time, Complaint Response Time
3 year average; Readmissions, Seclusions, Restraints, Vulnerable Patients, Staff Events, Complaints no, Short Notice postponements, Referrals, Length of stay, Patients over 7 & 21 days

**Appendix 4** **Commentary and data definitions**

| No | Measure | Commentary | Data Definition |
|---|---|---|---|
| 1 | Hospital Acquired Complications (HAC) per 10k episodes of care | Dunedin continues to be placed in the lower performing quartile for Hospital acquired complications. 4.9% of admitted patients suffering a major hospital acquired complication as against 3.4% of patients for peer hospitals across Australasia. This is to the end of September 21<br><br>Invercargill is in line with peers with 3% of admitted patients suffering a major hospital acquired complication. We have not yet received an update from HRT on Southland so the data remains to the end of June<br><br>Maori patients appear to have HAC at a lower rate compared to the overall rate particular in Dunedin Hospital (2.6 vs 3.4 for overall rate) | Data sourced from Health Round Table:% of episodes where the patient had one or more hospital acquired complications. An episode with a major hospital acquired complication is determined by the presence of one or more specified diagnosis codes with a condition onset flag indicating that the complication occurred during the episode of care. The list of complications is derived from the ACSQHC's Hospital Acquired Complications list<br><br>The next update from HRT is due in February |
| 2 | Healthcare Associated Infections per 10k episodes of care | Dunedin remains in red and is placed in the lower performing quartile against peers (ranked 14 out of 19 peers)<br><br>Invercargill is newly red and is showing an increasing trend over the last 8 periods. Ranked 14 out of 20 peers. We are working with the Southland team to understand the drivers of this trend.<br><br>Māori patients appear to have infections at either a lower rate or in line with the overall rate (57 vs 139 for Dunedin and 92 vs 93 for Invercargill) | Data sourced from Health Round Table Description: Includes the diagnosis groups: 3.1 Urinary tract infection, 3.2Surgical site infection, 3.3 Pneumonia, 3.4.Blood stream infection, 3.5Multi-resistant organism, 3.6 Infection associated with prosthetics/implantable devices, 3.7 Gastrointestinal infections, 3.8 Central line and peripheral line associated bloodstream infection<br><br>The next update from HRT is due in February |
| 3 | Medication Complications per 10k episodes of care | Dunedin medication complications are trending down but still remain in red relative to peers (ranked 15 out of 20)<br><br>Invercargill ranks solidly with peers (10 out of 20) | Data sourced from Health Round Table Description: Includes the diagnosis groups: 10.1 Drug related respiratory complications/depression, 10.2 Haemorrhagic disorder due to circulating anticoagulants, 10.3 Hypoglycaemia, 10.4 Movement |

| | | | |
|---|---|---|---|
| | | Māori patients appear to have complications at a lower rate compared to the overall rate (2.6 vs 3.4 for overall rate)<br><br>Māori patients appear to have infections at either a lower rate or in line with the overall rate (10 vs 46 for Dunedin and 17 vs 18 for Invercargill) | disorders due to psychotropic medication, 10.5 Serious alteration to conscious state due to psychotropic medication<br><br>The next update from HRT is due in February |
| 4 | Readmissions within 7 days % | Readmissions continue to be stable across both hospitals<br><br>Māori readmissions are slightly higher than the 3 year average | Unplanned Hospital Readmissions within 7 Days<br>Acute / Unplanned readmissions within 7 days of the initial discharge from hospital organised on the basis of the month of discharge |
| 5 | Mental Health Seclusions no | Seclusions continue to be stable across both hospitals | Seclusions<br>iPM and HCS data. The number of seclusion events per month. Seclusions are reportable for district only<br><br>Māori seclusion data is not verified at this time so is not included |
| 6 | Mental Health Restraints no | Restraints spiked in Dunedin in November and December. Mental Health are currently investigating. The great majority of restraints are due to a very small number of patients. For example, one patient is responsible for 52 restraints from May to October this year. Staff are continuing additional training, medication has been changed and Health & Safety views have been sought to reduce the number of restraints required | Restraints<br>Safety 1st data. The number of restraint events per month.<br><br>Māori restraint data is not verified at this time so is not included. |
| 7 | Deaths no | Deaths are stable over time.<br><br>Māori deaths in hospital are in the low single figures so it is difficult to draw meaningful conclusions from this data | Deaths<br>Number of patients deceased by discharge month. |
| 8 | ED Wait Time - % patients discharged within 6 hours | Our EDs continue to be under pressure and are struggling to meet this target | Monthly 6 Hour % |

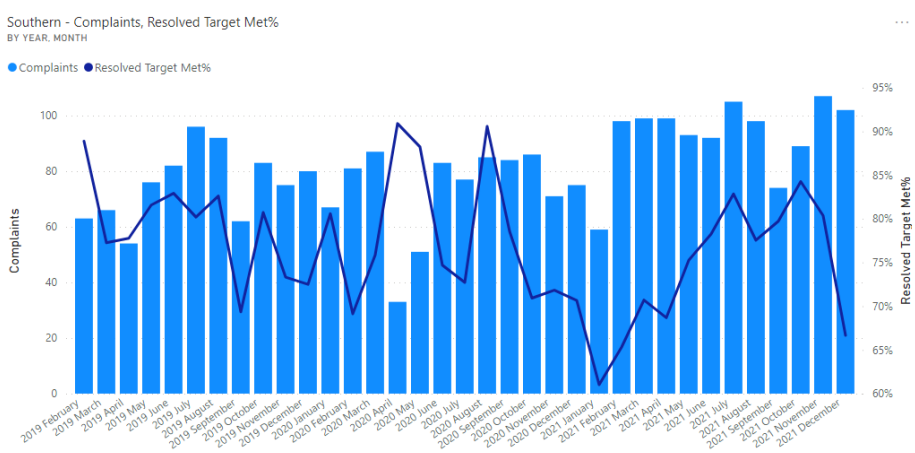
| | | | |
|---|---|---|---|
| | | | Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This excludes the time spent in ED observation<br><br>Māori ED data is not verified at this time so is not included |
| 9 | Vulnerable Patients > 6 hours in ED | Dunedin remains at high levels compared to the long term average while Invercargill has moved into line with the long term average<br><br>Māori patients are generally in line with long term trends and the numbers are low compared to overall numbers of vulnerable patients in ED | Patients aged 70 and over, who are triage category 1, 2, 3 who spend over 6 hours in ED |
| 10 | Falls | Dunedin is newly green from HRT which places the hospital in the top 25% of peers. For the last year Dunedin has ranked 11th out of 20 peers<br><br>Invercargill rates as green as well. | Data sourced from Health Round Table: Includes the diagnosis groups: 2.1 Fractured neck of femur, 2.2 Other fractures, 2.3 Intracranial injury<br><br>Māori falls data is not verified at this time so is not included |
| 11 | Pressure Injuries | While Safety1st is not benchmarked the HRT does measure pressure injuries. Invercargill rates as newly green via HRT and is 10 out of 20 peers for the last year. Dunedin is rated as red for HRT and rates 18 out of 20 peers. | Pressure injury data is taken from Safety1st.<br><br>Māori pressure injury data is not verified at this time so is not included |
| 12 | Staff Events - SAC 1 and 2 no | Continue at very low levels | Safety 1st data. The monthly number of reported staff adverse events. Categorised by severity assessment codes 1-2 |
| 13 | Staff Events - SAC 3 and 4 no | Events are stable over time | Safety 1st data. The monthly number of reported staff adverse events. Categorised by severity assessment codes 3-4 and by 'N/S' (Not Specified). |

| | | | |
|---|---|---|---|
| 14 | Complaints no | 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.<br><br>Māori complaints data is not available on a monthly basis however we do have a measure for the year 2021. Nine per cent of complaints related to Māori patients. Eighthly seven per cent related to European patients and four per cent to other ethnicities | Safety 1st data. Complaints<br>The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month. |
| 15 | Complaints response target met % | Response times have risen from low levels and have plateaued with workloads still high due to complaint numbers | Safety 1st data. Resolutions<br>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. |
| 16 | Short Notice Postponement No | In terms of numbers short notice postponements are in line with long term trends.<br><br>Māori numbers are in line with long term trends | Short Notice Postponements<br>Theatre postponements within 24 hours of the scheduled procedure |
| 17 | Short Notice Postponement % | Short notice postponements are above long term trends which is indicative of the pressure on surgical services | Short Notice Postponements %<br>Theatre postponements within 24 hours of the scheduled procedure |
| 18 | Referrals Declined % | Referrals declined and continue to be in line with the long term average | Referrals accepted (authorised), awaiting outcome or declined by month.<br>% referrals declined |
| 19 | Length of stay days | Dunedin LOS dropped this month after being slightly higher for a number of months<br>Invercargill LOS is stable | Average Length of stay<br>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<br><br>Māori LOS data is still to be verified and is not included |

| | | | |
|---|---|---|---|
| 20 | Patients with stay > 7 days no | Patients staying longer than 7 days are in line with long term trends<br><br>Māori patients are under long term trends | Number of Patients with LOS > 7 Days<br>Number of patients per month who have a LOS > 7 days |
| 21 | Patients with stay > 21 days no | Patients over 21 days have dropped within the last period<br><br>Māori patients are under long term trends | Number of Patients with LOS > 21 Days<br>Number of patients per month who have a LOS > 21 days |

Appendix 5

# Executive Dashboard – Patient Experience (Southern)




Safety 1st data.

Complaints

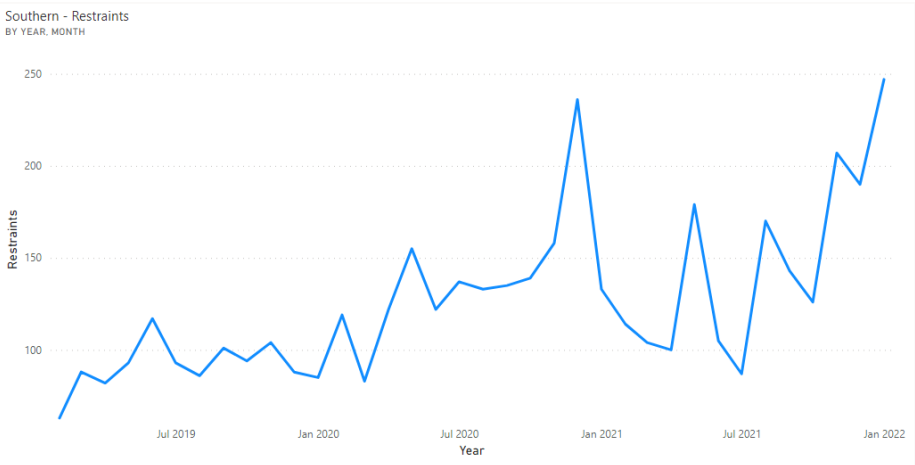
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

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.

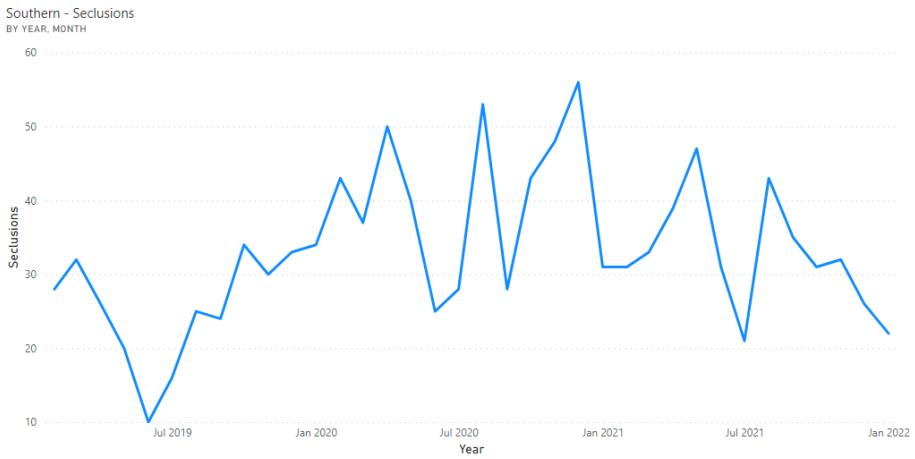
Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.

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

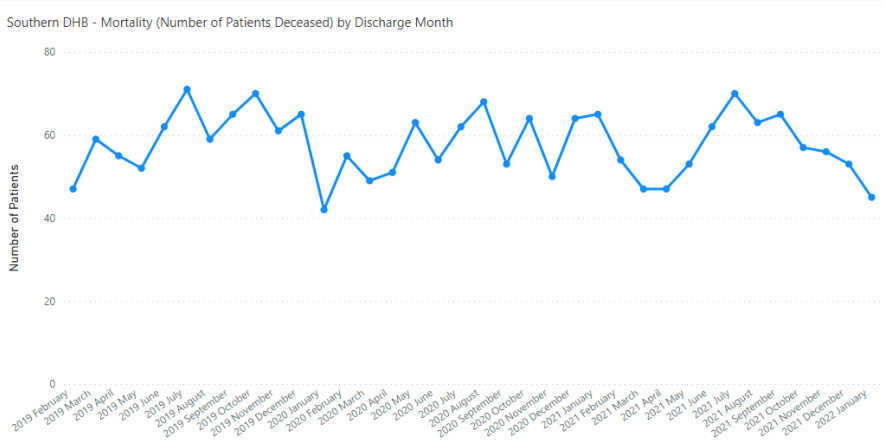
Safety 1st data. The number of restraint events per month. Restraints data includes Dunedin, Invercargill, Wakari and Lakes



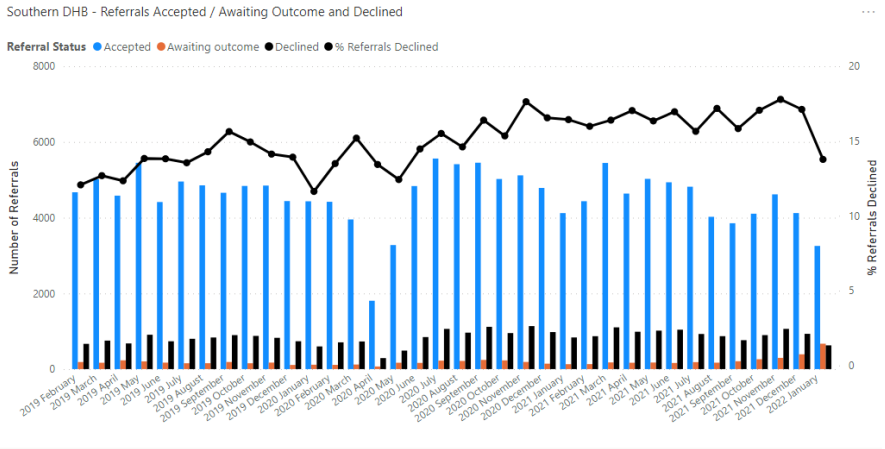

Seclusions

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

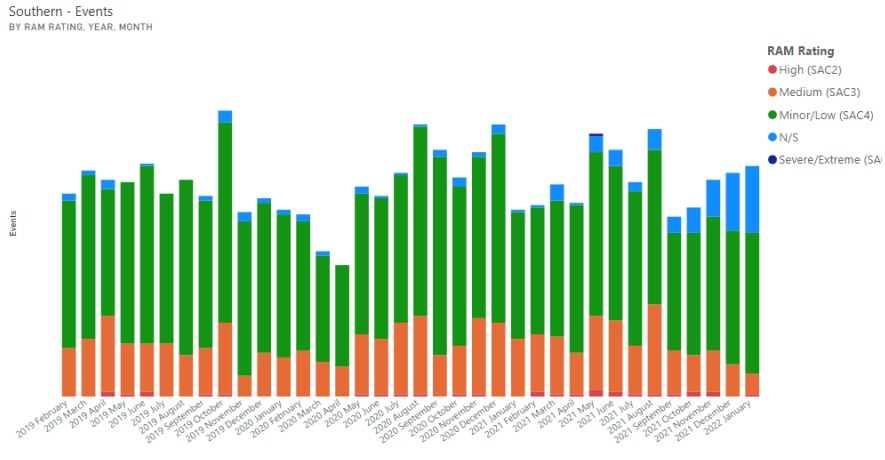
# Executive Dashboard – Experience (Southern)




Deaths
Number of patients deceased by discharge month



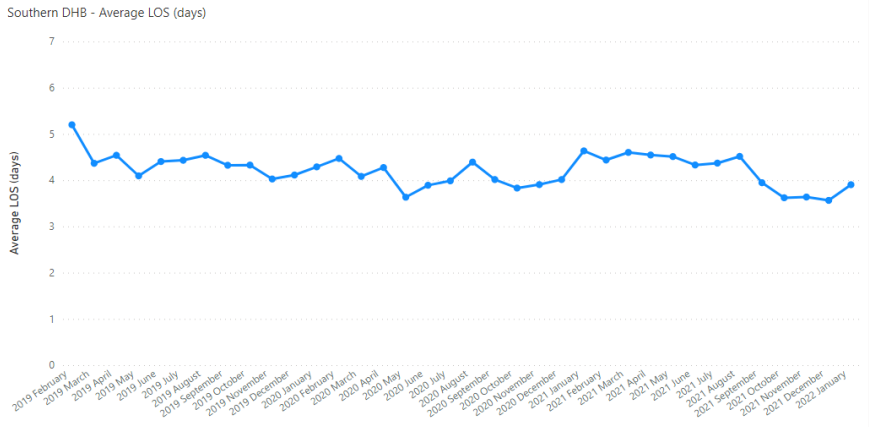

Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined




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

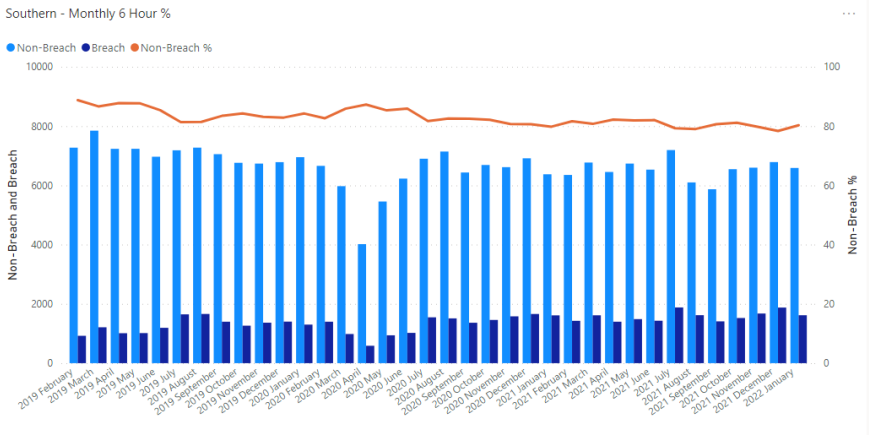
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls form (visitor falls) which were not associated with clinical practice. These events are not assessed in the same way as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

# Executive Dashboard – Efficiency (Southern)



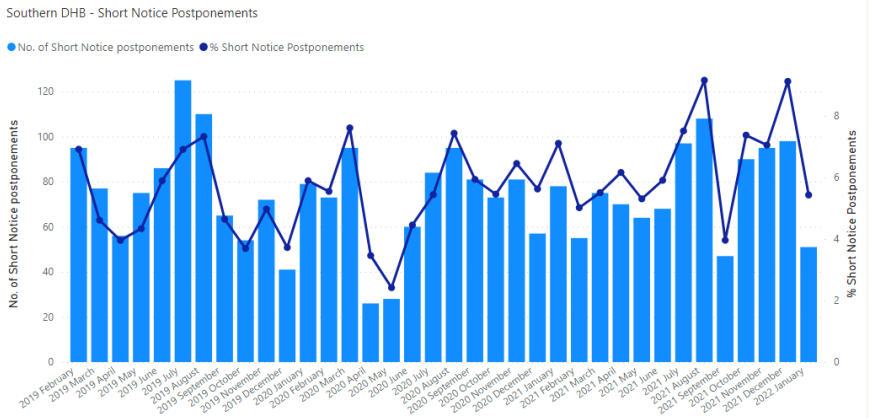

## Average Length of Stay

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

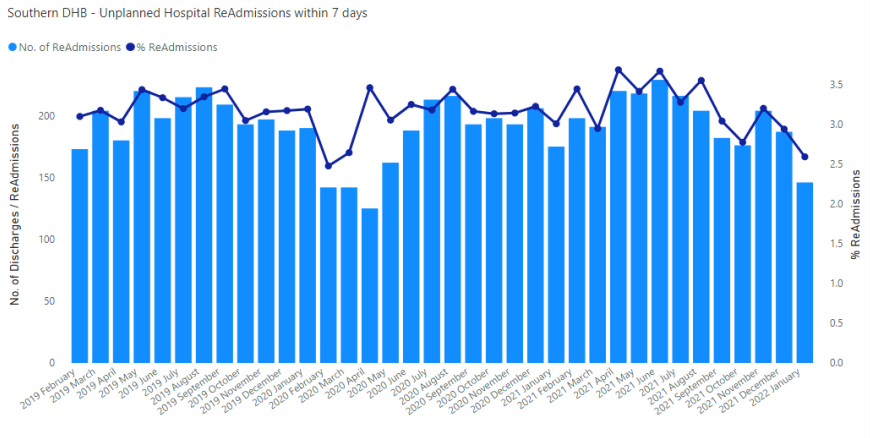
Theatre postponements within 24 hours of the scheduled procedure.

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

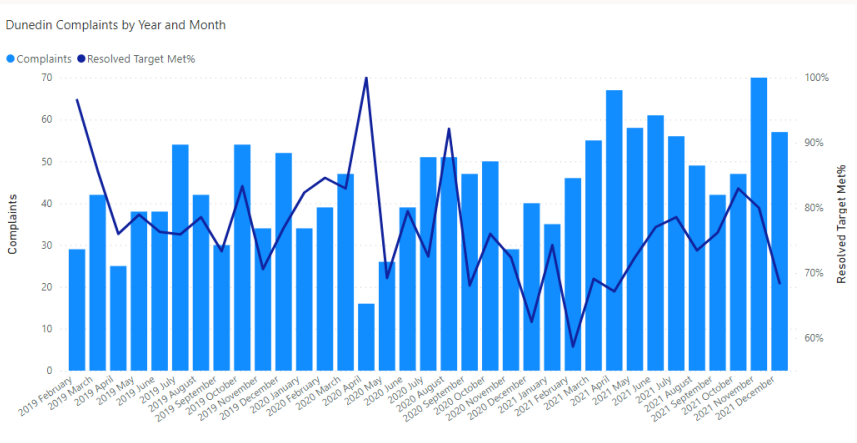
Number of patients in hospital at any point of time when they have exceeded 7 days since admission.




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)




Safety 1st data.

Complaints

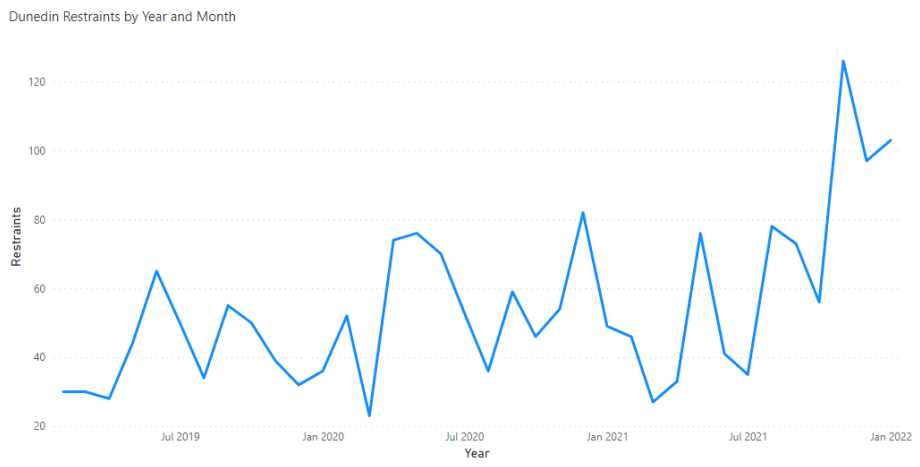
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

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.

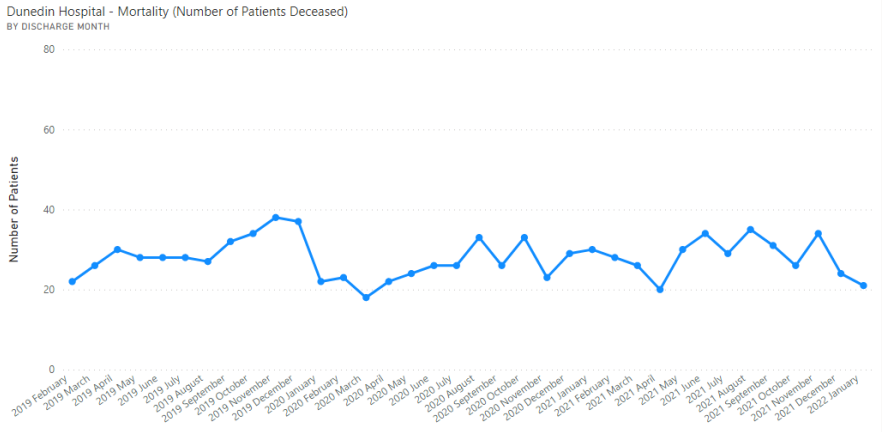
We have increased the number of complaints where we are responding to the consumer within target (20 days). It has increased from 60% in January to the high 70s in recent months.



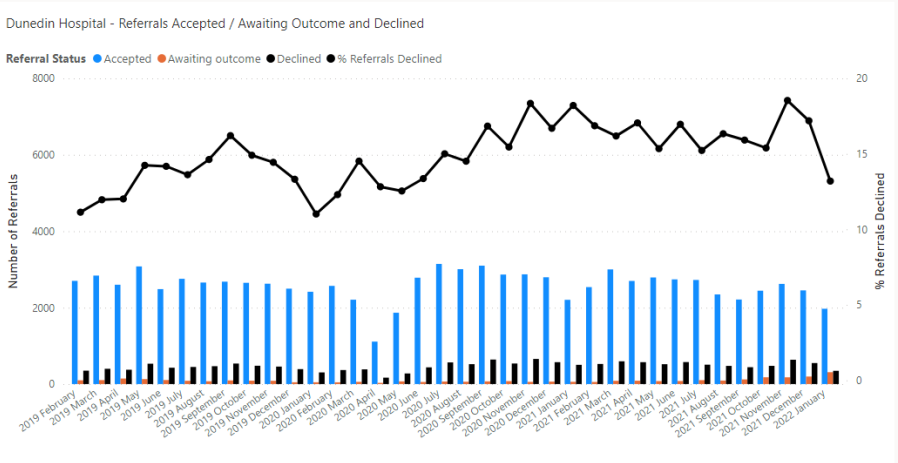

Restraints

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

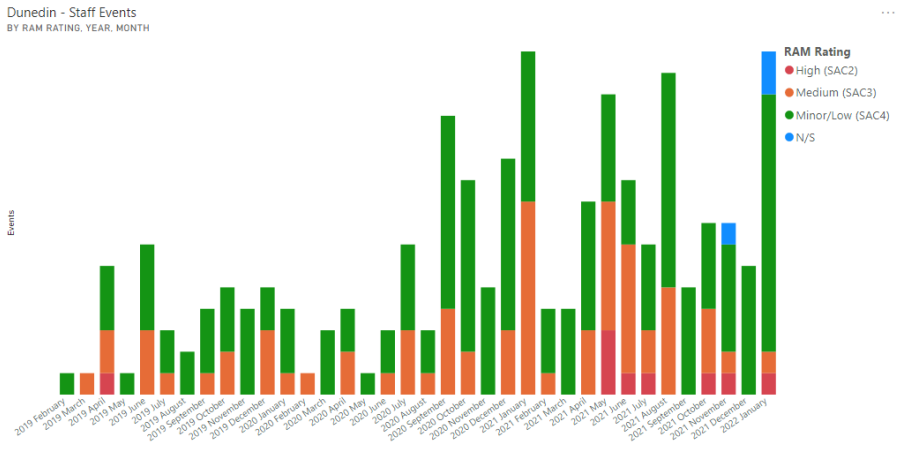
# Executive Dashboard – Effectiveness (Dunedin)




**Deaths**
Number of patients deceased by discharge month.

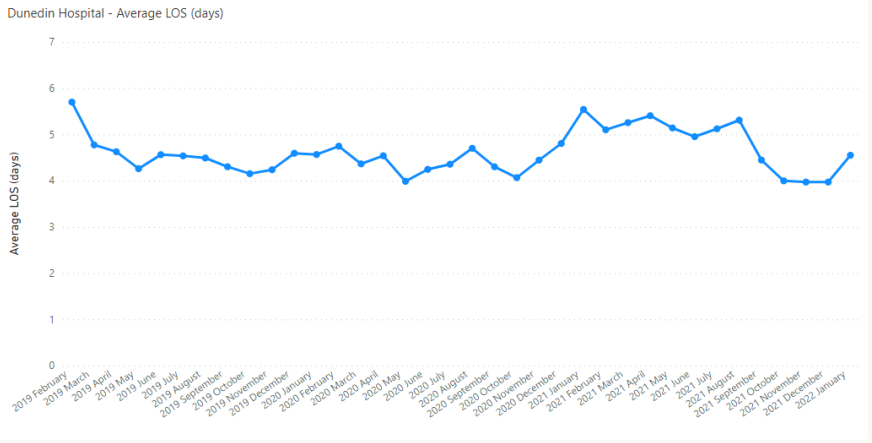



Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined




**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 (Dunedin)




## Average Length of Stay

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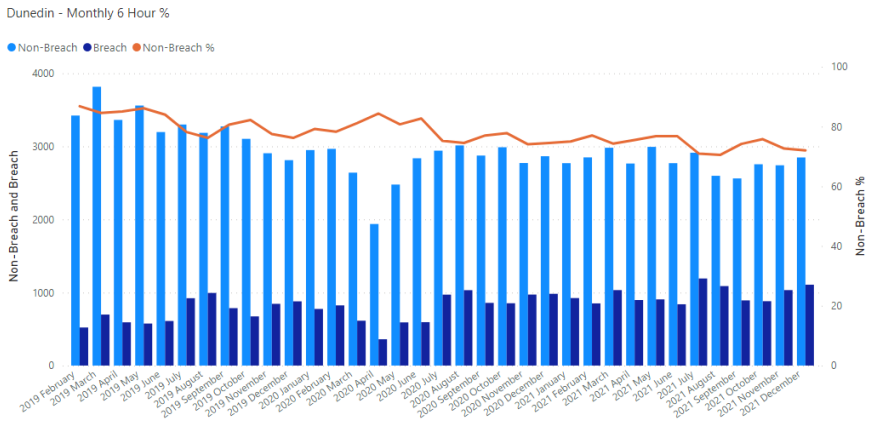
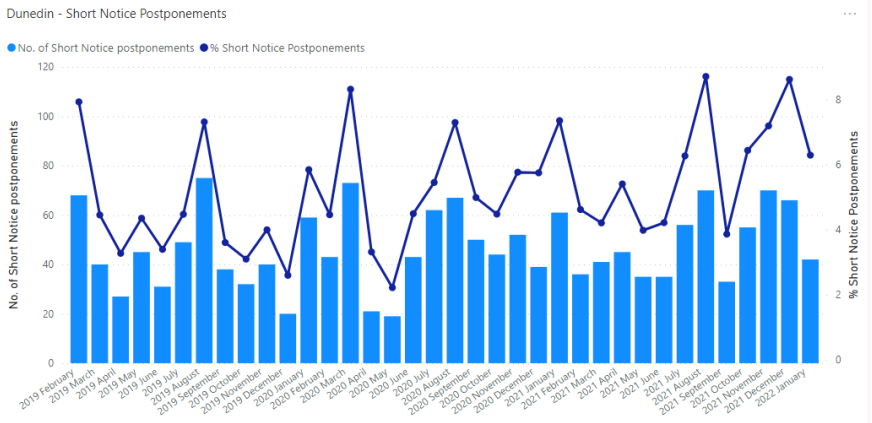



## Monthly 6 Hour %

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.

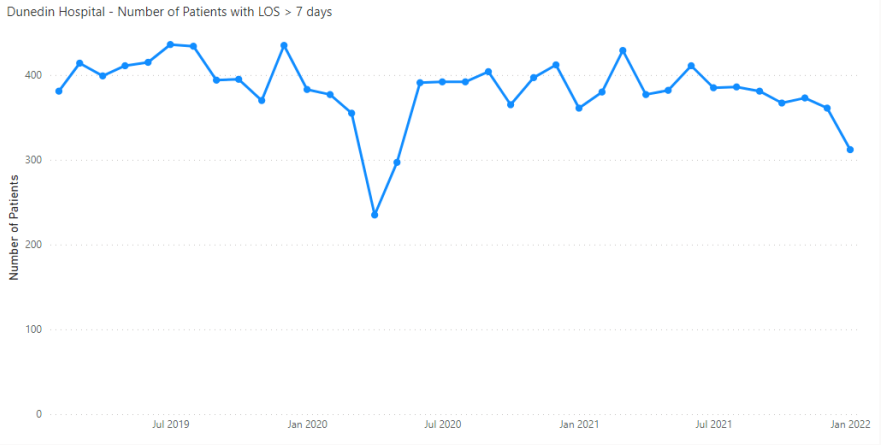



## Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure.

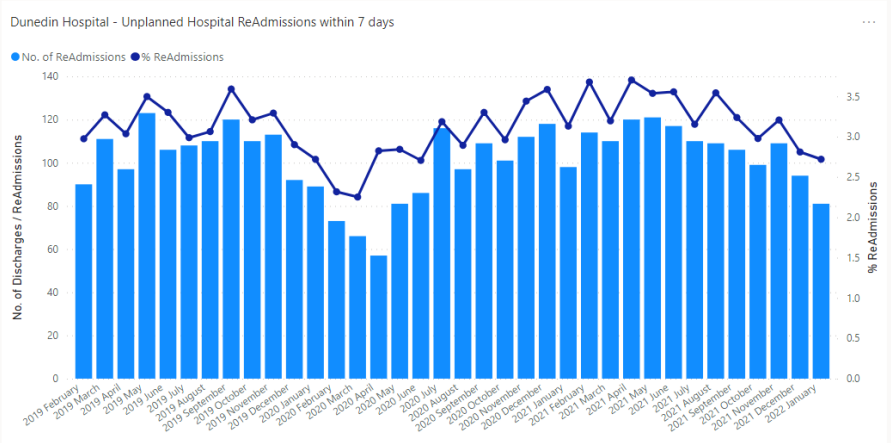
Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

# Executive Dashboard – Timely (Dunedin)




**Number of Patients with LOS > 7 days**

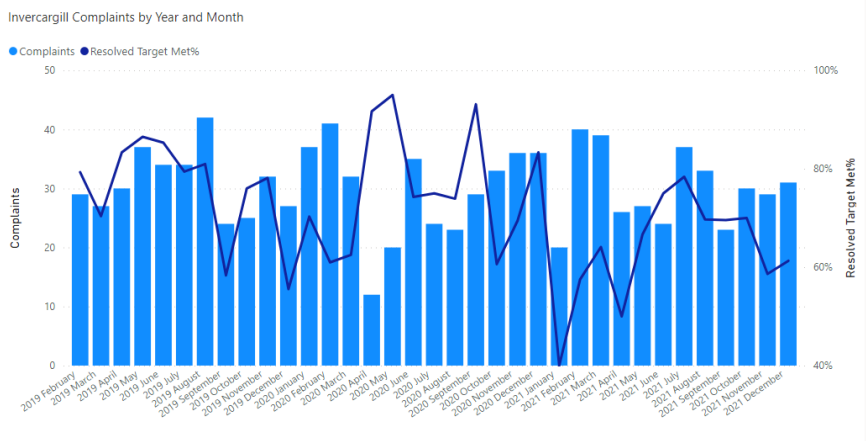
Number of patients per month who have a LOS > 7 days




**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.

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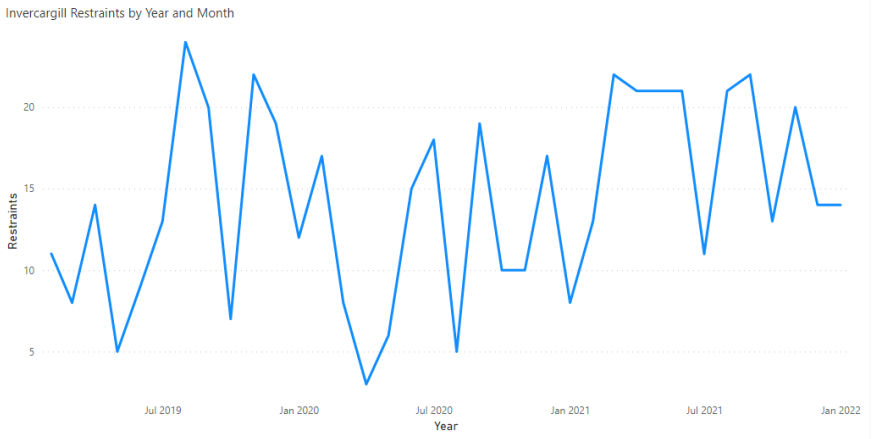
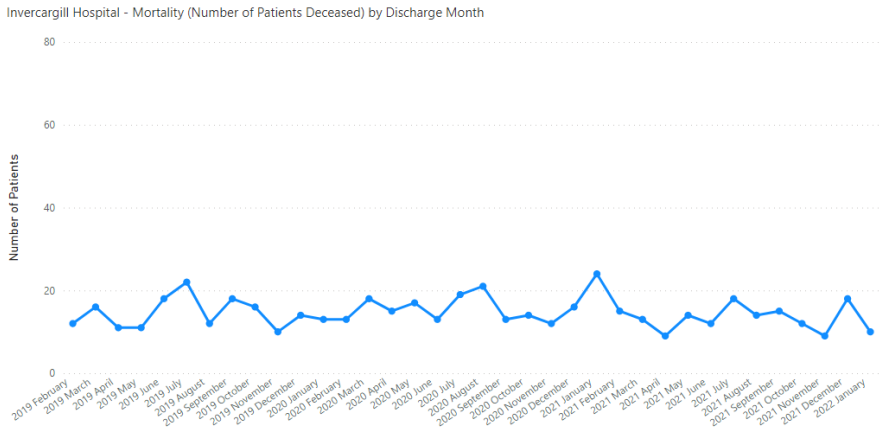



Restraints

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

# Executive Dashboard – Effectiveness (Invercargill)




**Deaths**
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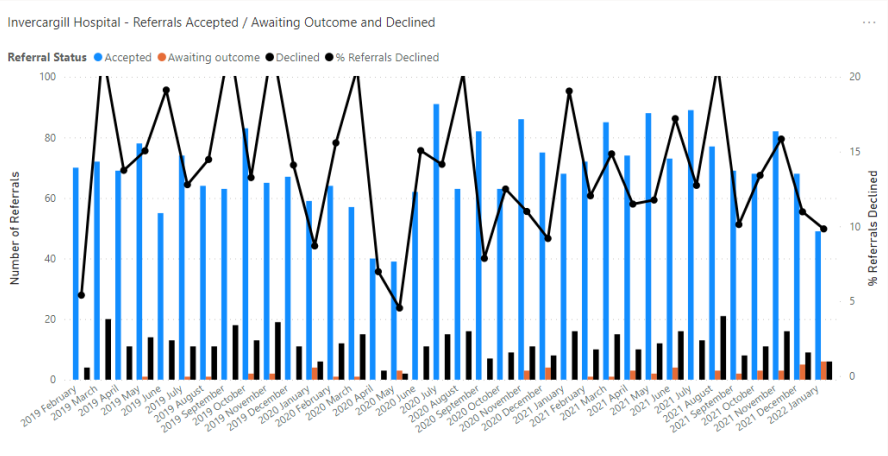
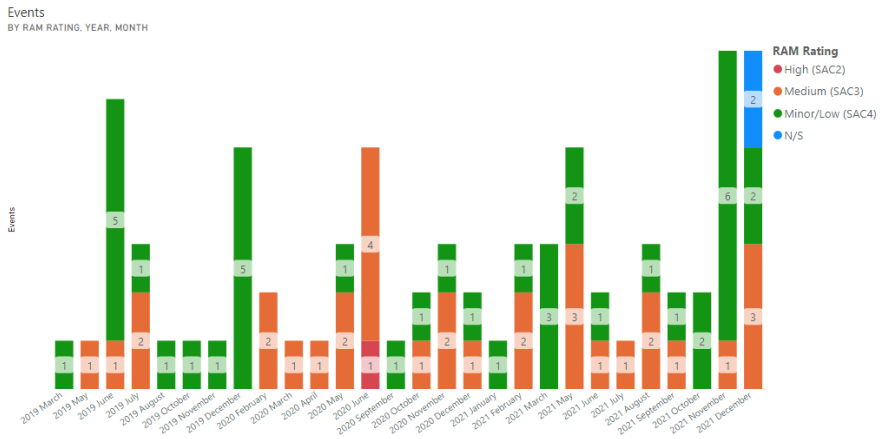



Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined.




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

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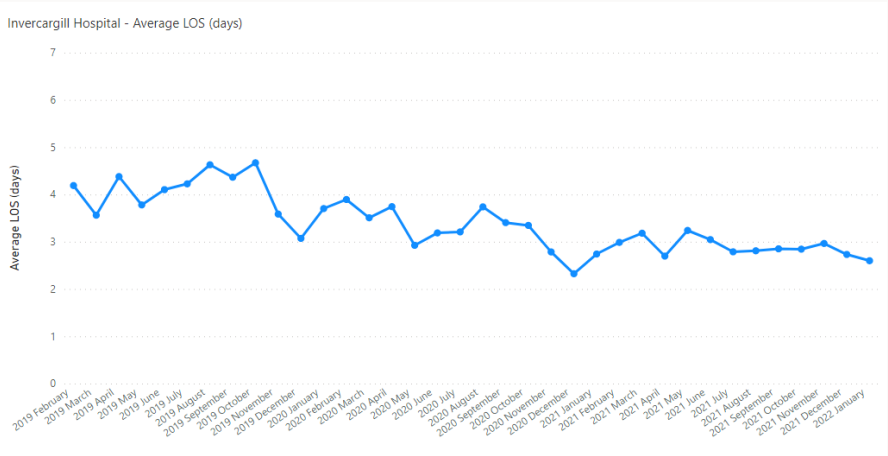
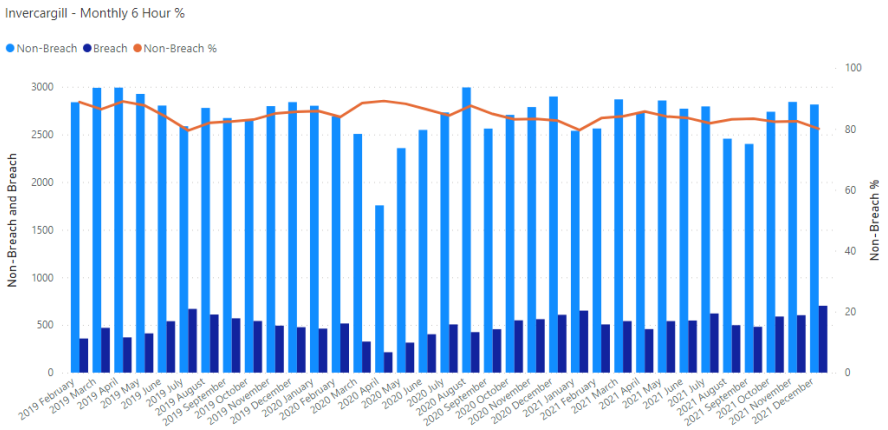


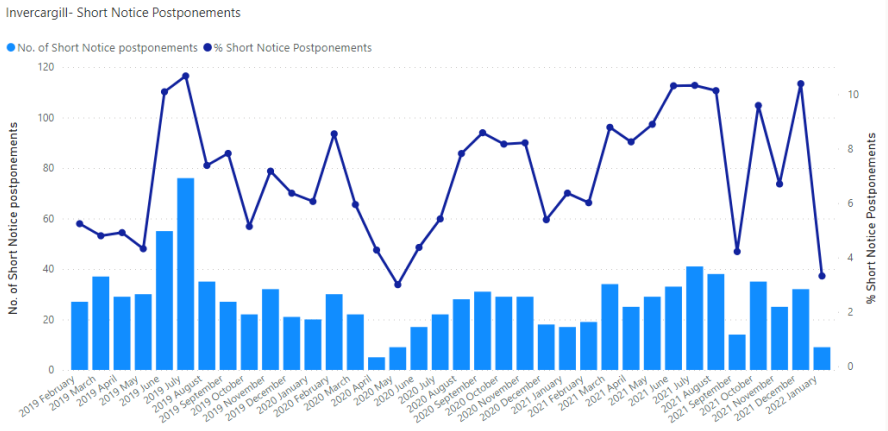

## Average Length of Stay

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 %

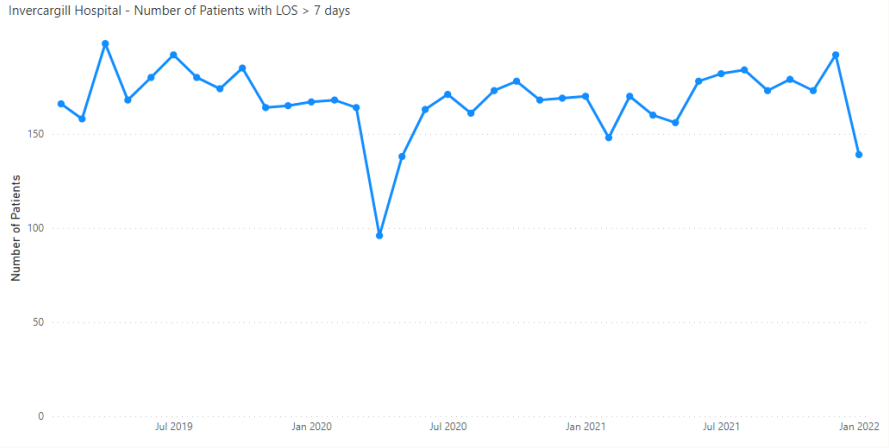
Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This includes the time spent in ED observation.




## Short Notice Postponements

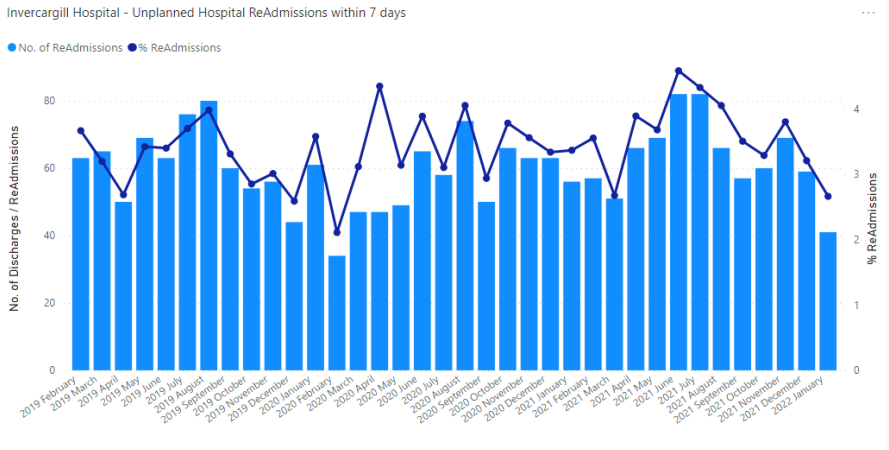
Theatre postponements Within 24 hours of the scheduled procedure.

# 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.

**FOR INFORMATION**

**Item:** Performance Dashboard Update January 2022

**Proposed by:** Planning & Accountability Manager

**Meeting of:** Board, 2 March 2022

## Recommendation

**That the Board notes the content of this update.**

## Purpose

**To provide a snapshot of DHB performance across a range of agreed metrics and advise that the dashboard is now largely complete and useable though there two main areas that continue to need further refinement – CCDM & HR data.**

## Specific Implications for Consideration

1. **Operational Efficiency:** System performance information located centrally in PowerBi accessible to Board members and the Executive.

## 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 a range of 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 is largely complete and awaiting just some final tweaks to some HR data & CCDM sign-off but is useable and a good source of information. The metrics provided here as snips is only a snapshot and there are some not included here as they don't translate easily into a static document.

**Next Steps & Actions:**

- The final tweaks to the HR data & CCDM need to be completed so that can be pulled into this dashboard.
- Further work establishing an effective cadence for capturing the monthly narratives by each of the service areas.
- Link to the PowerBi Dashboard: Executive Performance Dashboard Access is being organised for Board group.
- Note due to staff turnover and annual leave over the summer, these actions remain outstanding. Further staff turnover in the reporting team in the period since the last report has also delayed progress.

**Appendices**

1. **Performance Dashboard Progress Update January 2022**

## PERFORMANCE DASHBOARD INITIATIVE

**Summary of progress to date:**

The following tiles in the performance dashboard are yet to be completed:

| Measure | Stage/Status |
|---|---|
| Head Count (HR Dashboard) | In UAT/on hold due to Performance & Accountability framework work |
| Output per FTE | Not Started/Complexity over how this is measured |
| Community Pharms | Not Started/No dataset available to prepare this currently |
| CCDM Metrics | In User acceptance testing – almost complete but there are some further data adaptions that need to occur before final sign-off. |

**Monthly Snapshot of current metrics as of 14/02/22:**

**Figure 1:** View of dashboard initially – i.e.., the landing page.

**Note that the report extracts the latest COMPLETE month – this means the below are January data is influenced by the holiday period.**

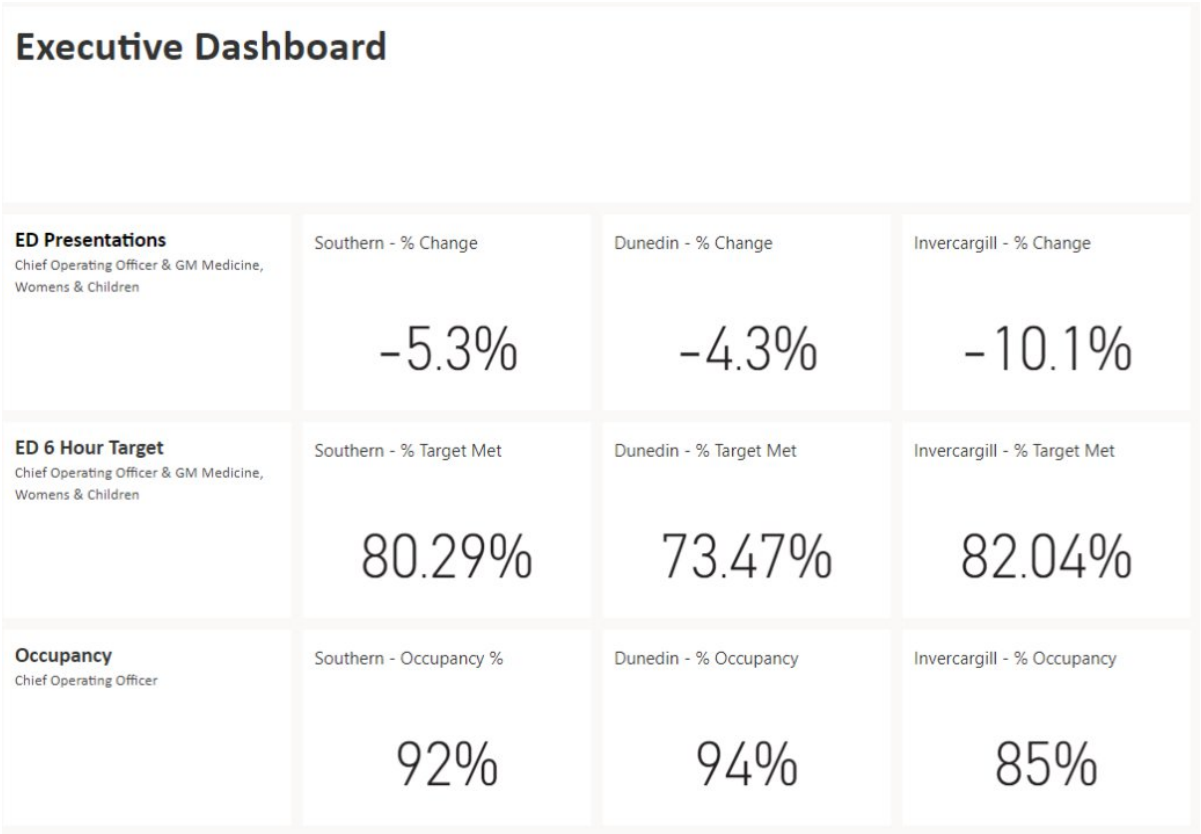


**Figure 2: ED Presentations - January 2022**

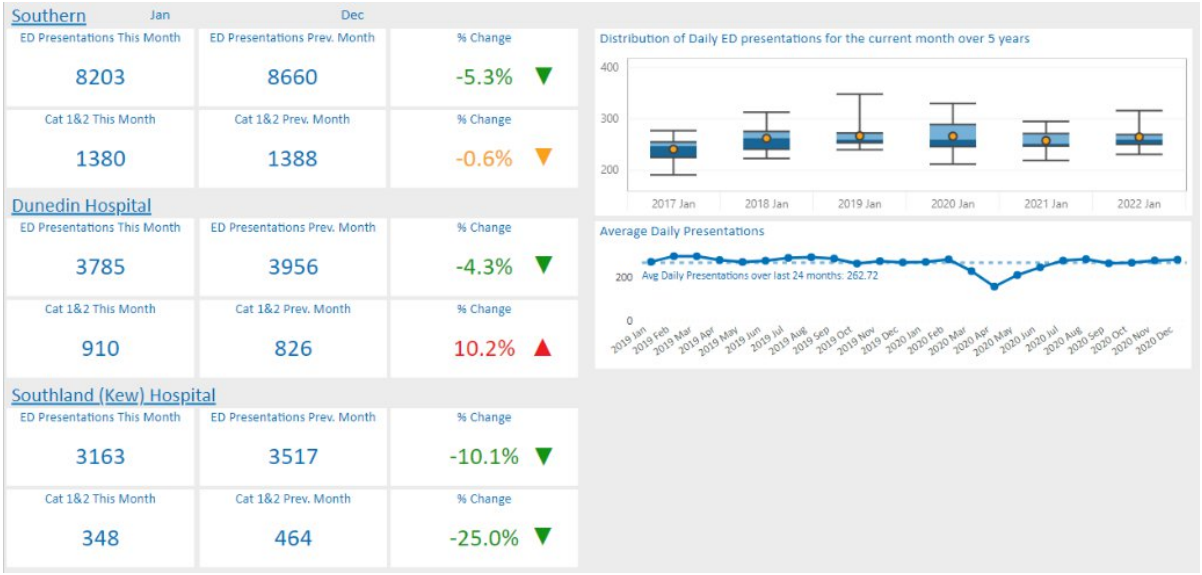



**Figure 3: ED 6 Hour Target – January 2022**

**Figure 4:**

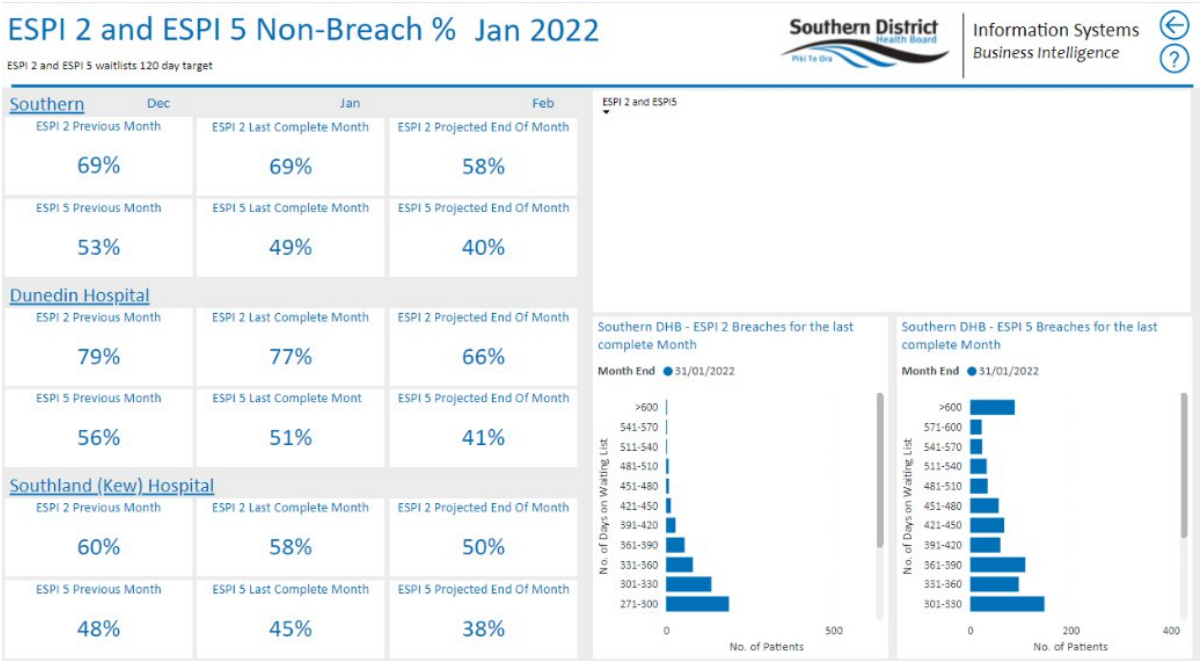



**Figure 5.**

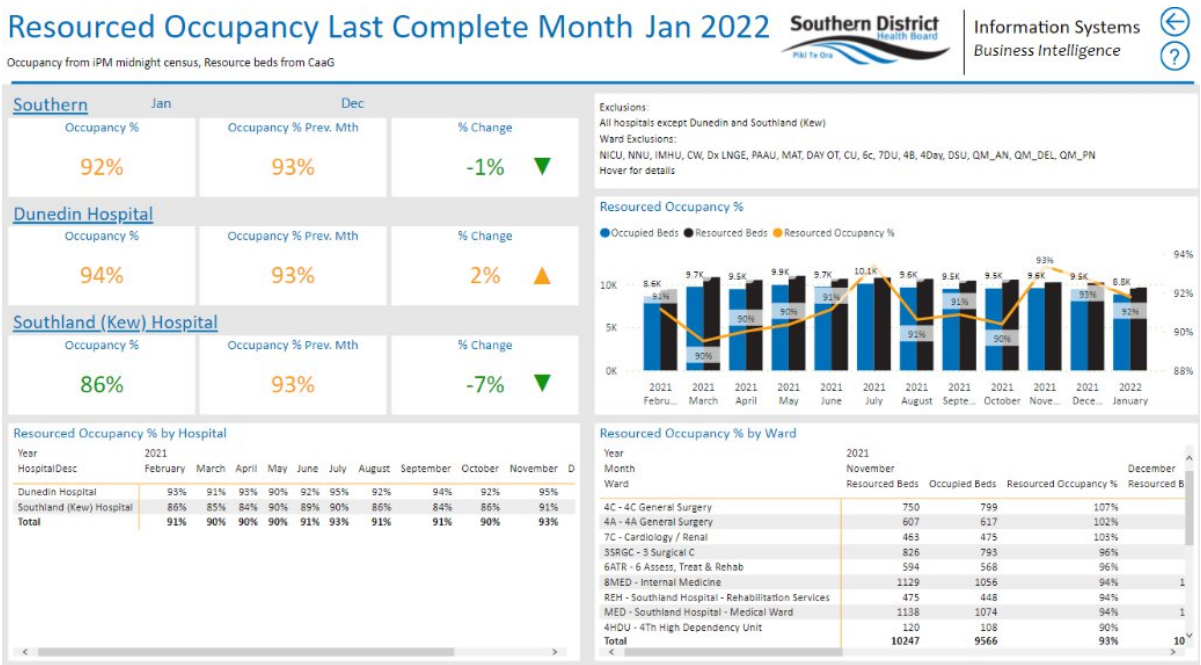


**Figure 6.**

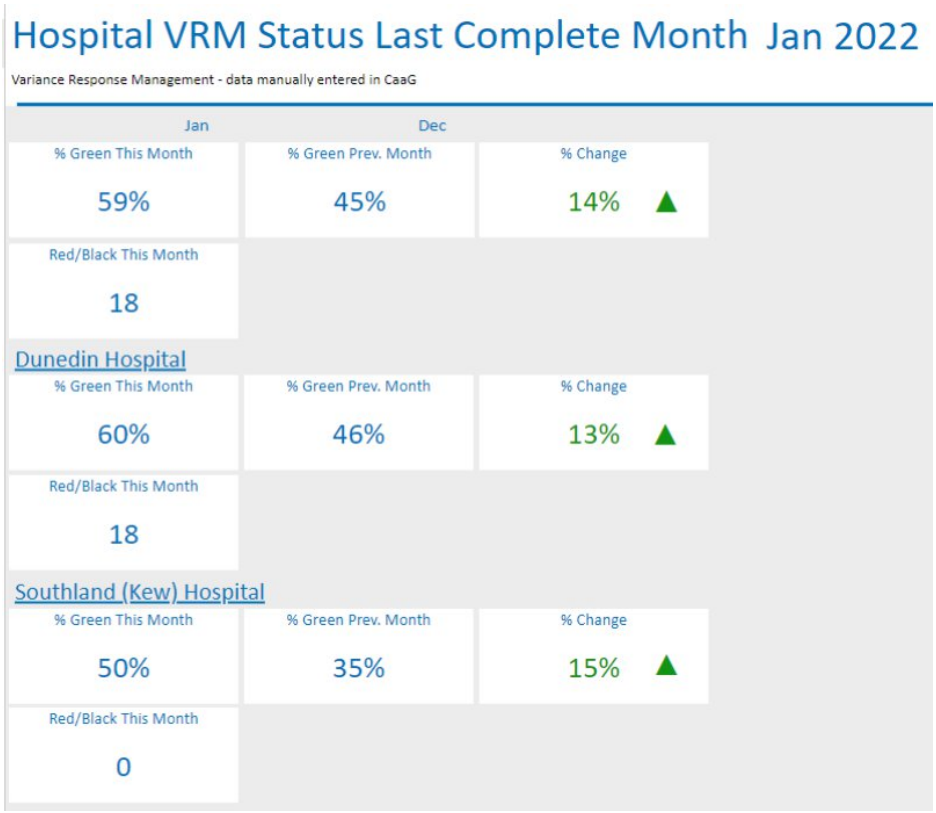



**Figure 7.**

**FOR INFORMATION**

**Item:** Performance & Accountability Framework

**Proposed by:** Planning & Accountability Manager

**Meeting of:** 2 March 2022

## Recommendation

That the Board notes the contents of this progress update acknowledging the evolutionary approach to rollout.

## Purpose

To update the Board on the progress of imbedding the Southern Performance and Accountability Framework.

## Specific Implications For Consideration

Nil

## Background

- The development of a Performance and Accountability Framework was signalled as an action in the Leena Singh report – Southern DHB Review.
- The objective of the Performance and Accountability Framework is to ensure that our DHB system has clear authority, responsibility and accountability and then ensuring accountable officers exercise their full responsibility for the performance of the systems in which they are responsible.
- While structures are being developed internally, we also report on progress of the rollout to the Ministry.

## Discussion

The appended paper provides detail of the rollout status and scope of the framework.

In summary, Medical and Surgical Directorates are underway. Planning & Funding, Public, Population and Community Health Directorate is due to commence in March. Mental Health Addictions and Intellectual Disability Directorate are anticipated to start shortly after this. Formalised P&AF reporting between Executive Director and Chief Executive is expected to start from meetings held February 2022, onwards, and a high level report will be provided to the Board.

## Next Steps & Actions

Formalise approaches in outstanding services. Make ongoing refinements from learnings.

## Appendices

Performance and Accountability Framework rollout status February 2022.docx

# Board update: Performance and Accountability Framework rollout status

Prepared by: Planning & Accountability Manager
16 February 2022

## 1.0 Background:

The development of a Performance and Accountability Framework was signalled as a recommendation in the Leena Singh report:

- The objective of the Performance and Accountability Framework is to ensure that our DHB system has clear authority, responsibility and accountability and then ensuring accountable officers are being held to account for the performance of the systems in which they are responsible.
- While structures are being developed internally, we also report on progress of the rollout to the Ministry.

### 1.1 Scope of Performance and Accountability Framework

*The P&AF is:*

- Regular monthly meetings supported with data and intelligence on key performance indicators and areas of strategic importance.
- Service-level meetings (e.g., Service Manager and GM) and Directorate-level meetings (e.g., Exec and GMs/Professional Directors)
- A philosophy and framework for:
    - Setting clear expectations on areas of focus/improvement
    - Achieving clarity on performance objectives and what is being measured and reported
    - Having a cascade to escalate any service-level concerns to executive and board visibility as required

Rollout has varied between utilising existing meeting structures (and formalising P&AF and activity reporting as an agenda item), or creating stand-alone meetings for this precise function.

## 2.0 Progress update:

The initial rollout focussed on Provider Arm and Funder Services. The below table summarises the progress made embedding meeting structures and reporting cycles across the DHB:

| Directorate | Status | Notes |
|---|---|---|
| Medical Directorate | **Underway. Commenced – Nov 2021** | Teams continue to evolve and make tweaks to ensure reporting is relevant and in-line with escalation framework |
| Surgical Directorate | **Underway. Commenced – Nov 2021** | As above |
| Planning and Funding, Public, Population and Community Health Directorate | **On track for embedding in Q3. First formal meeting planned for Mar 2022** | Monthly reporting cycle confirmed for portfolios. Team reviewing relevant KPIs and performance metrics for presentation in mid-March. |
| Mental Health Addictions and Intellectual Disability Directorate | **On track for embedding in Q4** | Initial planning meetings underway to define approach for delivery in the Directorate |
| Directorate summaries to Chief Executive | **Expected to commence from February** | This formalises the next "tier" of reporting / escalation |

## 3.0 Supportive resources

A framework document has been produced specifying details such as:

1) "Balanced scorecard" parameters of measuring performance
2) The accountability structure
3) Escalation tiers and triggers for escalation
4) Specification of responsibilities under the framework

These four frameworks are outlined below:

### 3.1 Framework for considering performance

Measurement of performance is viewed through seven main categories. The selection of these categories was to ensure balanced assessments of performance and to offer a framework for considering across what domains performance is being assessed. The stated comments after each bold heading are not exhaustive.

- **Equity:** What specific initiatives are being undertaken in areas to address equity for Māori? Equity of access for rural, disabled communities?
- **Quality:** Clinical indicators that show us what level of care our patients are experiencing. E.g medication errors, rates of infection, complaints.
- **Financial:** How are we performing against our budget, how productive are we, how are our savings initiative's tracking?
- **Risk:** What are the top risks currently for our service/area? How are we mitigating these? Are there plans in place?
- **People & Capability:** What does the FTE look like in our area, do we have vacancies/recruitment challenges etc. Are we managing our leave appropriately?
- **Operational:** How is patient flow tracking?
- **Strategic:** What strategic projects, initiatives or improvement work is underway in our area?

### 3.2 Accountability Structure

| | |
|---|---|
| 1 | Service/Unit Managers along with HR Business partners and clinical leads and business analyst ***to*** the relevant General Manager |
| 2 | General Managers and/or relevant SLT and DON/DAH (if relevant) ***to*** relevant Executive Leadership member |
| 3 | Executive Leadership member ***to*** Chief Executive |
| 4 | Chief Executive ***to*** the Board |
| 5 | The Board ***to*** the Minister |

### 3.3 Escalation Framework

The below specifies the process for escalation of variance/risk or operational issues. It ensures that each level of accountability is both empowered to resolve issues at their own tier, while also providing the supportive structure of enlisting more senior levels of management/board if problems are not easily resolved.

It is worth noting that issues identified through the P&AF reporting cycles which are able to be responded to and solved by management, ultimately will not be escalated to Board level.

| | | |
|---|---|---|
| **Level 0**<br>*(Accountable Officer: Service Manager, Unit Manager)* | **Steady State**<br>Performance is being achieved against plan. | Performance subject to routine performance monitoring by the relevant accountable officer. |
| **Level 1**<br>*(Accountable Role; Service Manager, Unit Manager)* | **A Variance emerges**<br>A variance from plan is identified and intervention and support in response to early signs of difficulty is managed at a provider level. | A decision to escalate an area of underperformance in individual services under their remit ***is made by*** The service manager and/or clinical lead. |
| **Level 2**<br>*(General Managers/SLT Directors of Nursing, Allied Health, Medical Directors)* | **The problem persists**<br>It becomes harder to fix and potentially has implications for other services. Intervention and support are required. | A decision to escalate an area of underperformance in certain service areas ***is made by*** the relevant General Manager, Medical Director, Nursing or Allied Health Director. |
| **Level 3**<br>*(Executive Leadership Team, Clinical Council)* | **The problem becomes critical or where prolonged underperformance puts quality, safety and financial sustainability at risk.**<br>The performance issue persists and the organisation has failed to reverse underperformance. Significant intervention is required. | A decision to escalate an area of underperformance ***is made by*** a member of the Executive Leadership Team or Clinical Council. External supports, interventions or sanctions may be required. A project team may be commissioned to lead on specific improvement initiatives. |
| **Level 4**<br>*(Chief Executive Officer)* | **Significant governance or organisational risks are identified that affect the functioning or reputation of the health service.**<br>The actions determined by the ELT do not achieve the necessary impact and action is required by the Chief Executive Officer. | A decision to escalate the significant governance or organisational risks is made by a member of the Executive Leadership Team, the CEO or Clinical Council. |

### 3.4 Specification of responsibilities

Each level of management is aligned to the level of service for which they are accountable: Keep performance under constant review.

- Have in place a monthly performance management process that will include formal performance meetings with their next line of managers aligned with the accountability structure
- At these meetings agree, monitor and report on actions to address underperformance. Performance meetings will focus on all seven categories as outlined above.
- Take timely corrective actions to address any underperformance emerging.
- Communicate in a timely manner any situations that require escalation
- In certain cases where the underperformance is systemic or has gone on for a sustained period, develop and put in place a full Improvement Plan or Recovery Plan.

**FOR INFORMATION**

**Item:** SDHB Change Programme Report February 2022

**Proposed by:** CEO

**Meeting of:** Board, 2 March 2022

## Recommendation

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

## Purpose

1. To communicate the totality of the SDHB's change portfolio and how it contributes to our strategic plan & focus areas. To also focus on those initiatives that contribute directly to the New Dunedin Hospital.

## Specific Implications For Consideration

None

## 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. Further work to refine the portfolio will be led by the newly-formed ePMO from February 2022

## Discussion

This month's change programme update is the fourth iteration generated out of the Cascade platform. As in last month's report, this month's update is the combination of two reports: the first being the subset of initiatives that have been tagged in the system as directly contributing to the New Dunedin Hospital and the second is the wider portfolio. It is important to note that there are still pockets where further content is needed to be built out. Feedback and comments are welcomed.

## Next Steps & Actions

- Continue uploading and refining content within Cascade and upskilling further users.

## Appendices

1. SDHB Change Programme Total February 2022

# SDHB CHANGE PORTFOLIO TOTAL

**22/02/2022**

**58**
GOALS

**32%**
GOAL COMPLETION

## STRATEGIC CHANGE PORTFOLIO PLAN

### MĀORI EQUITY

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Equity Actions Improvement Programme** | Gilbert Taurua | 0%<br>0 /<br>- | | **Greer Harper:**<br>WIP - Programme delayed due to COVID Vaccination/Endemic planning re-directing resource. *Further work to build out this focus area within Cascade needed.*<br>*24/11/2021* | 0%<br>- |
| → **Reducing amenable mortality** | Gilbert Taurua | 0%<br>0 /<br>- | | **Talis Liepins:**<br>Clinical Council is sponsor; established cardiac group in collaboration with WellSouth to improve screening<br>*21/02/2022* | Not started |
| → **Appoint equity data analyst role** | Gilbert Taurua | 0%<br>0 /<br>100% behind | | | 0%<br>- |
| → **Advance Māori workforce development programme** | Gilbert Taurua | 0%<br>0 /<br>- | **Recruiting for Māori workforce development specialist role** ☐ | **Talis Liepins:**<br>Interviews are being held in week 21 February 2022<br>*21/02/2022* | Not started |
| → **Development and rollout of affirmative recruitment strategy** | Gilbert Taurua | 0%<br>0 /<br>- | **Undertake supportive training for interviewing to ensure processes/kawa follow appropriate tikanga** ☐<br>**Policy Development** ☐ | | Not started |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Development of equity investment strategy** | Gilbert Taurua | 0% − 0 / - | **Explore options for commissioning the strategy** ☐ | | Not started |
| **Appoint 2x Clinical Nurse Specialist roles - 1x Cancer and 1x Cardiac/Respiratory** | Gilbert Taurua | 0% − 0 / - | | **Talis Liepins:** EOI released to find those who may be willing to develop in to the role, or appoint directly if skills/experience appropriate *21/02/2022* | Not started |

## POSITIONING PUBLIC HEALTH SERVICES FOR THE FUTURE

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Southern Strategic Briefing Project (nee refresh)** | Andrew Lesperance | 91%<br>90.91 /<br>1% behind | **Final polishing on full document including Te Reo transalation** ☑<br>**Community Consultation** ☐<br>**Web-based environment for strategy** ☑<br>**Implementation Guidance** ☑<br>**Detailed Strategic Design** ☑<br>**Synthesis, design/development Intesive co-design with Working Group** ☑<br>**Data Analysis** ☑<br>**Stakeholder Engagement** ☑<br>**Intensive Engagement with Working Group** ☑<br>**Document Review** ☑<br>**Project Set Up** ☑ | **Talis Liepins:** Translation work of full document has been completed. Website updates pending. Community consultation made complex by COVID outbreak - reorienting in this context.<br>*14/02/2022* | 91%<br>30% ahead |
| **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.** | Talis Liepins | 75%<br>75 /<br>19% behind | **Automate datastreams for internally held data** ☑<br>**Collect external data sources** ☑<br>**Deploy interactive data explorer on the website** ☑<br>**Soft launch - 40 / 82** ☑<br>**Formal Launch of Phase One Indicators - March 2022** ☐<br>**Remaining indicators live on website (Phase One)** ☐<br>**Soft Launch of website 8/82 indicators** ☑<br>**Development of health Indicators** ☑ | **Talis Liepins:** Redeployment of staff resource to support COVID remains a challenge for the project.<br>However, 55 of the indicators have been deployed to the HNA website, and the interactive data explorer is live in parallel.<br>For reference, this now means that we have more indicators published than the scope of Northland DHB's HNA which the Southern HNA drew inspiration from.<br>*14/02/2022* | 75%<br>19% behind |

## PRIMARY & COMMUNITY CARE

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Implementation of the Primary & Community Strategy** | Andrew Lesperance | 18% − 18 / 34% behind | | **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* | 18% 26% behind |
| → **Health hubs Implementation: Te Kaika Community Wellness Hub** | Andrew Lesperance | 50% − 50 / 50% behind | **First Floor Plan Complete** ☐<br>**Ground Floor Plan Complete** ☑<br>**Create and agree to development agreement** ☐<br>**Project Initiation, relationship agreement, preparation, RFP won** ☑<br>**"Go Live" opening date** ☐<br>**Initiate Co-Design Process (Te Kaika, MSD & SDHB)** ☑<br>**Heads of Agreement sign off (deferred - did not occur)** ☑<br>**Lease agreement sign off** ☐ | **Talis Liepins:** The development agreement is the key and foundational agreement that is currently being negotiated. The MOU and lease agreement are secondary as these will only become active when SDHB occupies the premises in December 2023.<br>Negotiation of the Heads of Agreement has been deferred and will be rolled in to the lease agreement.<br>Ground floor plan design has been completed.<br>*14/02/2022* | 50% 38% behind |
| → **Maternity Central Otago** | Andrew Lesperance | 25% − 25 / 2% behind | **Conclude RFP for Architect** ☑<br>**Build complete of Clyde PBU** ☐<br>**Build complete of Wanaka PBU** ☐<br>**Build started on Clyde PBU** ☐<br>**Build Started on Wanaka PBU** ☐<br>**Main contractor engagement: award of contract** ☐<br>**Tender released for main contractor** ☐<br>**Design complete for Wanaka & Clyde** ☐<br>**Design Tender** ☐<br>**Procurement of land in Wanaka** ☐<br>**Ministry of Health approval of Business Case** ☑<br>**Business case for the Primary Birthing Units completed and to CEO for sign off** ☑ | **Talis Liepins:** RFP for architect has concluded and preferred supplier is being taken to steering group for approval. Business Case has been approved by MoH.<br>*22/02/2022* | 25% 6% ahead |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Primary Care in Southland** | Andrew Lesperance | 28%<br>28 /<br>72% behind | | **Greer Harper:**<br>Recruitment challenges are hampering the WellSouth Primary care initiative<br>*25/11/2021* | 28%<br>28% ahead |
| **Wanaka After-Hours Service** | Andrew Lesperance | 0%<br>0 /<br>- | | | Not started |

## CLINICAL SERVICE REDESIGN

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Oncology Sustainability Planning** | Hamish Brown | 0%<br>0 /<br>- | | | 0%<br>- |
| → **Address recruitment challenges within the service** | Hamish Brown | 0%<br>0 /<br>- | **Meet with CDHB to collaborate on opportunities** ☑<br>**Initiate Haines Attract recruitment campaign** ☑ | | 0%<br>- |
| → **Establish outsourcing arrangement to reduce waitlist immediately** | Hamish Brown | 100%<br>100 /<br>- | | | 100%<br>- |
| → **Development of long term Oncology strategic plan** | Hamish Brown | 37%<br>37 /<br>37% ahead | | | 37%<br>37% ahead |
| **Improving Patient Flow through the Implementation of the SAFER Bundle: A framework for improving patient flow** | Jane Wilson | 50%<br>50 /<br>50% behind | **Discharge before Noon** ☐<br>**Flow from ED to inpatient wards** ☑<br>**Expected Date of Discharge & Clinical criteria for discharge** ☐<br>**Senior Review: Rapid Rounds & Red2Green** ☑ | **Greer Harper:**<br>Work on the 6 workstreams associated with Patient Flow is ongoing. ED flow improvement work is being driven by the ED team and work to progress the Integrated Operations centre initiative is in development. A MoH weekend discharge pilot is in flight as well.<br>*24/11/2021* | 50%<br>25% behind |
| **MHAID Review** | Gilbert Taurua | 100%<br>100 /<br>- | | **Greer Harper:**<br>*Review Complete - Recommendations are being implemented currently.*<br>*25/11/2021* | 100%<br>- |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Embedding Virtual Health** | Hamish Brown | 0%<br>0 /<br>74% behind | **Continue to refine and resource developments** ☑<br>**Complete supported roll-out to services and support establishment of identified hubs in the community** ☐<br>**Identify potential hubs in the community for delivery** ☐<br>**Supported Rollout to services** ☑<br>**Development of Implementation Plan** ☑<br>**On-board Project Mgr & technical resource/support** ☑ | **Greer Harper:** The past month has seen the telehealth implementation manager & AV technician, further supporting teams. All outpatient clinic rooms at Dunedin and Southland Hospitals are getting extra monitors and cameras to enable hybrid clinics so clinicians are able to carry out both in-person and telehealth appointments. Training for admin staff and clinical champions in the use of MS Teams with a telehealth focus will also be running in Dunedin and Southland during the week commencing 6 December.<br>*25/11/2021* | 0%<br>62% behind |
| **Enhanced Generalism Model** | Hamish Brown | 50%<br>50 /<br>14% ahead | **MAU Decant & Build** ☐<br>**MAU Design** ☐<br>**Recruitment: PM, SMO & Allied Health** ☐<br>**GAMA Implementation** ☑<br>**Communications Plan** ☑<br>**SLA/Referral Guidelines** ☑ | **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.<br>*21/10/2021* | 50%<br>25% ahead |
| **TCU – Transit Care Units** | | 0%<br>0 /<br>- | | | Not started |

## ENABLING OUR PEOPLE - OUR PEOPLE STRATEGY

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **CCDM Implementation** | Hamish Brown | 100%<br>100 /<br>- | | **Greer Harper:**<br>*WIP: Further content needed here.*<br>*25/11/2021* | 100%<br>- |
| **Talent Management - Attract, Support, develop & retain the talent we need** | Tanya Basel | 8%<br>8 /<br>92% behind | **Effective retention startegies for each workforce group/location** ☐<br>**Align budget cycle with Workforce and Service Plans** ☐<br>**Equity and Diversity recruitment strategies** ☐<br>**Expand workforce and Service Planning** ☐ | **Greer Harper:**<br>Work is progressing in all milestone areas, but not complete. Long term initiatives.<br>*24/11/2021* | Not started |
| **Leadership Development** | Tanya Basel | 33%<br>33.33 /<br>24% ahead | **Leadership Development Program for leadership layers: Fit for purpose** ☑<br>**Align Leadership Development with Health NZ** ☐<br>**Establish Leadership Framework** ☐ | | Not started |
| **Diversity and Inclusion** | Tanya Basel | 50%<br>50 /<br>50% ahead | **Support Disability Strategy establishing essential practices** ☐<br>**Pro-equity recruitment pilot in Allied Health focus on Maori** ☑<br>**Progress Rainbow Tick (strategy alignment dependent)** ☐<br>**Implement Pro-Equity Recruitment across all areas** ☐ | **Tanya Basel:**<br>Due to competing priorities some of our initiatives to improve diversity and inclusion has been affected by timing and limited resources.<br>*21/02/2022* | Not started |
| **Culture and Engagement** | Tanya Basel | 0%<br>0 /<br>- | **Focus on Wellbeing** ☐<br>**Establish recognition and retention frameworks** ☐<br>**Refresh Speak-up** ☐ | | Not started |
| **Capability Development** | Tanya Basel | 33%<br>33.33 /<br>33% ahead | **Change Cycle Program to support response to change** ☑<br>**Identify scare skills** ☐<br>**Establish career programmes** ☐ | | Not started |

## SYSTEMS FOR SUCCESS

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Specialist Services Operational structure re-design** | Chris Fleming | 100%<br>100 /<br>- | **External Recruitment of wider positions** ☑<br>**Initial Recruitment of Internal Positions** ☑<br>**Decision Document and Notification To Staff** ☑<br>**Consult on Proposal For Change** ☑<br>**Develop Proposal For Change** ☑ | **Greer Harper:**<br>Complete.<br>*25/11/2021* | 100%<br>- |
| **FPIM Implementation** | Nigel Trainor | 100%<br>100 /<br>- | | | 100%<br>- |
| **H R I S** | Tanya Basel | 0%<br>0 /<br>- | | | 0%<br>- |
| **Risk Management Maturity** | Hywel Lloyd | 95%<br>95 /<br>5% behind | **Adoption of Safety 1st as digital risk management tool** ☐ | **Hywel Lloyd:**<br>All risks were migrated to Safety1st by mid December 21. The electronic risk register is now fully operational with staff trained in the functionality and maintenance of Safety1st Risk Register system. Training has been well attended.<br><br>The operationalising of the Risk Register is now complete.<br><br>The Clinical Council have a fixed agenda item to review the high and extreme risks.<br>Directorate Leadership Teams review their risks and organisational wide risks with regular scheduled meetings with the Risk Adviser.<br><br>The final step is to bring the Risk Register into the Performance and Accountability Framework to provide the Chief Operating Officer with all the quality metrics into a single management framework.<br>*20/02/2022* | 95%<br>2% ahead |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Digital Transformation (detailed business case)** | Patrick Ng | **75%**<br>**75 /**<br>60% ahead | **Board signoff of DBC** ☐<br>**Book DBC Clinic with Treasury** ☐<br>**Confirm & schedule interviewees for Gateway** ☑<br>**Gateway review** ☑<br>**Confirm TQA arrangements** ☑<br>**Confirm IQA of DBC** ☑<br>**Draft version of Detailed Business Case** ☑ | **Greer Harper:**<br>Feedback to be incorporated from Gateway review to be ready for the Board review in Feb 2022.<br>*24/11/2021* | **75%**<br>72% ahead |
| **Scanning Project: The digitisation of clinical records** | Patrick Ng | **20%**<br>**20 /**<br>25% behind | **Clinical Engagement** ☐<br>**Bureau Service: Process Design** ☐<br>**Bureau Service: Transition & Training** ☐<br>**Management of Change: Consultation & Response** ☐<br>**Management of Change: Definition of roles & responsibilities** ☐ | **Greer Harper:**<br>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.<br>*21/10/2021* | **20%**<br>11% ahead |
| **Establishment of an Integrated Operations Centre** | Hamish Brown | **20%**<br>**20 /**<br>- | **SOPs/Regional SOPs** ☐<br>**Requirements** ☐<br>**Identify ands cope physical location** ☐<br>**recruitment PM 6 Months FT** ☑<br>**Define IOC scope and milestones** ☐ | **Greer Harper:**<br>Project will be lead out of Patient Flow and is currently being planned for. A scoping exercise is underway with a view to wrapping project resource around this to take it forward.<br>*24/11/2021* | Not started |
| **4. Improve risk identification, rollout the electronic reporting system as a matter of priority, embed a risk culture within the organisation.** | Hywel Lloyd | **0%**<br>**0 /**<br>- | | | Not started |

## SYSTEM IMPROVEMENTS

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Discharge Summaries Re-design** | John Eastwood | **75%**<br>**75 /**<br>23% behind | **Pilot of new documentation** ☐<br>**Pilot group of clincians established to trial NMDHB example** ☑<br>**NMDHB example shared with clinical leaders** ☑<br>**upload outline plan** ☑ | | **75%**<br>4% behind |
| **Clinical Costing System Implementation plan** | Nigel Trainor | **20%**<br>**20 /**<br>20% ahead | **Business Case approval by the board** ☐<br>**Business Case to the board** ☐<br>**Business Case proposal to ELT** ☐<br>**Appoint a Project Manager** ☑<br>**Complete RFP Process** ☐ | **Nigel Trainor:**<br>The RFP has been evaluated and the final decision is awaiting some site reference reports. These will happen in the next week. The Business case is on track to go to the Board at their April meeting<br>*21/02/2022* | **20%**<br>20% ahead |
| **ePMO & Project Governance framework** | Patrick Ng | **50%**<br>**50 /**<br>42% behind | **Setting of Project prioritisation criteria with Exec Team.** ☐<br>**Update & socialise current PM Policy** ☐<br>**On-Board Portfolio Manager** ☑<br>**ePMO service offering & governance structures endorsed by ELT** ☑ | **Greer Harper:**<br>Portfolio Manager starting in Feb 2022. Draft Portfolio management framework approved with edits by ELT in early Nov.<br>*25/11/2021* | **50%**<br>8% behind |
| **MHAID H&S Review and Improvement Plan** | Gilbert Taurua | **67%**<br>**66.67 /**<br>29% ahead | **Close out implementation plan** ☐<br>**Develop Implementation Plan** ☑<br>**External review by Purple Consulting** ☑ | **Talis Liepins:**<br>Public release occurred last week and focus is now on implementation<br>*21/02/2022* | **67%**<br>43% ahead |
| **Hospital Escalation Planning/Standard Operating Procedures** | Hamish Brown | **0%**<br>**0 /**<br>100% behind | | **Hamish Brown:**<br>This exists as a dependency of the IOC - tracking to a June 2022 deadline for IOC being online<br>*14/02/2022* | **0%**<br>- |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **PICS implementation: New regional Patient Information System which replaces IPM in Otago & Southland** | Patrick Ng | 30%<br>30 /<br>- | **Data Implementation Underway** ☑<br>**Go Live** ☐<br>**Initial DM Complete** ☐<br>**Testing Complete** ☐<br>**Integration Solutions finalised** ☐<br>**Operational Processes Defined** ☐<br>**Enterprise Level Changes determined** ☐<br>**Data Migration approach agreed** ☑<br>**Change & Engagement Plan Developed** ☑ | **Greer Harper:**<br>The project team are working through the data migration planning and implementing the comms plan which has been approved. Discovery work by project team around current systems/implications and integrations is ongoing.<br>*24/11/2021* | **30%**<br>17% ahead |
| **Central Decision Support Model** | | 0%<br>0 /<br>- | | | Not started |
| **Implementation of MH review recommendations** | Gilbert Taurua | 20%<br>20 /<br>20% ahead | | **Greer Harper:**<br>Implementation plan progressing well with Ministry support. Recruitment of Exec. Director MHAID continuing.<br>*25/11/2021* | **20%**<br>20% ahead |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **Rollout of the Performance & Accountability Framework** | Andrew Lesperance | 53%<br>**53 /**<br>53% ahead | **Roll out Strategy, Primary & Community Pack** ☐<br>**Dry-run of new meeting cadence settled and implemented** ☑<br>**Agree and define monthly process for pulling together monthly reporting pack** ☐<br>**Creation of dedicated PowerBI dashboard for one-stop monthly reporting** ☑<br>**Audit of metrics that will form basis of monthly report pack** ☑ | **Talis Liepins:**<br>The P&AF is established in Medical & Surgical Directorates and the teams continue to make refinements to reporting approaches.<br><br>Planning/Funding/Population/ Public Health Directorate are initiating their first meeting on 22nd March and have agreed on an approach of cycling portfolio areas through regular meetings rather than larger/longer meetings trying to cover all portfolios.<br><br>The GM for Public&Population Health and Planning&Accountability Mgr are working up the performance metrics for the meeting on March 22nd.<br><br>Meeting times are to be organised with Mental Health Services regarding the rollout in their Directorate.<br>*09/02/2022* | **53%**<br>53% ahead |
| **Health & Safety Workplan** | Tanya Basel | 0%<br>**0 /**<br>- | | **Greer Harper:**<br>*WIP - Need content build here*<br>*25/11/2021* | **0%**<br>- |
| **6. Establish a clear clinical governance framework, embed discipline around meeting structure, action follow through and focus** | Hywel Lloyd | 0%<br>**0 /**<br>- | | | Not started |
| **Implement Oncology Sustainability and Recovery Plan** | Hamish Brown | 0%<br>**0 /**<br>- | | | Not started |

## FACILITIES FOR THE FUTURE

| Goal | Owner | Current Completion | Task | | Comment | Historic Completion |
|---|---|---|---|---|---|---|
| **Embedding of Generalism Model (Int. Support Workstream 8)** | Hamish Brown | 43%<br>43 /<br>43% ahead | **MAU Design**<br>**MAU Build**<br>**Decant Process: Physiology, Rheumatology** | ☐<br>☑<br>☐ | **Greer Harper:**<br>Activity is continuing. Further focus is being given to the generalism model as a model of care (building aside). Further development of best practise, multi-disciplinary approach and patient flow. Building and decanting still delayed but progressing despite covid and long lead time delays.<br>*24/11/2021* | 43%<br>43% ahead |
| **Right-sizing Southland ED** | Nigel Trainor | 25%<br>25 /<br>25% ahead | | | **Nigel Trainor:**<br>The plans for the ED in Southland are well advanced and our now with the QS for final costings. The project is now affected by the 5th Theatre as the new theatres will go above this building extension<br>*21/02/2022* | 25%<br>25% ahead |
| **Security Review** | Nigel Trainor | 100%<br>100 /<br>- | | | | 100%<br>- |
| **Dunedin Master Site Planning** | Bridget Dickson | 80%<br>80 /<br>9% ahead | **Deliver & Document**<br>**Refine Preferred Scenario**<br>**Explore Spatial Options**<br>**Define Vision & Principles**<br>**Mobilisation/Lead-In** | ☐<br>☑<br>☑<br>☑<br>☑ | **Simon Crack:**<br>The programme is on track. Work to refine short-listed options continues, with ELT -- then SDHB's Board -- to be presented with the proposed preferred option in late Jan/early Feb. Collaboration with Aukaha continues to help ensure the preferred option(s) are consistent with the SMP's vision and values. A presentation will be made to the Southland Service Planning's Steering Group in Feb 22 to align work programmes.<br>*18/01/2022* | 80%<br>56% ahead |

| Goal | Owner | Current Completion | Task | Comment | Historic Completion |
|---|---|---|---|---|---|
| **CETES – Clinical Engineering, Tech & Equipment Service** | | 0% 0 / - | | | Not started |
| **Seven-Day Hospital** | | 0% 0 / - | | | Not started |
| **Acute Assessment & Planning Units** | | 0% 0 / - | | | Not started |
| **23 Hour Unit** | | 0% 0 / - | | | Not started |
| **Southland Master Site Planning** | Simon Donlevy | 33% 33.33 / - | | | Not started |

**FOR INFORMATION**

**Item:** Care Capacity Demand Management (CCDM) Update

**Presented by:** Jane Wilson CNMO, Hamish Brown COO, Nigel Trainor EDCS

**Meeting of:** 3 March 2022

## Recommendation

**That the Board notes the content of this report**

## Purpose

**For information**

## Specific Implications for Noting

1. **Financial:** Proposed CCDM investment has been estimated for the purposes of submitting a draft 2022/23 budget by MoH deadline. Once all FTE calculations have been completed, verification of final investment recommendation will be endorsed by the CCDM Council for subsequent Board approval in May
2. **Operational Efficiency:** There are opportunities to further improve operational efficiency and productivity by better matching workforce to demand
3. **Workforce:** A number of initiatives to improve workforce recruitment and retention are being progressed
4. **Equity:** Recruitment of nursing and midwifery FTE involves pro-equity actions to increase the Māori workforce.

## Background

On July 30th 2018, representatives of the New Zealand Nurses Organisation (NZNO), DHBs and the Ministry of Health signed an Accord committing the parties to there being sufficient nurses and midwives in our public hospitals to ensure both their own and their patients' safety. The Accord commits all three parties to ensure DHBs implement the additional staffing needs identified by CCDM within the agreed timeframe (June 2021).

The Care Capacity Demand Management (CCDM) programme is a decision-support system designed for use by DHBs to predict, plan and deliver nursing and midwifery staffing. The primary purpose of the CCDM programme is to support the delivery of safe, effective, and productive staffing on every shift. This is achieved through collecting and using data about patient demand and acuity to guide the yearly staffing cycle including; annually identifying the FTE requirement for each service (for recruitment and budgeting purposes), evidence-based demand planning and rostering, and productive deployment of resources on the day care is delivered.

A recent evaluation of the DHB's CCDM implementation status was undertaken by the Safe Staffing Healthy Workplaces Unit (SSHWU) in November 2021. The findings (previously reported to the Board in February 2022) confirmed that Southern DHB has achieved full CCDM implementation and compliance with all standards.

# Care Capacity Demand Management (CCDM) FTE Calculation Update

**CCDM investment 2021/22**

In 2021 the Chief Executive tasked the EDCS, CNMO and COO to work through the required staffing levels recommended by the CCDM Council to reach agreement about the level of additional investment that will be required for CCDM in the 2021/22 financial year. This included ensuring effective variance response management to respond to negative variances during the shift.

A robust process to validate the nursing and midwifery FTE requirements for the 2021/22 budget included an external review of our CCDM processes as well as 'moderation' of our FTE calculations by the Safe Staffing Healthy Workplaces Unit (SSHWU). This resulted in a significant investment of circa $9m/109 FTE annualised. As per the signed Accord, FTE calculations must be repeated annually.

**Recruitment progress against 2021/22 CCDM budget investment**

Although there has been reasonable success in our recruitment efforts, we have not been able to keep pace with filling both new CCDM approved and usual staff turnover FTE and vacancies remain high. Recruitment efforts have been further impacted by border restrictions and the need to deploy staff for COVID response work. This has resulted in continued negative shift variances where 'available hours' (nursing hours per shift) do not meet 'required hours' (patient care hours required per shift). Recruitment into the identified CCDM FTE (excluding recruitment into other 'turnover' vacancies) as at mid-February is at 68% YTD. It needs to be noted that a small proportion of appointments have been staff transferring between areas resulting in vacancies elsewhere in the DHB.

Examples of some of the successful recruitment strategies are outlined below:

- Maximising employment of new graduate nurses and growing the Māori and Pacific workforce - This has seen us employ the largest number of new graduates than in any previous year – circa 103 across the system in the Nursing Entry to Practice Programme NETP (82 DHB/21 across Primary Care, ARC and Rurals) and nine in the Nursing Entry to Specialty Practice NESP programme (Mental Health, Addictions and Intellectual Disability). Māori and Pacific graduates identifying Southern DHB as their preferred employer were prioritised and all appointed.

- Model of Care and Skill Mix Review - Considerable work has been undertaken and continues in evaluating staff type and skill mix to determine a safe and appropriate balance between regulated and non-regulated staff. A collaborative team based model of care ensures that the right staff are providing the right care enabling registered and enrolled nurses to work to top of scope.

- Health Care Assistant (HCA) Recruitment, Orientation and Education Programme - A DHB district wide project was established to support nursing workforce recruitment and orientation and training for HCAs. The project team have assisted Charge Nurse Managers with recruitment and orientation and approximately 60 new HCAs have been employed since October 2021. A key goal of the programme is to support and educate all HCAs to a standard at which they can effectively partner with the nursing team to deliver safe high-quality care within an environment in which they feel included, respected, supported, and valued.

- Supporting 'Returning to Practice' nurses – A workforce project focused on supporting home grown nurses and Internationally Qualified Nurses (IQNs) who are in our district but who have either not yet registered with Nursing Council New Zealand or who have moved out of nursing practice. A fixed term 'joint appointment' role with Otago Polytechnic was established to identity and find solutions to barriers to registration or APC renewal. The recently announced MoH fund for nurses returning to practice should further assist where cost has been identified as the barrier.

- Clinical Coaching support - Nursing education and clinical coaching support has been increased on the front line, as we recognise the additional oversight and support required of new starters

- Recruitment Campaigns – Southern DHB is working at a local, national and international level on recruitment campaigns to attract new and returning staff offering more flexible and attractive contract arrangements and other incentives such as scholarships.
- Growing the Undergraduate Pipeline – Regular engagement continues with Tertiary Education Providers in growing the workforce pipeline and participating in regional and national nursing and midwifery workforce groups. The proposed Nursing Education Unit (NEW) in Southland ATR service is an example of a creative initiative to staff more beds which is mutually beneficial to the DHB and Southern Institute of Technology.

While recruitment efforts continue, our focus needs to be on retention, particularly as border restrictions ease this year. Further work on skill sharing across professions using the Calderdale Framework and reviewing models of care is required so that we can ensure a sustainable, responsive and flexible workforce in the medium to longer term

**CCDM FTE Calculations 2022-2023**

This year is the first time FTE calculations have been undertaken for all 34 wards that currently use TrendCare. Data entry was completed in December 2021 using data for the previous 12mth period from 1 December 2020 to 30 November 2021. FTE calculation meetings have taken place throughout January and early February for 32 of the 34 wards to discuss the outcome of the calculations, and where possible, to determine the mix of staff where increases have been identified.

In all cases, the FTE engagement process has been managed via virtual Teams meetings, which has allowed the CCDM team to share screens and provide a brief overview of each tab in the FTE calculation software. As the majority of those involved had been through the FTE calculation process in mid-2021, this has been a relatively smooth process and feedback from the Directors of Nursing, Nurse Managers and NZNO attest to this. We have also been fortunate in having two of our Business Analysts attend the majority of meetings.

**Outcomes**

Time constraints to submit a draft budget to the MoH meant that the outcome of the calculations are estimates at this stage requiring review and endorsement by the CCDM Council. Several wards are yet to confirm their roster models. In preparing the estimates, we have broken the figures down as far as possible by role i.e. RN or RM, EN or HCA to assist in determining the average salary cost as closely as possible.

For some wards, there are larger increases than anticipated in this round of FTE calculations i.e. NICU, IMHU, OPAL, 8 Med, Puawai Rehab Unit and 6C. This is due to a number of reasons such as an increase in acuity or outdated data used in the previous budget round e.g. NICU. OPAL and Puawai Rehab Unit have not had any FTE calculations undertaken before due to multiple reconfigurations during COVID lockdowns in 2020-21. The proposed FTE increase in 8Med reflects the continuing high acuity on most shifts and the increasing number of 1:1 care hours (15,000hrs compared with 10,000hrs in the previous data period September 2019 – August 2020).

**Where to from here?**

The remaining roster models need to be completed for Puawai, OPAL, Children's Unit and 3 Surgical. It is expected that this work will be completed in March with FTE calculations and assumptions agreed by the CFO, CNMO and COO before being submitted to the CCDM Council for endorsement as per DHB's obligations under the Accord. The confirmed FTE calculations will then be submitted to the Board for approval in May.

SDHB has been on a transitional journey of bringing CCDM to life as per the Accord; this has initially focused on data collection of activity and acuity, building reporting tools such as the Capacity At A Glance (CAAG) screens and utilising TrendCare in planning. Now that we as an organisation are at the point of having calculated nursing and midwifery requirements of all wards on TrendCare, it is time to fully embrace CCDM as a foundational operational system. Education of the system must be taken broader to ensure that not only nursing and midwifery staff understand and use CCDM, but also management and support staff (HR & Finance). If we embed

CCDM in the organisation it will over time have a pay back in terms of quality of care, staff retention, holidays taken and productivity.

CCDM is still not well interfaced with other critical operational functions, specifically management of patient demand and production planning. There are clear patterns of acute presentation and we know the level of planned care we are required to deliver. Concurrent work is therefore required to address this, and will further enrich CCDM as a planning and analysis tool of the nursing workforce. With the production planning and CCDM interfaced we will better understand the impact that changes in patient and staff related factors are having on the available and required hour's e.g. patient watch/1:1 criteria, patient type and acuity, staff and patient expectations of safe staffing and quality patient care.


Clinical Council
SDHB board report
March 2022
• Dr David Gow
Southern Health
He hauora, he kuru pounamu
Southern District Health Board
Piki Te Ora

# Council Leadership and Membership

- Deputy Chair appointed:- Tracy Hogarty Director of Scientific and Technical.
- Medical director Southland Adam McLeay
- Southland Director of Nursing
- Working hard with IGC for iwi representation
- Standing CC Wellsouth representative
- CC Chair sitting on DHB board, CHC, Wellsouth CG group and Covid steering group.

# Clinical Council focus

**Clinical governance oversight across the system**

**Clinical governance policy**

Identifying and preventing hospital associated complications

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

# Implementing systems
# SDHB Clinical Governance Policy:- Ward to Board

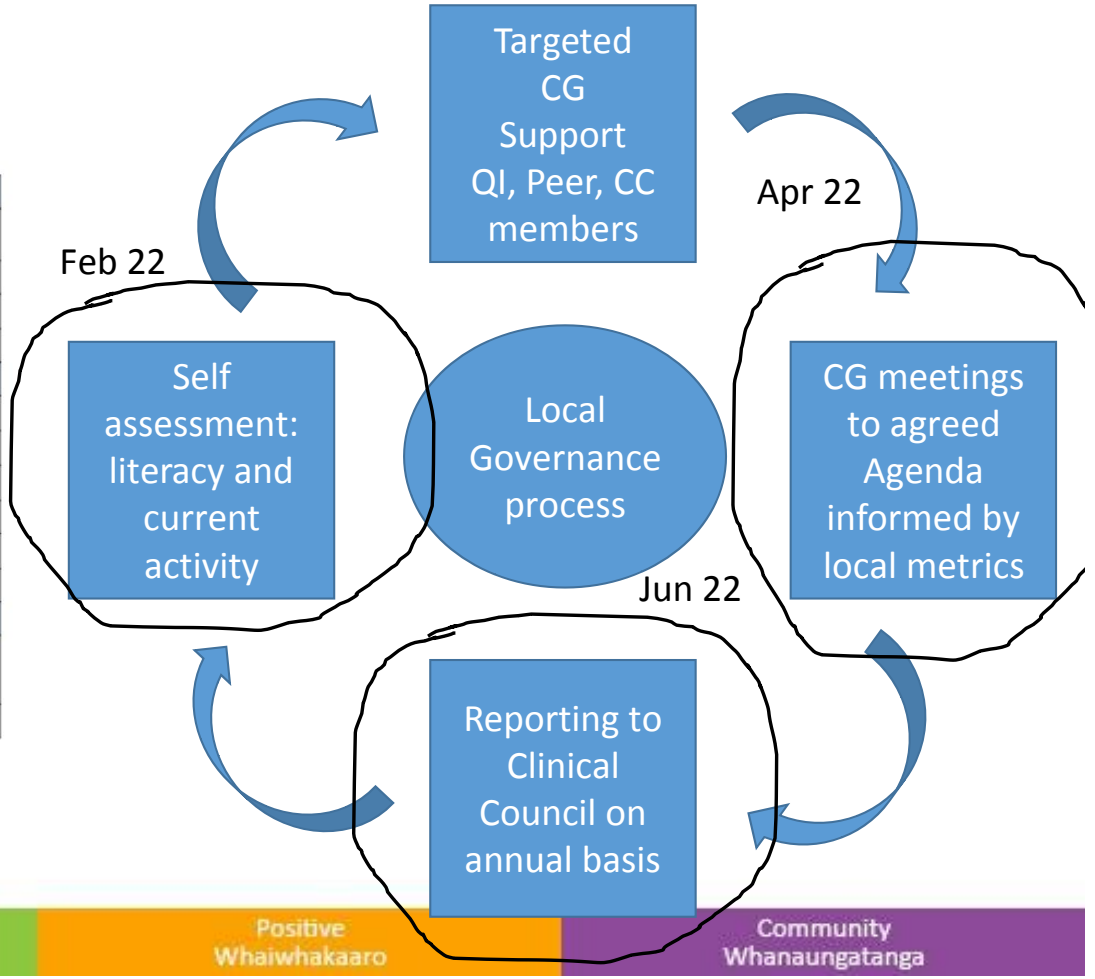
Quality & Clinical Governance
MEETING AGENDA

**Date:**

| | |
|---|---|
| Service | |
| Time: | |
| Venue: | |
| Attendees: | |
| Attendance: | |
| Apologies: | |

| Time | Item | Presenter/Paper |
|---|---|---|
| | 1. Karakia | |
| | 2. Apologies | |
| | 3. Minutes of last meeting | |
| | 4. Matters arising | |
| | 5. Review of Action Log and progress Completion mind-set | |
| | **Consumer Engagement, Equity & Participation** | |
| | 1. Consumer Quality & Safety Marker Rating: Consumer Engagement Maturity Plan | |
| | 2. Advance Care Plans & Shared Goals of Care | |
| | 3. Patient Experience & Consumer Representative | |
| | 4. Self-Management Support | |
| | 5. Complaints/Compliments - rates/themes | |
| | **Quality Improvement/Patient Safety** | |
| | 6. Adverse Events, Patient Safety, Harms. Measures Dashboard review | |
| | 7. Infection Prevention & Control | |
| | 8. Risk Register and Risk Management | |
| | 9. Patient Safety Culture | |
| | 10. Quality Improvements | |

| | | |
|---|---|---|
| | **Clinical Effectiveness** | |
| | 11. Clinical Outcomes: - Length of stay, Readmission rates, Cancelled procedures, Activity. | |
| | 12. Patient Flow Metrics, SAFER Bundle, R2G | |
| | 13. Mortality & Morbidity: - Review Themes and date of next formal M & M | |
| | 14. Clinical Audit | |
| | **Engaged Effective Workforce** | |
| | 15. Operational Status:- Nursing/SMO/Allied Health | |
| | 16. Sickness & Absence, Turnover and outstanding annual leave | |
| | 17. Education & Training: – mandatory compliance, opportunities | |
| | 18. Credentialled Date and Recommendations | |
| | 19. Annual Professional Development meetings (Appraisal) - Themes | |
| | 20. Orientation and Induction | |
| | **Items for action or escalation** | |
| | 1. Actions for attendees<br>2. Escalation to DLT (DON, Professional leads AH, MD, SM+/- GM, Clinical Council) | |
| | Closing Karakia | |




Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

# Clinical Council focus

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# Ward round safety checklist

Name: NHI No:
Address: DOB:
Tel:
Stick patient label here (or fill in if no label available)

Southern District Health Board

## Ward Round Patient Safety Checklist *(V2 PDSA test use in OPAL/ATR only)*

**Circle response when reviewed on Ward Round - bold font if additional risk response is needed**
**If ward round attention is required for a risk, any profession can tick small box and add optional note**

| Date | | | | |
|---|---|---|---|---|
| **IV cannula**<br>Can it be removed?<br>VIP score | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** |
| **VTE prophylaxis**<br>If no, then reason: | Yes / **No** | Yes / **No** | Yes / **No** | Yes / **No** |
| **Antibiotics**<br>Still needed?<br>'SWITCH' to oral? | **Yes** / No<br>**Y N**<br>**Y N** | **Yes** / No<br>**Y N**<br>**Y N** | **Yes** / No<br>**Y N**<br>**Y N** | **Yes** / No<br>**Y N**<br>**Y N** |
| **IDUC**<br>Can it be removed? | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** |
| **Pressure Injury risk?**<br>If present, document the stage | **Yes** / No | **Yes** / No | **Yes** / No | **Yes** / No |
| **Falls Risk**<br>Falls care plan in place | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** | **Yes** / No<br>**Y N** |
| **EWS**<br>>6 in last 24 hours?<br>Was it escalated?<br>Was there a response?<br>Modification needed? | **Yes** / No<br>**Y N**<br>**Y N**<br>**Y N** | **Yes** / No<br>**Y N**<br>**Y N**<br>**Y N** | **Yes** / No<br>**Y N**<br>**Y N**<br>**Y N** | **Yes** / No<br>**Y N**<br>**Y N**<br>**Y N** |
| **CPR status confirmed** | Yes / No | Yes / No | Yes / No | Yes / No |

**Acronyms used: IV (intravenous), VTE (Venous thromboembolism), IDUC (in-dwelling urinary catheter), EWS (Early warning score), VIP (Visual Infusion Phlebitis score), CPR (Cardio-Pulmonary resuscitation), Y (yes), N (no)**

## Patient Safety Checklist

### Responses to your feedback – 11 Feb

Thank-you for your feedback which was collected over the 2 week period testing the Ward Round Checklist on OPAL. Replies are below in back to your questions in blue.

**Form layout/design**

- **Can it be a ward round sticker?**
  This was discussed in the early stages but the clinical team felt locating it with the observation chart made it easier for all disciplines to access and it was easy to note any changes over the days; stickers can be 'lost' in notes once the day/time put there has passed
- **Who fills it out?**
  The idea is to ensure interprofessional discussions are occurring and all staff involved in the patients care should have input in raising safety issues. Nursing and AH can tick the box to alert the medical team to a concern which will then be discussed and actioned on the WR. Name change to Ward Round Patient Safety Checklist which should add clarification
- **Where do we sign?**
  There isn't a need to sign as anything relevant (concerns/changes) will be documented in the clinical/progress notes. This checklist is to ensure a conversation happens.
- **There should be a section for Pain/Adequate Pain relief or review**
  This checklist is about ensuring safety concerns where harm can occur to the patient are addressed. Pain like nutrition is an important conversation but doesn't carry immediate risk of harm.

**Location of form with obs charts and is it used?**

- **Not consistent, I found it in notes folder and the obs charts**
  It should be in the observations folder – this was feedback from staff earlier in this piece of QI work. This needs to be managed and communicated locally

**Other**

- **PI Stage and Braden Score – not known to team, MIDAS numbers there but need time for self learning**
  As a DHB management of PI needs improving so this is a good opportunity to address it. The MIDAS documents are informative and concise and most ward areas have images of the PI stages available – ask the nursing or AH team. We agree the form could be clearer and have adjusted the form to make this section more user friendly
- **Add to H/S orientation**
  There is already a lot covered at these but it could be explored. Alternatively as part of new staff orientation in to the team at ward level this could be done by their team?

**Next steps:**

- Review, collate and share the audit data (4 sets of patient notes were reviewed daily)
- Use your feedback in the comments above
- Make necessary changes to the checklist form, print and supply – note it will say V2 on the top
- Expand the size of the area testing – this might include the patients in 6ATR
- We will keep you in the loop of plans and timeframes – watch this space.

Southern District Health Board
Piki Te Ora

Opal Jan 22

6ATR Feb 22

8 MED Mar 22

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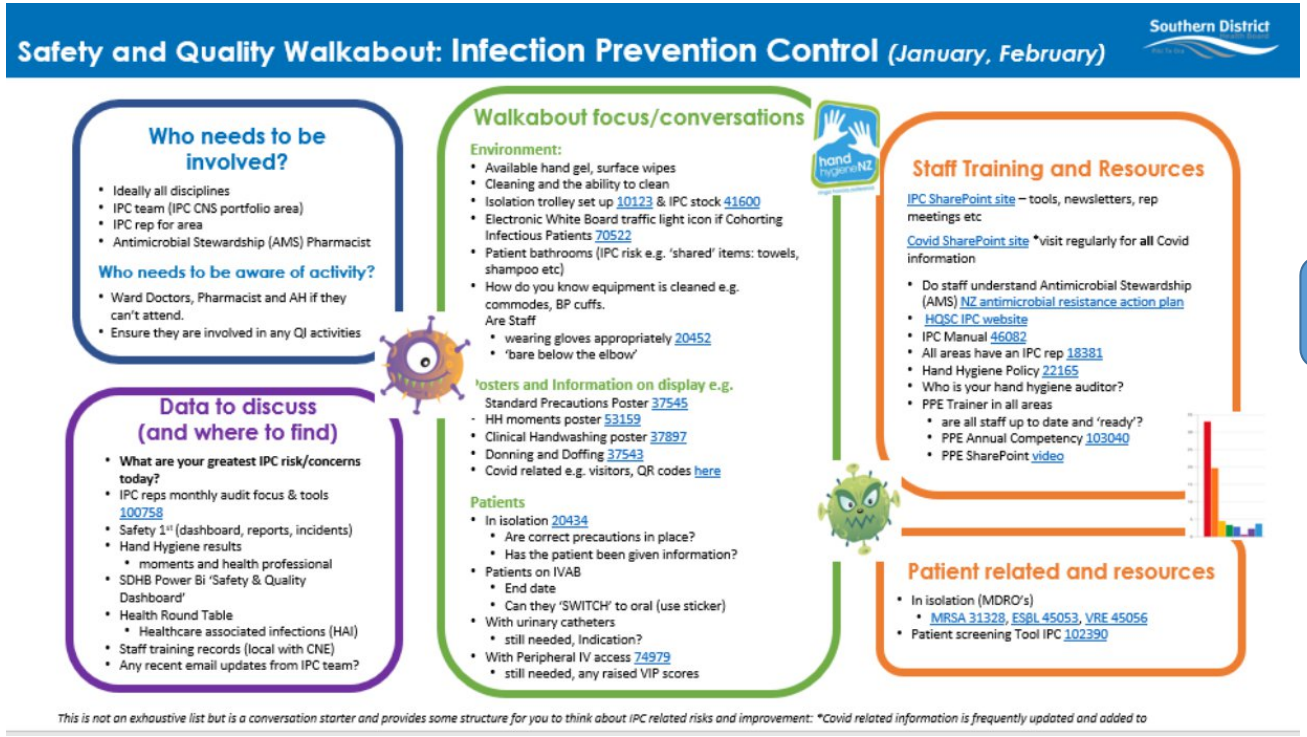
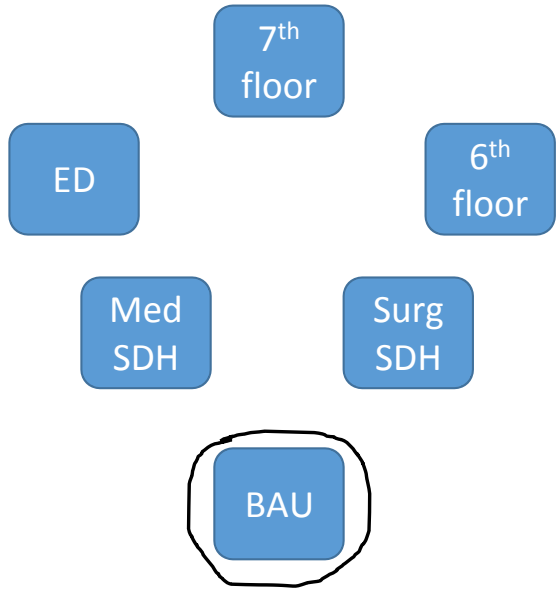
# Quality and safety walkabouts




Future focus :- Pressure injury, Falls

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# Clinical Council focus

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**Managing risk**

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# Managing Risk

| Likelihood | Risk Matrix | Consequence | | | | |
|---|---|---|---|---|---|---|
| | | Minimal | Minor | Moderate | Major | Severe |
| | **Almost Certain**...is almost certain to occur within the foreseeable future, or within 3 months | Low | Medium | High | Extreme | Extreme |
| | **Likely**...is likely to occur within the foreseeable future; or in the next 4-12 months | Low | Medium | High | High | Extreme |
| | **Possible**...may occur in the foreseeable, or in the next 1-2 years | Low | Medium | Medium | High | High |
| | **Unlikely**...is not likely to occur within the foreseeable future, or in the next 2-5 years | Low | Low | Medium | Medium | High |
| | **Rare**...may occur in exceptional circumstances, or in the next 5+ years | Low | Low | Low | Low | Medium |

Extreme & High Clinical Risks

KEY: Extreme High Medium Low

| Safety1st Item | Safety1st Value |
|---|---|
| Key Register: | |
| Risk Register Type: | |
| Risk Type/Category: | |

CLINICAL RISK = POTENTIAL HARM TO PATIENTS

Demand for healthcare is likely to exceed capacity for the foreseeable future. Therefore, good processes are essential to ensure that areas of stress in the system are continuously examined, resources are aligned as far as possible to risk and service provision is prioritised to those in greatest need and at greatest risk of harm if care is delayed.

SUMMARY

| | ALL Extreme / High 82 | Organisation Wide | Mental Health Addiction and Intellectual Disability | Operations (to be disbanded and shared amongst other directorates) | Specialist Services and Radiology |
|---|---|---|---|---|---|
| Extreme | 15 | 2 | 3 | 2 | 5 |
| High | 67 | 22 | 9 | 15 | 11 |

Aqua text = Risk has been updated in this reporting period

Quarterly Risk review meeting January 22.

-Reviewed in detail Extreme and High risks for organisation

CEO deep dive MHAID February 22.

Key points-

-Wider system effects i.e. nursing recruitment.

-Need for RR to be living document with review of risk based upon mitigation.

-Insensitivity of matrix to positive change.

# Managing Risk : Worked example Falls


| Risk Matrix | Consequence | | | | |
|---|---|---|---|---|---|
| | Minimal | Minor | Moderate | Major | Severe |
| Almost Certain...is almost certain to occur within | Low | Medium | High | Extreme | Extreme |

| Risk Category | Severe | Major | Moderate | Minor | Minimal |
|---|---|---|---|---|---|
| | Risk of: | Risk of: | Risk of: | Risk of: | Risk of: |
| Patient Safety<br>Patient harm resulting from the process of health care, unrelated to the natural course of the illness and differs from the expected outcome of a patient's management. | Death or permanent severe loss of function:<br>• not related to the natural course of the illness.<br>• differs from the immediate expected outcome of the care management.<br>• can be sensory, motor, physiological, psychological or intellectual. | Permanent major or temporary severe loss of function:<br>• not related to the natural course of the illness.<br>• differs from the immediate expected outcome of the care management.<br>• can be sensory, motor, physiological, psychological or intellectual. | Permanent moderate or temporary major loss of function:<br>• not related to the natural course of the illness.<br>• differs from the immediate expected outcome of the care management.<br>• can be sensory, motor, physiological, psychological or intellectual. | Requiring increased level of care including:<br>• review and evaluation.<br>• additional investigations.<br>• referral to another clinician. | • No injury.<br>• No increased level of care or length of stay.<br>• Includes near misses. |

# Clinical Council focus

Clinical governance oversight across the system

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Managing risk

**Monitoring consumer engagement and promoting equity**

Implementing system improvements and sponsoring projects

# Monitoring consumer engagement and promoting equity

- Close partnership with CHC has helped develop consumer engagement component of local CG policy.
- Council supporting focus on HQSC QSM programme for Consumer Engagement through review of CG agenda.
- Working with IGC to get best possible representation on Council to promote equity.

# Clinical Council focus

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**Implementing system improvements and sponsoring projects**

# Implementing system improvements and sponsoring projects

Clinical documentation improvement audit.

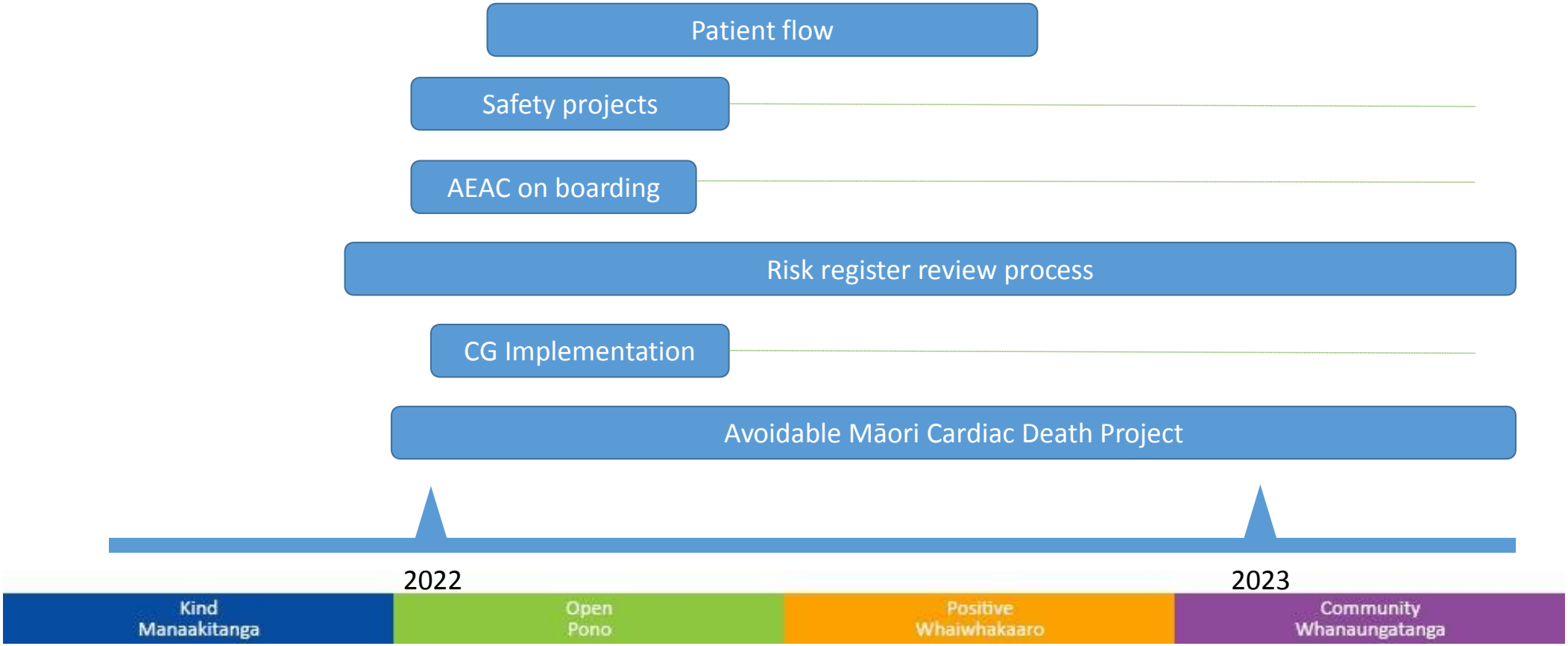
Underway and  we are anticipating major benefits for coding and clinical safety.

Mid March with feedback end of March.

# Patient flow

- Council performed a deep dive into the acute admissions element of the system.
- Clearly one part of complex health system.
- Focus on models of care.

# Work plan.


Patient flow
Safety projects
AEAC on boarding
Risk register review process
CG Implementation
Avoidable Māori Cardiac Death Project
2022
2023
Kind
Manaakitanga
Open
Pono
Positive
Whaiwhakaaro
Community
Whanaungatanga

**FOR INFORMATION**

**Item:** Patient Flow Update Report for February 2022

**Proposed by:** Patient Flow Taskforce

**Meeting of:** Board, 2 March 2022

## 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. 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.

## Background

The Patient Flow Taskforce was established in response to urgent focus needed addressing our base hospitals bed block issues and staff stress and burnout. The 'SAFER' Bundle framework (used extensively internationally) was introduced as an evolution of the 'Valuing Patient Time' work and is being used as a vehicle to embed and standardised the necessary day to day operational processes to alleviate pressure, increase patient and staff wellbeing. There are a number of additional initiatives or workstreams that are underway to shape or reduce demand, match capacity and demand and redesign systems.

## Discussion

Despite success in embedding components of the SAFER bundle to standardise processes such as Rapid Rounds and setting and regularly reviewing patients' Expected Date of Discharge (EDD), addressing barriers to timely patient flow and 'moving the metrics' has not been realised at a rate of pace we had hoped for. Getting traction on actions and sustaining momentum in the key workstreams is critical to make any step change. Progress on various workstreams, constraints and challenges are outlined in this update.

### Next Steps & Actions:

- Identification of ED resourcing to drive patient flow improvements and safer care
- Move forward standing up Integrated Ops Centre
- Continue progress on actions for other initiatives as outlined

**Appendices**

1. Patient Flow Taskforce Progress Update

## PATIENT FLOW IMPROVEMENT PROGRAMME

Although activity on patient flow remains constrained due to Omicron COVID endemic planning and settling of the new operational structure, work continues to progress in the 6 identified areas. It was noted that Southern was ahead of the curve in our attempts to embed the SAFER bundle of improvements compared to other DHB's in the MoH weekend discharge pilot meetings and as such should feel reassured with the direction and progress in this area. All of the participating DHB's are experiencing the same frustrations as us relating specifically to making the various improvements stick.

Specific workstreams/projects previously identified:

- **ED Processes – Bed request to bed access & Parallel Processes:**

The Clinical Director, ED, Dunedin Hospital, Dr Rich Stephenson, presented to the Hospital Advisory Committee on behalf of the wider ED leadership team highlighting key issues and proposed solutions to improve patient flow and performance. The data driven presentation was well received by committee members and the follow up discussion enabled deeper understanding of the challenges the department face. A lot of the issues highlighted related to preventable disease that could be more appropriately managed in the community. The flow of the low acuity patients through the Dunedin Hospital ED is not an issue for the service. The wider issue of managing people's health better, intervening earlier and having better access to rapid diagnostics in primary care has significant scope for avoiding people becoming unwell and having to go to the ED.

There was discussion about General Medicine patients who shouldn't really need to be admitted and readmitted through the ED - the provision of Outpatient Clinics and providing a step between Inpatient and Primary Care would assist with the flow through ED.

The bed booking parallel process has now been in place since September and the ED Leadership Team have commenced a review of this process. They are developing a survey to all stakeholders to capture some qualitative data in addition to the quantitative data that we already have. The aim of this was to improve the overall length of stay for patients being admitted from ED to the wards.

Resources necessary to expedite improvements need to be considered with urgency so they can be considered for 2022/23. The ED team are attempting to quantify this for board consideration.

- **Model of Care for the MAU:**

The MAU model of care team is working on current MAU improvements while collaborating on incorporating best practices for our future co-located MAU. There is now a dedicated CNM assigned to the MAU and the team can now progress more rapidly with improvements to focus and create synergy with current processes and work through issues as they arise. With the CNM in place, the team is experiencing consistent AH support and have begun direct admissions through GP referrals to GenMed. Recently the first direct admit patient was able to be turned around in a 24 hr period. The team are also going to lead a patient journey exercise to map in a detailed manner the experience from a patient's perspective to further enable the teams to work more in this model.

Actions currently in progress involve:

- Evaluation of MAU admission criteria, e.g., 1 assist, EWS score, etc.
- Development of Direct Admission Path protocols for MAU.
- Communication plan for staff combined with meetings with staff having a direct relationship/impact to MAU patient flow to establish expectations.
- Establish clear distinction in criteria where there may be uncertainty, e.g., MAU vs OPAL appropriate patients
- Evaluation of House Officer staffing on 7$^{th}$ floor

There are still challenges in current processes, with staffing shortages and closing of beds, it can be difficult to process patients to an inpatient ward. However, the team will continue to streamline and develop more efficient processes so they are prepared as the patient flow improves.

Conversations are being held at management and executive level, exploring the opportunity to run a pilot for a pathway between the General Medicine patients in the Hospital who get admitted acutely and the General Medicine patients who come through to the MAU and looking at establishing a Community Team who can work with the less unwell patients in the community so they don't need to come through into the MAU or the Hospital.

- **AT&R beds in Southland being commissioned:**

The Nurse Education Ward (NEW) plans for ATR in Southland are progressing but not opened as yet. The ward has recruited to the required nursing leadership and clinical coaching positions and orientation is underway. SIT Educators have been orientated to the ward, but SIT is also being challenged with having enough Educators, due to attrition and unexpected leave to be able to safely staff the area. SIT have an active recruitment campaign underway and are committed to the NEW. Weekly planning meetings are occurring between SDHB and SIT. Given the current recruitment challenges the aim in the next 6-8 weeks is to get the 4 additional beds open in AT&R.

The full complement of additional 12 beds will not open until there is a supply of required nurses to open and safely staff the beds. The number of nurses that are required to open the beds fully is much less because of innovative NEW model. Given that there are considerable vacancies, upwards of 25 FTE across Medicine, Surgery and ATR in Southland the decision has been made to stop ATR recruitment beyond opening the four beds until the other areas have successfully filled vacancies. The existing beds on Medical and Surgical Wards need to be fully staffed before any additional beds can be opened.

- **Integrated Operations Centres:**

Some further planning around this has occurred and a project resource is due to commence by the end of February who will work with the lead (recently appointed Patient Flow& Operations Manager. A paper is being worked up for the COO outlining the project brief and phased approach to the implementation across both Dunedin and Invercargill.

- **Weekend Discharge Pilot:**

Southern DHB is one of four DHBs that have been asked by the Ministry of Health to participate in a four-month Weekend Discharge Pilot. Discussions with the operational teams commenced last year with the Ministry of Health, and it was agreed that the focus would be on improving discharges across the 7 days on 8MED Dunedin Hospital. The Ministry are supporting by contributing to funding for release time for some clinical staff, along with funding for some fixed term positions. There are a number of perceived barriers identified in relation to delays in discharging across the week, and in particular some that are unique to the weekend. A steering group has been formed and their first meeting was held 9 February 2022. The team is really keen to understand what the barriers are to fully implementing criteria lead discharge, as both the House Officer and Senior Nurses on the Steering Group believe this is an opportunity.

- **Discharge documentation project:**

There appear to be two main drivers for reviewing the discharge summary - potential patient flow impacts, and the need to move off the current discharge summary template due to the (older) technology being retired and a newer (more flexible) form toolset being available.

With regards to patient flow impacts, 'documentation' has been noted is a key challenge, particularly by RMOs. Further discussion around this has identified that most challenges are not specifically related to the existing discharge summary template itself (i.e. changing the template in Health Connect South will not necessarily resolve the issue(s)). These include:

- Process - the vast majority of admission/assessment and procedure related content is not captured directly in HCS. There is a mix of Word documents and handwritten/scanned content. Reviewing the

process as a whole (admission -> discharge) is likely to identify where improvements to workflow and content can be made, and subsequently more timely discharge summary completion.

- Content - the primary purpose of discharge summaries is to provide appropriate summarised information and instructions to the patient, and for transfer of care to the GP following inpatient care. Review of a selection of other DHB discharge summaries indicates that Southern's current template is already relatively succinct. Adding more content, particularly if the content needs to be manually located and populated, is likely to increase time to complete, and needs to be considered with regards to content relevance/purpose, particularly whether it adds value for provision to GP and/or patient. Specific challenges have been noted with regards to reviewing and confirming medications, particularly changes from admission and the rationale for these (with no medication reconciliation content able to be utilised or populated into the discharge summary). It has been noted that this aspect alone can consume 50% of the time to complete a discharge summary. NMH's proposed discharge summary is still in development and includes a considerable amount of additional content. There are other examples that may be valuable to consider, such as CDHB's *Transfer of Care* summary, and Central TAS's *Regional Discharge Summary*. It is also worth noting that as progression to more 'joined-up' solutions occurs, notification of changes/additions and access to a shared record becomes more relevant than the provision of static forms between providers.
- Environment/workforce - challenges have been identified, including:
    - Appropriate location(s) to complete discharge summaries, including access to computer equipment and space with minimal interruptions.
    - Issues with using equipment/solutions, training in use of solutions
    - Lack of continuity of care - particularly when on-call or in the weekend. This can mean completion of discharge summaries for patients the RMO has not met or had minimal contact with. This adds further pressure to ensuring accurate and appropriate information can be located, reviewed, and signed off.
    - Timing expectations to complete discharge summaries before midday

As outlined above, many of the issues aren't specifically related to discharge summary form itself. It is likely this process will require some more focussed/dedicated resourcing to work through.

Next steps - complete brief survey for RMOs and a selection of additional respondents; compete TOR for review group and re-convene to progress project.

Current Metrics

**Fig 1. Dunedin – Bed Request to admission time**

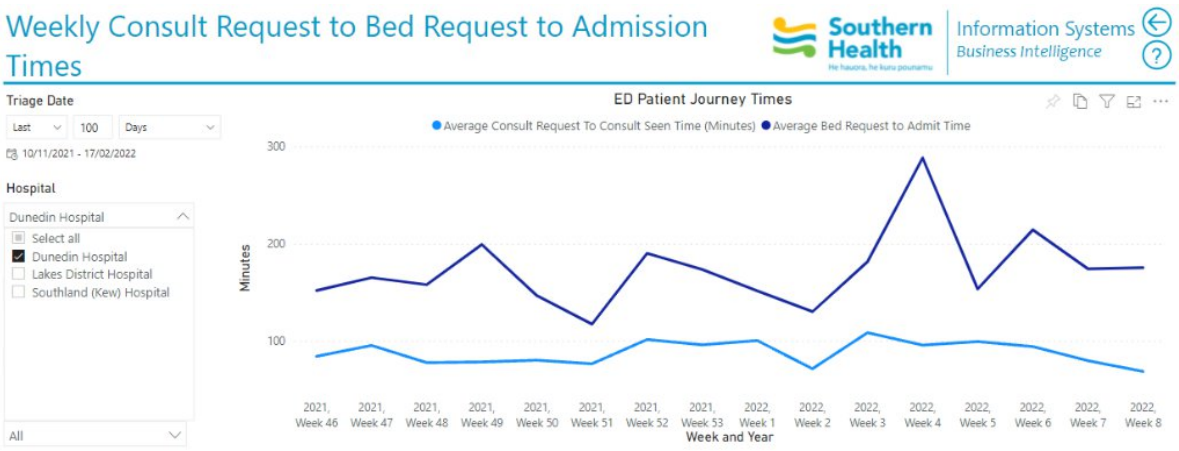



**Fig. 2 Southland – Bed Request to admission time**

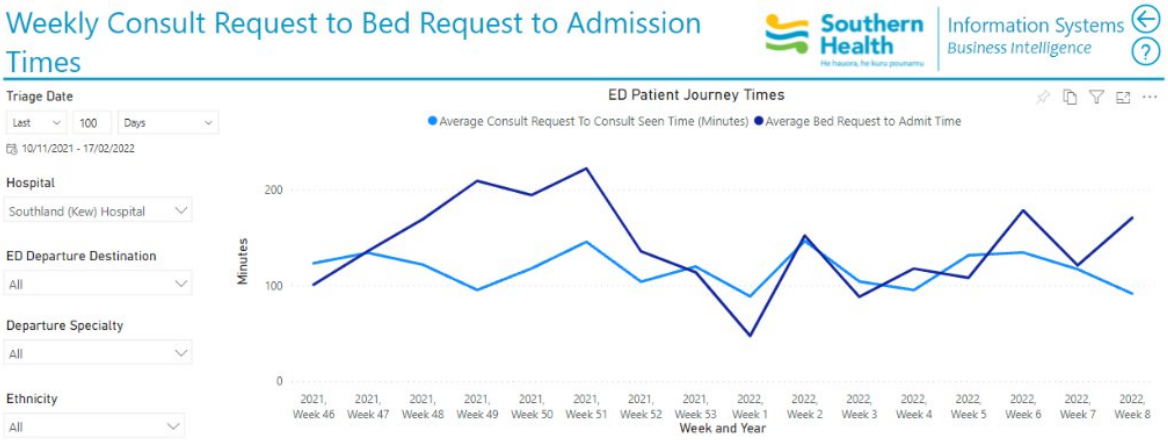



**Fig 3. Dunedin – ED Patients left before being seen or Did Not Wait**

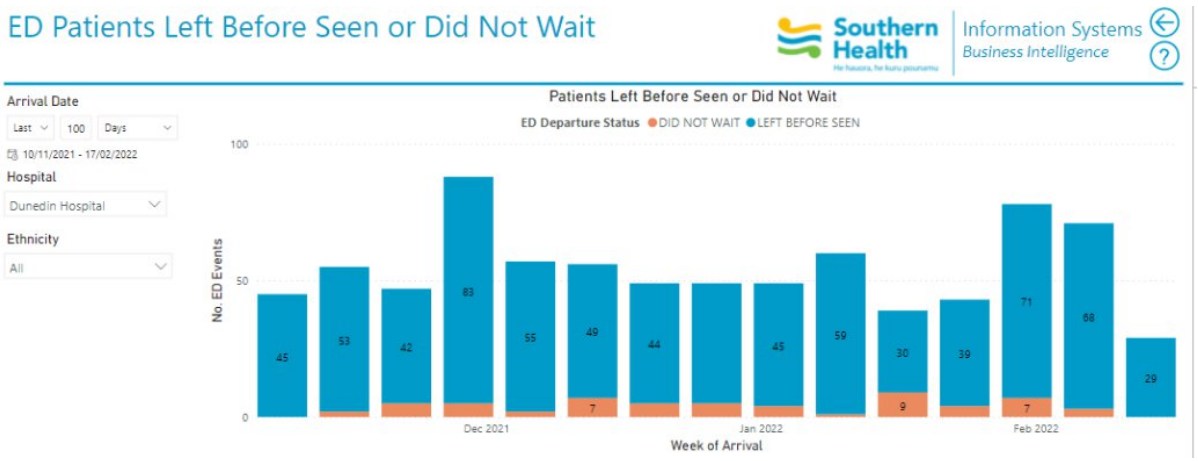


**Fig 4. Southland – ED Patients left before being seen or Did Not Wait**

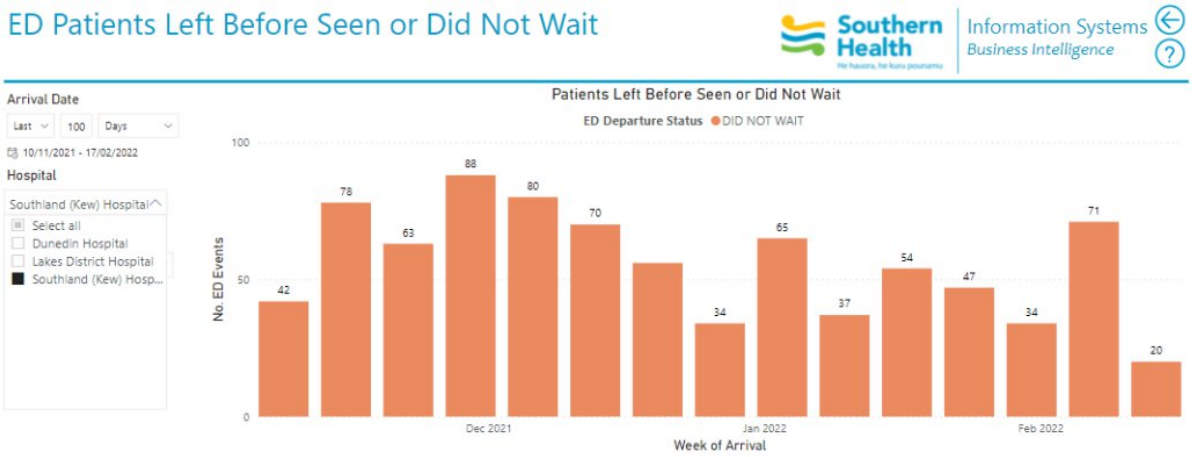



**Fig. 5 Dunedin – Discharges before Noon**

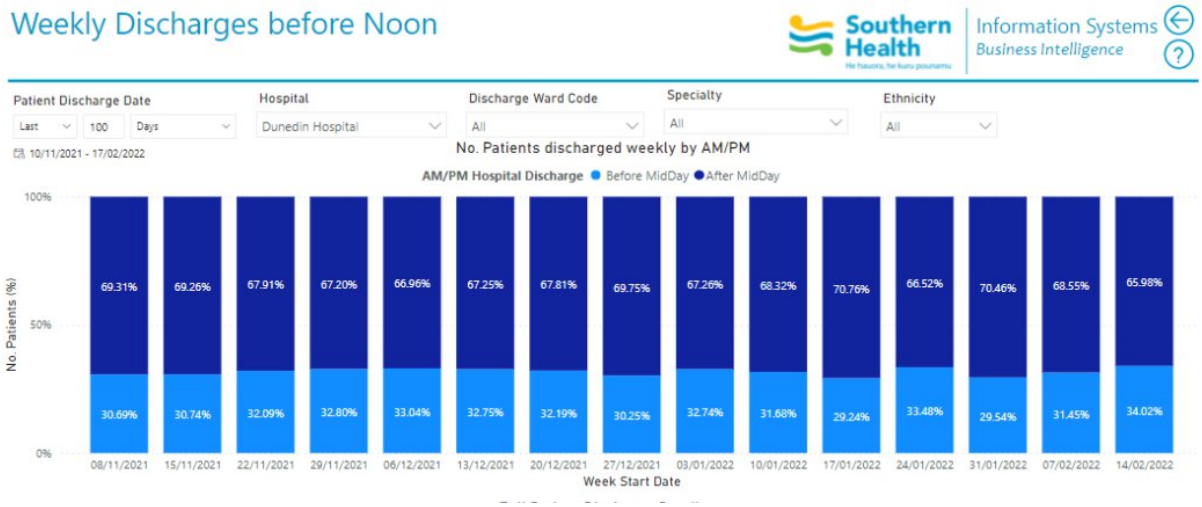



**Fig. 6 Dunedin – Discharges before Noon for General Medicine – drill down**

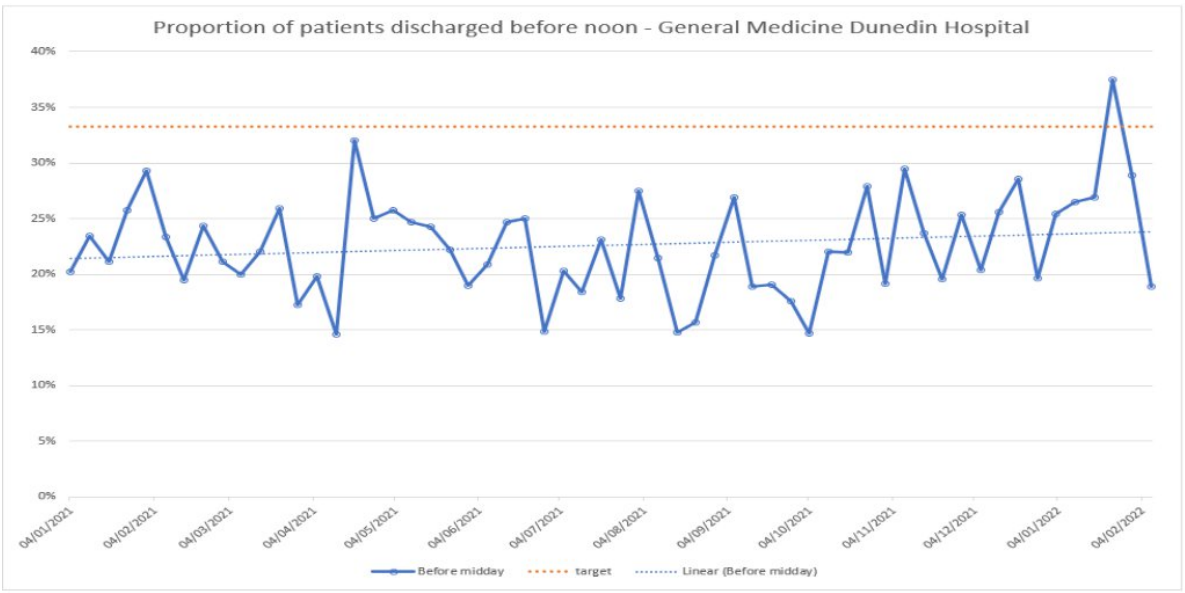


**Fig. 7 Southland – Discharges before Noon**

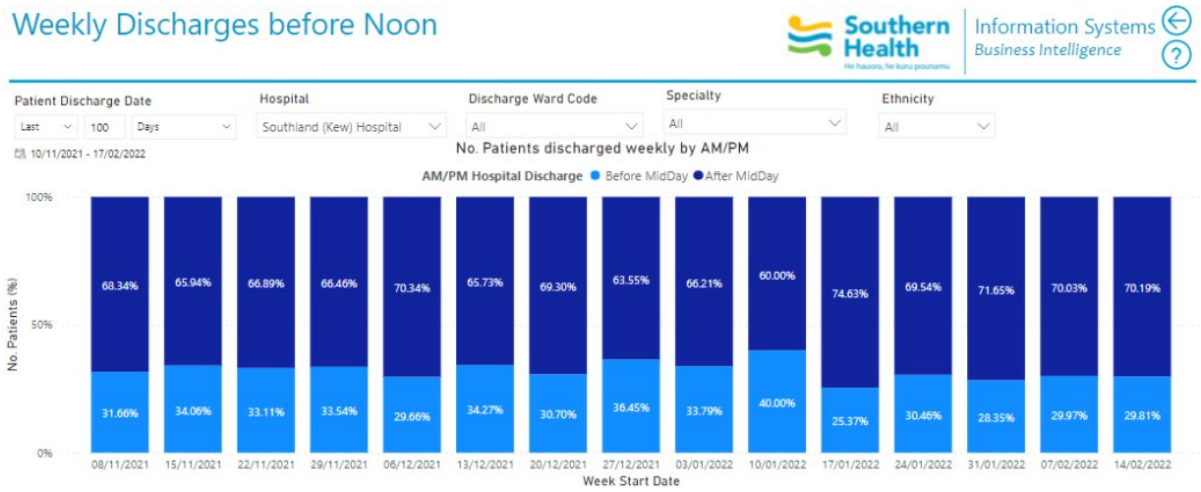



**Fig. 8 Dunedin – Weekend vs weekday discharges**

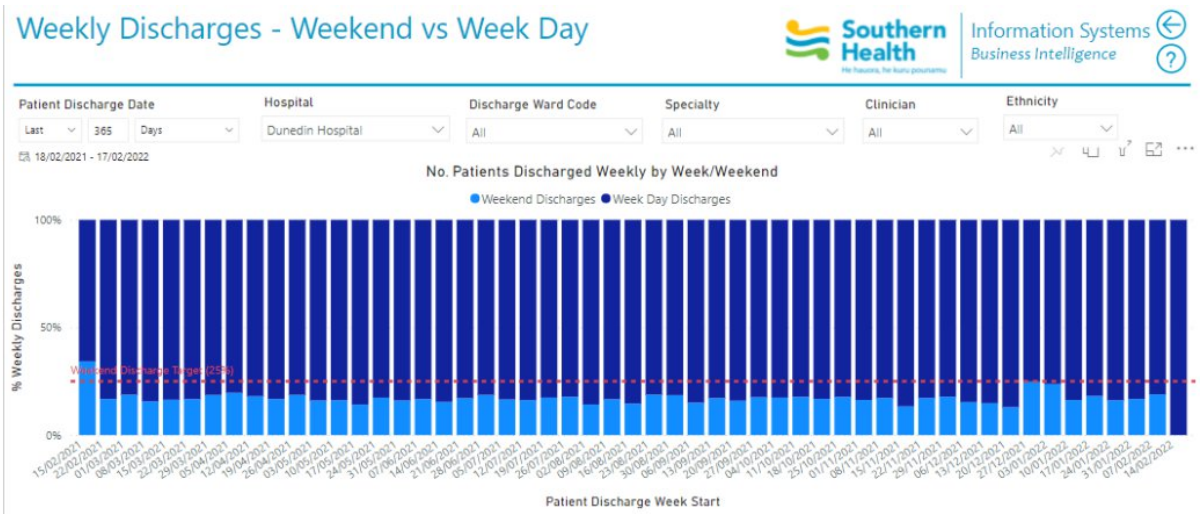



**Fig. 9 Southland – Weekend vs weekday discharges**

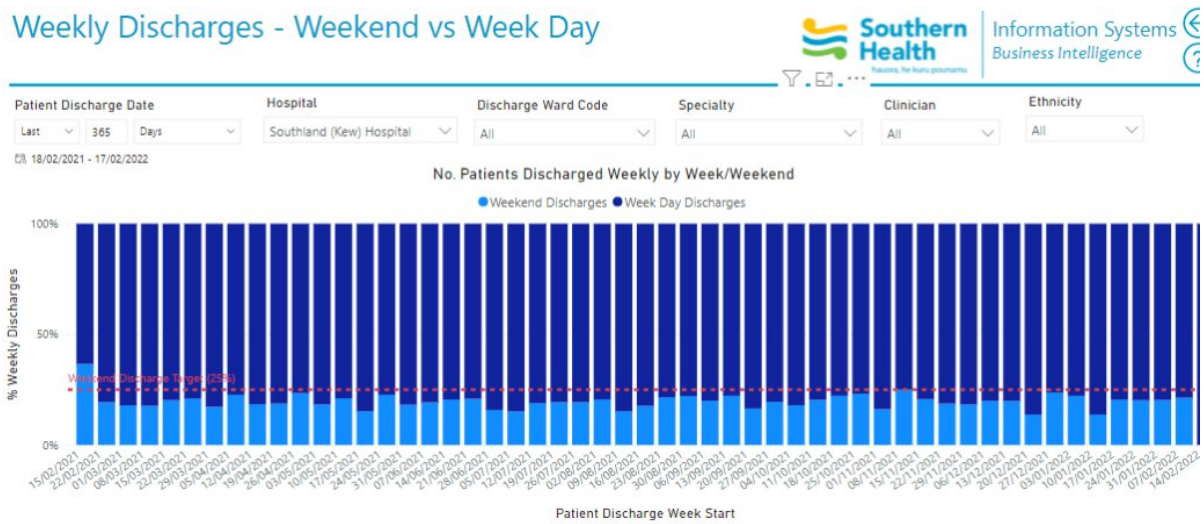
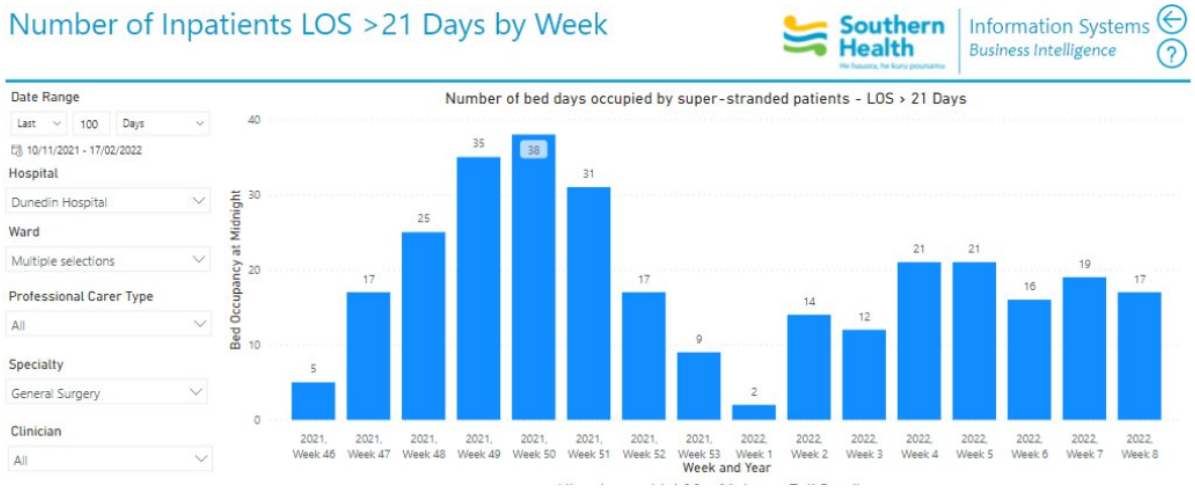


**Fig. 10 Dunedin – LOS >21 Days**



**FOR INFORMATION**

**Item:** Update on Southland Clinical Needs Analysis

**Presented by:** Simon Donlevy General Manager Southland/Deputy Chief Operating Officer

**Meeting of:** 02 March 2022

## Recommendation

**That the Board notes the update and associated paper**

## Purpose

**Update on progress**

## Specific Implications for Noting

1. Financial
2. Quality and Patient Safety
3. Operational Efficiency
4. Workforce
5. Equity
    - Engagement with Maori/Iwi providers has proved difficult and is an ongoing area of focus
6. Other

## Background

The Southland Clinical Needs Analysis project was commenced in October 2021 with the aim to create a clear pathway for the development of Southland Hospital over the next 10+ years considering the anticipated needs of the population across the Southern DHB region and changes in models of care over this period.

Sapere have been engaged to undertake this work including collecting the required data, engaging broadly with relevant stakeholders and the provision of a report detailing their analysis based upon their discovery work and associated analysis.

## Current Status

The project is currently still in the discovery phase with data continuing to be collected and ongoing face to face engagement meetings. Of note Sapere have faced difficulty getting traction engaging with Maori / iwi providers and engagement with individual general practices has not yet occurred these, alongside the gathering of additional clinical data, will be the areas of focus.

The overall status of the project is Amber and there have been some unanticipated delays in being able to access all necessary stakeholders and obtaining the necessary data has proven more difficult than assumed. We are actively engaging with Sapere and arranging a weekly meeting outside of

the steering group to resolve any barriers to accessing data are removed and that they are appropriately introduced to stakeholders that they need to engage. The May 2022 delivery date of the final document remains. The Board should note the new risk of the Sapere team concurrently working upon the Digital Solutions Business case for Southern DHB.

The detailed project status summary is included.

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# Project progress update: Southland clinical needs analysis

| | | | |
|---|---|---|---|
| **Project Name** | Southland clinical needs analysis | **Date of progress report** | 17 February 2022 |
| **Project Director** | David Moore | **Project start date** | October 2021 |
| **Case Manager** | Rebecca Rippon | **Project finish date** | April/May 2022 |

## Project Status

| | |
|---|---|
| **Overall this project is**[1]: **Amber** | **Explanation**: Prior to Christmas and in the new year, data collection and engaging a full range of providers has taken longer than anticipated. This is mostly due to the holiday period and COVID-19 planning, and particularly for primary care. We have had some feedback about 'review fatigue'.<br><br>We had a successful round of engagement prior to Christmas with the hospital services and clear themes are emerging. A de-brief on the engagement was held with the Steering Group in December.<br><br>Next steps:<br>• Continue working to engage general practices and Māori providers<br>• Develop a current state document that sets out the population profile (current and future), the baseline demographic-driven service volumes, and the key issues and opportunities identified in the engagement to date. **End February**.<br>• Escalate additional data requests where necessary (e.g. theatre data)<br>• Plan next round of engagement (future models) |

## Progress

| Stage | Completion | Progress | Comments/outputs completed |
|---|---|---|---|
| Horizon scan | February 2022 | 10% | Desktop review of emerging trends in healthcare commenced and plan to complete within the next 3 weeks. |
| Population analysis | December 2021 | 70% | Population estimates (locality level) and projections collected. Visitor numbers investigated. Initial population profiles complete and presented as part of engagement with services in December 2021.<br><br>Additional scenarios may be added subsequent to engagement with local authorities.<br><br>Social determinants to be compiled. |

[1] Green = High probability of success – on track
Amber = Requires active management to reduce risk and achieve scope
Red = Project in trouble – Unable to achieve agreed scope parameter

| Progress | | | |
|---|---|---|---|
| Burden of disease and intervention rates | February 2022 | 20% | Still in the process of gathering data. We met with Planning & Funding which has provided some data available on rates by TLA (council area).<br>National collections data to compare against other 'peer' hospitals (i.e. surgical casemix) is being requested via Canterbury DHB and MoH. This is behind schedule. |
| Clinical service volume projections | Baseline - December 2022<br>Modifications – March/April 2022 | 40% | Initial baseline projections completed and presented as part of engagement with services in December 2021.<br>Theatre data has been requested from SDHB to develop theatre requirement model – this request may need escalating. |
| Engagement | First round Dec 2021<br>Second round late Jan/early Feb<br>Third round late March/early April 2022? | 30% | A round of engagement was completed in December 2021 during which we met with:<br>• Southland Hospital:<br>  ○ AT&R (including NASC)<br>  ○ General Surgery, Urology, ENT<br>  ○ Orthopaedics<br>  ○ Paediatrics<br>  ○ General Medicine (Clinical Leader)<br>  ○ ED (Clinical Director & Charge Nurse)<br>  ○ Maternity – only one SMO was able to attend<br>• Lakes District Hospital leadership<br>Further interviews have been completed with:<br>• General Manager (previous & current) Southland Hospital<br>• Rural hospital lead<br>• WellSouth PHO (CEO & Director of Nursing)<br>• GM Māori Health<br>• Helen Telford (Chair Central Lakes Locality Network)<br>• Gore Health (CEO)<br>• Nigel Copson (business analyst)<br>• GM Planning & Funding and service analyst<br>It has been a difficult time to engage with Māori / iwi providers and general practice, over the Christmas and holiday period and given COVID-19 preparations. This will be a strong focus for the next couple of weeks.<br>Once we have completed additional benchmarking / intervention rate analysis and developed an initial theatre time model we anticipate a further site visit to re-engage with the services. |
| Clinical models of care | March 2022 | - | Work planned (and a focus of next engagement):<br>Investigate how service delivery models and models of care may need to change in future, considering demographic and population forecasts in the long term, and how this will impact the healthcare system and capacity implications (beds, theatres). |

| Progress | | | |
|---|---|---|---|
| Financial and workforce modelling | April 2022 | - | Work planned:<br>Modelling of workforce requirements (and potentially financial modelling). This will draw on existing work (e.g. Des Gorman/Health Workforce NZ). |
| Consultation and reporting | May 2022 | - | |

| Risks and mitigation | | |
|---|---|---|
| **Risk** | **Mitigation** | **Update** |
| Unavailability of data. | Use multiple sources if required (e.g. MOH data as well as DHB). | Initial service volume data provided by the DHB.<br>Theatre data is only available from the DHB's internal system and this has not been made available yet.<br>WellSouth has offered data – we need to follow up and determine what is available.<br>Statistics NZ population projections updated for small areas (but not by ethnicity yet).<br>Canterbury DHB are able to access national collections on SDHB's behalf.<br>Contacted MBIE and Queenstown-Lakes District Council to determine if any projections of visitor numbers available. |
| Unavailability of key stakeholders for meetings. | Ideally have long lead in times. Use clinical and executive leadership to engage people. Tap into existing forums if possible/appropriate. | Southland Hospital administrative support organised onsite meetings.<br>Some feedback about review fatigue and lack of capacity due to endemic COVID-19 planning (particularly from primary care).<br>Need another round of face-to-face engagement. |
| Competing expectations among key stakeholders can cause significant disruption to a project and compromise timeframes and overall buy-in. | Clear Terms of Reference to refer back to. Communication and a willingness to meet to discuss issues as they arise but with escalation via Steering Group if not resolved. | No issues identified to date. |
| Scope creep / emerging issues may detract from the timeframes and outputs. | Report up through a change control process any material changes to scope and negotiate a way forward. | No scope issues identified to date. |

## 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:**<br>a) Community and Public Health Advisory Committee<br>▪ Verbal report of 1 March 2022 meeting<br>b) Iwi Governance Committee<br>▪ Unconfirmed minutes of 31 January meeting<br>▪ Verbal report of 1 March 2022 meeting<br>c) Finance, Audit & Risk Committee<br>▪ Unconfirmed minutes of 1 February 2022 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. |
| **New Dunedin Hospital**<br>▪ Monthly Update<br>▪ Interprofessional Learning Centre Business Case | Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage | Sections 9(2)(i) and 9(2)(j) of the Official Information Act. |
| **Patient Flow Taskforce** | To allow activities and negotiations to be carried on without prejudice or disadvantage | Section 9(2)(j) of the Official Information Act |
| **Capex Approvals**<br>▪ Anaesthetic Machine Replacement/Upgrade<br>▪ ICU/HDU HVAC Remediation Works | 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. |
| **Māori Health 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. |
| **Data Sharing Agreement – WellSouth/Southern DHB** | To allow activities and negotiations to be carried on without prejudice or disadvantage | Section 9(2)(j) of the Official Information Act. |
| **Contract Approvals**<br>▪ Strategy Primary and Community<br>▪ Data Sharing Agreement – WellSouth/Southern DHB | 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. |
| **Information Items:**<br>▪ Rural Southland Murihiku Locality Prototype Proposal<br>▪ Operating Theatre Efficiency, Southland Hospital | To allow activities and negotiations to be carried on without prejudice or disadvantage | Section 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.