Southern DHB Board Meeting

By Zoom

05/04/2022 09:30 AM - 12:30 PM

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APOLOGIES

Apologies have been received from Andrew Lesperance, Executive Director Planning, Funding and Population/Public Health, and Fiona Pimm, Member, Interim Māori Health Authority.

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Board, 5 April 2022

Recommendation

That the Board receive and note the Interests Registers.

Purpose

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

Changes to Interests Registers since the last Board meeting:

- Mata Cherrington added
- Patrick Ng's entry updated

Background

Board, Committee and Executive Team members are required to declare any potential conflicts (pecuniary or non-pecuniary) and agree how these will be managed. A member who makes a disclosure must not take part in any decision relating to their declared interest.

Interest declarations, and how they are to be managed, are required to be recorded in the minutes and separate interests register (s36, Schedule 3, NZ Public Health and Disability Act 2000).

Appendices

- Board and Executive Leadership Team Interests Registers

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Pete Hodgson (Board Chair)	22.12.2020	Trustee, Koputai Lodge Trust (unpaid)	Mental Health Provider	
	22.12.2020	Chair, Callaghan Innovation Board (paid)		
	22.12.2020	Chair, Local Advisory Group, New Dunedin Hospital		
	22.12.2020 (updated 26.08.2021)	Ex-officio Member, Executive Steering Group, New Dunedin Hospital		
	22.12.2020	Board Member, Otago Innovation Ltd (paid)		
	25.02.2021	Board Member, Quitta Ltd (unpaid)	Nicotine replacement therapy under development.	
Peter Crampton (Deputy Board Chair)	16.04.2021	Employment: Professor, Kōhatu Centre for Hauora Māori, University of Otago (appointed July 2018)		
	16.04.2021	Member, Health Quality and Safety Commission Board (appointed April 2020)		
	16.04.2021	~~Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)~~	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.	
	24.02.2022	Representative, Southland Inter-Agency Forum	No foreseeable conflict apart from advocacy.	
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	12.01.2021	Nga Kete Matauranga Pounamu Trust Board Member		
Jean O'Callaghan	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	
	26.08.2021	Idea Services Board of IHC	Possible conflict with contracts and service delivery models.	
Tuari Potiki	09.12.2019	Employee, University of Otago		
	09.12.2019	Chair, Te Rūnaka Otākou 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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	21.01.2020 (updated 02.06.2021)	Clinical Advisor to the Board, Waikato DHB		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	Advisor to Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020 (Updated 28.01.2021)	Chair, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		
	18.06.2021	Treasury: Health Reform Challenge Panel		
	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	
Mata CHERRINGTON	18.03.2022	Chair, Community Trust South	Nil
		Associate, Centre for Social Impact	Nil
		Director, Hiringa Oranga o Awarua Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
		Director, MATA Consultancy Ltd	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

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017 (updated 26.08.2021)	Ex-officio Member, Executive Steering Group, New Dunedin Hospital	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
	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~~	Removed 10.03.2022
	10.03.2022	Daughter is a junior doctor at Middlemore Hospital and is undertaking a PhD.	PhD is in the field of general surgery and may involve engagement with general surgeons at SDHB in coming years.
	23.07.2020	~~Wife, Chief Data Architect, Inde Technology~~ - resigned (updated 10.03.2022)	Inde is part of WSP's Digital Health Collective, the consultancy service supporting the NDH Digital Infrastructure and Digital Facility Services

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	10.03.2022	50% shareholder in wife's company *Ava Technology Solutions Limited*	Will avoid engaging with Southern Health system and the only health businesses that will be pursued will be private entities. No approach to public health will be made without the express pre-approval of the future HNZ and with the potential for conflicts noted. She will also expressly avoid recruiting from the Southern Health System.
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	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Minutes of the Southern District Health Board Meeting

Wednesday, 2 March 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	*(until 2.18 pm)*
	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 Capability
	Mr Hamish Brown	Acting Chief Operating Officer
	Ms Mata Cherrington	Chief Māori Health Strategy and Improvement Officer
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	Prof John Eastwood	Chief Medical Officer
	Dr David Gow	Chair, Clinical Council
	Ms Toni Gutschlag	Executive Director Mental Health, Addictions and Intellectual Disability
	Mr Andrew Lesperance	Executive Director Planning, Funding and Population/Public Health
	Dr Hywel Lloyd	Director Quality and Clinical Governance Solutions *(from 9.30 to 10.00 am)*
	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

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

Apologies were received from Ms Fiona Pimm, member of the interim Māori Health Authority, and Ms Amy Adams, member of Interim Health NZ.

3.0 DECLARATION OF INTERESTS

The Interests Registers (tab 2) were noted with the addition of Southland Inter-Agency Forum to Mrs Kaye Crowther's entry.

The Chair asked that any other 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 OMICRON UPDATE

The Board received a verbal update from Dr Hywel Lloyd, Director of Quality and Clinical Governance Solutions and Southern DHB's Emergency Co-ordination Centre (ECC) Controller.

Dr Lloyd reported that:

- There had been 582 new COVID cases reported in the Southern district the previous day.
- There were just over 5,000 active cases in the district, however there was likely to be under-reporting of new cases due to the shift to rapid antigen tests (RATs), which relied on self-reporting into My COVID Record.
- There were cases throughout the district but the hotspots were Dunedin, followed by Queenstown.
- Public Health's focus had shifted to high risk exposure events and they were doing less contact tracing.
- WellSouth reported that there was a national issue with supply chains, and they had some initial teething trouble receiving RATs, but they now had good supplies and distribution was flowing well.
- Testing centres remained busy, with steady attendance. There had been an issue with PCR test processing capacity but the shift to RATs had eased the pressure on the laboratory system.
- The Ministry of Social Development (MSD) reported they were managing well. They had to shift some resources to support the Auckland surge but were not under great pressure with local welfare.
- Within Southern hospitals, there was only one positive COVID case in Southland Hospital and that patient was not admitted due to COVID. There had been three COVID patients in Dunedin Hospital, all of whom had been discharged.
- There were no COVID cases or issues in the rural hospitals or the Mental Health service.
- Support was being provided to residential aged care facilities who had been reporting positive cases amongst their staff. There had been one exposure event in a Dunedin facility, where 20 residents out of 26 had tested positive. The cases were being managed in the facility and the residents were doing okay.
- There had also been an episode in the community, with a support worker and client testing positive.

  Dr Lloyd advised that such events were likely to become more common as the COVID outbreak spread.

Following his briefing, Dr Lloyd responded to questions on positive test rates, the strains of COVID in the community, management of COVID patients, and the recovery of elective services after the COVID outbreak had peaked.

The Executive Director People and Capability (EDP&C) briefed the Board on the 'four pillars' of workforce initiatives under way.

1. Mobilising the community to support the Southern health system. In conjunction with Business South, an initiative called *Southern Heroes* had been launched where organisations could volunteer and be linked to Southern health providers in need of help, eg Workforce Central for the New Dunedin Hospital helped WellSouth break up RAT packs at the weekend.

   Southern DHB had also joined forces with Volunteer South, who would co-ordinate individuals who wanted to help.

2. Redeploying Southern DHB staff internally and providing external clinical support as needed, eg some Registered Nurses had gone to support one of the aged care facilities. Staff would be mobilised according to priority, with Māori and Pasifika being a high priority, followed by midwifery and aged care.

   Management were looking at which services could be switched off if necessary so support could be put into mitigating risk in higher need areas.

3. Supporting Southern DHB's partners, including GP practices, particularly in rural communities, eg through telehealth.

4. Looking after the welfare needs of staff to ensure they were well and able to respond.

In addition, the Chief Nursing and Midwifery Officer reported that management were working closely with lecturers at Otago Polytechnic and the Southland Institute of Technology (SIT) who were willing to support students in place, and virtual support was being provided to rest homes by geriatricians and respiratory specialists.

The Chair advised that the Board would be receptive to management proactively backfilling positions with part-time or retired staff if they felt the need, noting that this would be a budgetary consideration.

5.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the Board meeting held on 2 February 2022 be approved and adopted as a true and correct record."

K Crowther/L Kelly

6.0 ACTION SHEET

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

- *Māori Workforce* – The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) and EDP&C had conducted interviews for a Māori Workforce Development Specialist and an appointment was being progressed. Māori workforce issues had been discussed with the Iwi Governance Committee the previous day.

  It was agreed that this item could be removed from the Board action sheet.

- *People and Capability Data* – The workforce dashboard had been delayed due to the COVID response.

- *Policies* - This action had also been delayed due to COVID endemic planning.

- *District Head of Department (HoD) for Intensive Care* – This action was complete. The Dunedin team were currently in Southland working with the

Critical Care team and a procurement process was being worked up for a digital solution to enable Intensive Care to operate as a single service across the district.

- *Performance and Accountability Framework* – It was noted that this action was complete and monthly reports would be submitted to the Board.

7.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The Board received the following verbal synopsis of the Community and Public Health Advisory Committee (CPHAC) meeting held on 1 March 2022 from Mr Tuari Potiki, Chair of CPHAC.

The Committee received:

- Updates on Planning, Funding and Population/Public Health activity and Māori Health;
- A verbal report from the WellSouth CEO on GP recruitment and sustainability within the district;
- Presentations on Health Needs Assessment and an evaluation of the implementation of the Primary and Community Care Strategy.

Disability Support Advisory Committee

The Board received a verbal report from A/Prof Moana Theodore, Chair of the Disability Support Advisory Committee (DSAC), on the DSAC meeting held on 1 March 2022, during which she advised the Committee received:

- An update on patient stories and their refresh, noting their importance internally for staff;
- A report from John Marrable, Chair of the Disability Working Group, on a range of issues, including health passports and their thinking for creating a portable version for people living with disabilities;
- A report in response to concerns raised by Southland Board members on behalf of Parent to Parent Southland, a group of parents raising children with disabilities. The Committee noted the report and endorsed the approach of direct engagement between Southland Board members and Parent to Parent to address the issues raised.
- The Committee also received updates on COVID vaccination rates for people living with disabilities and changes to accessibility and mobility parking around Dunedin and Southland Hospitals.

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee (HAC) meeting held 1 February 2022 (tab 6.3) were taken as read and Mrs Jean O'Callaghan, HAC Chair, took questions.

It was noted that the statement on page 3 of the draft minutes that 71% of patients not admitted to ED could be cared for elsewhere did not appear to be accurate.

8.0 EY ONCOLOGY REPORT

Blair McLaren, Clinical Director Medical Oncology, Shaun Costello, Clinical Director Radiation Oncology, Therese Duncan, Nurse Manager, and Phil Witchall, Service Manager, Southern Blood and Cancer Service, were welcomed to the meeting for this item.

The Board considered a report from EY on the Southern Blood and Cancer Service (SBCS) and a recommended three-year action plan for SBCS (tab 7).

Dr McLaren reported that two new Medical Oncologists had commenced that week and a new Radiation Oncologist and Haematologist had joined SBCS in the preceding months. This was a significant improvement for the service but more investment was required as per the roadmap of recommendations on page 7 of the EY report.

The CEO reported that the investment identified in the EY report was included in the draft 2022/23 budget to be discussed with Health NZ. The investment for Year 1 was estimated to be circa another $1 million.

The CEO noted that, in comparison to other blood and cancer services, SBCS had a significant outreach service but retrenching that to bring it into line with other centres would be a retrograde step.

It was resolved:

> **"That the Board approve and adopt the EY report *Southern Blood and Cancer Service Action Plan* and request that management draw attention to this when engaging with Health NZ on the 2022/23 budget for the region."**
>
> L Soper/T Potiki

The Board thanked SBCS staff for their attendance and wished them well.

9.0 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.

Health System Reforms

- No further substantive detail had been received on the Health System Reforms but it was expected that the tier 2, and possibly tier 3, structure for Health NZ would be released in the following couple of weeks.
- A `business as usual' 2022/23 budget for the district had been submitted and a preliminary high level review meeting held with Health NZ.

Key Appointments and Recruitment

- The CEO was delighted to welcome Mata Cherrington, Chief Māori Health Strategy and Improvement Officer, and Toni Gutschlag, Executive Director Mental Health, Addictions and Intellectual Disability, to the Executive Leadership Team.
- To date, recruitment to the Executive Director Communications position, had been unsuccessful.

- Prof John Eastwood's Acting Chief Medical Officer (CMO) role had been extended to 31 August 2022 and a process would commence to appoint a permanent CMO.
- The secondment of Hamish Brown to the Acting Chief Operating Officer role had been extended to the end of September 2022.
- The Chief Operating Officer's team was now largely in place.

Emergency Departments

- The Dunedin Emergency Department (ED) Provisional Improvement Notice (PIN) had been cancelled.
- There was also pressure on Southland ED.

Industrial Action

- Medical Physicists had issued several strike notices throughout the country and the Public Service Association (PSA) was planning nationwide strike action by Allied Health, Public Health and Technical staff.

Ministry of Health/HealthCERT Certification Audit 2021

- Certification to Provide Certain Health Care Services had been received for three years.

Strategic Briefing for the Southern Health System

The CEO proposed that consultation on the *Strategic Briefing for the Southern Health System* be held digitally by either a pre-recorded message from the Chair of the group, Iwi, himself and others, or via webinar sessions.

Prof Crampton, Chair of the Strategic Briefing Steering Group, stated his support for proceeding with virtual engagement to meet the Board's obligation to hand over a strategic briefing that had been consulted on.

10.0 FINANCE AND PERFORMANCE

Financial Report

The Executive Director Corporate Services (EDCS) presented the financial results for the period ended 31 January 2022 (tab 8.1), In doing so he advised that:

- The key categories of budget variance (pharmaceuticals, outsourced clinical services, air ambulance, and ICT and software) would continue throughout the financial year and management were looking at whether these could be offset or reduced.
- If accounts payable and capital expenditure were caught up, the year-end cash position would be worse than that shown in the Statement of Cashflows. An updated forecast would be submitted to the Finance, Audit and Risk Committee's April meeting.

Volumes Report

The Acting COO presented the volumes report for the year to 31 January 2022 (tab 8.2), noting that:

- Medical caseweights were up and surgical caseweights down for the month. For the year to date medical caseweights were up 6%, offset by surgical caseweights, which were about 5% down;
- Elective surgical caseweights were about 715 behind, with 550 of those attributed to COVID. A slight improvement was forecast for February.

The Acting COO advised that most of the under-delivery related to access to beds, which was affected by workforce availability. Although nursing numbers had improved, it was anticipated that Omicron related sick leave would have an impact.

Productivity

Members expressed concern about the level of productivity, in particular the reduction in elective surgery, and the impact of that on patients.

In summarising the discussion, the Chair noted that the Board was mindful of the potential impact of COVID, however reduced productivity was a persistent issue, and it was clear something needed to be done to address it. The Board still had three months left in office and wished to see some progress during that time, and would be revisiting the issue at its next meeting.

The CEO informed the Board that management should be able to provide clarity on Care Capacity Demand Management (CCDM) and visibility of capacity for the April meeting. To this end he had:

- Asked the Chief Nursing and Midwifery Officer, Chief Operating Officer and Executive Director Corporate Services to provide their collective position on Care Capacity Demand Management (CCDM), and
- Requested that visibility of bed closures be reported on manually immediately and IT develop an electronic reporting system.

In addition, the CEO advised that some structured qualitative research could be undertaken concurrently, possibly with the assistance of the University of Otago.

Quality Dashboard

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

Dr Gow, Chair of the Clinical Council, informed the Board that it was not clear whether performance was benchmarked against external or internal data and he had raised this issue with the Director Quality and Clinical Governance Solutions and the Quality and Performance Improvement Manager.

Dr Gow responded to members' concerns about the quality indicator trendlines and what the Clinical Council was doing to address these.

Performance

The performance dashboard report for January 2022 (tab 8.4) was taken as read.

Performance and Accountability Framework

A report on embedding the Southern Performance and Accountability Framework (tab 8.5) was taken as read.

11.0 STRATEGIC CHANGE PROGRAMME

An update on the Strategic Change Programme, which included initiatives contributing directly to the new Dunedin Hospital (tab 9), was taken as read.

12.0 CARE CAPACITY DEMAND MANAGEMENT (CCDM)

The Board received and noted an update from the Chief Nursing and Midwifery Officer (CNMO), Chief Operating Officer (COO) and Executive Director Corporate Services (EDCS) on Care Capacity Demand Management (tab 10).

13.0 PRESENTATIONS

Clinical Council

The Board received a presentation from Dr David Gow, Chair of the Clinical Council (tab 12.2), which included an update on the Council's leadership and membership, and its key areas of focus:

- Clinical governance oversight across the system
- Clinic governance policy
- Identifying and preventing hospital associated complications
- Managing risk
- Monitoring consumer engagement and promoting equity
- Implementing system improvements and sponsoring projects

Dr Gow then responded to questions on the Council's work plan.

The Board noted the importance of the Council's work, particularly during the transition to Health NZ, and thanked Dr Gow for his update.

Midwifery

The Board received a presentation from Karen Ferraccioli, Director of Midwifery, on the *SDHB Midwifery Workforce – key challenges and opportunities* (tab 13.2). This included a profile of the national midwifery workforce, an overview of Southern DHB's maternity services, and the work undertaken by Ms Ferraccioli to set up a midwifery framework since taking up her role in November 2021.

During her presentation Ms Ferraccioli advised that:

- Southern had a good number of independent Lead Maternity Carers (LMCs) compared to other DHBs, and only a couple more were required in Dunedin to close the outreach maternity service. The LMC model of care, together with the rural trusts and lower birth rate in Southern, meant SDHB employed fewer midwives than other DHBs.

- Across the Board, midwives were under stress. Despite this, Southern DHB midwives had a longer length of service than other DHBs, which showed the resilience and dedication of the team.

- The key workforce challenges and opportunities included:
  - Leadership: structure, model, career pathway
  - Staffing shortage
  - Skill mix issues

- LMCs and Primary Care
- Work environment and culture

Ms Ferraccioli was thanked for her presentation and the initiatives she was leading.

When available, the Board requested comparable data on the total number of midwives (DHB and LMCs) per birth, or number of women of reproductive age, to give the full picture across Southern DHB.

Patient Flow Taskforce

Ms Megan Boivin, Patient Flow Operations Manager, Dunedin, was welcomed to the meeting.

An 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) (tab 12.3) was taken as read and Ms Boivin outlined her new role and the work she was progressing. This included:

- Preparing a paper for the Chief Operating Officer on the development of an Integrated Ops Centre on the Dunedin site; phase two being the Southland site;
- Participating in a Ministry of Health weekend discharge pilot;
- Criteria led discharge;
- Joining rapid rounds in the morning and monitoring what happened following those at several points during the day.

Ms Boivin advised that:

- An 0.2 FTE Internal Medicine Physician and a House Officer would be joining the team;
- Support was required from the Information Systems team to extract data and present it in a useful way.

The Chair expressed the Board's support for the work Ms Boivin was undertaking and requested an update for the April or May meeting.

14.0 SOUTHLAND CLINICAL NEEDS ANALYSIS

The Board received a progress report on the Southland clinical needs analysis being undertaken by Sapere (tab 13.1).

The CEO acknowledged the clear message there was no tolerance for not having the clinical needs analysis completed and presented to the Board in May.

PUBLIC EXCLUDED SESSION

***At 12.58 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Community and Public Health Advisory Committee ▪ Verbal report of 1 March 2022 meeting b) Iwi Governance Committee ▪ Unconfirmed minutes of 31 January meeting ▪ Verbal report of 1 March 2022 meeting c) Finance, Audit & Risk Committee ▪ 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 ▪ Monthly Update ▪ 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 ▪ Anaesthetic Machine Replacement/Upgrade ▪ 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 ▪ Strategy Primary and Community ▪ 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.

L Soper/K Crowther

The meeting closed with a karakia at 4.30 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 25 March 2022

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2021	**Southland Site Planning** (Minute 9.0)	Master plan identifying issues and future needs relating to facilities at Southland Hospital to be developed.	CEO	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.	
Feb 2022	(Minute 5.0)	GM Southland to provide Southland Board members with an update following his return from leave.	GM Southland	Sapere are still undertaking discovery work and engaging with appropriate stakeholders.	
March 2022	(Minute 13.0)	Southland Clinical Needs Analysis to be submitted to May Board meeting.	COO		May 2022
May 2021	**Quality Dashboard** (Minute 8.0)	Calibration points (expected norms or standards) and an equity lens (Māori, Pacifika, etc) to be added to the quality graphs, along with management or Clinical Council comment.	DQCGS	Requires further work from IT.	In progress.
June 2021	(Minute 6.0)	Completion date to be supplied for adding calibration points.	DQCGS		Completed
Dec 2021	(Minute 9.0)	Health Roundtable data to be added to routine reporting to benchmark Southern's performance, including the areas where it performs well.	DQCGS		Completed
March 2022	(Minute 10.0)	Clarification to be provided whether benchmarking is against external or internal data.	DQCGS		Completed

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
August 2021	**People and Capability** (Minute 8.0)	Comparative data from other DHBs on staff churn and vacancy rate to be provided.	EDP&C	Dashboard included in Finance, Audit and Risk Committee documents.	Completed
November 2021	**Workforce Dashboard** (Minute 13.0)	▪ Disability and diversity data by directorate to be included in the workforce dashboard. ▪ 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~~ June 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	Included in agenda.	April 2022
Oct 2021	**Te Kaika Health and Wellness Hub** (Minute 9.0)	Lease approval to be sought from the Minister.	CMHS&IO CEO		
Sept 2021	**Māori Health – Actions to Address Amenable Mortality and Conditions** (Minute 24.0)	Monthly reports to be submitted to Board.	CMHS&IO		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	**Productivity** (Minute 9.0)	Analysis to be submitted to the February Hospital Advisory Committee meeting.	EDCS COO		April 2022
Feb 2022	(Minute 5.0)	To be a standing HAC agenda item.	COO		

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
March 2022	(Minute 10.0)	Progress to be reported monthly to Board.	CEO		
March 2022	**Midwifery** (Minute 13.0)	Comparable data to be provided on total number of midwives (DHB+LMCs) per birth, or no. of women of reproductive age, to give the full picture for SDHB.	CN&MO	Awaiting further data.	May 2022

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Tuesday, 1 March 2022, commencing at 1.00 pm, by Zoom

Present:	Mr Tuari Potiki	Chair
	Dr Moana Theodore	Deputy Chair
	Prof Peter Crampton	
	Mrs Kaye Crowther	
	Dr Doug Hill	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr John Chambers	Board Member
	Mrs Jean O'Callaghan	Board Member
	Ms Lesley Soper	Board Member
	Mr Roger Jarrold	Crown Monitor *(from 1.13 pm)*
	Mr Chris Fleming	Chief Executive Officer
	Mr Andrew Lesperance	Executive Director Planning, Funding and Population/Public Health
	Ms Mata Cherrington	Chief Māori Health Strategy and Improvement Officer
	Prof John Eastwood	Chief Medical Officer
	Ms Toni Gutschlag	Executive Director Mental Health, Addictions and Intellectual Disability
	Mr Andrew Swanson-Dobbs	Chief Executive, WellSouth Primary Health Network
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer/Acting ED MHAID
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

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

A special welcome was extended to Mr Andrew Lesperance, Executive Director Planning, Funding and Population/Public Health, who was attending his first CPHAC meeting.

2.0 APOLOGIES

Apologies were received from Dr Ben Pearson, Crown Monitor, Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer, and Ms Jane Wilson, Chief Nursing and Midwifery Officer.

An apology for intermittent departures during the meeting was received from the Chief Executive Officer.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 6 December 2021 be approved and adopted as a correct record."

T Potiki/L Kelly

5.0 MATTERS ARISING

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

6.0 REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 6).

Opioid Substitution Treatment

The Acting Executive Director Mental Health, Addictions and Intellectual Disability (MHAID) reported that the Board had supported additional investment in MHAID services. As part of that, the recently appointed Executive Director MHAID was having discussions with the sector to strengthen community based addiction services and the referral base of the Specialist Addiction Service was being restructured.

The Executive Director MHAID reported that she had engaged with the Specialist Addiction Service and other AOD service providers in Dunedin, and an opportunity to establish a new service in the community was being explored.

It was agreed that this matter could be removed from the action sheet, as updates on AOD would be included in Mental Health *Time for Change* reports to each CPHAC meeting.

Autism Spectrum Disorder (ASD)

The Acting Executive Director MHAID reported that he had asked the team to drill down into the data supplied for ASD, as it did not appear to be accurate, and a report would be submitted to the next meeting.

The Chief Medical Officer (CMO) advised that ASD was predominantly diagnosed by Paediatricians. The South Island Alliance, Ministry of Education, and University of Otago were also suggested as useful sources of information.

Mr Roger Jarrold, Crown Monitor, joined the meeting at 1.13 pm.

It was suggested that data on the prevalence of all developmental and behavioural disorders, including AHD and alcohol spectrum disorder, would also be useful in assessing whether the needs of whānau were being met.

Dental General Anaesthetic Waiting List

The Executive Director, Planning, Funding and Population/Public Health (EDPF&P/PH) presented an update on the recommended process to manage children overdue for their scheduled examinations on the Paediatric General Anaesthetic Sedation Waiting List, currently managed by the Faculty of Dentistry (FoD), University of Otago (tab 6), and advised that a full report would be submitted to the May 2022 meeting.

In response to questions about consultation on the dental contract and provision of information to referrers, the CEO advised that:

- Renewal of the contract would probably come to the Board for approval, as it was likely to be outside his delegated authority to approve, and would include an explanation of how the position was arrived at and who had been involved;
- He would ask the Chief Digital Officer to investigate whether it was possible for SDHB clinicians to receive information on patients they refer to the Faculty of Dentistry via HealthConnect South.

  The Chief Medical Officer (CMO) also advised that he would consider including this matter in the Discharge Summary Project.

The Chair highlighted the importance of consulting the people who interact with the FoD service early in the contract renewal process.

7.0 PLANNING, FUNDING AND POPULATION/PUBLIC HEALTH REPORT

The Planning, Funding and Population/Public Health Report (tab 7) was taken as read and the Executive Director, Planning, Funding and Population/Public Health (EDPF&P/PH) highlighted the following items.

- *COVID Management* – So far, the Omicron outbreak was being managed reasonably well, with the PHO and Māori providers doing a great job.
- *Vaccination Programme* – The Ministry of Health was pushing to have measles, mumps and rubella (MMR) vaccinations boosted over the next couple of months.

  The EDPF&P/PH commended Nancy Todd's efforts to increase Māori vaccination rates.

Dr Hill reported that the change to Rapid Antigen Tests (RATs) had been a beneficial change for primary care, as it allowed them to focus more on treating their unwell patients, instead of routine testing. There was widespread COVID amongst students and he suspected the numbers were higher than being reported. The concern was when COVID moved into the older population, however general practices were coping for now.

The Chair reported that the University of Otago had just under 1,000 active COVID cases in its colleges. A plan was in place to manage this, and a network of volunteers were delivering kai and supplies to affected students.

Mr Swanson-Dobbs, CEO, WellSouth, informed the Committee that WellSouth was in constant contact with general practices and were surveying them twice a week to ensure they had capacity to cope. The PHO, DHB and Public Health were working well together to ensure a joined up response to the COVID outbreak and a lot of work had been undertaken with Māori health providers to increase capacity for swabbing.

Mr Swanson-Dobbs reported that the COVID Care in the Community Clinical Network had at least 3,500 people in its system, with the majority opting for self-management.

In response to questions about the Ministry of Social Development's welfare assistance, Mr Swanson-Dobbs and the EDPF&P/PH advised that there had been no issues reported within the district.

Mr Swanson-Dobbs noted the impact of COVID on the Pacifika community and recommended that the CPHAC agenda include a standing item on Pacifika health.

Management then responded to questions on COVID vaccination status reporting, immunisation, access to N95 masks for the Home and Community Support Services (HCSS) workforce, Māori PHO enrolment rates, service planning, aged residential care bed numbers, and the location of CT scanners within the district.

8.0 MĀORI HEALTH UPDATE

An update on the Māori Health Directorate work programme and Māori primary care enrolment (tab 8) was taken as read.

Mr Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer (CMHS&IO) and Acting Executive Director Mental Health and Intellectual Disability (MHAID), introduced Mata Cherrington, who was taking on the Māori Health part of his role. Mr Taurua also expressed his gratitude to Toni Gutschlag, who had come on board as the Executive Director MHAID.

The CMHS&SIO reported that a very positive Iwi Governance Committee meeting had been held that morning, with full representation from the seven Rūnaka in attendance. He then highlighted the appointments that had been made as part of addressing Māori amenable mortality and endorsed the WellSouth CEO's comments about Pacifika health.

The CEO WellSouth reported that WellSouth:

- Had been working closely with the Māori Health Directorate and held weekly meetings with Pasifika leaders within the district;
- Had employed a number of young Māori and Pasifika who were phoning people to encourage them to get vaccinated;
- In collaboration with Public Health, they had a number of Māori and Pasifika navigators to ensure COVID positive people in the community were connected and their needs were being met.

On behalf of CPHAC, the Chair acknowledged Mr Taurua's incredible work across the DHB and PHO during his time as Chief Māori Health Strategy and Improvement Officer and the progress that had been made under his leadership when he took on the Acting Executive Director Mental Health and Intellectual Disability role. The Chair also expressed the Committee's gratitude to Mr Taurua for the arrangements he had put in place to carry the organisation forward.

The Chair acknowledged the work that had gone into achieving a 90% COVID vaccination rate for Māori across the district.

The Board Chair commended the PHO on employing Māori and Pasifika staff. He noted that the tertiary institutions within the district trained a lot of Māori students but the DHB had not been good at recruiting them.

9.0 PHO PERFORMANCE UPDATE

A report on primary care performance (tab 9) was taken as read and the EDPF&P/PH highlighted that Invercargill doctors were now providing free after-hours primary care for under 14 year-olds. The role of the PHO and Community Health Council in achieving this significant milestone was acknowledged.

The EDPF&P/PH and CEO, WellSouth, responded to questions on ambulatory sensitive hospitalisations and the percentage of the diabetic population who had a HbA1c measurement in the past year.

The Committee requested information on the number of Invercargill GP practices that still had a surcharge for under 14 year-olds.

GP Recruitment and Sustainability

The Committee received a verbal update from the Chief Executive, WellSouth Primary Health Network on GP recruitment within the district, during which he reported that:

- An Auckland GP had been recruited to work for the partnered primary care service in Invercargill, however when the borders opened he decided to go overseas.
- During 2021 General Practice in the Southern district did 1.1 million consults, which was 45,000 more than the previous year.
- There was a shortage of GPs and a report produced by the Royal College of General Practitioners late last year show a burnout rate of up to 30%.
- GPs intending to retire in the next five years was 31% and in the next ten years 49%.
- This highlighted the need to review the General Practice model of care and structures, and to incentivise doctors to work in primary care.

10.0 HEALTH NEEDS ASSESSMENT

Mr Talis Liepins, Planning and Accountability Manager, and Dr Anu Shinnamon, Public Health Registrar, joined the meeting and presented the Southern Health Needs Assessment to the Committee.

The presentation included an overview of the background and purpose of the Health Needs Assessment (HNA), the scope of the project and its current state, and an illustration of the information that could be found on the HNA website https://www.southernhealth.nz/about-us/health-profile (tab 10).

Mr Liepins and Dr Shinnamon responded to member's questions on the HNA and were congratulated on their work.

11.0 EVALUATION OF THE IMPLEMENTATION OF THE PRIMARY AND COMMUNITY CARE STRATEGY

Dr Carol Atmore, Medical Director, WellSouth, and Dr Patti Napier, Strategy Evaluation Lead, Quality and Performance, Southern DHB, presented a report on the findings from a mid-point evaluation of the following projects that form part of the Primary and Community Care Strategy implementation: Consumer Led

Integrated Care (CLIC), Home Team, Health Care Homes, Locality Networks, and Community Health Hubs (tab 11).

Drs Atmore and Napier responded to questions on the 'Ko Awatea of the South' concept, the future direction of primary care, the Central Otago Locality Network, and CLIC programme.

Dr Atmore extended an invitation to Committee members to attend the next colloquium, scheduled for 10 May 2022, presenting the findings from the projects included in the evaluation of the implementation of the Primary and Community Care Strategy.

Drs Atmore and Napier were thanked for their presentation.

12.0 FINANCE REPORT

A report on Planning, Funding and Population/Public Health financial performance to 31 January 2022 (tab 12) was taken as read. The EDPF&P/PH commented on the variances, then responded to questions.

The Crown Monitor requested that the EDPF&P/PH liaise with the Executive Director Corporate Services (EDCS) to improve the coherency of the CPHAC financial report.

PUBLIC EXCLUDED SESSION

It was agreed that confirmation of the 'in committee' minutes of the previous meeting be carried over to the May 2022 meeting.

The meeting closed at 3.30 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board

Minutes of the Disability Support Advisory Committee meeting held on Monday, 1 March 2022, commencing at 3.30 pm, by Zoom

Present:	Dr Moana Theodore	Chair
	Mrs Kaye Crowther	Deputy Chair
	Dr John Chambers	
	Prof Peter Crampton	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Mr John Chambers	Board Member
	Mrs Jean O'Callaghan	Board Member
	Miss Lesley Soper	Board Member *(from 4.18 pm)*
	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer *(until 4.30 pm)*
	Dr Hywel Lloyd	Director Quality and Clinical Governance Solutions
	Ms Mata Cherrington	Chief Māori Health Strategy and Improvement Officer
	Mr Andrew Lesperance	Executive Director Planning, Funding and Population/Public Health
	Prof John Eastwood	Chief Medical Officer
	Mr John Marrable	Chair, Disability Working Group
	Mr William Robertson	Consumer Experience Manager
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer/Acting Executive Director MHAID
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

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

A special welcome was extended to Mata Cherrington, newly appointed Chief Māori Health Strategy and Improvement Officer, who was attending her first Disability Support Advisory Committee meeting. A round of introductions followed.

2.0 APOLOGIES

Apologies were received Mr Tuari Potiki and Ms Paula Waby.

An apology for an early departure was received from the Chief Executive Officer (CEO).

3.0 DECLARATION OF INTERESTS

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

Mrs Kaye Crowther informed the Committee that she had added her membership of the Southland Inter-Agency Forum to the Register.

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 6 December 2021 be approved and adopted as a correct record."

M Theodore/K Crowther

5.0 MATTERS ARISING

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

6.0 REVIEW OF ACTION SHEET

The Committee received the action sheet (tab 6).

The Director Quality and Clinical Governance Solutions (DQ&CGS) reported that:

- The patient stories would be updated;
- Setting up two factor authentication for Board and Committee members to enable them to access the on-line staff disability awareness training was proving problematic, so other options were being explored.

The Chair requested that:

- If it was not possible to give members access to the disability awareness training module, it be covered in a presentation to the next meeting;
- An update on an internal directory of community services for people living with disability be provided for the next meeting;
- That an update on the Disability Strategy Action Plan be included in the next agenda;
- All actions be closed off at the May meeting.

7.0 CHAIR'S UPDATE

The Chair:

- Noted that the last meeting of the Disability Support Advisory Committee would be held in May 2022 and invited members to consider how the Committee's advice could ensure work to implement the Southern Disability Strategy continued following the change to Health NZ;
- Reminded members that the vision of the Southern Disability Strategy was that, "*Within the southern district all disabled people, tāngata whaikaha, and Deaf people will have an equal opportunity to achieve their best possible health outcomes, enabling their participation within their community. Health and*

disability support services will recognise the agency of disabled people, tāngata whaikaha, and Deaf people and their family or whānau through responding to their diverse requirements and removing disabling barriers."

8.0 PATIENT STORY REFRESH

The Chair noted that the Committee had seen several patient stories and informed members that the ones left were of poorer viewing video quality.

The Consumer Experience Manager reported that it was intended to refresh the stories by reviewing consumer feedback, both positive and negative, and identifying good stories that could be packaged into 'bite sized' pieces for internal learning opportunities using a wide range of media.

The Committee supported the use of patient stories for educational purposes and to set the scene for discussion. It was suggested that a link to the stories be put on Pulse (the SDHB staff intranet), so staff could access them easily.

9.0 DISABILITY STRATEGY AND ACTION PLAN IMPLEMENTATION

Mr John Marrable, Chair of the Disability Working Group (DWG), presented an update on DWG activity (tab 9), during which he commented on the following items.

- As well as the COVID situation, the DWG had been focused on the Health Passport, with a view to finding a practical solution that worked for everyone. This included investigating an IT solution, possibly using a credit card-sized card that would link into information stored on SDHB's patient management system.
- A representative from Invercargill would be joining the DWG the following week.

Mr Marrable then responded to questions on telehealth appointment times, health passports, ensuring the voice of the people and their whānau are heard, and the DWG membership.

The Committee discussed the question of governance oversight of the Southern Disability Strategy implementation work and how it would be taken forward into the new Health system and the Ministry for Disabled People when it is established. The DQ&CGS gave an assurance that Mr Marrable's work would continue when the Disability Support Advisory Committee finished and people within the Health system would continue to drive the Disability Strategy and ensure it did not lose momentum. It was agreed that this would be discussed further at the Committee's next meeting.

Miss Soper joined the meeting at 4.18 pm.

Mr Marrable confirmed that the Disability Working Group would continue its work and ensure the Southern Disability Strategy was ready to transition to the new structure.

Mr Marrable was thanked for his work and report.

10.0 PARENT TO PARENT MEETING REPORT

The Director Quality and Clinical Governance Solutions (DQ&CGS) presented a report prepared by the Consumer Experience Manager and Chair of the Disability

Working Group in response to the concerns raised by Southland Board Members on behalf of Parent to Parent Southland (tab 10).

In speaking to the report, the Consumer Experience Manager advised that most of the concerns were operational matters but they raised some fundamental issues about equity of access to health services. A very useful meeting had been held with Parent to Parent Southland to identify what was important to them and it was agreed that one of their members would sit on the Disability Work Group (DWG).

The Chief Executive Officer left the meeting at 4.30 pm.

The Consumer Experience Manager advised that he was concerned members of the community were reluctant to come forward and express their concern directly to Southern DHB. With the DWG Chair's assistance, he wished to break down that barrier.

The Southland Board Members advised that the matter was brought to their attention by the local Labour list MP and thanked Southern DHB staff and DWG Chair for their report and sensitive, practical action in response to the issues raised.

Mr Taurua, Chief Māori Health Strategy and Improvement Officer, advised that the recently appointed Kaiāwhina positions in Invercargill and Dunedin could also play a role and he would discuss that further with Mata Cherrington and DWG Chair.

It was resolved:

"That the Committee note the report and endorse the approach of direct engagement with Southland Board members and Parent to Parent to address the issues raised."

K Crowther/T King

The Committee acknowledged the leadership shown by Parent to Parent Southland and Southland Board Members and thanked them for bringing these matters forward.

11.0 PEOPLE LIVING WITH DISABILITY VACCINATION RATE

A report on the current COVID vaccination coverage for people living with a disability within the Southern district was taken as read (tab 11).

The DQ&CGS informed the Committee that:

- He was impressed by the way the vaccination team had engaged, particularly with tamariki with disability, to drive the vaccination rates up;
- The vaccination rate for DSS and ACC populations over the age of 18 was 93%, with 81% boosted.

Omicron Outbreak Response

The Consumer Experience Manager reported that, in conjunction with the Dunedin City Council, the parks outside the main entrance of Dunedin Hospital on Great King Street had been replaced with seven mobility parks and about six short term parks. The mobility parks at Southland Hospital and Lakes District Hospital were positioned near the entrance, so no changes had been made to them.

It was suggested that additional mobility parks may be needed at the new entrance to Southland Hospital. It was agreed that Mr King would liaise with the Consumer Experience Manager on this issue.

The Chair extended the Committee's thanks to the SDHB executives and staff who were dealing with the current wave of Omicron.

12.0 FAREWELL TO CHIEF MĀORI HEALTH STRATEGY AND IMPROVEMENT OFFICER

The Chair expressed the Committee's thanks to Mr Gilbert Taurua, departing Chief Māori Health Strategy and Improvement Officer, for the support he had provided to the Disability Support Advisory Committee (DSAC), and to her personally as DSAC Chair, and wished him well for his next role at Canterbury University.

The meeting closed with a karakia at 5.00 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

HOSPITAL ADVISORY COMMITTEE MEETING

4 April 2022

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

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 5 April 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 Hospital Advisory Committee (HAC) meeting month the Chief Executive report assumes Board members would have reviewed the HAC papers and as such many issues raised in these papers are not repeated here, but the Board are welcome to refer to any issue for further discussion at the Board meeting.

1. Organisational Performance

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

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

The operating environment has remained highly complex in February dominated by workforce issues as COVID-19 absenteeism has begun to impact areas with an already low base. Planning/reporting and coordinating COVID response activities and supporting ECC/EOC functions is also impacting staff and business as usual (BAU) functions. Flow through the hospitals has remained manageable, however at the expense of a reduction in planned care especially for those patients requiring inpatient beds. COVID issues not withstanding, improvement in base nursing numbers is expected to improve by late March as NETP nursing staff come out of their supernumerary time. The reduction in inpatient planned care has seen an increase in day surgery cases.

Financial performance for the month of February was adverse to plan as expected. The result was an operating surplus of $1.898 million compared to a planned surplus of $3.001 million, so $1.103 million adverse to plan. The year to date deficit is now $14.878 million compared to a budgeted deficit of $5.557 million, a variance of $9.321 million.

The Business as Usual (BAU) budget (which excludes COVID related revenue and expenditure) is a year to date deficit of $13.885 million against a plan of $5.557 million, so $8.328 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 $609k for the month
- Pharmaceuticals which relates to both the phasing and the underlying budget issue identified last month of $317k
- Air Ambulance Services $107k
- ICT and Software exceeding budget $362k.

From a volumes perspective:

- Total case weighted discharges were adverse to plan at -317 or -7.2% for the month compared to the plan, and down 316 or 7.2% on the same month last year. Year to date case weighted discharges are adverse 160 or 0.4% year to date against plan and down 1,139 or 2.9% against last year.
- Medical case weights are up 750 or 5.5% year to date on plan, and down 189 or 1.3% compared to last year.
- Surgical case weights are down on plan 1,176 or 5.8% with acutes down 345 or 3.6% and electives down 831 or 7.7%. Compared to last year, surgical acute case weights are down 331 or 3.4% and electives are down 652 or 6.1%.
- Raw discharges (actual number of patients) are up 9 or 0.2% for the month against plan, which is down 161 or 3.4% compared to the same month last year. Year to date raw discharges are down 712 or 1.8% compared to last year.
- Mental Health bed days are 731 or 24.6% below planned levels for the month (indicating a 75.4% bed occupancy) and 828 or 4.0% 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 down 422 or 5.8% compared to February 2021, with Dunedin down 6.4%, Southland down 5.5%, and Lakes down 4.8%. On a year to date basis ED presentations are down 1.9% with only Lakes having a 1.9% 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. Health Reforms

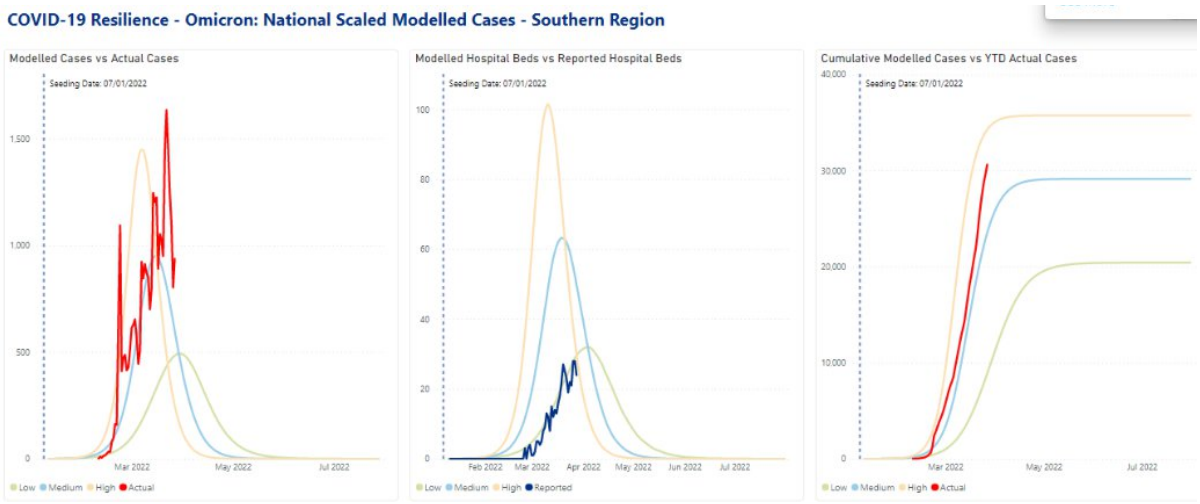
By the time the Board meets on the 4th April there will only be 86 calendar days, or 63 working days until the District Health Board is disestablished and Health New Zealand is established. At the time of writing this report there has been no formal release of any decision document or consultation documents related to the national, regional or district structures in Health New Zealand. We are expecting a webinar to be held with tier 2 leaders nationally in the week of 4th April.

At this stage it would appear that the focus will be on recruiting the national level leadership roles to be in place for Day One however time is rapidly running out. The regional and district level alignment is clearly something that will occur progressively over the coming months. It is anticipated that the District Health Board will continue to operate largely as it is on 1 July, however, there remains a lack of clarity around accountabilities given the fact that there will not be any governance structures remaining in place.

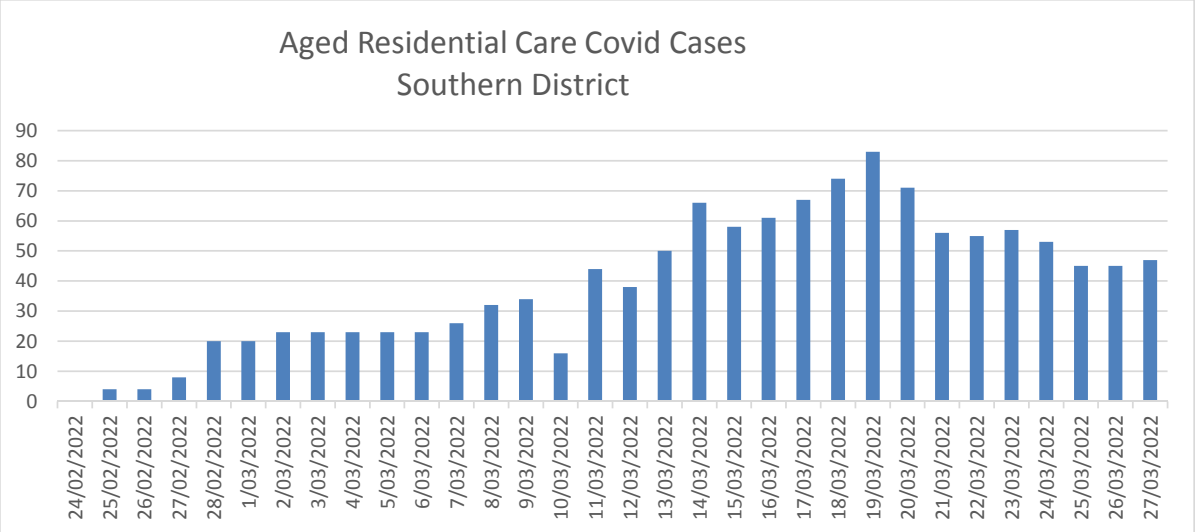
The Chief Executive of Health NZ and the Māori Health Authority will be visiting Dunedin on the 11th April at which point we will both hear from them in terms of direction of travel plus we have the opportunity to share with them some of our challenges and our successes.

3. COVID – Omicron Outbreak

The graphs below show the current situation with Covid cases within the Southern District Health Board's catchment. It is still early but there are clearly positive signs indicating that we may be approaching our peak of cases within the community, however we need to see another week's data to be able to speak confidently. The highest day to date 22nd March 2022 was the day with the highest case numbers at 1,634 cases. Hospitalisation peaks are expected to be roughly 10 days after the peak of cases which would suggest in early to mid April. It is important to note however that there are fluctuations which could influence this.



The table below however shows the numbers of covid positive cases in Aged Residential Care facilities. The peak saw 83 cases on the 19th March. Aged Residential Care providers have been outstanding in terms of working with our teams to manage and mitigate the situation, and overall there has been very successful management of these cases with only a very small number of residents requiring hospitalisation.



Hospitals

The operating environment has remained highly complex in February and into March, dominated by workforce issues as COVID-19 absenteeism has begun to impact areas with an already low base. Planning/reporting and coordinating COVID response activities and supporting Emergency Coordination Centre (ECC) / Emergency Operations Centre (EOC) functions is also impacting staff and business as usual functions. Flow through the hospitals has remained manageable, however at the expense of a reduction in planned care especially those for patients requiring inpatient beds. The reduction in inpatient planned care has seen an increase in day surgery cases.

Public Health South

Public Health South continues to have two Case and Contact Management Teams stood up, which are on a seven day roster. The rostered teams are currently responding to high and medium risk COVID-19 cases, exposure events (settings where the case had contact with people), and household close contacts. This has been very demanding work and it has meant that staff not on the roster are helping the response during their usual working hours. We are seeing our case numbers in Southern starting to rapidly increase and expect this to continue over the next week or so. Alongside the increase in numbers of cases we are seeing an increase in the number of high-risk exposure events.

Phase 3 started on 25 February, which has moved staff from case and contact tracing to outbreak management. This phase focuses on outbreaks in high-risk settings and is a move away from the case and contact investigation. We have moved a number of staff to leading particular high-risk settings while working alongside our Māori and Pasifika staff to support any manaaki concerns that might arise.

Our Māori and Pasifika liaison have been busy supporting our Māori and Pasifika communities with manaaki and welfare needs as well as supporting our investigators with conducting interviews in the cases and household contacts' preferred languages. With moving to phase 3 Public Health South are having planning meetings with the Māori Health Directorate and WellSouth Primary Health Network (PHN) around a plan moving forward to ensure that our Māori and Pasifika communities are being looked after.

We continue to on-board and train new staff joining our COVID-19 response unit.

Community Supported Isolation/Quarantine

Alternative accommodation has been used over the past month in Queenstown, Dunedin and Invercargill to house both COVID-19 cases and contacts. So far there have been no significant issues with contractors, however, capacity is very limited. The focus is on those with clinical needs or people who are unable to safely isolate where they are. We continue to work very closely with the Ministry of Social Development (MSD) and WellSouth PHN to ensure systems are refined and any emerging issues are resolved.

Scaling up is difficult as this requires significant work with infection control staff to ensure that facilities can manage COVID-19 cases. In addition, there is still negative stigma associated with housing COVID-19 cases and how this may impact the business. Going forward we are awaiting clarity from the Ministry of Health as to the future of supported isolation and quarantine and how phase 3 and high case numbers will impact this service.

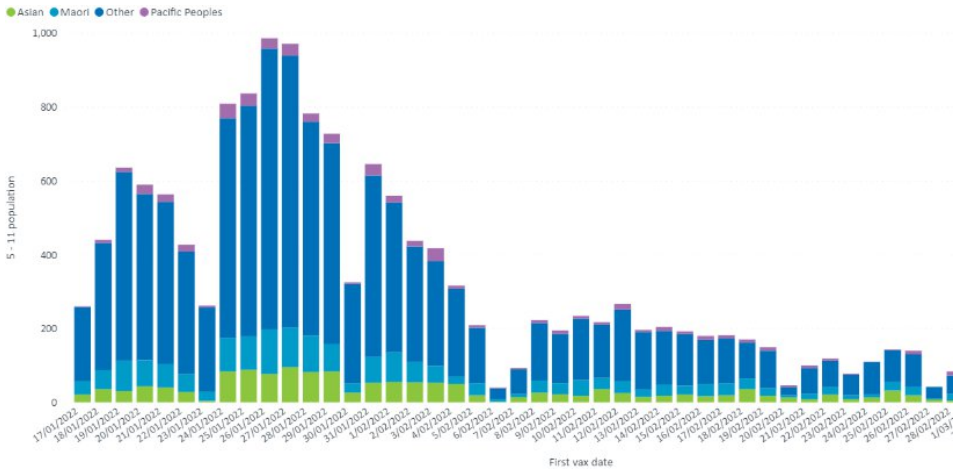
Quarantine Free Travel

The Queenstown Airport health team continue to be utilised in the Case and Contact Management Teams and as vaccinators at the vaccination clinics.

The Ministry of Health have released key dates and information as to what 're-connecting New Zealand' will look like. At this stage there is no indication as to when Queenstown Airport will open to international flights. When this does happen, it will impact on our COVID-19 response team as the staff contracted to undertake the airport work have been valuable members of the Case and Contact Management team.

4. COVID-19 Vaccination Programme

The Southern DHB remains above the national average for the proportion of both booster doses and paediatric doses administered. As of 21 March 2022, 96.9% of the eligible population are double-dosed and 75% boosted; 91.3% of Māori are double-dosed and 63% boosted; and >99% of Pasifika are double-dosed and 60.7% boosted. For 5-11 year olds - 54.8% of the eligible population are at least partially vaccinated; 40.3% of Māori; and 53.5% of Pasifika. The chart below shows the date of first vaccination for 5–11-year-olds across the District from 17 January 2022 through 1 March 2022.



Māori and Pacific Population Rollout

Impact of Omicron

- The Māori and Pacific vaccination rates for all eligible groups continues to decline. Contributing factors include whānau being afraid to go out into the community with the increased risk of catching COVID-19 and impacts of inconsistent messaging.
- Southern continues to engage with Dr Sue Crengle who facilitates online COVID-19 vaccination education for whānau. Two events were held in February 2022, with no whānau attending. Prior to the Omicron outbreak, there was a strong uptake of online whānau education.
- There has been engagement between the Associate Dean Pacific from the University Losa Moata'ane, the ED P&F and the Medical Director around the need for additional resource to support the overall Pacifika response.
- Māori Health providers and leaders continue to be visible amongst communities to support whānau. Southern has engaged with Te Rūnanga o Ngāi Tahu and the Ministry of Health Equity Account Managers to assist with advice, guidance, and innovation across Aotearoa to promote vaccination uptake.

National Inequities

- The COVID-19 Vaccination Programme exacerbates inequities for Māori and Pacific communities in Southern. Significant factors adding to inequities raised by Southern to Minister Henare, Ministry of Health, and Deputy Director General Māori Health (John Whaanga) include the COVID-19 vaccination sequencing framework, the Bookmyvaccine system, and data sharing to District Health Boards (DHBs) in a timely manner.

Workforce Capacity and Capability

- Māori and Pacific providers continue to be under increasing workforce pressure due to positive COVID-19 cases in their workforce and increasing demands to pivot to both testing and vaccinations.

- The COVID-19 vaccination non-regulated workforce continue to be trained by Immunisation Advisory Centre (IMAC) to support with recruitment challenges.
- The local Rūnuka and Kura Kaupapa continue to engage with Māori health providers and assist where needed.

COVID-19 Vaccination Delivery Models

- Māori and Pacific providers continue to deliver vaccination and testing services and respond to community demands. They are reviewing their plans for the 2022 influenza season and Measles, Mumps and Rubella (MMR) immunisations to be incorporated into their COVID-19 vaccination programme.
- Vaccinations continue to be delivered through drive through models, onsite clinics, and outreach home visits in both rural and urban areas. The providers are confident that with time the Māori and Pacific communities will feel safe to receive their vaccinations.

Vulnerable Populations

Onsite booster clinics at Aged Residential Care facilities, Mental Health and Addictions Residential facilities, and Disability Residential facilities were completed in February 2022. Processes and relationships are in place to support vaccinations for new arrivals as required.

Security

Responding to the increased security threats and incidents to providers, the programme maintains a report to review security issues and where appropriate the Police have been informed or involved.

COVID-19 Vaccination Outreach Service

Since 1 January 2022 the Outreach Service has administered 1,471 vaccinations to hard-to-reach individuals and health care workers.

Novavax

Novavax has now been approved for use as a primary vaccination course by Cabinet. Demand for Novavax is expected to be low. Planning is underway to deliver Novavax at selected sites.

5-11 Year-old Vaccinations

Demand is decreasing in line with a national trend and the vaccination programme is ensuring capacity is maintained across the Southern district. Specialist paediatric COVID-19 vaccination clinics have been organised at Dunedin and Southland Hospitals to assist tamariki unable to receive their COVID-19 vaccination through other means.

Pharmacies

Two new pharmacies went live in February (one in Dunedin and one in Palmerston), and two rural pharmacies are undergoing the onboarding process (one in Wanaka and one in Riverton).

Pop-up Clinics

Te Kaika partnered with Otago University to offer a two-day campus vaccination booster clinic to both staff and students.

All-in Vaccinations

Staff at both mass vaccination clinics (Meridian and Civic Theatre) are completing training to administer MMR in the clinics as part of the long-term redevelopment of the sites as all-in vaccination centres. It is envisioned that this will be available from mid to late March 2022.

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

On Monday, 7 March 2022, the SDHB Covid-19 Vaccination Programme began contacting 1,571 individuals affected by a cold-chain failure incident impacting a subset of vaccinations delivered by an occupational health provider (Engage Safety) in the Queenstown Lakes and Central Otago area. Initial investigations have identified 1601 doses given to 1571 people at various locations in Queenstown Lakes and Central Otago between 1 December 2021 and 28 January 2022. The affected patients have been advised to receive a replacement vaccination to ensure that they benefit from a high level of immunity against Covid-19.

Summary of progress to date as at end of day 27/03/22.

- 943 (60%) replacement doses have been completed.
- Overall 67% active response by Service User (either had a dose or booked or declined/deferred).
- Outbound calling underway by SDHB staff for those who;
    - either have no associated Whakarongorau (WA) call record or evidence of a response from the individual, or
    - have associated Covid Immunisation Consumer Support (CICs) notes that require further follow up (such as the individual was indecisive or had covid at the time of last call).
- This activity won't show on the WA call stats but will show in updated CICs records and/or active response.

Summary of CICS comments for the 641 people who have not yet had a replacement dose and are actively being contacted by a SDHB team (ongoing work):

- Have/had Covid 2%
- Deferred vaccination (for health or other reason) 4.8%
- Undecided 3.5%
- Expressed intention to get replacement 12.4%
- Declines 6.1%
- Have not actively responded to communications and require a first conversation 70%

Independent review

- The independent review commenced last week, including review of documentation and interviewing of relevant SDHB staff members. The review team will be located in Queenstown from 29 March to 31 March.

Incorrect CIR records under investigation – potential additional people affected

- As part of feedback from individual members of the public and enquiries to the COVAX team from vaccinating providers, 16 incorrect CIR entries have been identified relating to Engage Safety. 4 of the 16 individuals either had no vaccination recorded in the CIR for the period 1 Dec 2021 to 28 Jan 2022 or the CIR entry was incorrectly recorded as outside the affected timeframe, therefore they were not included in the original cohort of people contacted for replacement vaccination. Each of the 4 affected individuals has had phone follow-up with the COVAX Clinical Quality Lead, a letter of apology and documentation with advice to have a replacement vaccination. The remaining 12 individuals with incorrect date entries in the CIR have received a phone call from SDHB and follow-up letters advising the CIR has been updated to include the correct vaccination date. SDHB has communicated with all COVAX vaccinating providers and relevant non COVAX vaccinating providers/general practices alerting them to this potential issue and requesting if any individuals present stating they received a vaccination from Engage Safety during the affected cold chain failure timeframe but this is not reflected in the CIR record that SDHB COVAX team will follow-up directly with the individual to investigate.

7. Wellbeing of Staff and Providers

As a collective group of District Health Boards we have all taken steps to acknowledge the contribution that our staff have given to the health system and our community as we have tackled the Omicron outbreak. At Southern we have offered staff a contribution to their wellbeing.

The Aukaha Kia Kaha welling group came up with the idea of linking the gifts to the Mental Health Foundations 5 ways to Wellbeing, Give, Be Active, Keep Learning, Connect and Take notice. We have offered our staff across the district a choice of vouchers – swimming, movie, farmers market, Café or prepared meal vouchers. Alternatively they can select a care package – which has a range of treats and activities in it. Each gift has a value of $40.

We also want to recognise that while we are not the employer of the thousands of people who work for our contracted health and disability service providers, these organisations and their staff have also gone above and beyond for the good of our community. Gift baskets will also be provided to the wider health sector to acknowledge their contribution to our covid response.

8. Executive Team Key Appointments and Recruitment

Toni Gutschlag started as Executive Director Mental Health, Addictions and Intellectual Disability on 21 February 2022. This is the first time the Directorate has had a dedicated Executive Director and ensures that there is a strong Mental Health, Addictions and Intellectual Disability voice in the Executive Team. This appointment ensures the work and momentum for change developed over recent months is not lost.

Mata Cherrington started on 28 February 2022 in a fixed term role as Chief Māori Health Strategy and Improvement Officer until 30 September 2022. This allowed for cross-over before Gilbert Taurua left the DHB on 11 March 2022.

Interviews for the Executive Director Communications role were held on 14 March 2022 and we are reference checking a preferred candidate.

Phillip Davis, Cardio Thoracic Surgeon, and Mark Thompson Fawcett, General Surgeon, have been appointed in a joint role as Medical Director Surgical Services & Radiology. Adam McLeay has been appointed as Medical Director, Southland Hospital.

9. Industrial Action

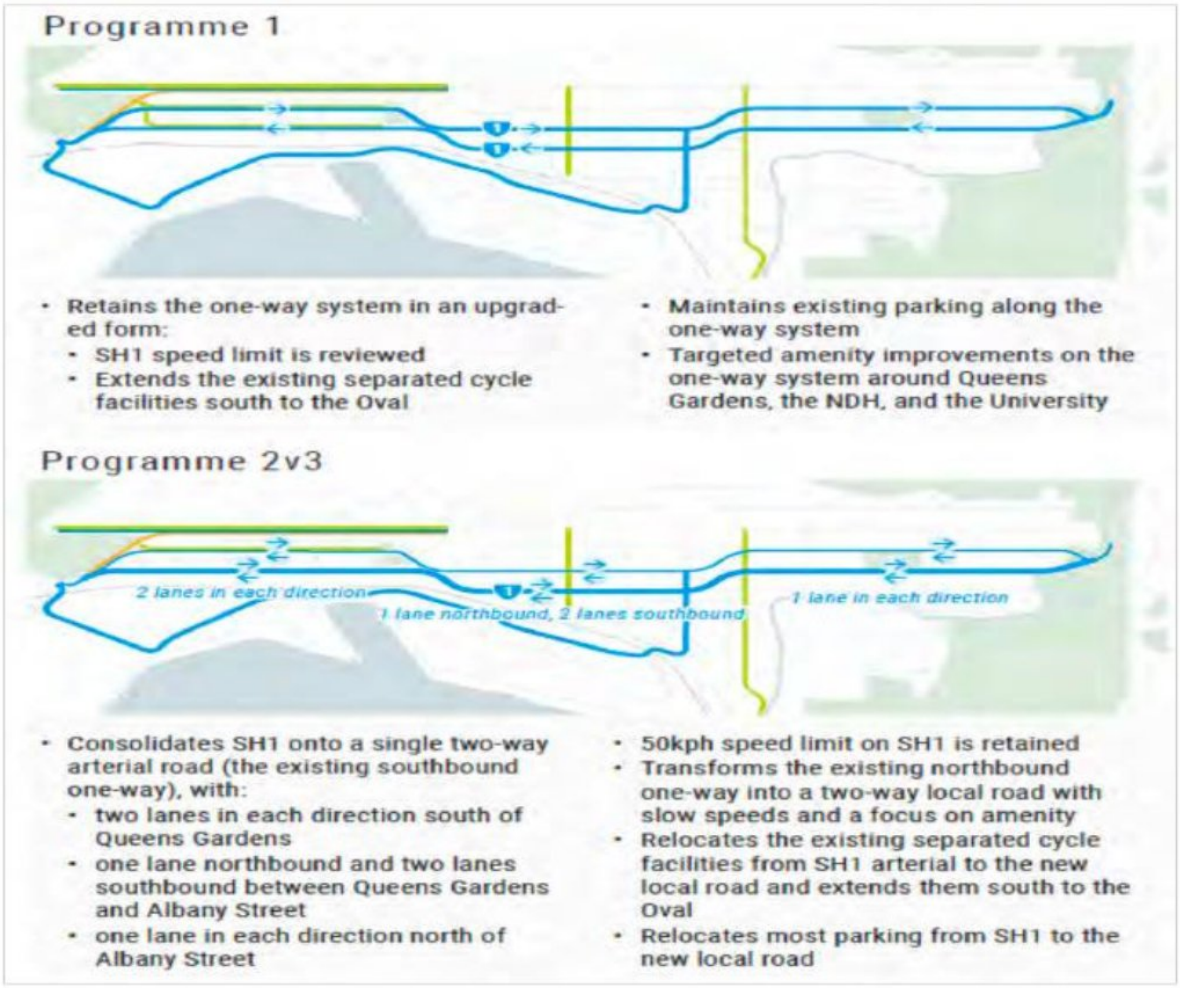
The notices of industrial action by Medical Physicists in March 2022 were withdrawn. Prior industrial action by Medical Physicists has meant additional unbudgeted outsourcing has been required. This is partially offset financially by the under-utilised outsourcing budget. We are continuing to receive strong support from Te Aho o Te Kahu, Cancer Control Agency.

The Public Service Association (PSA) strike notices for industrial action by Allied Health, Public Health, and Technical staff in March were lifted following an injunction, however, due to the timing of the injunction for the 4-5 March strike little if any planned care could be stood up – approximately 50 case weights were lost.

10. Dunedin Roading Network – Shaping Future Dunedin Transport

Waka Kotahi has prepared a Shaping Future Dunedin Transport Programme Business Case. This was released last year, and it had two options:

- Programme 1 retains the One Way System
- Programme 2v3 consolidates SH1 onto a single two way arterial road (the existing southbound one-way) and transforms the existing northbound one-way into a two way local road as noted below:



Waka Kotahi have ultimately landed on supporting Programme 1 which potentially significantly impacts the New Dunedin Hospital and the health and wellbeing of the people of Dunedin and the wider Southern district. It should be noted that earlier the suggestion of retaining the one way system but supplementing this with enhancements through the arterial route around the industrial area would have been a middle ground, however it is understood that due to the heights of the bridges oversized loads will not be able to take that route and will continue to utilise the one way system. One suspects this will result in most heavy traffic taking the quickest route rather than the arterial one.

An independent Health Impact Analysis was undertaken by Robert Quigley, of Quigley and Watts Limited and they scored P1 as +0.75, while P2v3 scored +2.25. A score of 0 to +1 is deemed to be slightly positive, or "minor positive impact, may be confined to limited area, possibly only short term. A score of +2 is moderately positive "Moderate positive impact, which may provide improvements or enhancements, and new opportunities of short, medium or long term duration".

The District Health Board has always been clear that building a major tertiary hospital in between two state highways is not the right thing to do with current traffic volume and speed is not acceptable. Had the location of the hospital been purely based on healthcare needs the hospital would not be in the centre of town. The hospital is however being developed in this location because of the integral linkages between health and education and the importance to the economy of Dunedin and the wider Otago region.

It is our understanding that the University actively backed P2 v 3, as it is the right thing to align both health and education activities and link clearly with the city. As a District Health Board we have written to Minister Wood who will be visiting Dunedin to review the business

case in April to clarify that our position is first and foremost the speed of traffic travelling along Cumberland Street past the hospital must be reduced preferably to 30 kilometres per hour and that our strong preference is the adoption of the option P2 v3 as it optimises the utility of the hospital, enhances active transport options, and the connects the hospital to the city

11. Southland Needs Analysis

The work on the Southland Needs Analysis is proceeding well and Sapere now have the datasets that they require to start to model the demand forecast for the Southland region which will cover both primary and secondary care. Sapere are about to commence a second round of clinical engagement using some of the data to test assumptions and gain further insights. Pivotal to making recommendations or determinations to the needs analysis for Southland is a discussion around possible planning scenarios which requires the answering of strategic questions that will be posed at the next steering group meeting. These will include discussion, for example, as to whether facilities in Central Otago will be developed and where it is anticipated that ambulatory care will be primarily delivered. The project remains on target to be completed by May with an interim report is being planned for the May meeting.

12. Discharge Summaries

Development of a new discharge summary template for use by RMOs - Impacts on patient flow have been raised, specifically in relation to the time required for RMOs to complete discharge summaries. Simplifying and reducing variability of content has also been mentioned.

Likely to be minimal improvements to RMO time and mitigation of patient flow issues by solely changing/implementing a new discharge summary template. There are several dependencies that would require investigation to leverage capabilities a new form could provide. These include workforce and training issues, development, and implementation of preceding inpatient-related documentation to consolidate patient record and enable population of key information into a summary, and other gaps in key components (e.g., Medchart issues and no routine medication reconciliation process).

13. Education Perfect Te Ao Māori for Professionals: Engagement and Participation Award

Southern DHB has been awarded the Education Perfect Te Ao Māori for Professionals: Engagement and Participation Award. The award was for the highest engagement and participation in February 2022 of the 50+ large organisations involved in the course. Presentation of the award was originally scheduled to occur on 23 March, but this has been delayed.

Southern DHB Pou Tāki Educator, Mathew Kiore introduced and leads this initiative into the Southern health system with Education Perfect having a positive and significant uptake. Mathew has provided support, online tutorials, face to face learning events, support to Southern DHB, General Practice, Rural Trust Hospital and other health services. Mel Warhurst, Southern DHB Organisational Development Specialist, has also supported the Education Perfect Programme to ensure its success.

Education Perfect presented to Herenga Hauora in March and mentioned the Southern DHB's participation in this programme. They highlighted the importance of having leadership within the organisation to awhi and tautoko their colleagues as they traverse their journey in akonga. Te Rau referred to Mathew as an exemplar of what leadership looks like to ensure transformative success.

14. Time for Change - Mental Health and Addiction System review Outcome Care

Momentum is building with implementation of Time for Change. The Change Leadership Group has been finalised and the first meeting of the Cross Sector Group occurred late in the month. A meeting was held with the three preferred EOI providers regarding the new community/residential service, with all indicating an interest in progressing to the next step. Engagement on the crisis response model for crisis responses in Queenstown and Central Lakes is almost complete. Planning for expanded alcohol and other drug services in Dunedin is progressing well, consumer engagement will commence in May on a proposed service model. The Board has endorsed the investment/disinvestment plan providing confidence that funding to support the change process will be available.

15. Tourism Recovery Fund – Psychosocial Mental Wellbeing Recovery

Te Hau Toka (THT) has partnered with Great South to establish a Community Wellbeing Coordinator for Fiordland. The successful applicant will be working with us and a range of others to help support wellbeing in the community through the coming months. THT is also about to commence with the next funding round for the Connecting Communities initiative. We are also working collaboratively with Regional Business partners to amplify and support wellbeing initiatives with the business community. We have contracted an evaluation expert to assist in developing an evaluation framework for the initiatives we are leading.

16. Combined Response Team (CRT)

This 12 month pilot continues to work well with no operational issues being reported between the three services involved – Police, St Johns and Southern DHB Mental Health Services.

17. Emergency Psychiatric Services and Emergency Department Enhancement

Emergency Psychiatric Service (EPS) and the Emergency Department (ED) continue to have regular meetings to work through any operational issues. This month the service introduced a proposed Intoxication Pathway to the ED Clinical Director who will lead discussion with the ED team. One of the aims is to look at earlier medication intervention in an attempt to reduce the levels of aggression that services are responding to.

18. Frailty Pathway Project

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

A Frailty Council has now been created which has unified other frailty steering groups within the Southern DHB (community and hospital based). Key work streams include maximising system wide communication through the use of electronic Shared Care Plans (within Health Connect South) and reducing fractures and falls in our frail population. The Frailty Council will report to the Clinical Council on direction and outcomes. The Frailty Council has now met twice, including a session on priorities. This will inform the workplan that is currently under development.

19. Measles, Mumps and Rubella (MMR) Campaign – 15 to 30 year olds

The MMR campaign is now underway. The Campaign Coordinator has now completed orientation and is currently liaising with key stakeholders.

There has been excellent progress with Pharmacies creating more opportunities for access. Two new graduates have started their orientation including full vaccination training and will assist resourcing the MMR programme. Pacific Trust in Otago is underway with MMR, alongside an all-in adult vaccination approach. Corstorphine Hub day had small numbers attending and small number receiving their MMR vaccination.

Plans are in progress to get both COVID-19 vaccination centres up and going with MMR vaccinations and Otago University Student Health is already providing MMR to new students and promoting this during their 'O-week'.

All Public Health Nursing staff still use available platforms to promote MMR, for example, B4 school checks, outreach appointments, school, and alternative education programmes. A road show was undertaken in February around the whole district alongside the 'Shaken Baby' community agency education. The Campaign Coordinator was able to present at each of these forums promoting MMR and making important connections with Māori and Pacific providers.

20. Allied Health

Recruitment to Southland physiotherapy is now showing results with four new graduate physiotherapists starting work in late January. While numbers have increased, the new staff are predominantly junior and inexperienced. This will mean the skill mix within the teams is not yet where we need it to be and will take time to develop. This will put pressure on the few remaining senior staff for supervision, training, and mentoring. We are putting in place plans and additional supports, including a clinical coach with the sole role of staff support.

Outsourcing of outpatient work continues, with two external providers supporting inpatient work in a limited capacity. This outsourcing will be reduced as DHB capacity increases.

Dunedin is also noting some increasing challenges recruiting allied health, especially for people with higher/specialist skill levels.

21. Aged Residential Care (ARC) Workforce Shortages and Omicron Readiness

Two plus years of planning began to pay off in February, as Omicron became reality in Southern. Our ARC Steering Group and Locality Networks have been critical. And a tremendous effort from our analysts resulted in a Daily ARC COVID Survey, which, due to the strong relationship with ARC, facilities are consistently responding on a daily (weekdays) basis. This gives us timely information about the entire sector, allowing us to focus on facilities where there are issues, with the confidence that the others are managing.

Likewise, our Infection Prevention and Control (IPC) Clinical Nurse Specialists have been invaluable in supporting Care Homes as COVID enters their facilities, usually via staff, despite mandatory vaccination and good screening.

Supporting the sector has become a massive effort, spanning seven days a week. The General Manager and Director of Nursing have provided significant, valuable and necessary support which is increasing. Public Health has also been extremely supportive but is looking to become less involved as the outbreak progresses.

Workforce shortages have continued to worsen, only to be further hampered by COVID positive staff and isolation due to household contacts. Many facilities are operating on skeletal, or less than skeletal staffing.

22. Home and Community Support Services (HCSS) Workforce and Service Delivery

Workforce Shortages continue to plague the HCSS Sector, with more staff leaving due to the additional booster requirement to the Mandatory Vaccination Order.

Agencies are prioritising supports based on client need, circumstances and workforce availability. All referrals for domestic services have not been accepted since November 2020 and are unlikely to be considered until the workforce recovers, post-Omicron.

23. Colonoscopy Report to Southern District Health Board

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

Chris Fleming
Chief Executive Officer

29 March 2022

Appendix 1

Colonoscopy Update for the Chair, SDHB

The delivery of colonoscopy continues to improve.

We have a sustained improvement in resource utilization and fewer short-notice cancellations.

The specialist referral process is embedded and functions well.

Direct access referral processes are likewise embedded and any referral declined is automatically reviewed with any one reviewer able to accept the case without further debate.

Timeliness is very excellent for Urgent and very good for non-urgent symptomatic cases.

Surveillance waiting times have dramatically improved.

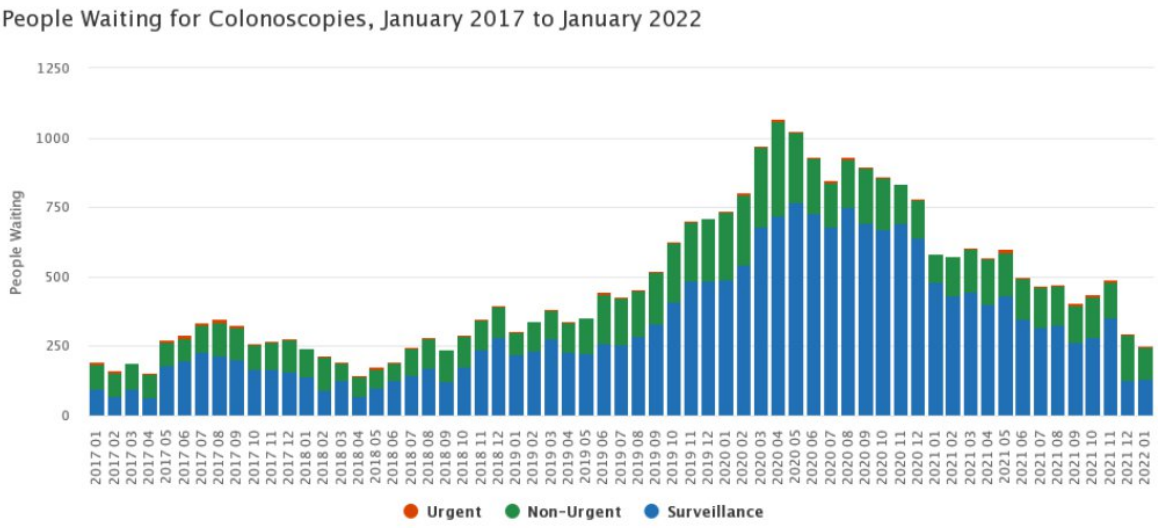
Screening performance remains excellent.

We have recruited nursing staff especially on the Dunedin site. The need for further workforce recruitment exists for the Invercargill site, including at SMO level.

The graphs in this report are from Te Aho o Te Kaho (the National Cancer Agency,) noting I have also discussed the DHB performance with Dr Diana Sarfati, Chief Executive of Te Aho o Te Kaho.

Data:

Graph one – the waiting list:



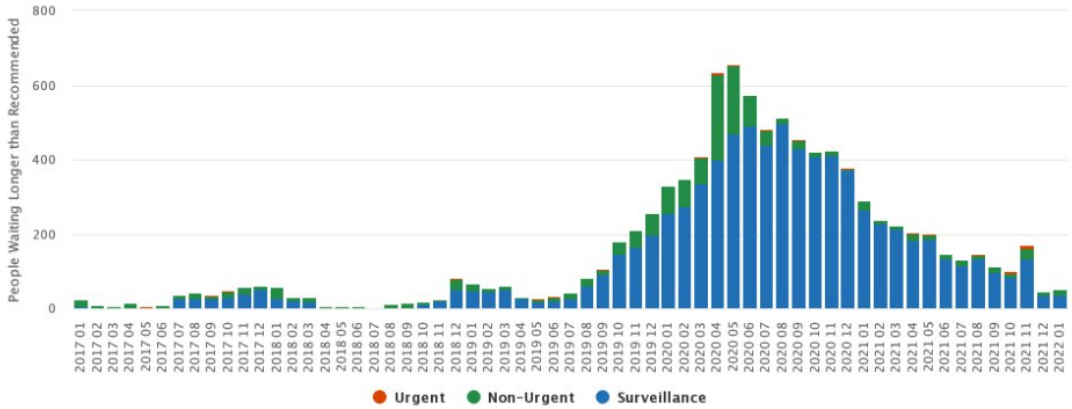
This graph is of all cases in the symptomatic and surveillance groups (it does not include screening) and therefore includes those cases waiting within the designated timeframes.

Graph 2 -patients waiting over recommended time

Graph Two below shows only those cases waiting longer than the recommended timeframes (again for symptomatic and surveillance cases). It shows clear and sustained progress with very few P2 (non-urgent) waiting over time and a huge improvement in surveillance. The graph highlights

aspects of the growing problem identified by the DHB over 2019/2020 which ultimately led to the Board decisions regarding the recommended actions from various reports made circa August/September 2020. The progress since late 2020 is obvious – and it is important to note this progress has occurred whilst the DHB has also met its screening timeframes.

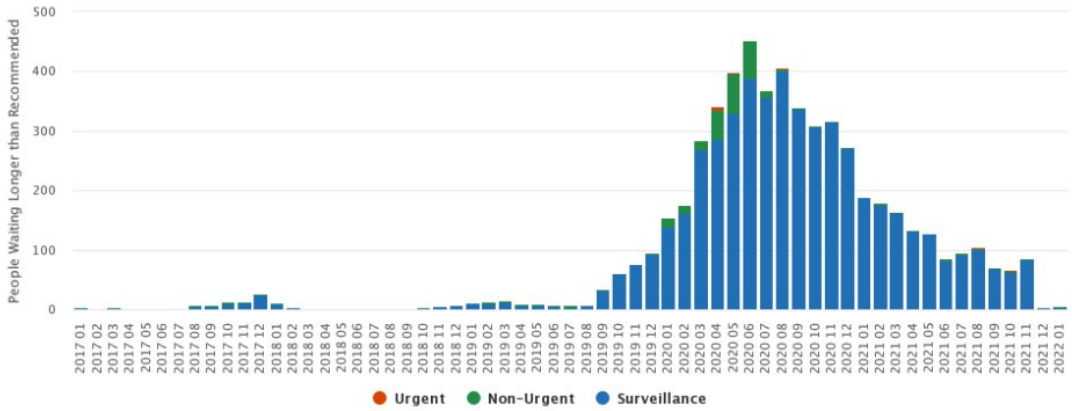
People Waiting for Colonoscopies Longer than the Recommended Time, January 2017 to January 2022



Critics may suggest the growth in surveillance cases wating longer than recommended follows the introduction of screening, but the most important feature of this graph in my view is the relative lack of significant growth in symptomatic cases waiting too long after the introduction of screening (noting April and May 2020 correlate with the first Level 4 and 3 of the pandemic). This again in my view refutes some of the repetitive criticism regarding the introduction of screening. We also know that since 2019 the incidence of acute cancer presentations in people declined a colonoscopy is extremely low (data previously publicly reported by me to the Board).

Graph Three – waiting over the maximum time

People Waiting for Colonoscopies Longer than the Maximum Time, January 2017 to January 2022



This graph refers to what we deem the "maximum clinically acceptable delay" (but even that is strongly debateable for surveillance as it is such a diverse group). The key feature of this graph is the lack of any symptomatic cases waiting too long, again countering the argument that screening worsened access for symptomatic cases. We have also reviewed the surveillance cases over recent

years and found the clinical risk of developing a cancer whilst on the waiting list was vanishingly rare. Graph three also reinforces that the introduction of screening did not delay symptomatic cases to the point of exceeding the maximum timeframes where clinical concerns would generally be felt to be escalating.

Other matters:

Electronic referrals within the DHB are working well.

Quality assurance reviews demonstrate the high standard of colonoscopy provided.

We continue to audit acute cancers to ensure we had not declined a colonoscopy or appropriate other DHB service such as a clinic appointment.

The Endoscopy Oversight Group continues to meet (moving to Quarterly given the sustained nature of the success).

Future focus:

We are exploring further SMO endoscopist FTE for Invercargill.

Resourcing to allow more training opportunities on both sites is important. We must expand and value training.

The DHB is turning its attention to the opportunities that will come via Health NZ.

Andrew Connolly

Chair, Endoscopy Oversight Group

25 March 2022

FOR APPROVAL

Item: Financial Report for the period ended 28 February 2022.

Proposed by: Nigel Trainor, Executive Director Corporate Services

Meeting of: Board, 5 April 2022

Recommendation

That the Board approves the Financial Report for the period ended 28 February 2022.

Purpose

1. To provide the Board and Finance, Audit & Risk Committee with the financial performance of the DHB for the month and year to date ended 28 February 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

Southern DHB Financial Report

Financial Report for:	28 February 2022
Report Prepared by:	Finance
Date:	22 March 2022

Report to Board

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the period ending 28 February 2022.

February 2022 result was a surplus of $1.9m, being $1.1m unfavourable to budget.
The year to date result is a deficit of $14.9m which is $9.3m 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 February 2022

	Month Actual Total $000	Month Nursing MECA Settlement $000	Month COVID-19 Vaccination $000	Month COVID-19 Resurgance $000	Month COVID-19 Endemic $000	Month COVID-19 MIQ $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	110,011		4,302	628	105	231	-	103,251	102,451	800	F	1,494	500	994	F
Non-Government & Crown Agency	513		-	-			-	513	847	(334)	U	-	-	-	
Total Revenue	110,524	-	4,302	628	105	231	-	103,764	103,298	466	F	1,494	500	994	
EXPENSES															
Workforce Costs	41,055		661	61	69	14	(2)	40,252	39,192	(1,060)	U	-	-	-	
Outsourced Services	4,537		12	-		-	-	4,525	3,902	(623)	U	-	-	-	
Clinical Supplies	8,244		6	23		8	-	8,207	8,990	783	F	-	-	-	
Infrastructure & Non-Clinical Supplies	5,752		193	378	36	107	2	5,036	5,138	102	F	-	-	-	
Provider Payments	45,719		3,430	27	-	-	-	40,768	39,611	(1,157)	U	1,494	500	(994)	U
Non-Operating Expenses	3,319		-	-	-	-	-	3,319	3,464	145	F	-	-	-	
Total Expenses	108,626	-	4,302	489	105	129	-	102,107	100,297	(1,810)	U	1,494	500	(994)	
NET SURPLUS / (DEFICIT)	1,898	-	-	139	-	102	-	1,657	3,001	(1,344)	U	-	-	-	

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 28 February 2022

	YTD Actual Total $000	YTD Nursing MECA Pay Equity Settlement $000	YTD COVID-19 Vaccination $000	YTD COVID-19 Resurgance $000	YTD COVID-19 Endemic $000	YTD COVID-19 MIQ $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	882,662	15,103	30,643	3,233	118	360	94	825,090	818,533	6,557	F	8,021	4,000	4,021	F
Non-Government & Crown Agency	6,382		-	-	-	-	-	6,382	6,778	(396)	U	-	-	-	
Total Revenue	889,044	15,103	30,643	3,233	118	360	94	831,472	825,311	6,161	F	8,021	4,000	4,021	
EXPENSES															
Workforce Costs	350,518	16,096	6,316	2,502	82	56	74	325,392	326,838	1,446	F	-	-	-	
Outsourced Services	34,705		502	-	-	-	-	34,203	30,766	(3,437)	U	-	-	-	
Clinical Supplies	76,586		93	131	-	10	-	76,352	70,887	(5,465)	U	-	-	-	
Infrastructure & Non-Clinical Supplies	47,904		1,335	573	36	294	20	45,646	42,761	(2,885)	U	-	-	-	
Provider Payments	368,480		22,397	27	-	-	-	338,035	333,529	(4,506)	U	8,021	4,000	(4,021)	U
Non-Operating Expenses	25,729		-	-	-	-	-	25,729	26,087	358	F	-	-	-	
Total Expenses	903,922	16,096	30,643	3,233	118	360	94	845,357	830,868	(14,489)	U	8,021	4,000	(4,021)	
NET SURPLUS / (DEFICIT)	(14,878)	(993)	-	-	-	-	-	(13,885)	(5,557)	(8,328)	U	-	-	-	

8.1

Drivers of the result:

The main drivers of the unfavourable BAU result are 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 Funder $2.8m and Provider $3.1m)	(317)	(5,885)
Outsourced clinical services – related to Surgical services	(609)	(3,700)
Air Ambulance mix usage and 10% price increase	(107)	(1,819)
ICT & Software	(362)	(2,007)
Sub Total	**(1,395)**	**(13,411)**
Offset by		
Unbudgeted Public Health core contract uplift	195	1,558
Other Government Revenue – ACC back pay & price increase	(326)	1,549
Workforce costs – BAU – refer above	(1,060)	1,446
Total Variance	**(2,586)**	**(8,858)**

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 $77.2m ($54.7m Community and $22.5m Provider), a crude extrapolation would give a full year spend of $116m. There are two additional variables that can also impact on the final Pharmaceutical impact being the level of rebate and the additional revenue to offset cost increases.

Month detail:

Consolidated Revenue was $6.7m favourable to budget.

Variance area	**Variance**
Covid related	
Unbudgeted COVID-19 Vaccination Revenue	$4.30m
Unbudgeted COVID-19 Incremental Costs funding	$0.63m
COVID-19 Surveillance & Testing funding	$0.99m
Nursing Pay Equity funding	$0.82m
Reduction PBF – Pharms COVID-19 revenue	$(0.43)m
Total	**$6.31m**

Expenses were $7.8m unfavourable to budget.

Workforce costs were $1.9m unfavourable including $0.6m for unbudgeted Vaccination programme costs.

Variance area	**Variance**
SMOs – 8.47 FTE favourable with continued vacancies, offset by additional overtime and outsourced in a number of areas for cover	$0.26m
RMOs – remain unfavourable with low rates of leave being taken plus overtime, over budget by 13.5 FTE	$(0.51)m
Nursing – 50.75 FTE unfavourable of which 57.1 are unbudgeted relating to Covid response, reflecting $0.6m unbudgeted Covid activity Covered by revenue. The MECA settlement monthly cost $0.8m is funded by the MoH.	$(1.42)m
Allied Health – 45.72 FTE favourable in a number of areas including Dental Therapists, Occupational Therapists, Physiotherapists, Psychologists & Technicians, largely driven by continued unfilled vacancies.	$0.39m
Management/Admin – 78 FTE unfavourable of which 65 are unbudgeted relating to Covid response, reflecting $0.51m unbudgeted Covid activity Covered by revenue.	$(0.52)m

Outsourced Services is $0.6m unfavourable with additional surgical activity including ENT, Ophthalmology, Plastics, Urology and Orthopaedics.

Clinical Supplies are $0.7m favourable. This includes underspends in Treatment Disposables, Instruments & Equipment, Pharmaceuticals and Implants & Prostheses (Cardiac, Hips, Knees and Shunts/Stents), partially offset by higher than budgeted Air Ambulance costs.

Provider Payments were $5.6m unfavourable, reflecting $3.4m COVID-19 Vaccination expenses (offset by additional revenue) and other costs unfavourable to budget including Community Pharmaceuticals $0.4m, Primary Health Care $0.2m and Rural Primary Health Support $0.2m.

Year To Date

Revenue is $59.7m favourable to budget. This is made up as follows:

Variance area	**Variance**
Nursing Pay Equity	$16.75m
Unbudgeted COVID-19 Vaccination Revenue (incl Māori)	$30.64m
Unbudgeted COVID-19 Incremental Costs funding	$3.23m
COVID-19 Surveillance & Testing funding	$4.02m
Unbudgeted Public Health core contract uplift	$1.56m
ACC Contract increase	$2.17m
Mental Health	$0.93m
Primary Care	$1.34m
Reduction PBF – Pharms COVID-19 revenue net	($2.24)m
IDFs	($1.08)m
Ineligible Patients	($0.78)m
Total	**$56.54m**

Expenses are $69.1m unfavourable to budget.

Workforce costs are $23.7m unfavourable including $6.3m unbudgeted Vaccination programme costs.

Variance area	**Variance**
SMO – indirect costs $1.8m unfavourable being mostly CME, outsourced remains $0.5m higher than budget in a number of areas due to vacancies. FTE are 9.92 under budget but is offset by increased overtime payments of $3.0m against a budget of $0.3m	$(1.54)m
RMOs – remain unfavourable with low rates of leave being taken, increased overtime, relocation costs and FTE's over budget by 9.2.	$(1.32)m
Nursing – remains complex as there are three main areas that need separating, these are: • Nursing Meca settlement – pay equity partial settlement cost $16.1m and was offset by revenue of $15.1m • Unbudgeted Nursing FTE of 63.3 YTD at a cost $4.2m for Covid response covered by unbudgeted revenue • BAU Nursing FTE for the YTD is on budget at 1,943, due to a number of reasons the BAU Nursing costs is under budget. The budget has higher costs per nurse this is related to the mix of employees classified as nursing.	$(19.19)m
Allied Health – remains favourable in a number of areas including Occupational Therapists, Physiotherapists, Psychologists & Technicians, 48.5 FTE overall, largely driven by continued unfilled vacancies.	$1.76m

Management/Admin – continues to be unfavourable, driven by unbudgeted Covid FTE of 71.6 and costs $3.4m	$(3.06)m

Outsourced Clinical Services is $3.7m 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 $0.8m favourable in Radiation Oncology with lower than budgeted volumes through St Georges.

Clinical Supplies are $5.7m unfavourable. This includes higher than budgeted costs in Treatment Disposables, Instruments & Equipment, Air Ambulance and Pharmaceuticals, offset by underspends in Implants & Prostheses.

Infrastructure and Non-Clinical Supplies are $5.1m unfavourable in a range of areas, including COVID-19 expenses $2.3m, Patient Meals, Cleaning, Facilities, Transport & Travel, IT Services and Microsoft Licenses.

Provider Payments are $31.0m unfavourable, reflecting $0.4m ARRC back-payments, $2.8m Community Pharmaceuticals, $2.5m Primary Care and $22.4m COVID-19 Vaccination expenses (offset by additional revenue).

Staffing Covid-19 impact

The table below has been included to highlight the movement in FTE over the last 13 months. COVID FTE has increased from 2 FTE in February 2021 to 220 FTE in February 2022. It must be noted however that the increase from the prior month is due to prior period movements as staff incorrectly charged to Operational cost centres were corrected to the COVID cost centres.

Operational FTE has increased from 4,080 FTE to 4,154 FTE, the largest increase being in Nursing staff mainly associated with increases due to CCDM (Care Capacity Demand Management). The transfer of staff into COVID cost centres has had the opposite effect on operational FTE reducing Allied Health and Management FTE below what we would normally incur. This is a one-off impact and we would expect operational FTE levels to be higher in March.

SDHB FTE Trend - 13 months - February 2021 to February 2022

		2020/21					2021/22								2021/22 YTD	Variance Feb to Feb	Variance Feb to YTD	
Type	Staff Type	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Average	Feb	Average	Comment
COVID	SMO				0.13	0.11		0.15	0.07	0.15	0.03	0.85	1.48	14.46	2.15	(14.46)	(12.31)	Feb incls prior period adj from Public Health
	RMO							0.30	2.30	0.20	0.00	0.10	2.00	0.88	0.72	(0.88)	(0.16)	Feb incls prior period adj from Public Health
	Nursing	1.64	3.08	14.38	42.11	59.27	55.91	77.78	93.61	64.95	58.67	57.76	47.49	69.30	65.68	(67.66)	(3.62)	Feb incls prior period adj from Public Health
	Allied Health		0.00	0.11	0.15	0.46	0.47	6.98	47.97	3.15	5.92	4.24	6.50	48.88	15.51	(48.88)	(33.37)	Feb incls prior period adj from Public Health
	Support								0.05						0.01	0.00	0.01	
	Mgmt / Admin	0.50	8.41	17.88	40.56	63.11	62.97	87.21	97.67	73.32	65.02	62.83	58.49	86.46	74.25	(85.96)	(12.21)	Feb incls prior period adj from Public Health
COVID Total		2.14	11.49	32.37	82.95	122.95	119.35	172.42	241.67	141.77	129.64	125.78	115.96	219.98	**158.32**	**(217.84)**	**(61.66)**	
Operational	SMO	298.55	315.36	330.91	305.10	325.48	308.43	319.98	312.75	309.72	325.80	322.08	296.67	303.07	312.31	(4.52)	9.24	
	RMO	352.75	349.38	373.35	365.72	357.45	346.06	347.38	337.59	341.20	346.55	336.39	366.39	368.69	348.78	(15.94)	(19.91)	
	Nursing	1,862.66	1,879.81	2,000.09	1,947.95	1,937.20	1,896.83	1,891.69	1,892.00	1,897.51	2,004.58	1,964.56	1,996.57	1,970.47	1,939.28	(107.81)	(31.19)	CCDM (Feb to Feb) + impact of stat day
	Allied Health	724.60	741.88	758.58	737.55	742.20	716.01	733.06	694.07	707.19	716.10	711.17	633.26	674.53	698.17	50.07	23.64	Feb lower as prior period FTE transferred to COVID from Public Health
	Support	98.38	101.73	105.44	105.50	104.31	101.00	102.05	100.67	99.74	101.64	101.57	94.41	102.76	100.48	(4.38)	(2.28)	
	Mgmt / Admin	742.87	744.08	758.92	753.05	752.02	756.94	765.62	746.30	737.79	750.04	738.45	637.00	734.76	733.36	8.11	(1.40)	Feb lower as prior period FTE transferred to COVID from Public Health
Operational Total		4,079.81	4,132.24	4,327.29	4,214.87	4,218.66	4,125.27	4,159.78	4,083.38	4,093.15	4,244.71	4,174.22	4,024.30	4,154.28	**4,132.39**	**(74.47)**	**(21.89)**	
Grand Total		4,081.95	4,143.73	4,359.66	4,297.82	4,341.61	4,244.62	4,332.20	4,325.05	4,234.92	4,374.35	4,300.00	4,140.26	4,374.26	**4,290.71**	**(292.31)**	**(83.55)**	

Financial Summary Reports

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 28 February 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						
110,011	102,951	7,060	F	Government & Crown Agency	882,662	822,533	60,129	F	1,187,928	1,233,735
513	847	(334)	U	Non-Government & Crown Agency	6,382	6,778	(396)	U	12,489	10,168
110,524	103,798	6,726	F	*Total Revenue*	889,044	829,311	59,733	F	1,200,417	1,243,903
				EXPENSES						
41,055	39,192	(1,863)	U	Workforce Costs	350,518	326,838	(23,680)	U	481,291	502,352
4,537	3,902	(635)	U	Outsourced Services	34,705	30,766	(3,939)	U	47,821	46,095
8,244	8,990	746	F	Clinical Supplies	76,586	70,887	(5,699)	U	111,249	107,947
5,752	5,138	(614)	U	Infrastructure & Non-Clinical Supplies	47,904	42,761	(5,143)	U	62,476	64,693
45,719	40,111	(5,608)	U	Provider Payments	368,480	337,529	(30,951)	U	489,958	506,799
3,319	3,464	145	F	Non-Operating Expenses	25,729	26,087	358	F	37,059	40,324
108,626	100,797	(7,829)	U	*Total Expenses*	903,922	834,868	(69,054)	U	1,229,854	1,268,210
1,898	3,001	(1,103)	U	**NET SURPLUS / (DEFICIT)**	(14,878)	(5,557)	(9,321)	U	(29,437)	(24,307)

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 28 February 2022

Actual 30 June 2021 $000		Actual 28 February 2022 $000	Budget 28 February 2022 $000	Actual 31 January 2022 $000	Budget 30 June 2022 $000
	CURRENT ASSETS				
7,582	Cash & Cash Equivalents	13,692	7	10,855	7
61,439	Trade & Other Receivables	68,911	53,609	65,516	48,474
6,159	Inventories	6,545	5,122	6,370	5,235
75,180	*Total Current Assets*	89,148	58,738	82,741	53,716
	NON-CURRENT ASSETS				
325,558	Property, Plant & Equipment	326,721	342,146	325,751	358,043
6,258	Intangible Assets	10,898	21,028	11,019	25,118
331,816	*Total Non-Current Assets*	337,619	363,174	336,770	383,161
406,996	**TOTAL ASSETS**	426,767	421,912	419,511	436,877
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	17,764	-	33,663
72,840	Payables & Deferred Revenue	93,483	63,782	90,660	69,492
235	Short Term Borrowings	109	908	108	1,979
82,596	Holidays Act 2003	86,786	87,596	86,786	90,146
95,374	Employee Entitlements	103,207	86,946	101,993	88,211
251,045	*Total Current Liabilities*	283,585	256,996	279,547	283,491
	NON-CURRENT LIABILITIES				
856	Term Borrowings	782	4,884	792	10,754
19,411	Employee Entitlements	18,706	20,177	18,706	20,144
20,267	*Total Non-Current Liabilities*	19,488	25,061	19,498	30,898
271,312	**TOTAL LIABILITIES**	303,073	282,057	299,045	314,389
135,684	**NET ASSETS**	123,694	139,855	120,466	122,488
	EQUITY				
486,579	Contributed Capital	489,467	493,781	488,142	495,164
108,500	Property Revaluation Reserves	108,500	108,500	108,500	108,500
(459,395)	Accumulated Surplus/(Deficit)	(474,273)	(462,426)	(476,176)	(481,176)
135,684	*Total Equity*	123,694	139,855	120,466	122,488
	Statement of Changes in Equity				
165,991	Opening Balance	135,684	138,188	135,684	138,189
(30,933)	Operating Surplus/(Deficit)	(14,878)	(5,557)	(16,779)	(24,307)
1,333	Crown Capital Contributions	2,888	7,224	1,562	9,313
(707)	Return of Capital	-	-	-	(707)
135,684	Closing Balance	123,694	139,855	120,466	122,488

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 28 February 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	880,873	829,704	51,169	1,240,738	785,634
Non-Government & Crown Agency Revenue	6,027	6,555	(528)	9,832	7,157
Interest Received	354	224	130	336	245
Cash was applied to:					
Payments to Suppliers	(517,708)	(485,616)	(32,092)	(719,719)	(474,777)
Payments to Employees	(336,654)	(330,111)	(6,543)	(498,453)	(299,775)
Capital Charge	(3,368)	(3,507)	139	(7,142)	(4,124)
Goods & Services Tax (net)	1,115	(1,836)	2,951	(2,604)	847
Net Cash Inflow / (Outflow) from Operations	30,639	15,413	15,226	22,988	15,207
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	-	-	-	-	3
Cash was applied to:					
Capital Expenditure	(27,217)	(47,657)	20,440	(71,902)	(19,185)
Net Cash Inflow / (Outflow) from Investing Activity	(27,217)	(47,657)	20,440	(71,902)	(19,182)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	2,888	7,224	(4,336)	8,556	1,145
Cash was applied to:					
Repayment of Borrowings	(200)	(317)	117	(879)	(710)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	2,688	6,907	(4,219)	7,677	435
Total Increase / (Decrease) in Cash	6,110	(25,337)	31,447	(41,237)	(3,540)
Net Opening Cash & Cash Equivalents	7,582	7,582	0	7,582	31,011
Net Closing Cash & Cash Equivalents	13,692	(17,755)	31,447	(33,655)	27,471

Cash flow from Operating Activities is favourable to budget by $15.2m. 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 $14.8m.

Cash flow from Investing Activities is favourable to budget by $20.4m. The Capital Expenditure cash spend continues to reflect project delays.
Cashflow from Financing Activities is $4.2m unfavourable with delays in Capital project drawdowns. Overall, Cash flow is favourable to budget by $31.4m.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure - Cash Flow
For the period ending 28 February 2022

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	7,298	18,541	11,243	U	4,304
Clinical Equipment	15,454	14,132	(1,322)	O	10,088
Other Equipment	553	1,065	512	U	350
Information Technology	2,062	2,080	18	U	2,224
Motor Vehicles	-	30	30	U	14
Software	1,848	11,809	9,961	U	2,203
Total Expenditure	27,215	47,657	20,442	U	19,183

At 28 February 2022, our Financial Position on page 8 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $337.6m, which is $25.6m less than the budget of $363.2m.

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.

COVID-19 Capex

Total capital expenditure to date on Covid-19 related items is below.

Covid-19 Capex	MoH Funded	DHB Funded
Clinical Equipment		1,699,624
Non-Clinical Equipment		53,904
Building Works	39,718	115,823
Total Approved/ Committed/ Spent	**39,718**	**1,869,352**
Capex Requests submitted for approval		716,984
Total Currently Proposed	**39,718**	**2,586,335**

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

As at: 7/03/2022 5:43:24 ...

1/07/2021 28/02/2022

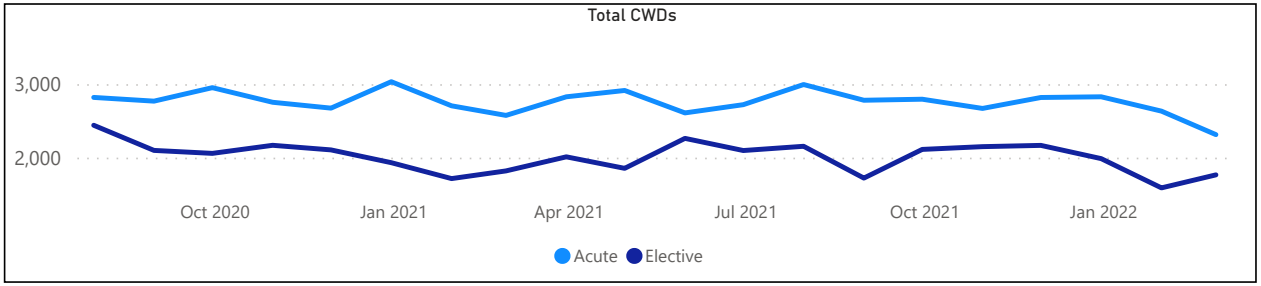
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Medical Caseweights												
Medical Acute	1,279	1,315	-35	-3%	1,333	-54	11,754	11,397	356	3%	11,882	-128
Medical Elective	339	267	72	27%	316	24	2,689	2,296	393	17%	2,750	-61
Total	**1,619**	**1,582**	**37**	**2%**	**1,649**	**-30**	**14,443**	**13,693**	**750**	**5%**	**14,632**	**-189**
Surgical Caseweights												
Surgical Acute	964	1,148	-184	-16%	1,114	-150	9,294	9,640	-345	-4%	9,625	-331
Surgical Elective	1,122	1,263	-141	-11%	1,141	-20	9,970	10,801	-831	-8%	10,622	-652
Total	**2,086**	**2,411**	**-325**	**-13%**	**2,255**	**-169**	**19,265**	**20,441**	**-1,176**	**-6%**	**20,247**	**-982**
Maternity Caseweights												
Maternity Acute	69	81	-12	-15%	127	-58	785	708	77	11%	774	11
Maternity Elective	305	322	-17	-5%	363	-58	2,988	2,798	190	7%	2,965	22
Total	**374**	**403**	**-29**	**-7%**	**490**	**-116**	**3,773**	**3,506**	**267**	**8%**	**3,739**	**33**
Total	**4,079**	**4,396**	**-317**	**-7%**	**4,395**	**-316**	**37,480**	**37,640**	**-160**	**-0%**	**38,618**	**-1,139**

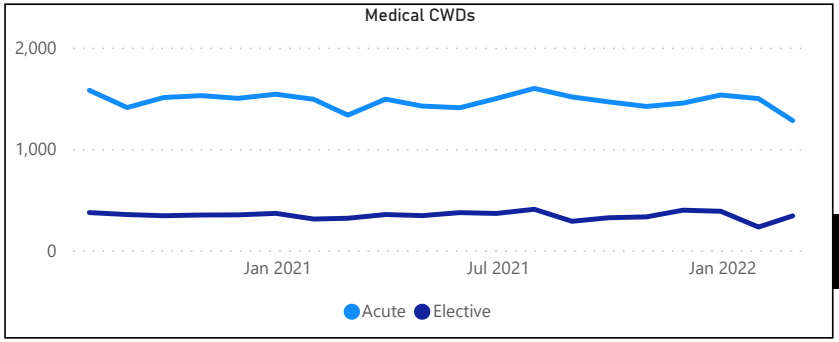
TOTALS

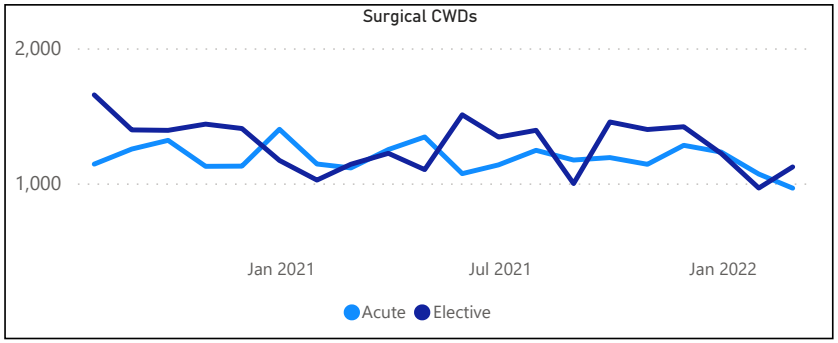
Acute	2,313	2,544	-231	-9%	2,575	-262	21,833	21,745	88	0%	22,281	-448
Elective	1,766	1,852	-86	-5%	1,820	-54	15,647	15,895	-248	-2%	16,337	-691
Total	**4,079**	**4,396**	**-317**	**-7%**	**4,395**	**-316**	**37,480**	**37,640**	**-160**	**-0%**	**38,618**	**-1,139**

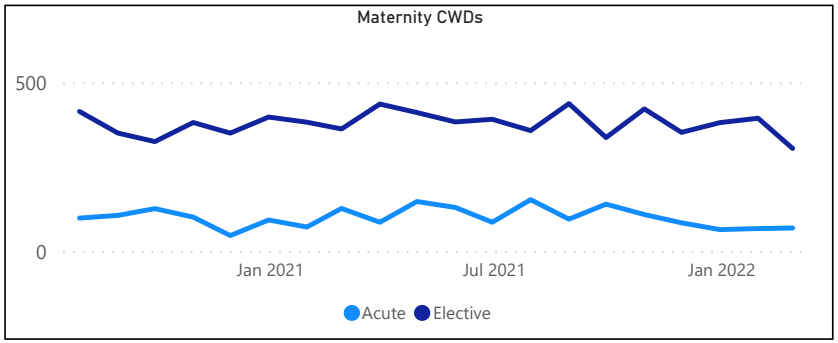
TOTALS excluding Maternity

Acute	2,244	2,463	-219	-9%	2,447	-204	21,048	21,037	11	0%	21,507	-459
Elective	1,461	1,530	-69	-5%	1,457	4	12,659	13,097	-438	-3%	13,372	-713
Total	**3,705**	**3,993**	**-288**	**-7%**	**3,905**	**-200**	**33,707**	**34,134**	**-427**	**-1%**	**34,879**	**-1,172**









8.2

SERVICE PROVIDER RAW DISCHARGES

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1/07/2021 28/02/2022

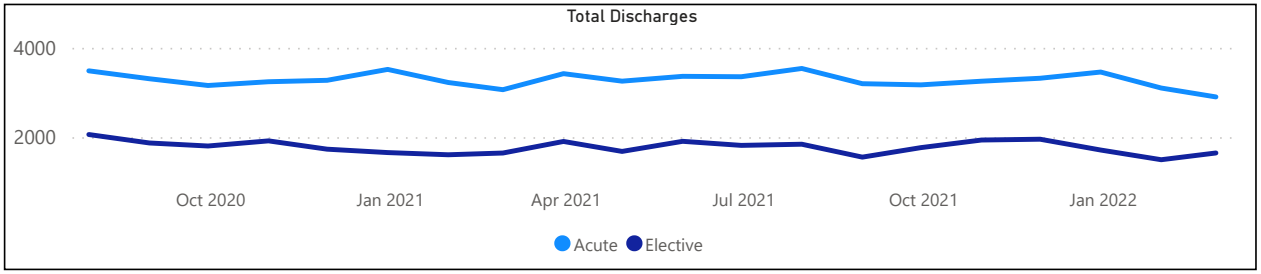
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Medical Discharges												
Medical Acute	2,204	2,099	105	5%	2,234	-30	19,349	18,227	1,122	6%	19,104	245
Medical Elective	392	308	84	27%	375	17	3,152	2,656	496	19%	3,106	46
Total	**2,596**	**2,407**	**189**	**8%**	**2,609**	**-13**	**22,501**	**20,883**	**1,618**	**8%**	**22,210**	**291**
Surgical Discharges												
Surgical Acute	641	743	-102	-14%	754	-113	5,943	6,245	-302	-5%	6,460	-517
Surgical Elective	826	885	-59	-7%	785	41	6,614	7,539	-925	-12%	7,296	-682
Total	**1,467**	**1,628**	**-161**	**-10%**	**1,539**	**-72**	**12,557**	**13,783**	**-1,226**	**-9%**	**13,756**	**-1,199**
Maternity Discharges												
Maternity Acute	56	73	-17	-23%	75	-19	645	631	14	2%	704	-59
Maternity Elective	428	431	-3	-1%	485	-57	4,138	3,744	394	11%	3,883	255
Total	**484**	**503**	**-19**	**-4%**	**560**	**-76**	**4,783**	**4,375**	**408**	**9%**	**4,587**	**196**
Total	**4,547**	**4,538**	**9**	**0%**	**4,708**	**-161**	**39,841**	**39,041**	**800**	**2%**	**40,553**	**-712**

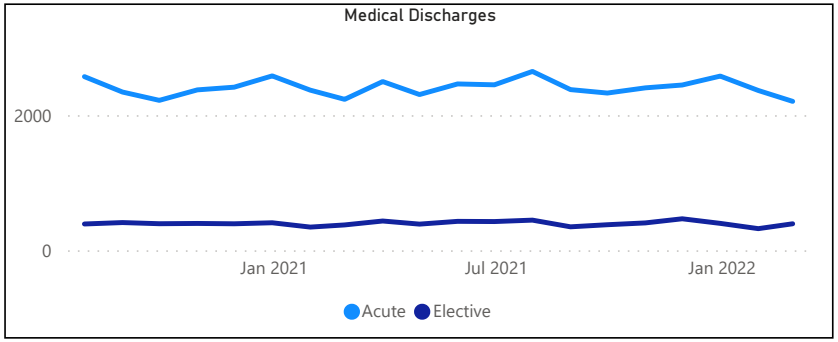
TOTALS

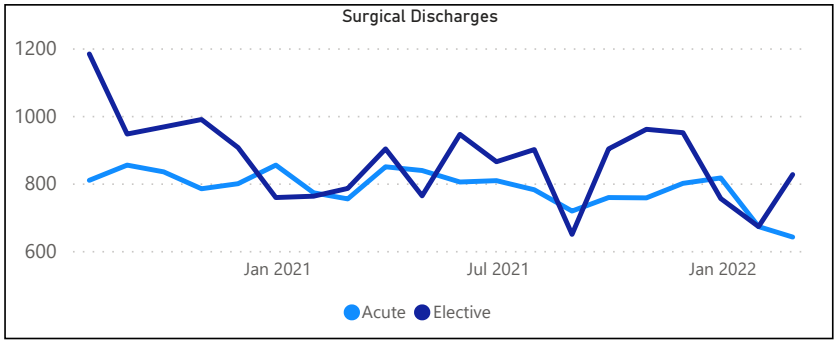
Elective	1,646	1,624	22	1%	1,645	1	13,904	13,938	-34	-0%	14,285	-381
Acute	2,901	2,915	-14	-0%	3,063	-162	25,937	25,103	834	3%	26,268	-331
Total	**4,547**	**4,538**	**9**	**0%**	**4,708**	**-161**	**39,841**	**39,041**	**800**	**2%**	**40,553**	**-712**

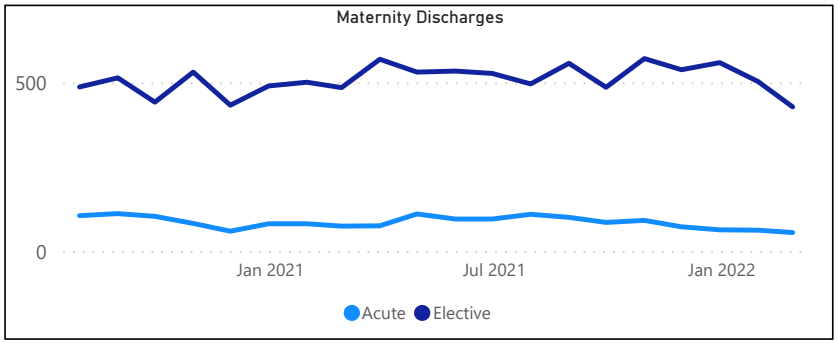
TOTALS excluding Maternity

Elective	1,218	1,193	25	2%	1,160	58	9,766	10,194	-428	-4%	10,402	-636
Acute	2,845	2,842	3	0%	2,988	-143	25,292	24,472	820	3%	25,564	-272
Total	**4,063**	**4,035**	**28**	**1%**	**4,148**	**-85**	**35,058**	**34,666**	**392**	**1%**	**35,966**	**-908**



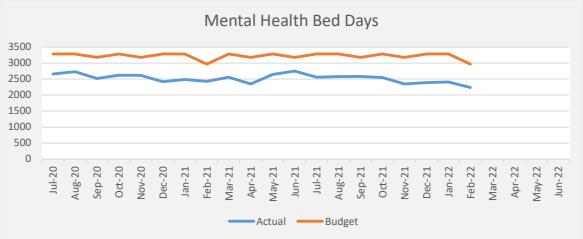




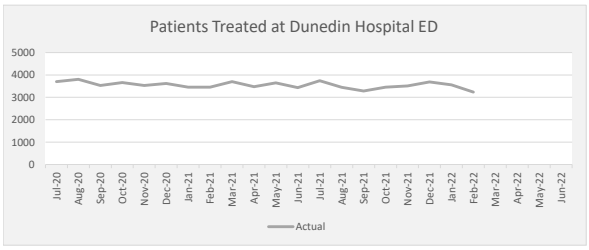


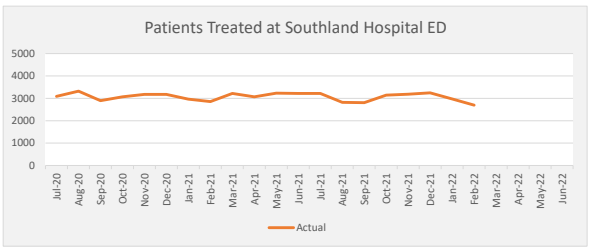
OTHER ACTIVITY

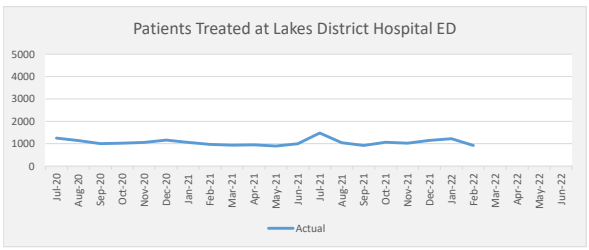
Feb-22				Feb-21	YEAR ON YEAR		YTD 2021/2022				YTD Feb-21	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,237	2,968	(731)	-25%	2,428	(191)	**Mental Health bed days**	19,660	25,758	(6,098)	-24%	20,488	(828)

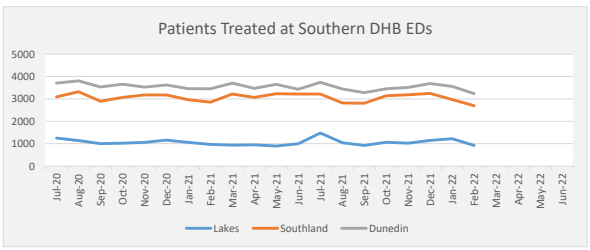


Feb-22	Feb-21	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2021/2022	YTD Feb-21	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,235	3,455	(220)	Dunedin	27,915	28,768	(853)
921	967	(46)	Lakes	8,823	8,662	161
2,696	2,852	(156)	Southland	24,084	24,544	(460)
6,852	7,274	(422)	**Total ED presentations**	60,822	61,974	(1,152)









8.2

FOR INFORMATION

Item: Quality Dashboard – April 2022

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

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – April 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. Māori ED Wait Time had been added this month

10. We are expecting an update from the Health Round Table on March so will update the HRT benchmarked measures for next month

11. Please see commentary for further details on measures

Next Steps & Actions

Equity reporting continues to be reviewed and worked on with the new Equity Analyst in IT and we expect further measure to be added over the coming months. Exact timeframes are difficult to establish due to resources being assigned to the COVID response. Please note that the graphs for SAC events require updating. This is in the work programme for IT and should be completed for next month.

Appendices

Appendix 1	**Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital**
Appendix 2	**Executive Quality Dashboard - Maori**
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

		Southern			Dunedin			Invercargill		
	Quality of care	*Actual*	*Benchmark/ 3 year average*	*Trend*	*Actual*	*Benchmark/ 3 year average*	*Trend*	*Actual*	*Benchmark/ 3 year average*	*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 %				2.5	3.4		4.1	3.2	
5	Mental Health Seclusions no	24	32							
6	Mental Health Restraints no	140	131		47	48		5	13	
7	Deaths no	53	58		25	28		15	14	
8	ED Wait Time - % patients discharged within 6 hours				72	95		81	95	
9	Vulnerable Patients (Aged 70 and over; Triage Category 1 2 3) in ED > 6 hours				174	162		164	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	25	24							
	Staff									
12	Staff Events - SAC 1 and 2 no				0	0		0	0	
13	Staff Events - SAC 3 and 4 no				29	16		5	4	
	Patient Experience									
14	Complaints no	82	82		51	42		20	30	
15	Complaint response target met %	72	100		75	100		42	100	
16	Short Notice Postponments No				26	42		27	28	
17	Short Notice Postponments %				3.61	4.5		9.8	6.5	
	Operations									
18	Referrals Declined %				15	15		13	14	
19	Length of stay days				3.4	4.5		3.1	3.3	
20	Patients with stay > 7 days no				308	384		151	169	
21	Patients with stay > 21 days no				79	87		48	42	

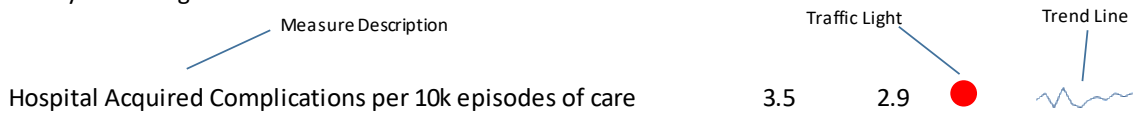
Appendix 2 Executive Quality Dashboard – Māori

		Southern			Dunedin			Invercargill		
	Quality of care	*Actual*	*3 year average*	*Trend*	*Actual*	*3 year average*	*Trend*	*Actual*	*3 year 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	6	3							
8	ED Wait Time - % patients discharged within 6 hours				78	95		85	95	
9	Vulnerable Patients (Aged 70 and over; Triage Category 1 2 3) in ED > 6 hours	15	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	3	7							
17	Short Notice Postponments %	4	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: On or better than target or: In line with 3 year average	Performing well and/or stable process
	In the middle 50% of Health Round Table peer comparison or: Within 10% of target or: 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: Great than 10% away from target or: 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 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 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 The next update from HRT is due in March Benchmark: HRT
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) 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. 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 The next update from HRT is due in March Benchmark: HRT
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) 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) 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 The next update from HRT is due in March Benchmark: HRT
4	Readmissions within 7 days %	Readmissions continue to be stable across both hospitals Māori readmissions are slightly higher than the 3 year average	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 Benchmark: Internal - 3 year average
5	Mental Health Seclusions no	Seclusions continue to be stable across both hospitals	Seclusions iPM and HCS data. The number of seclusion events per month. Seclusions are reportable for district only Māori seclusion data is not verified at this time so is not included Benchmark: Internal - 3 year average
6	Mental Health Restraints no	Restraints have reduced significantly in the last period, particularly in Dunedin. Over the last periods there has been significant variation in restraint numbers. This is likely due to the majority of restraints occurring in a very small number of patients. Mental Health are working on a number of mitigations to these issues including medication changes and staff training	Restraints Safety 1st data. The number of restraint events per month. Māori restraint data is not verified at this time so is not included. Benchmark: Internal - 3 year average
7	Deaths no	Deaths are stable over time.	Deaths Number of patients deceased by discharge month.

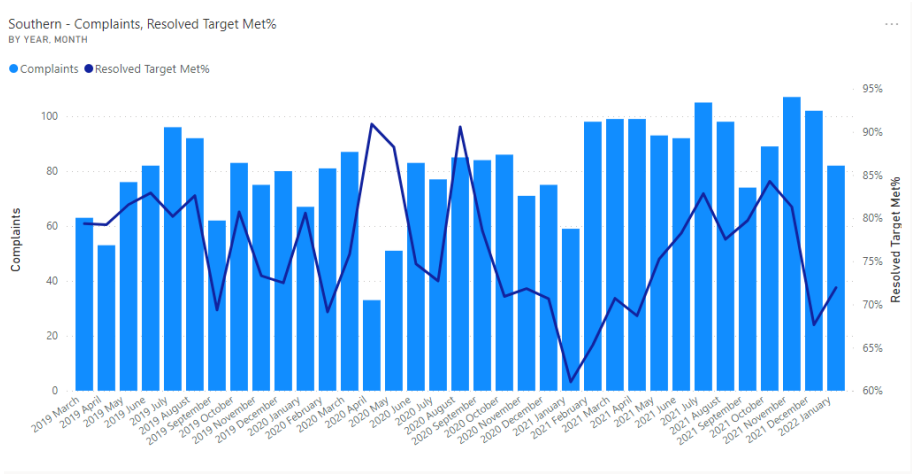
		Māori deaths in hospital are in the low single figures so it is difficult to draw meaningful conclusions from this data	Benchmark: Internal - 3 year average
8	ED Wait Time - % patients discharged within 6 hours	Our EDs continue to be under pressure and are struggling to meet this target Maori ED Wait Time figures are in line with the rest of the population	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 Benchmark: MOH Target
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 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 Benchmark: Internal - 3 year average
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 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 Benchmark: HRT
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. Māori pressure injury data is not verified at this time so is not included Benchmark: Internal – 12 month average

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 Benchmark: Internal - 3 year average
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). Benchmark: Internal - 3 year average
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. 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 The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month. Benchmark: Internal - 3 year average
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 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. Benchmark: Internal - 3 year average
16	Short Notice Postponement No	In terms of numbers short notice postponements are in line with long term trends. Māori numbers are in line with long term trends	Short Notice Postponements Theatre postponements within 24 hours of the scheduled procedure Benchmark: Internal - 3 year average

17	Short Notice Postponement %	Short notice postponements are above long term trends which is indicative of the pressure on surgical services	Short Notice Postponements % Theatre postponements within 24 hours of the scheduled procedure Benchmark: Internal - 3 year average
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. % referrals declined Benchmark: Internal - 3 year average
19	Length of stay days	Dunedin LOS dropped this month after being slightly higher for a number of months Invercargill LOS is stable	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 Māori LOS data is still to be verified and is not included Benchmark: Internal - 3 year average
20	Patients with stay > 7 days no	Patients staying longer than 7 days are in line with long term trends Māori patients are under long term trends	Number of Patients with LOS > 7 Days Number of patients per month who have a LOS > 7 days Benchmark: Internal - 3 year average
21	Patients with stay > 21 days no	Patients over 21 days have dropped within the last period Māori patients are under long term trends	Number of Patients with LOS > 21 Days Number of patients per month who have a LOS > 21 days Benchmark: Internal - 3 year average

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

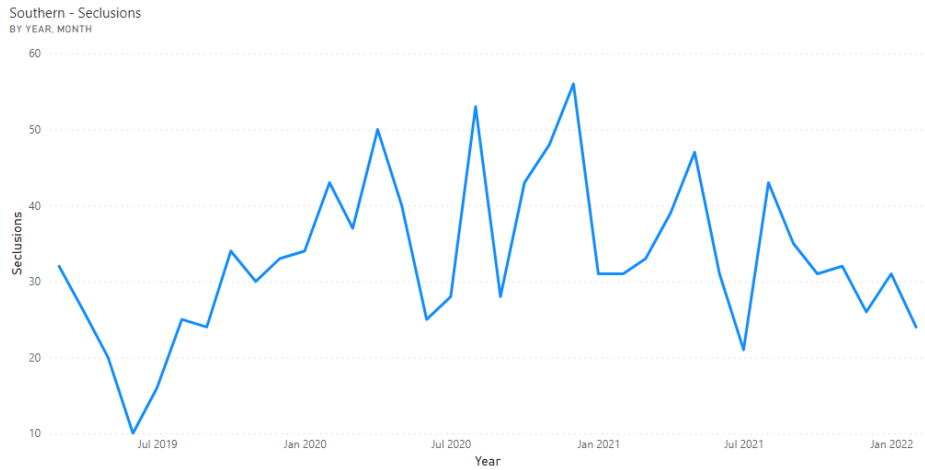
There is a one month (20 working days) time period for complaints to be resolved, or to communicate additional time required to the patient. For that reason the current reporting month will always appear as a lag.

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

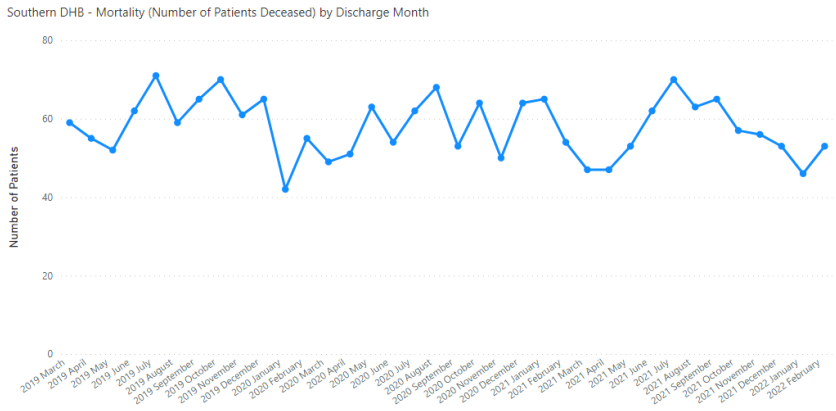
Safety 1st data. The number of restraint events per month. Restraints data includes Dunedin, Invercargill, Wakari and Lakes



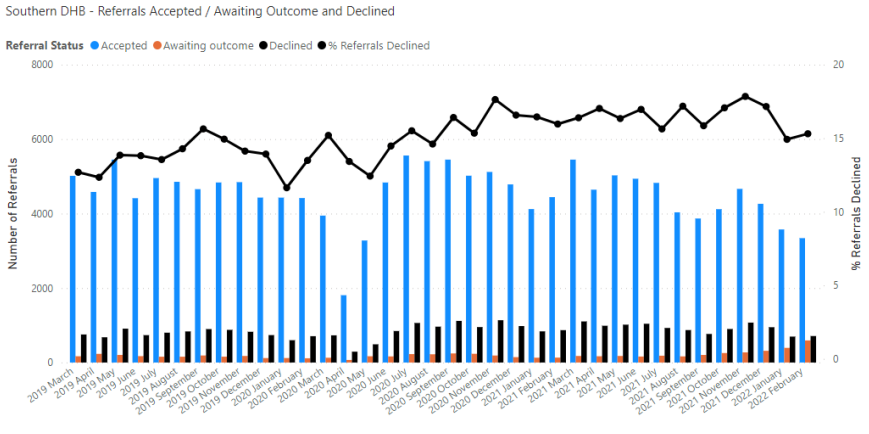
Seclusions

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

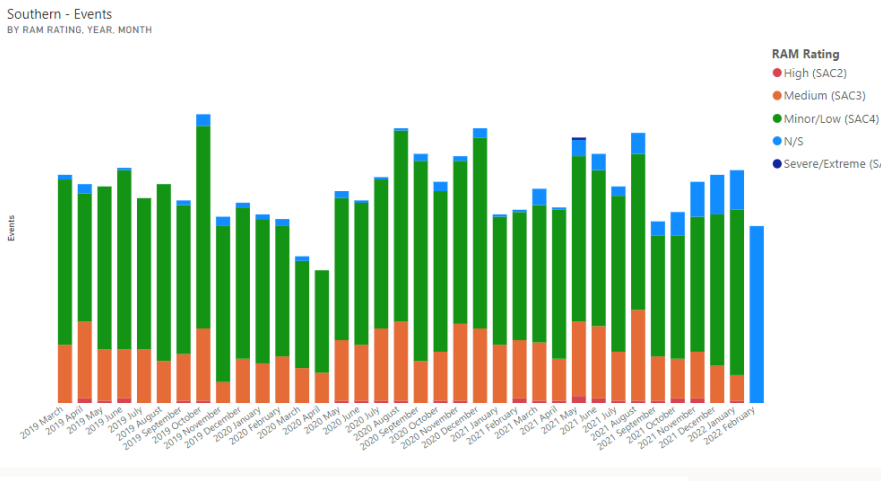
Executive Dashboard – Experience (Southern)



Deaths
Number of patients deceased by discharge month



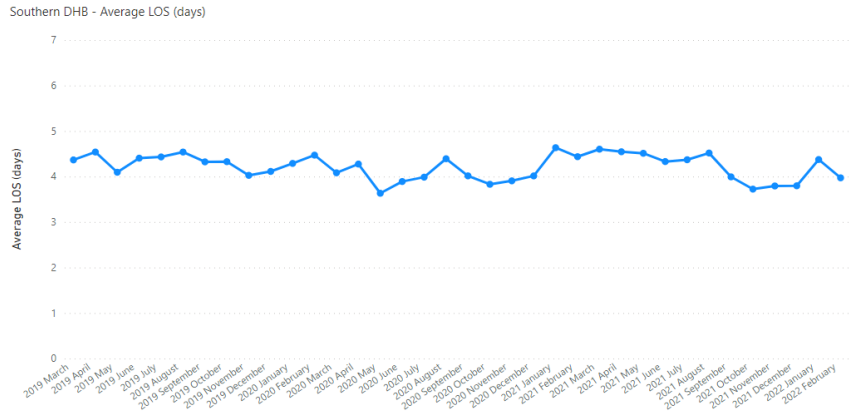
Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



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

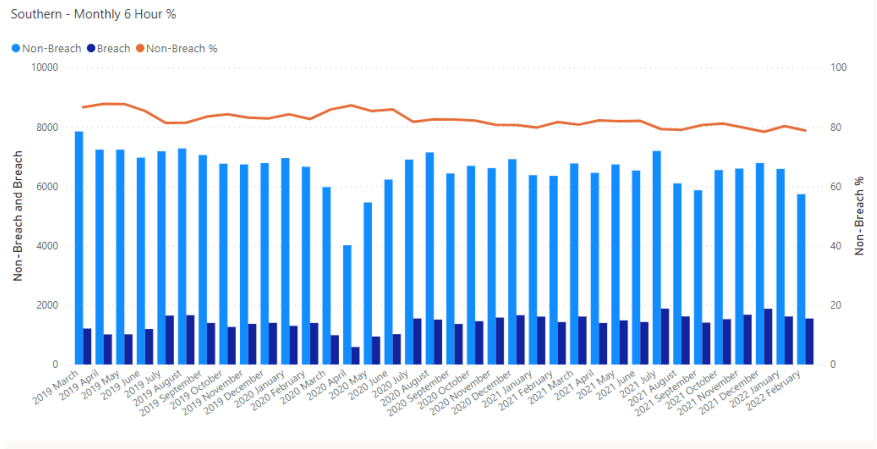
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls form (visitor falls) which were not associated with clinical practice. These events are not assessed in the same way as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

Executive Dashboard – Efficiency (Southern)



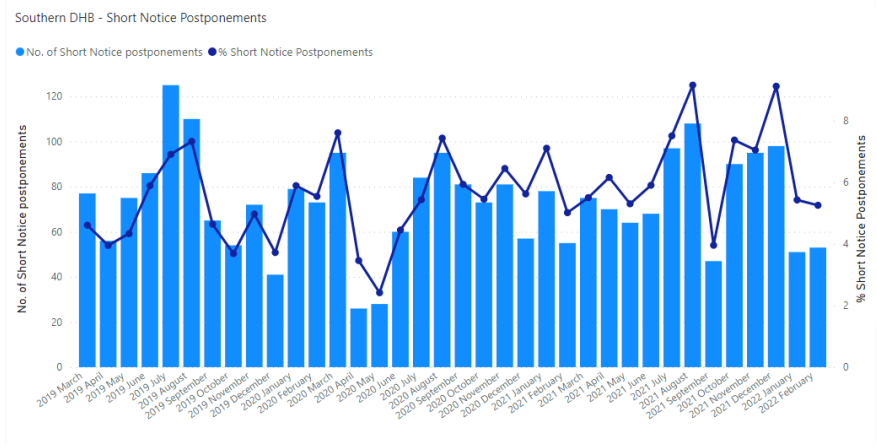
Average Length of Stay

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

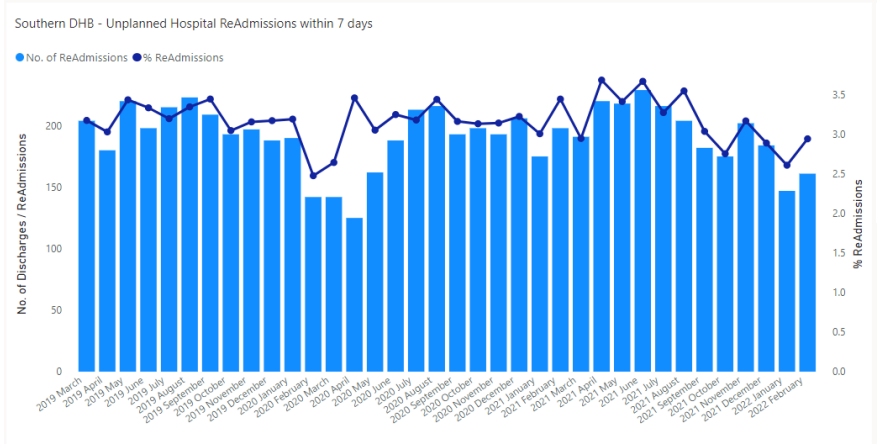
Theatre postponements within 24 hours of the scheduled procedure.

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

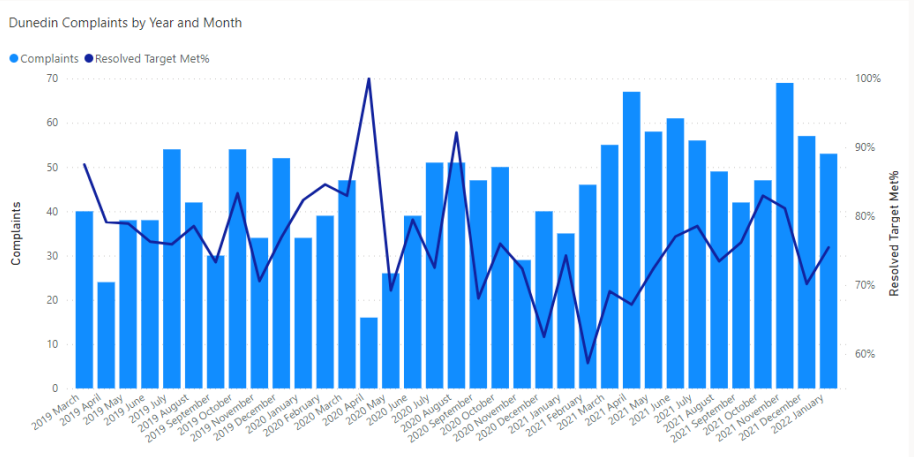
Number of patients in hospital at any point of time when they have exceeded 7 days since admission.



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

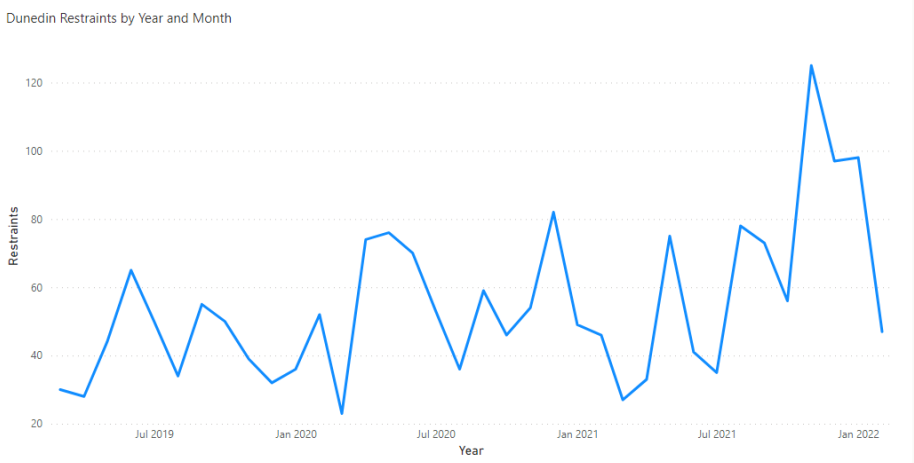
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

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.

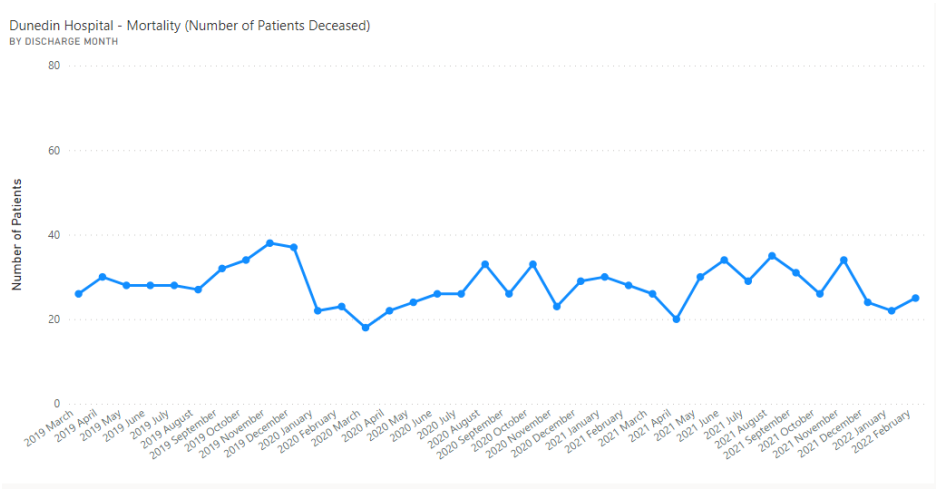


Restraints

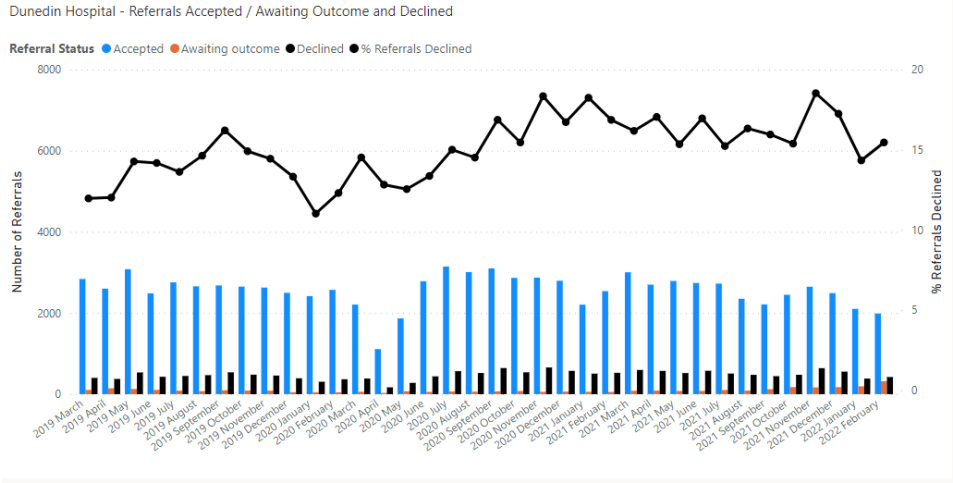
Safety 1st data. The number of restraint events per month.

8.3

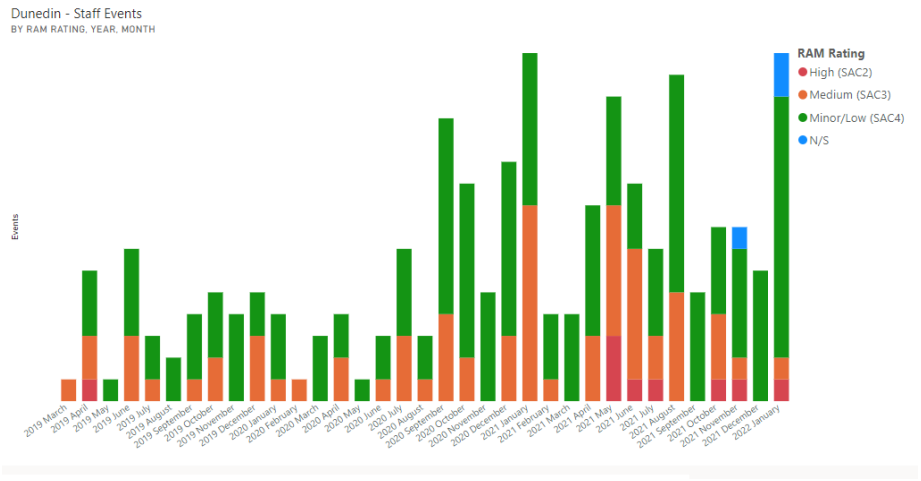
Executive Dashboard – Effectiveness (Dunedin)



Deaths
Number of patients deceased by discharge month.

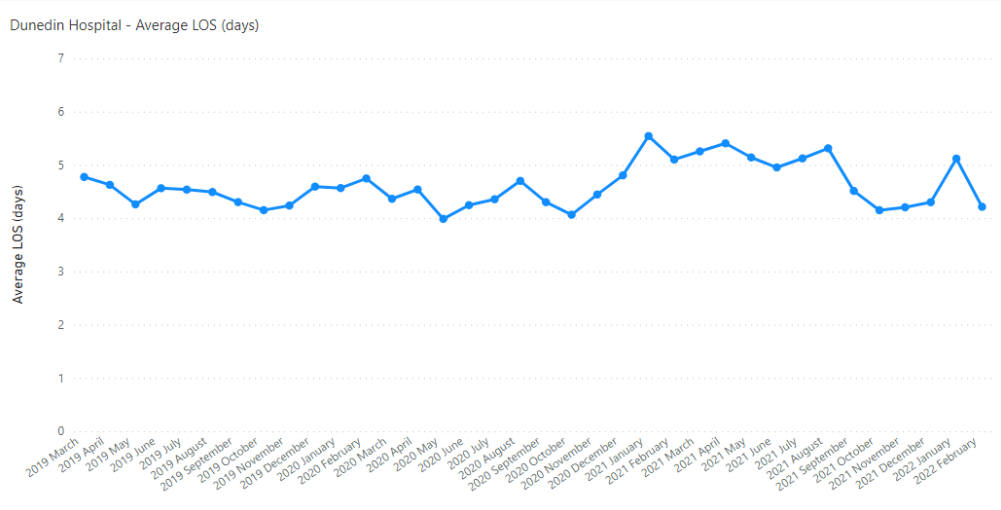


Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



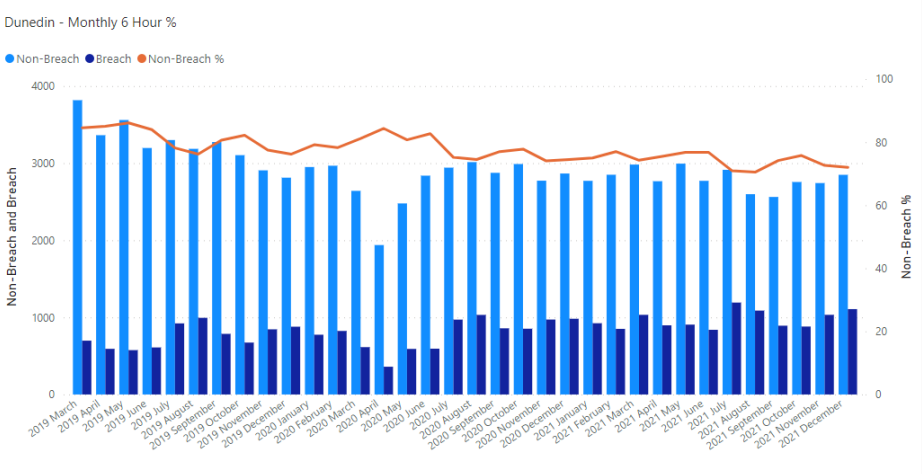
Safety 1st data.
The monthly number of reported staff adverse events Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

Executive Dashboard – Efficiency (Dunedin)



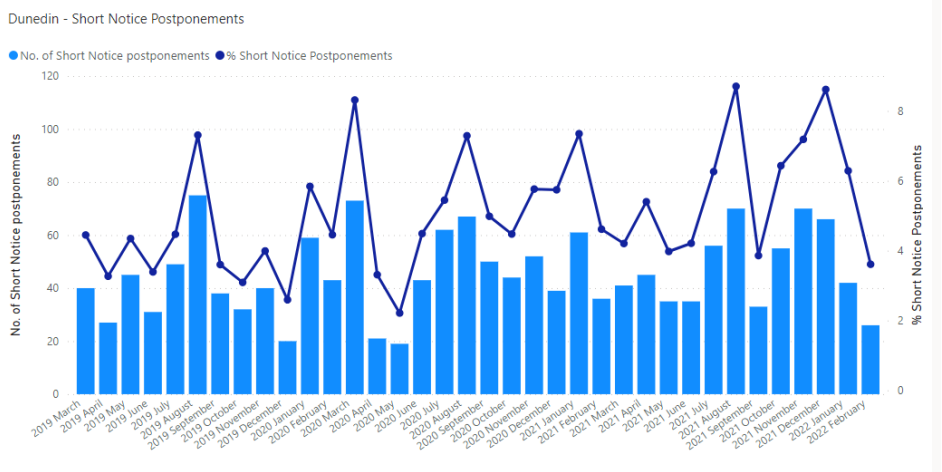
Average Length of Stay

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.

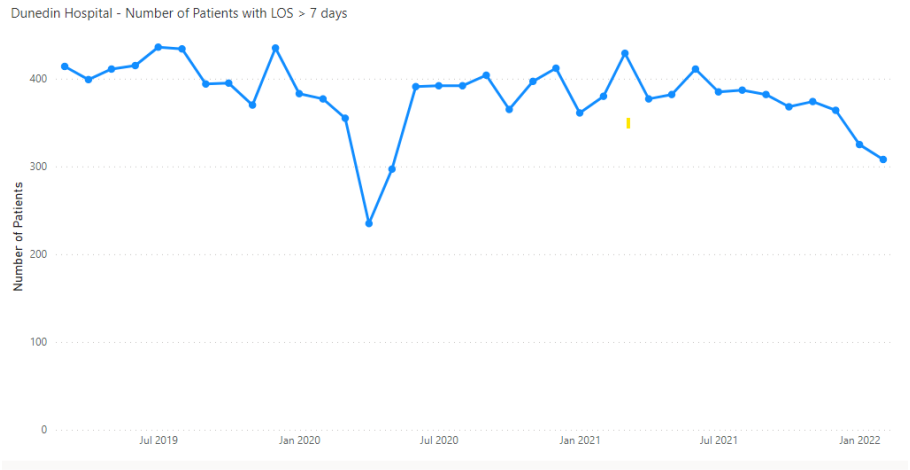


Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure.

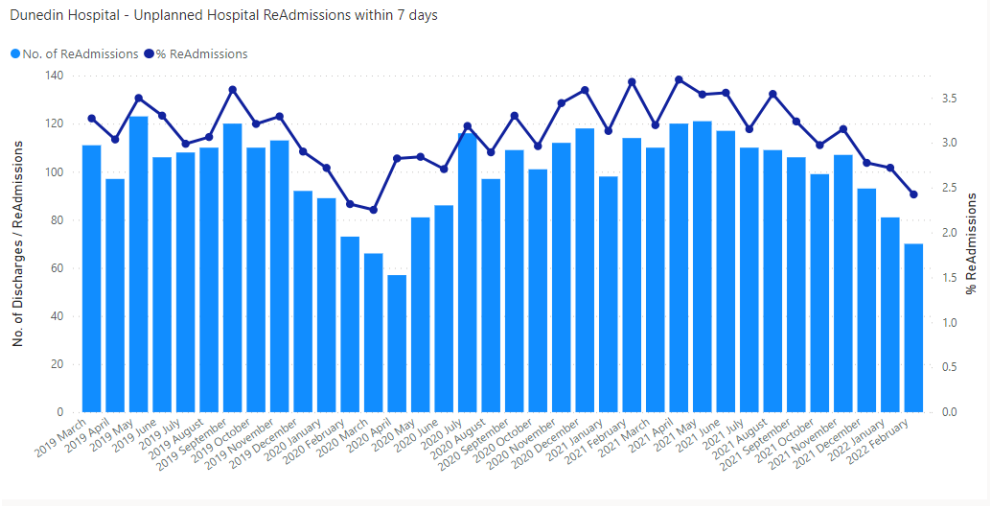
Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

Executive Dashboard – Timely (Dunedin)



Number of Patients with LOS > 7 days

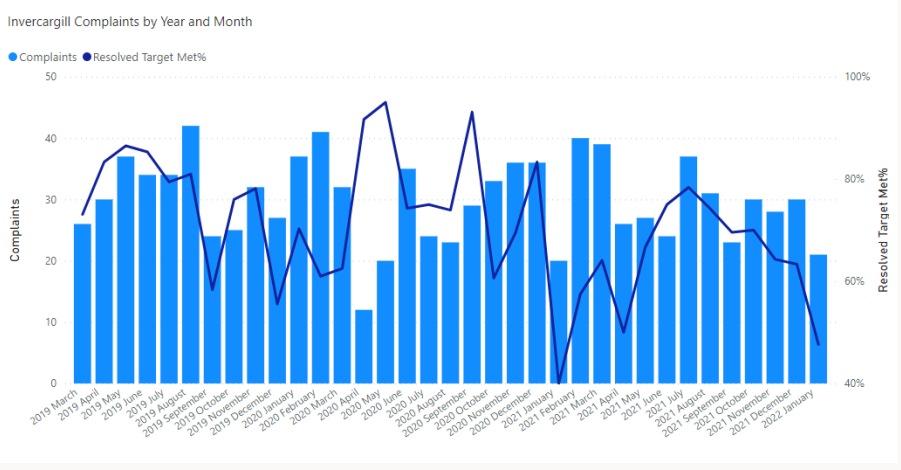
Number of patients per month who have a LOS > 7 days



Unplanned Hospital Readmissions within 7 Days

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

Executive Dashboard – Patient Experience (Invercargill)



Safety 1st data.

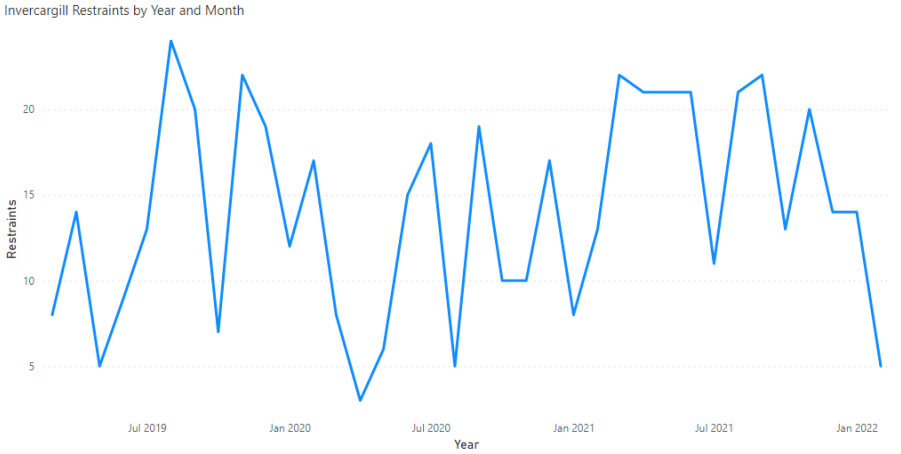
Complaints

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

Resolutions

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

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

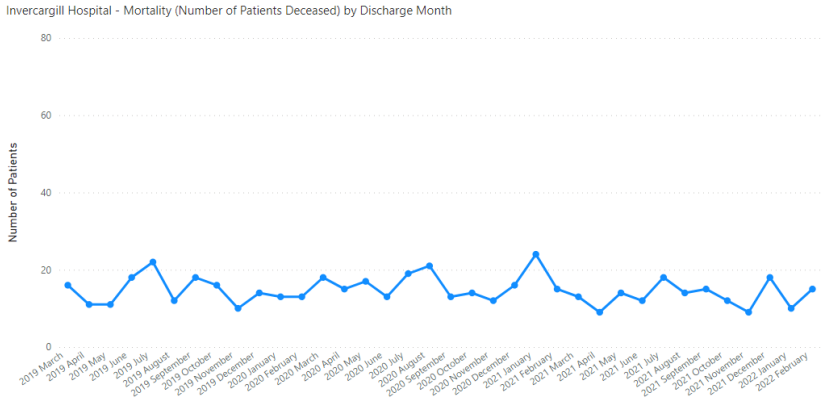


Restraints

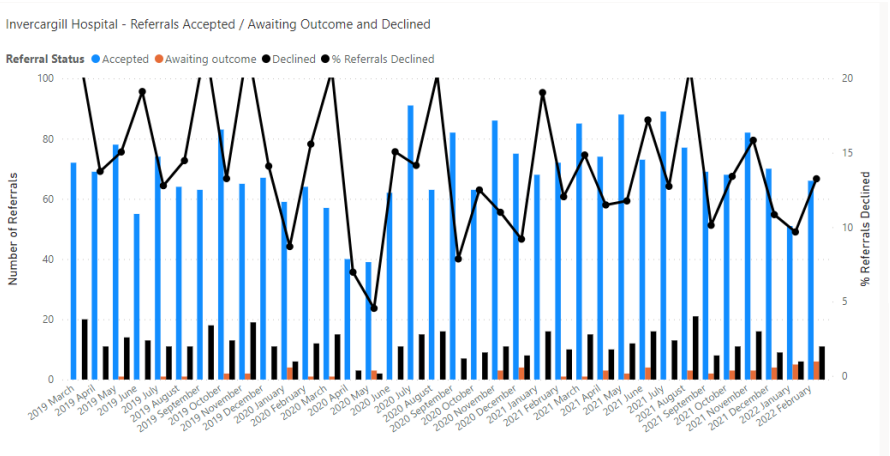
Safety 1st data. The number of restraint events per month. Restraints data for Invercargill only.

8.3

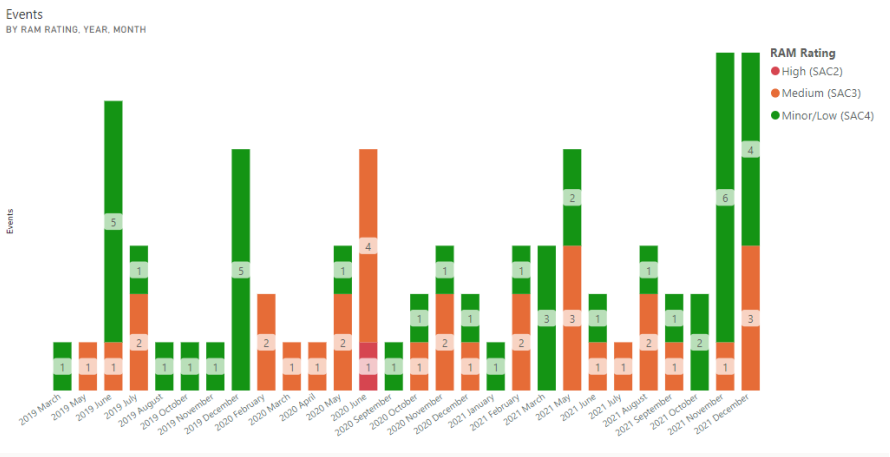
Executive Dashboard – Effectiveness (Invercargill)



Deaths
Number of patients deceased by discharge month.

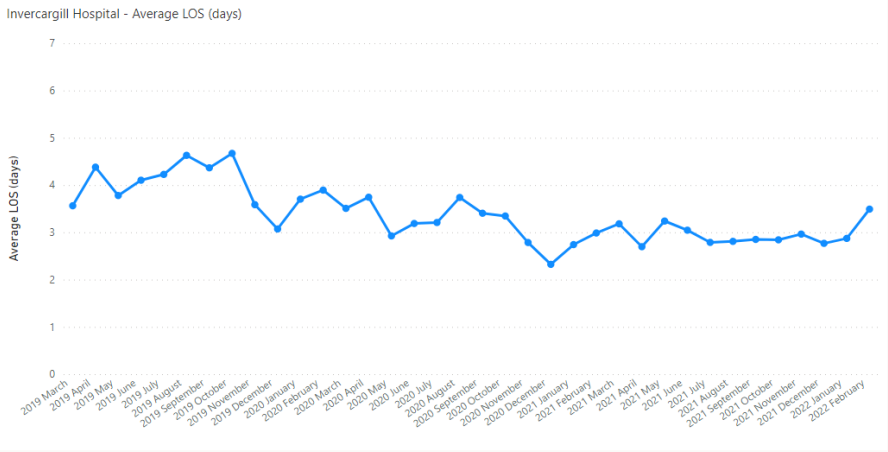


Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined.

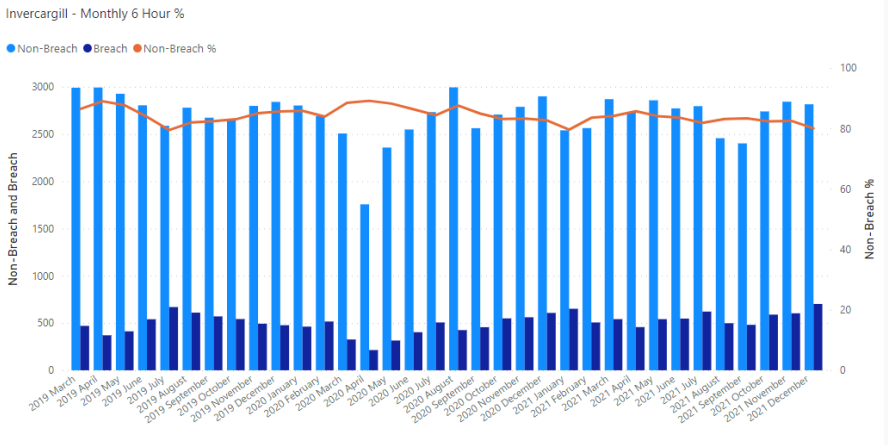


Safety 1st data.
The monthly number of reported
Staff adverse events.
Categorised by severity assessment Codes 1-4 and by 'N/S' (Not specified).

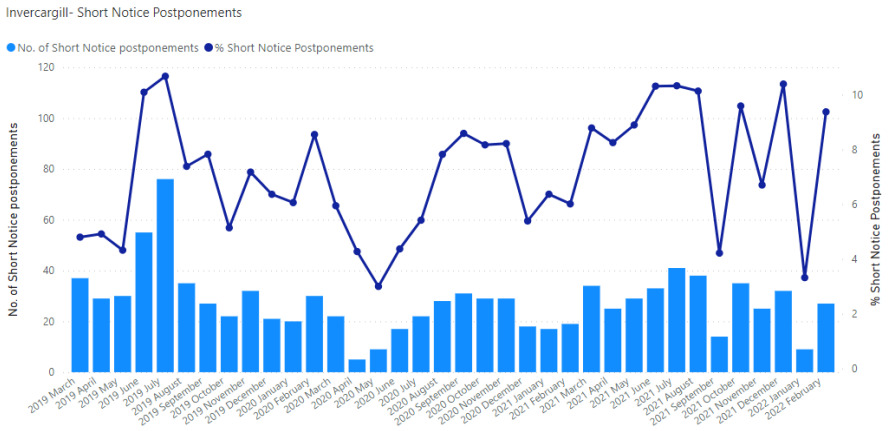
Executive Dashboard – Efficiency (Invercargill)



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

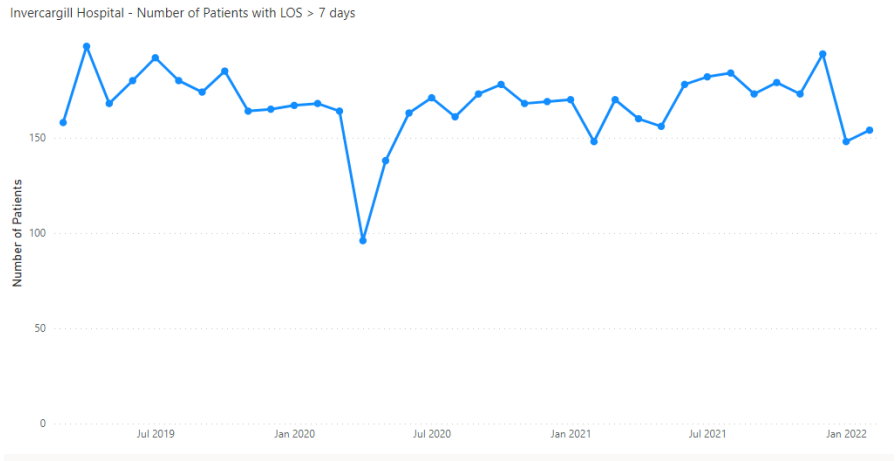


Monthly 6 Hour %
Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This includes the time spent in ED observation.



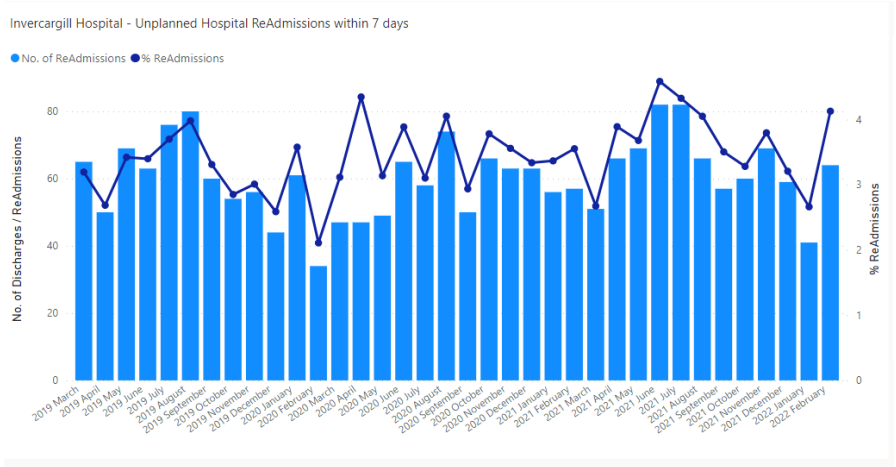
Short Notice Postponements
Theatre postponements Within 24 hours of the scheduled procedure.

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 March 2022

Proposed by: Planning & Accountability Mgr

Meeting of: 5 April 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 complete with CCDM data reporting being built since the last update. Some final tweaks to HR metrics are pending. The metrics provided here as snips are only a snapshot and there are some indicators not included here as they don't translate easily into a static document.

Next Steps & Actions:

- Link to the PowerBi Dashboard: Executive Performance Dashboard
- Continue to monitor system performance and make adjustments to dashboard for legibility as required.

Appendices

1. **Performance Dashboard Progress Update March 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

Monthly Snapshot of current metrics as of 14/03/22:

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 February data because they have been extracted in February.

Figure 2

ED 6 Hr Target KPI Feb 2022

ED 6 Hour Target (95%) SS10: Shorter Stays in Emergency Departments.

Southern	Feb	Jan	
	% Non-Breach	% Non-Breach Prev. Mth	% Non-Breach Change
	78.76%	80.29%	-1.52% ▼
	ED Presentations for the Month	Non-Breaches	Breaches
	7280	5734	1546
Dunedin Hospital			
	% Non-Breach	% Non-Breach Prev. Mth	% Non-Breach Change
	72.31%	73.47%	-1.17% ▼
	ED Presentations for the Month	Non-Breaches	Breaches
	3463	2504	959
Southland (Kew) Hospital			
	% Non-Breach	% Non-Breach Prev. Mth	% Non-Breach Change
	81.10%	82.04%	-0.94% ▼
	ED Presentations for the Month	Non-Breaches	Breaches
	2878	2334	544

Figure 3.

Resourced Occupancy Last Complete Month Feb 2022

Southern District Health Board Pīki Te Ora

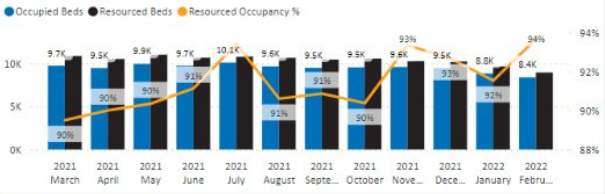
Information Systems
Business Intelligence

Occupancy from IPM midnight census, Resource beds from CaaG

Southern	Feb	Jan	
	Occupancy %	Occupancy % Prev. Mth	% Change
	94%	92%	2% ▲
Dunedin Hospital			
	Occupancy %	Occupancy % Prev. Mth	% Change
	95%	94%	1% ▲
Southland (Kew) Hospital			
	Occupancy %	Occupancy % Prev. Mth	% Change
	91%	86%	5% ▲

Exclusions:
All hospitals except Dunedin and Southland (Kew)
Ward Exclusions:
NICU, NNU, IMHU, CW, Dx LNGE, PAAU, MAT, DAY OT, CU, 6c, 7DU, 4B, 4Day, DSU, QM_AN, QM_DEL, QM_PN
Hover for details

Resourced Occupancy %



Resourced Occupancy % by Hospital

Year	2021									
HospitalDesc	March	April	May	June	July	August	September	October	November	December
Dunedin Hospital	91%	93%	90%	92%	95%	92%	94%	92%	95%	93%
Southland (Kew) Hospital	85%	84%	90%	89%	90%	86%	84%	86%	91%	93%
Total	**90%**	**90%**	**90%**	**91%**	**93%**	**91%**	**91%**	**90%**	**93%**	**93%**

Resourced Occupancy % by Ward

Year	2022			
Month		February		
Ward	Occupancy %	Resourced Beds	Occupied Beds	Resourced Occupancy %
4C - 4C General Surgery	99%	695	714	103%
4A - 4A General Surgery	96%	556	562	101%
3SRGC - 3 Surgical C	99%	601	598	100%
7C - Cardiology / Renal	97%	409	413	101%
4HDU - 4Th High Dependency Unit	98%	112	109	97%
6ATR - 6 Assess, Treat & Rehab	94%	548	535	98%
8MED - Internal Medicine	95%	881	842	96%
REH - Southland Hospital - Rehabilitation Services	91%	482	465	96%
MED - Southland Hospital - Medical Ward	93%	1038	984	95%
Total	**92%**	**8934**	**8370**	**94%**

Figure 4.

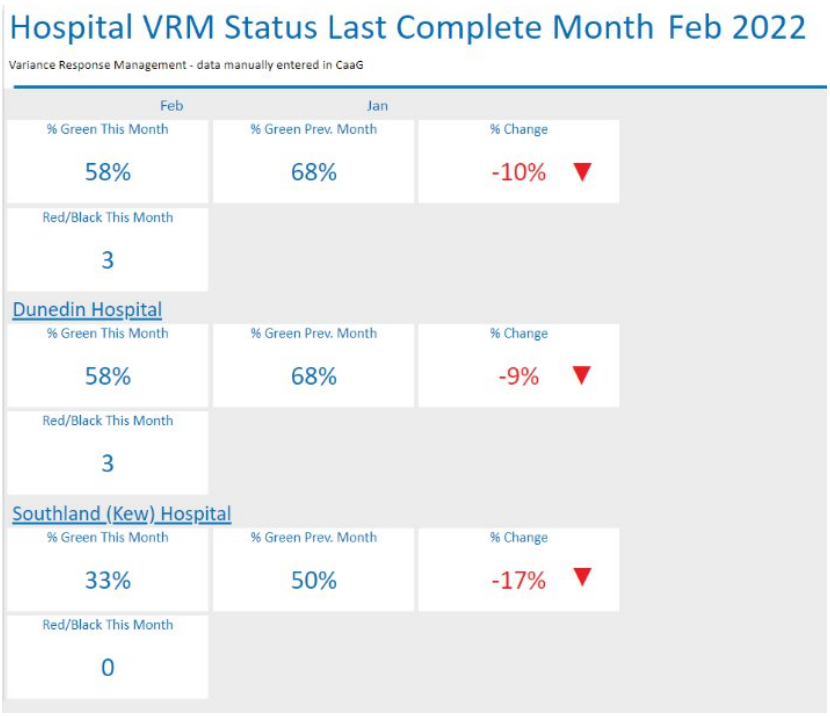


Figure 5.

FOR INFORMATION

Item:	Quarter Two 2021/22 Reporting: Southern DHB Performance and Annual Plan Reporting to the Ministry Of Health
Proposed by:	Andrew Lesperance, Executive Director, Planning, Funding and Population/Public Health
Meeting of:	Board, 5 April 2022

Recommendation

That Board notes the content of these papers.

Purpose

1. To provide an overview of Southern DHB Performance Reporting to the Ministry of Health for Quarter Two 2021/22, including comment where targets or expectations have not been met.

2. To provide a summary of DHB Annual Plan Reporting to the Ministry of Health for Quarter Two 2021/22.

Specific Implications for Consideration

3. Financial

    - Recovery due to missed targets may have financial implications.

4. Quality and Patient Safety

    - Reports may signal need for improvements in service quality.

5. Operational Efficiency

    - Reports may signal need for improvements in operational efficiency.

6. Workforce

    - Recovery due to missed targets may have workforce implications.

7. Equity

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

8. Other

    - Not identified

Background

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

10. Annual Plan Quarterly Reports are prepared quarterly to demonstrate progress against Annual Plan actions. Reports are submitted to the Ministry of Health as part of performance monitoring requirements.

Discussion

11. The document, *Performance Monitoring Report Q2 21.22*, summarises Southern DHB quarter one performance reporting to the Ministry of Health. This report includes comments where targets or expectations have not been met.

12. The document, *Annual Plan Quarterly Report Q2 2021/22* summarises Annual Plan Reporting to the Ministry of Health.

Next Steps & Actions

13. Southern DHB will submit the Quarter Three performance monitoring reports to the Ministry of Health on 20 April 2022. The compiled document, *Performance Monitoring Report Q3 21.22*, will be submitted to ELT following Ministry of Health ratings and final feedback.

14. Southern DHB will submit the Quarter Three 21/22 Annual Plan report to the Ministry of Health on 20 April 2022.

Appendices

Appendix 1 *Performance Reporting Q2 2021.22*

Appendix 2 *Annual Plan Quarterly Report Q2 21.22*

Southern DHB Performance Reporting Q2 2021.22

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

Performance Measure Reporting

Performance Measures are categorised into five different areas related to Government priorities. Government priorities for Performance Measures include:

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

Progress towards each measure will be assessed and reported to the Minister of Health according to the reporting frequency outlined in the indicator dictionary for each measure (found on the NSFL https://nsfl.health.govt.nz/accountability/performance-and-monitoring/performance-measures/performance-measures-202122
A resolution plan, that outlines the actions being taken to address poorer than planned performance, must be supplied where performance does not meet the agreed expectation. Where a performance measure description does not include specific assessment criteria, the following criteria will apply:

Assessment Criteria/Ratings for Performance Measures

Rating	Abbrev	Criteria
Outstanding performer/sector leader	O	1. This rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations. 2. This rating is applied when the DHB has met the target agreed in its Annual Plan and has achieved the target level of performance for the Māori population group, and the Pacific population group. Note: this rating can only be applied in the fourth quarter for measures that are reported quarterly or six-monthly. Measures reported annually can receive an 'O' rating, irrespective of when the reporting is due.
Achieved	A	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. For those measures where reporting by ethnicity is expected, this rating should only be applied when the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and the Pacific population group. 4. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	1. Target/expectation not fully met, (including not meeting expectations for Māori and Pacific population groups) but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required.

		3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved, and a resolution plan satisfies the assessor that the DHB is on track to compliance for the requirements not met.
Not achieved – escalation required	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

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

Annual Plan Reporting

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

CFA Variation Reporting

Assessment criteria are different to the criteria applied to health targets and performance measures. The progress and developmental reporting nature for CFA variations is more compliance based, and therefore the target-oriented nature of performance measure assessment is not considered appropriate. The assessment criteria detailed below reflect the more qualitative nature of this component.

Assessment Criteria/Ratings for CFA Variations

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

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

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

Index of reports

Key to Owner Initials

Initial	Owner	Title/Directorate
AL	Andrew Lesperance	Executive Director Planning, Funding & Population/Public Health
HB	Hamish Brown	Acting Chief Operating Officer
HL	Hywel Lloyd	Acting Executive Director Quality & Clinical Governance Solutions
GT	Gilbert Taurua / Mata Cherrington	Chief Māori Health Strategy & Improvement Officer
TG	Toni Gutschlag / Gilbert Taurua	Executive Director Mental Health Addictions and Intellectual Disability
JW	Jane Wilson	Chief Nursing and Midwifery Officer
NT	Nigel Trainor	Executive Director Corporate Services
PN	Patrick Ng	Chief Digital Officer

Executive Summary: Southern DHB Non-Financial Performance Reporting

Performance Measures Overview

Performance area	Number of outstanding measures	Number of achieved measures	Number of partially achieved measures	Number of not achieved measures	Unreported measures	Unrated measures	Total number of measures
Improving Child Wellbeing		2	5*	1			8
Improving Mental Wellbeing		8	3				11
Better Population Health Outcomes supported by Strong and Equitable Public Health Services	2	6	5	3		1	17
Better Population Health Outcomes supported by Primary Health Care		1	2	1			4
Improving wellbeing through Prevention			1				1
Health System Indicators						7	7
Status Update Reports – Annual Plan Actions		2	5				7
Total	2	18	22	5	0	8	55

*One measure is rated B but is included as partially achieved for the purposes of this report

Crown Funding Agreements

	Number of satisfactory ratings	Number of further work required ratings	Number of not acceptable measures	Unreported	Total number
CFA agreements	7*	1			8

*Two measures have been rated A but is included as satisfactory for the purposes of this report

Summary of Reports with 'N' Ratings

Code	Performance Measure	Final Rating	Change from previous rating	Page number	Owner initials
Child Wellbeing					
CW08	Increased Immunisation (at 2 years)	N	→	16	AL
Better population health outcomes supported by strong and equitable public health services					
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA2: Improving the quality of data submitted to National Collections	N	↓	31	PN
SS11	Faster Cancer Treatment (62 days)	N	→	35	HB
SS13	Improved management for long term conditions FA5: Stroke service	N	↓	40	AL
Better Population Health Outcomes supported by Primary Health Care					
PH04	Better help for smokers to quit (primary care)	N	↓	48	AL

Summary of Quarter 2 ratings 2020/21

Code	Performance Measure	Final Rating	Change from previous rating	Page number	Owner initials
Improving child wellbeing					
CW08	Increased immunisation at 2 years of age	**N**	→	16	**AL**
CW03	Improving the number of children enrolled in and accessing the Community Oral Health Service	**P**	→	9	**AL**
CW05	Immunisation coverage: FA1 8-month old immunisation coverage	**P**	↑	9	**AL**
CW05	Immunisation coverage: FA2 5-year old immunisation coverage	**P**	↑	12	**AL**
CW07	Improving newborn enrolment in General Practice	**P**	→	15	**AL**
CW09	Better help for smokers to quit (maternity)	**P(B)**	↑	19	**AL**
CW10	Raising healthy kids	**A**	→	19	**AL**
CW12	Youth mental health initiatives (Initiative 1 SBHS, Initiative 2 Youth primary mental health, Initiative 3 Improve the responsiveness of primary care to youth)	**A**	→	20	**AL**
Improving mental wellbeing					
MH02	Improving mental health services using wellness and transition (discharge) planning	**P**	→	22	**GT**
MH04	Mental Health and Addiction Service Development: FA3 Improving Crisis Response Services	**P**	↓	24	**GT**
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	**P**	→	27	**GT**
MH01	Improving the health status of people with severe mental illness through improved access	**A**	→	21	**GT**
MH03	Shorter waits for mental health services for under 25 year olds	**A**	→	23	**GT**
MH04	Mental Health and Addiction Service Development: FA1 Primary Mental Health	**A**	→	24	**GT**
MH04	Mental Health and Addiction Service Development: FA2 District Suicide Prevention and Postvention	**A**	→	24	**GT**
MH04	Mental Health and Addiction Service Development: FA4 Improve outcomes for children	**A**	→	25	**GT**
MH04	Mental Health and Addiction Service Development: FA5 Improving employment and physical health needs of people with low prevalence conditions	**A**	↑	25	**GT**
MH06	Mental health output delivery against plan	**A**	→	28	**GT**
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge follow-up rates	**A**	→	28	**GT**
Better population health outcomes supported by strong and equitable public health services					
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections: FA2 Improving the quality of data submitted to National Collections	**N**	↓	31	**PN**
SS11	Faster Cancer Treatment (62 days)	**N**	→	35	**HB**

SS13	Improved management for long term conditions: FA5: Stroke service		N	↓	40	AL
SS01	Faster cancer treatment (31 days) indicator		P	↑	28	HB
SS07	Planned Care Measures		P	→	30	HB
SS10	Shorter stays in emergency departments		P	→	32	HB
SS13	Improved management for long term conditions: FA3: Cardiovascular health		P	↓	36	AL
SS15	Improving waiting times for colonoscopies		P	→	44	HB
SS04	Implementing the Healthy Ageing Strategy		A	→	29	AL
SS05	Ambulatory sensitive hospitalisations (ASH adult)		A	→	29	AL
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA3 Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		A	→	31	PN
SS13	Improved management for long term conditions FA1: Long Term Conditions		A	→	36	AL
SS13	Improved management for long term conditions FA2: Diabetes services		A	→	36	AL
SS13	Improved management for long term conditions: FA4: Acute heart service		A	↑	38	HB
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections: FA1 Improving the quality of identity data within the NHI		O	→	30	PN
SS12	Engagement and obligations as a Treaty partner		O	↑	36	GT
SS03	Ensuring delivery of service coverage (NB: Focus of this measure changes each quarter)		No Rating		29	HB
	Care capacity demand management calculation		No Rating		28	JW
Better population health outcomes supported by primary care						
PH04	Better help for smokers to quit (primary care)		N	↓	48	AL
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers		P	→	46	AL
PH03	Improving Māori enrolment in PHOs to meet the national average of 95%		P	→	47	AL
PH01	Improving system integration and SLMs		A	↑	46	AL
Prevention						
PV01	Improving breast screening coverage and equity for priority women		P	↑	45	AL
Health System Indicators						
HSI	Better population health outcomes supported by strong and equitable public health system	Access to planned care 21/22	No Rating	No Rating	52	AL
		Acute hospital bed day rate 21/22	No Rating	No Rating	52	AL
HSI	Improving wellbeing through prevention	Ambulatory sensitive hospitalisations for adults (age range 45–64) 21/22	No Rating	No Rating	52	AL
HSI	Improving child wellbeing	Ambulatory sensitive hospitalisations for children (age range 0–4) 21/22	No Rating	No Rating	52	AL
		Immunisation rates for children at 24 months 21/22	No Rating	No Rating	52	AL
HSI	Better population health outcomes supported by primary care	Primary care patient experience 21/22	No Rating	No Rating	52	AL

HSI	Improving mental wellbeing	Under-25s able to access specialist mental health services within three weeks of referral 21/22	No Rating	No Rating	53	**AL**
Annual Plan Status Update Reports						
Updates	Annual Plan actions: Improving wellbeing through prevention		**P**	→	50	**AL**
Updates	Annual Plan actions: Better population health outcomes supported by strong and equitable public health services		**P**	→	51	**HB**
Updates	Annual Plan actions: Improving child wellbeing		**P**	↓	50	**AL**
Updates	Annual Plan actions: Better population health outcomes supported by primary health care		**P**	→	50	**AL**
Updates	Annual Plan actions: Improving sustainability		**P**	→	52	**NT**
Updates	Annual Plan actions: Give Practical effect to Whakamaua– Māori Health Action Plan		**A**	→	52	**GT**
Updates	Annual Plan actions: Improving mental wellbeing		**A**	→	50	**GT**

Crown Funding Agreements (CFA) Variations		**Final Rating**	**Change from previous rating**	**Page Number**	**Owner Initials**
CFA	National Immunisation Register (NIR) Ongoing Administration Services	**B**	↓	56	**AL**
CFA	Primary Health Care Services	**S**	↑	54	**AL**
CFA	B4 School Check Services	**S**	→	54	**AL**
CFA	Well Child Tamariki Ora Services	**S**	→	54	**AL**
CFA	DHB level service component of the National SUDI Prevention Programme	**S**	→	54	**AL**
CFA	Additional School Based Health Services	**S(A)**	→	56	**AL**
CFA	Health services for Emergency Quota Refugees	**S(A)**	→	54	**AL**
CFA	Immunisation Coordination Service	**S**	→	56	**AL**

NA=Not applicable; FA=Focus area; NR=No report * MoH has not given ratings this quarter

Southern DHB Performance Reporting – Quarter 2 2021/22

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td>Child Wellbeing</td><td></td><td></td><td>Achieving Government's priority goals/objectives and targets</td></tr>
<tr><td>CW03: Improving the number of children enrolled and accessing the Community Oral health service</td><td>P</td><td>AL</td><td>Result: Number of enrolled pre-school and primary school children overdue for their scheduled examinations, October to December performance as at 31 December 2021
<table>
<tr><th></th><th colspan="4">Percent overdue</th></tr>
<tr><th></th><th>All ethnicities</th><th>Māori only</th><th>Pacific only</th><th>Other</th></tr>
<tr><td>Preschool children (age 0-4)</td><td>28%</td><td>32%</td><td>32%</td><td>27%</td></tr>
<tr><td>Primary school children (age 5-8)</td><td>25%</td><td>29%</td><td>31%</td><td>24%</td></tr>
<tr><td>Total</td><td>26%</td><td>30%</td><td>31%</td><td>25%</td></tr>
</table>
MoH feedback:
Thank you for your report. Please continue to maintain your focus and effort on services for high needs/risk children, while also reducing the percentage of children arrears. We look forward to seeing improvements in the next quarter.</td></tr>
<tr><td>CW05: Immunisation coverage: FA1 eight-month old immunisation coverage</td><td>P</td><td>AL</td><td>Results: 94.2% total coverage; Māori infant immunisation coverage at 91.7%. Rank 2nd out of 20 DHBs (total coverage). National result percent is 87.3% (total coverage). Target: 95%

MoH feedback:
National immunisation coverage has stabilised across all age groups this quarter, and is up half a percent to 83.9% at the key 24-month milestone age. This is an important gain for this age group in a challenging quarter, however at the same 24-month milestone, the coverage for tamariki Māori is 69.7%, a difference of 18.7%. At 8 months coverage is maintained at 87.3% and 5 years up slightly to 83.5%. Pacific coverage is equitable with non-Pacific rates across the milestone ages. The Ministry requests that all providers proactively check the immunisation status of ALL children they come into contact with, and to ensure that they are caught up with all Schedule immunisations, in particular the 12 and 15 months events/MMR.

We're aware the NIR has recently been experiencing a higher level of outages than usual and the Ministry's NIR team has been looking into what's behind those. We do know that running immunisation status queries with long date parameters (5+ years) can overwhelm the system, resulting in outages to the reporting function and sometimes to the wider application. Other outages are harder to pin down but its also likely that demand on some part of the system is simply outstripping it's capacity. We have arranged for additional memory to be allocated to the reporting system to alleviate some of the effects of large status queries, however you will still need to keep reports to maximum 5 year spans to reduce the pressure on the system for everyone else.</td></tr>
</table>

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			Another good performance this quarter in Southern delivering an increase in already high coverage rates, well done! Great to see you have been able to really dig into the real-time capabilities of Qlik reporting to ensure resources are targeted for maximum effect. It would be good to capture what you have learned here, to pass on to other DHBs really struggling to maintain accurate data on their highly mobile populations. Southern DHB narrative report: • *It is pleasing that Southern DHB was collectively 2nd in NZ for 8-month, 1st for 24-month and 2nd for 5-year Childhood immunisation milestones and is reflective of the dedication and commitment to ensure access in Primary Care and Outreach services continues for Southern tamariki. Commitment to utilising lead data such as QLIK 'Opportunity to immunise' has been invaluable.* • *Additionally noting collectively, Southern has some of the lowest Opt-Off + Decline as well as Missed rates across the milestone measures in NZ has boded well. This is reflective of the combined efforts across Southern that immunisation Services provide within Southern DHB and across our Primary Health community.* • *It is encouraging to see that Southern has increased equity for Māori and Pacific this quarter.* • *Total population coverage for 8 months was 94.2%, therefore Southern DHB did not achieve the 8-month target this quarter. There has however been an increase of 2.2% from last quarter which is pleasing.* • *Total Opt off & declined is 2.9%. with a decrease of 1.7% from last quarter.* • *Total Missed 2.9% and a decrease of 1.0% from last quarter.* • *Opt off & declined rate for Māori is 3.5% in this quarter which is 5.3% reduction since the previous quarter.* • *Opt off & declined rate for Pacific was 4.0% in this quarter which is an increase of 4.0% since the previous quarter.* **Data used in this report sourced from Qlik reporting dashboards Childhood: quarterly results* Actions to address issues/barriers impacting on performance • *The October 2020 schedule change and 12-month event is still impacting services. Families aren't responding to recalls for the 12-month event increasing Outreach referral numbers.* • *Alert level restrictions resulted in GPs delaying recalling their patients due to other demands, creating a barrier to families accessing the GP and increasing the demand for Outreach services. The Outreach service*

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			was able to support practices and providers to immunise children during alert level 4, due to the availability of Public Health Nurses working in the programme. • *NIR & Outreach services are contacting families to provide education and encourage families back to practices. Outreach nurses are attending Well Child meetings monthly to liaise with other Well Child Providers and address barriers to immunisation.* • *NIR are constantly running overdue reports and communicating with practices around overdue children and referring to Outreach Services.* • *NIR work closely with Outreach services and run reports to identify children and their siblings that are due their milestone immunisation.* **FUTURE ACTIONS** • *Identify practices with large decline rates and pass this information on to Immunisation Coordinators to follow up via Practice Liaison staff.* • *Looking to alleviate compounding factors due to current COVID-19 Vaccination programme having flow on effects to childhood immunisation hesitancy. Increase in parents wishing to opt off and decline. Parents themselves wanting to opt themselves off not understanding the different systems used for COVID Vaccination versus NIR. This has been noted as increasing since COVID vaccinations.* • *As we have been doing with missed events, we now also audit Opt Off and declines to identify how many children in this category may no longer be in the SDHB.* • *Continued targeting of action utilising 'near real time' Qlik reporting.* • *Contact and educating parents to let them know about MMR change in schedule which is causing confusion. Aware and encouraging to make appointments to have 12 month vaccination done.* • *Recruitment underway for Population Health Missed Events Coordinator that will support into Childhood Immunisation programmes to look to increase equity of access and education within the community.* New initiatives and successes

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			• *NIR has a refined focus on utilizing Qlik Immunisation reports to drive action. This has helped identify gaps and trends in immunization coverage especially for Maori and Pacific Populations. This approach has seen gains in our Childhood Immunisation rates for the previous quarter.* • *Use of these reports include utilising projected opportunity to immunise data. Auditing all missed events to ensuring these children are still living in our DHB. Identifying all children On Hold with Outreach who have time to be vaccinated in time to reach target and pass this data on to the O/R team. Sending practices spreadsheets with all immunisations that are past their due date and not waiting until these immunisations become Overdue. Updating due reports with findings including children who have moved overseas.* • *Public Health Nurses have been supporting the Outreach service and have trained as childhood vaccinators to extend our workforce.* • *Outreach staff have been committed to reaching our more vulnerable population and offering accessibility and more after hour appointments especially in our rural areas where there is larger Maori and Pacific population.* • *Planning is underway to offer more flexible arrangements for vaccination services in the home and community setting. This will include extended evening hours and weekends.*
CW05 Immunisation coverage FA2: 5-year old immunisation coverage	**P**	**AL**	Results: *93.3%* for total population and 90.4% for Māori population. Rank 2nd out of 20 (total population). Target: 95%. National result is 83.5% MoH feedback: National immunisation coverage has stabilised across all age groups this quarter, and is up half a percent to 83.9% at the key 24-month milestone age. This is an important gain for this age group in a challenging quarter, however at the same 24-month milestone, the coverage for tamariki Māori is 69.7%, a difference of 18.7%. At 8 months coverage is maintained at 87.3% and 5 years up slightly to 83.5%. Pacific coverage is equitable with non-Pacific rates across the milestone ages. The Ministry requests that all providers proactively check the immunisation status of ALL children they come into contact with, and to ensure that they are caught up with all Schedule immunisations, in particular the 12 and 15 months events/MMR. We're aware the NIR has recently been experiencing a higher level of outages than usual and the Ministry's NIR team has been looking into what's behind those. We do know that running immunisation status queries with long date parameters (5+ years) can overwhelm the system, resulting in outages to the reporting function and sometimes to the wider application. Other outages are harder to pin down but its also likely that demand on some part of the system is simply outstripping it's capacity. We have arranged for additional memory to be allocated to the reporting system to alleviate some of the effects of large

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			status queries, however you will still need to keep reports to maximum 5 year spans to reduce the pressure on the system for everyone else. Another good performance this quarter in Southern delivering an increase in already high coverage rates, well done! Great to see you have been able to really dig into the real-time capabilities of Qlik reporting to ensure resources are targeted for maximum effect. It would be good to capture what you have learned here, to pass on to other DHBs really struggling to maintain accurate data on their highly mobile populations. Southern DHB progress report: • *It is pleasing that Southern DHB was collectively 2nd in NZ for 8-month, 1st for 24-month and 2nd for 5-year Childhood immunisation milestones and is reflective of the dedication and commitment to ensure access in Primary Care and Outreach services continues for Southern tamariki. Commitment to utilizing lead data such as QLIK 'Opportunity to immunise' has been invaluable.* • *Additionally noting collectively, Southern has some of the lowest Opt-Off + Decline as well as Missed rates across the milestone measures in NZ has boded well, this is reflective of the combined efforts across Southern that immunisation Services provide within Southern DHB and across our Primary Health community.* • *Total population coverage for 5 years was 93.3%, therefore Southern DHB did not achieve the 5-year target this quarter.* • *Total opt off & declined for this quarter was 3.3% which is a decrease of 2.7% from last quarter* • *Total Missed 3.4%, up 0.7% on previous quarter.* • *Opt off & declined rate for Māori is 4.5 % in this quarter which is 5.1% decrease since the previous quarter.* • *Opt off & declined rate for Pacific 2.1 % in this quarter which is 0.3% decrease since the previous quarter.* **Data used in this report sourced from Qlik reporting dashboards Childhood: quarterly results* Actions to address issues/barriers impacting on performance • *Checking for immunisations that can be closed off due to children being 5 years plus, to ensure target figures are current and correct. Children of this age are checked for updated geographic details utilising Health UI database for current addresses and GPs. This shall decrease the number of missed children.*

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			• *NIR has a refined focus on utilizing Qlik Immunisation reports to drive action. This has helped identify gaps and trends in immunization coverage especially for Maori and Pacific Populations. This approach has seen gains in our Childhood Immunisation rates for the previous quarter.* • *Use of these reports include utilising projected opportunity to immunise data. Auditing all missed events to ensuring these children are still living in our DHB. Identifying all children On Hold with Outreach who have time to be vaccinated in time to reach target and pass this data on to the O/R team. Sending practices spreadsheets with all immunisations that are past their due date and not waiting until these immunisations become Overdue. Updating due reports with findings including children who have moved overseas.* • *Public Health Nurses have been supporting the Outreach service and have trained as childhood vaccinators to extend our workforce.* • *Outreach staff have been committed to reaching our more vulnerable population and offering accessibility and more after hour appointments especially in our rural areas where there is larger Maori and Pacific population.* • *Planning is underway to offer more flexible arrangements for vaccination services in the home and community setting. This will include extended evening hours and weekends.* New initiatives and successes • *The October 2020 schedule change and 12-month event is still impacting services. Families aren't responding to recalls for the 12-month event increasing Outreach referral numbers.* • *Alert level restrictions resulted in GPs delaying recalling their patients due to other demands, creating a barrier to families accessing the GP and increasing the demand for Outreach services. The Outreach service was able to support practices and providers to immunise children during alert level 4, due to the availability of Public Health Nurses working in the programme.* • *NIR & Outreach services are contacting families to provide education and encourage families back to practices. Outreach nurses are attending Well Child meetings monthly to liaise with other Well Child Providers and address barriers to immunisation.* • *NIR are constantly running overdue reports and communicating with practices around overdue children and referring to Outreach Services.* • *NIR work closely with Outreach services and run reports to identify children and their siblings that are due their milestone immunisation.*

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>FUTURE ACTIONS
Identify practices with large decline rates and pass this information on to Immunisation Coordinators to follow up via Practice Liaison staff.
Looking to alleviate compounding factors due to current COVID-19 Vaccination programme having flow on effects to childhood immunisation hesitancy. Increase in parents wishing to opt off and decline. Parents themselves wanting to opt themselves off not understanding the different systems used for COVID Vaccination versus NIR. This has been noted as increasing since COVID vaccinations.
As we have been doing with missed events, we now also audit Opt Off and declines to identify how many children in this category may no longer be in the SDHB.
Continued targeting of action utilising ‘near real time’ Qlik reporting.
Contact and educating parents to let them know about MMR change in schedule which is causing confusion. Aware and encouraging to make appointments to have 12-month vaccination done.
Recruitment underway for Population Health Missed Events Coordinator that will support into Childhood Immunisation programmes to look to increase equity of access and education within the community.</td></tr>
<tr><td>CW07: Improving newborn enrolment with General Practice</td><td>P</td><td>AL</td><td>Result: Newborns enrolled by 6 weeks of age: total population 67.6%, target 55%. Newborns enrolled by 3 months of age: total population 90.0%, target 85%.

<table><tr><th>Newborn enrolment</th><th>Results 6 weeks of age</th><th>Results 3 months of age</th></tr><tr><td>Māori</td><td>58.4%</td><td>72.6%</td></tr><tr><td>Pacific</td><td>76.0%</td><td>96.3%</td></tr><tr><td>Asian</td><td>67.7%</td><td>92.0%</td></tr><tr><td>Other</td><td>69.8%</td><td>95.1%</td></tr><tr><td>Total</td><td>67.6%</td><td>90.0%</td></tr></table>
MoH feedback:
Thank you for your report. Your performance is credible, overall targets are met but requires a tight focus on improving Māori tamariki enrolment for 3 month target.</td></tr>
</table>

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			Southern DHB (WellSouth) narrative report: The Southern region through the WellSouth Health Care Home Programme continue to provide guidance and support to practices to ensure enrolments for babies continues to be a focus. The health promotion team are continuing to work with our Maori health providers to encourage the enrolment of new born babies to ensure they receive the care and support needed for the best start to their life. Progress is being made, especially in the 3 month enrolment figures so the promotion work is starting show positive results. The Southern DHB will continue to work with WellSouth to see how this success can also be reflected better in the 6 week of age enrolments.
CW08: Increased immunisation at 2 years of age	**N**	**AL**	Result: 93.6% for total population and 85% for Māori population. Rank 1st out of 20 (total population). National result: 83.9% for total population. Target: 95%. Achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. MoH feedback: National immunisation coverage has stabilised across all age groups this quarter, and is up half a percent to 83.9% at the key 24-month milestone age. This is an important gain for this age group in a challenging quarter, however at the same 24-month milestone, the coverage for tamariki Māori is 69.7%, a difference of 18.7%. At 8 months coverage is maintained at 87.3% and 5 years up slightly to 83.5%. Pacific coverage is equitable with non-Pacific rates across the milestone ages. The Ministry requests that all providers proactively check the immunisation status of ALL children they come into contact with, and to ensure that they are caught up with all Schedule immunisations, in particular the 12 and 15 months events/MMR. We're aware the NIR has recently been experiencing a higher level of outages than usual and the Ministry's NIR team has been looking into what's behind those. We do know that running immunisation status queries with long date parameters (5+ years) can overwhelm the system, resulting in outages to the reporting function and sometimes to the wider application. Other outages are harder to pin down but its also likely that demand on some part of the system is simply outstripping it's capacity. We have arranged for additional memory to be allocated to the reporting system to alleviate some of the effects of large status queries, however you will still need to keep reports to maximum 5 year spans to reduce the pressure on the system for everyone else. Another good performance this quarter in Southern delivering an increase in already high coverage rates, well done! Great to see you have been able to really dig into the real-time capabilities of Qlik reporting to ensure resources are targeted for maximum effect. It would be good to capture what you have learned here, to pass on to other DHBs really struggling to maintain accurate data on their highly mobile populations. Southern DHB progress report:

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			• *It is pleasing that Southern DHB was collectively 2nd in NZ for 8-month, 1st for 24-month and 2nd for 5-year Childhood immunisation milestones and is reflective of the dedication and commitment to ensure access in Primary Care and Outreach services continues for Southern tamariki. Commitment to utilizing lead data such as QLIK 'Opportunity to immunise' has been invaluable.* • *Additionally noting collectively, Southern has some of the lowest Opt-Off + Decline as well as Missed rates across the milestone measures in NZ has boded well. This is reflective of the combined efforts across Southern that immunisation Services provide within Southern DHB and across our Primary Health community.* • *Total population coverage for 2 years was 93.6%, therefore Southern DHB did not achieve the 2-year target this quarter.* • *Total opt off and decline was 4.7%, an increase of 1.0% from last quarter* • *Total missed was 1.7%, a decrease of 2.1% from last quarter* • *Opt off & declined rate for Māori is 11.8% in this quarter which is 6.4% increase since the previous quarter.* • *Opt off & declined rate for Pacific was 0.0% down 2..9% on previous quarter.* • *It is disappointing that to see that Southern has not achieved equity for Māori but encouraging to see an increase of 3.4% in Pacific equity this quarter.* **Data used in this report sourced from Qlik reporting dashboards Childhood: quarterly results* Actions to address issues/barriers impacting on performance • *The October 2020 schedule change and 12-month event is still impacting services. Families aren't responding to recalls for the 12-month event increasing Outreach referral numbers. Increase in outreach referrals due to MOH schedule change for MMR 12 months. Contacting parents to inform them of the schedule change and asking them to make appointments.* • *Alert level restrictions resulted in GPs delaying recalling their patients due to other demands, creating a barrier to families accessing the GP and increasing the demand for Outreach services. The Outreach service was able to support practices and providers to immunise children during alert level 4, due to the availability of Public Health Nurses working in the programme.* • *NIR & Outreach services are contacting families to provide education and encourage families back to practices. Outreach nurses are attending Well Child meetings monthly to liaise with other Well Child Providers and address barriers to immunisation.*

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			• *NIR are constantly running overdue reports and communicating with practices around overdue children and referring to Outreach Services.* *NIR work closely with Outreach services and run reports to identify children and their siblings that are due their milestone immunisation.* **FUTURE ACTIONS** • *Identify practices with large decline rates and pass this information on to Immunisation Coordinators to follow up via Practice Liaison staff.* • *Looking to alleviate compounding factors due to current COVID-19 Vaccination programme having flow on effects to childhood immunisation hesitancy. Increase in parents wishing to opt off and decline. Parents themselves wanting to opt themselves off not understanding the different systems used for COVID Vaccination versus NIR. This has been noted as increasing since COVID vaccinations.* • *As we have been doing with missed events, we now also audit Opt Off and declines to identify how many children in this category may no longer be in the SDHB.* • *Continued targeting of action utilising 'near real time' Qlik reporting.* • *Contact and educating parents to let them know about MMR change in schedule which is causing confusion. Aware and encouraging to make appointments to have 12 month vaccination done.* • *Recruitment underway for Population Health Missed Events Coordinator that will support into Childhood Immunisation programmes to look to increase equity of access and education within the community.* New initiatives and successes • *NIR has a refined focus on utilizing Qlik Immunisation reports to drive action. This has helped identify gaps and trends in immunization coverage especially for Maori and Pacific Populations. This approach has seen gains in our Childhood Immunisation rates for the previous quarter.* • *Use of these reports include utilising projected opportunity to immunise data. Auditing all missed events to ensuring these children are still living in our DHB. Identifying all children On Hold with Outreach who have time to be vaccinated in time to reach target and pass this data on to the O/R team. Sending practices spreadsheets with all immunisations that are past their due date and not waiting until these immunisations become Overdue. Updating due reports with findings including children who have moved overseas.*

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			• *Public Health Nurses have been supporting the Outreach service and have trained as childhood vaccinators to extend our workforce.* • *Outreach staff have been committed to reaching our more vulnerable population and offering accessibility and more after hour appointments especially in our rural areas where there is larger Maori and Pacific population.* • *Planning is underway to offer more flexible arrangements for vaccination services in the home and community setting. This will include extended evening hours and weekends.*
CW09: Better help smokers to quit- Maternity	**B (P)**	**AL**	Results not given. Ministry of Health comment: · 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking. Please note that the data provided on the template seems to have an error for the wāhine Māori group – ie there were 2 women who smoke recorded, but 3 offered brief advice, would you please be able to clarify what these numbers should be, so I can provide the data. Thank you for sending in the narrative report outlining the collaborative work Southern DHB is undertaking and planning to support Māori and Pacific women reach support to quit smoking. Please pass my thanks on to the team, this is great mahi. I hope you are able to increase smokefree champions on the ward, and health promotion activity in the community, please keep me updated. Southern DHB response to MoH feedback: Apologies, this should be recorded as 3 Maori women who smoke
CW10: Raising healthy kids	**A**	**AL**	**Target:** 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions **Southern DHB Comments:** Result for Quarter: General 96%. Māori 98%. Pacific 94%. Continued effort required to prioritise Māori and Pacific B4School checks and follow up of growth interventions and referrals

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			We have started using electronic communications directly to GP inbox for growth referrals and this is improving the response time The service continues to refine referral pathways inclusive of utilising the Tenana Ora resource and other options and choices for whānau in their areas. Looking to recruit Missed Events Coordinator for Population Health in 2022 which will support DHBs, PHOs and other primary care and community partners work together to ensure familiar experience seamless transition and support post referral. There have been some disruptions to B4SC program due to covid deployment Rural areas are challenging as there fewer options in these areas, nurses refer to Public health nurse in the area for follow up interventions and support that works best for the whanau. All nurses proactively engage with schools and preschools, home visiting around healthy eating, eating together, food policy and activity decreasing screen time and sleep routines. Southern DHB remains committed to providing B4 School Checks to priority groups and is doing everything possible to address this. Activity has already commenced in 2022 particularly focussed on working collaboratively with Southern Māori and Pacific partners in an 'all vaccines and B4SC' approach to whānau and Pacific people's friendly community clinic provision. Building relationships through vaccination programs has enabled wider discussions and supports for B4School checks program. Southern has also embarked on a resource development project to provide Māori and Pacific resources for nurses to use when delivering the B4 School Check program. Southern DHB has completed a Before school check parent, whānau feedback survey across the region the results of which are still under review. The Plan is to utilise a 'Plan Do Study Act' (PDSA) approach to look for opportunities for improvement based on feedback received. Furthermore, the service has undertaken audits of nursing clinical documentation, PDSA approach has already resulted in changes to referral pathways for growth utilising an electronic growth referrals process to ensure we are making timely referrals. Monitoring will be on-going. **MoH Feedback:** Tēnā koe, Thank you for your report. The ministry acknowledges enhanced performance for Māori and Pasific population. Ka pai! Ngā mihi Meenakshi Panda
CW12: Youth mental health initiatives	**A**	**AL**	
Improving mental wellbeing			**Achieving Government's priority goals/objectives and targets**

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td>MH01: Improving the health status of people with severe mental illness through improved access</td><td>A</td><td>GT</td><td>

Results:

<table>
<tr><th>Age 0-19 yrs</th><th>Target</th><th>Previous Quarter</th><th>This Quarter Reporting</th></tr>
<tr><td>Total</td><td rowspan="3">3.75%</td><td>5.19%</td><td>5.21%</td></tr>
<tr><td>Maori</td><td>5.78%</td><td>5.68%</td></tr>
<tr><td>Other</td><td>5.06%</td><td>5..11%</td></tr>
</table>

<table>
<tr><th>Age 20-64 yrs</th><th>Target</th><th>Previous Quarter</th><th>This Quarter Reporting</th></tr>
<tr><td>Total</td><td rowspan="3">3.75%</td><td>3.76%</td><td>3.85%</td></tr>
<tr><td>Maori</td><td>7.08%</td><td>7.20%</td></tr>
<tr><td>Other</td><td>3.40%</td><td>3.48%</td></tr>
</table>

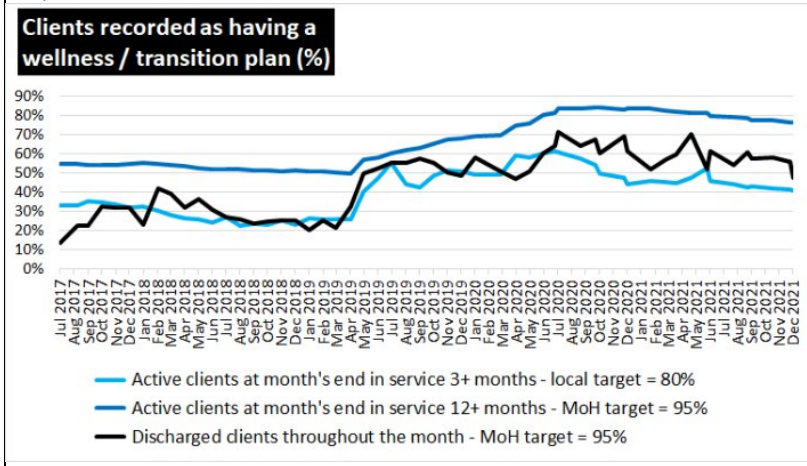
<table>
<tr><th>Age 65+ yrs</th><th>Target</th><th>Previous Quarter</th><th>This Quarter Reporting</th></tr>
<tr><td>Total</td><td rowspan="3">1.00%</td><td>0.94%</td><td>1.00%</td></tr>
<tr><td>Maori</td><td>1.42%</td><td>1.48%</td></tr>
<tr><td>Other</td><td>0.92%</td><td>0.98%</td></tr>
</table>

DHB Commentary:
Southern DHB continues to experience gradual increases in access rates across the age spectrum, with an increasing complexity of referrals in presentation and risk. We have seen an increase in adult Maori accessing our services.
Inpatient services are consistently busy with high occupancy rates and new presentations, with obvious flow-on to community treatment services.
Servies continue to monitor referrals for any potential emerging trends.
There remains a strong and developing focus on engaging with our partners across the sector, lead and underpinned by Raise Hope – Hāpai te Tūmanako Strategy 2019-2023: https://www.southernhealth.nz/publications/raise-hope-hapai-te-tumanako-strategy-2019-2023-0 and the primary and community strategy from the DHB The review of which is due to occur in the first half of 2021.

</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td>MH02: Improving mental health services using well and transition (discharge) planning</td><td>P</td><td>GT</td><td>Results:
<table>
<tr><th></th><th>Percent of clients with a transition (discharge) plan</th><th>Target</th><th>Percent of clients with a wellness plan</th><th>Target</th></tr>
<tr><td>Community</td><td>59.8%</td><td>95%</td><td>77.9%</td><td>95%</td></tr>
<tr><td>Inpatient</td><td>100%</td><td>95%</td><td></td><td></td></tr>
</table>
Southern DHB report:
Across the Southern region we continue to maintain a focus on clients transition plans, and that sharing of these plans is occurring with GP’s and whanau

We continue in Southern to maintain a focus on clients transition plans and monitoring is occurring with unit managers.
Ongoing work is occurring re the quality of the plans and sharing with GP’s
With increasing access rates and referrals, this has put additional demands on clinician time and we are monitoring this.

DHB commentary re community clients:
A more up-to-date analysis of community clients (current and discharged) is provided here that shows trends and any improvements over time.

</td></tr>
</table>

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<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>DHB commentary re Inpatient clients:
All clients discharged from inpatient settings have in place a discharge plan that is uploaded into the clinical workstation (Health Connect South), accessible also by GPs / PHOs via HealthOne.

Inpatient units continue to support all clients have a discharge plan which continues to be uploaded to HCS.

MoH Feedback: Thanks for your report</td></tr>
<tr><td>MH03: Shorter waits for mental health services for under 25- year olds</td><td>A</td><td>GT</td><td>Results:
<table>
<tr><th></th><th>Number of new clients aged under 25 seen within three weeks this quarter reporting.</th><th>Total new clients aged under 25 this quarter reporting</th><th>Percentage seen within 3 weeks for this quarter reporting period.</th></tr>
<tr><td>Under 25 total</td><td>1036</td><td>1455</td><td>71%</td></tr>
<tr><td>Under 25 Māori</td><td>254</td><td>197</td><td>78%</td></tr>
<tr><td>Under 25 Pacific</td><td>34</td><td>41</td><td>83%</td></tr>
<tr><td>Under 25 non-Māori</td><td>839</td><td>1301</td><td>70%</td></tr>
<tr><td>Under 25 non-Māori, non Pacific</td><td>805</td><td>1160</td><td>69%</td></tr>
</table>
Southern DHB narrative report:
Identify what processes have been put in place to reduce waiting times
• We are now using e-Referrals which has improved front-end workflow.
• We are pleased that wait times have remained stable despite an increase in referrals and challenges with COVID.
• We continue with dedicated triage staff and tools to manage wait lists.
• Phoning, providing on-line apps, texting appointments.
• A team approach- CAPA process. Defined MDT to picking up young people based on staff skill-sets.

How is the DHB working across service boundaries (Adult and Child and Youth) to improve waiting times?
• Telehealth implementation
• Robust triage of referrals with wait lists monitored. Including embedded e-referral system.
• Robust MDT
• Follow up appointments offered in the main centres.
• Liaison with GP practices by Psychiatrists.

How are the DHB adult services prioritising the needs of 18-24-year olds?
As above</td></tr>
</table>

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
MH04: Mental Health and Addiction Service Development	FA1:	A	GT	FA1: Primary mental health
	FA2:	A	GT	FA2: District suicide prevention and postvention
	FA3:	P	GT	FA3: Improving crisis response services MoH feedback: Thanks for your Q2 report. We note that you are still developing a Crisis Capability Plan and that this plan would be finalised soon. We would be interested in seeing that plan when you are able to share it with the Ministry. We also note your MHS/ED Educator, is still waiting to return to New Zealand after completing the necessary stay in a MIQ facility, after having to travel overseas urgently last quarter. Southern DHB report: The SDHB Mental Health and Addictions Service has worked closely with the two main Emergency Departments in Dunedin and Invercargill to develop the newly funded 0.7 FTE Educator position. The person description and internal process for approval to recruit has been completed. The position was subsequently advertised and interviews are scheduled for mid October. The service is confident an appointment will be made. The aims of the role as outlined in the Service Specification will be used as the basis of how this new position will be developed. Stage two of the role out of this role will include expanding to the districts rural hospital emergency departments which will likely be in the first quarter of 2022. Although the role is aligned with the Mental Health Addictions service the intention is for the appointee to be positioned and present in the ED environment(s). The service will develop a process to monitor and evaluate the effectiveness of having an educator working alongside both the regulated and non regulated workforce that is focusing on improving and enhancing responses to people experiencing a mental health crises. Quarter 2 The service appointed a 0.7 FTE Educator who commenced December 2020. The initial period of employment has involved a staged orientation plan focusing on the two main Emergency Departments in the district while also identifying where and how the role will be most effective across the district considering it is a relatively small resource for an expansive area to cover.

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
	FA4:	**A**	**GT**	FA4: Improve outcomes for children
	FA5:	**A**	**GT**	FA5: Improving employment and physical health needs of people with low prevalence conditions MoH feedback: Thank you for your report. Southern DHB report Southern DHB were selected to be part of *Tōkeke: Building Equity in Access to Work* research project. This is a research project that *Te Pou o te Whakaaro Nui* have partnered with *Work Counts* and *Synergia* to undertake. We see this as an opportunity for learning and progressing our initiatives in this area. We understand that there are at least two other DHB sites participating in this project. The aim of the research is to identify effective approaches to collaboration which support people with mental health and addiction issues to gain and maintain employment. Data will be gathered during the development of case studies for each included site. The primary outcome from the research project is a framework that will include the attributes of a successful approach to collaborative case management and can support the development of implementation guidelines for Work and Income case managers. In the case of Southern we agreed to work alongside Te Pou, the Ministry of Social Development and one of our contracted NGOs, Adventure Development Ltd to achieve the aims of the study. Ethics approval from Health Research South was sought and given to commence the study. An MoU between the parties described above was agreed and signed in March 2020. It is expected that the case sites would host 2-6 site visits from the research team which would include: - Participation in a programme logic workshop - Interviews with key stakeholders - Interviews with whairoa/clints.

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td colspan="2"></td><td></td><td></td><td>The programme logic workshop was held in March along with an initial set of interviews with key stakeholders.

Unfortunately, subsequent work has been curtailed with the C19 situation. As a DHB we are keen to progress this important piece of research and will be in touch with Te Pou to determine whether there is a possibility of this work continuing, possibly through the use of teleconferencing or other means.

UPDATE Q2 2021/22
As of the end of 2021, the program was established in 27 General practices, with a further 7 practices confirmed for rollout in early 2022. Underspend has been used to continue to rollout this programme ahead of schedule. Contracted FTE is due to be fully implemented by April 2022. Building integration across existing community/ primary and secondary providers remain a focus for the program.

<table>
<tr><th>Workforce Role</th><th>Actual FTE (end of 2021)</th><th>Contracted FTE at the end of 2022/23</th></tr>
<tr><td>Health Improvement Practitioners</td><td>16.4</td><td>19.2</td></tr>
<tr><td>Health Coaches/Support Workers</td><td>23.5</td><td>28.9</td></tr>
</table>
</td></tr>
<tr><td colspan="2">MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders</td><td>P</td><td>GT</td><td>Result: For the period between July 21 and September 21 the percentage (of DHB population) of patients under section 29 in Southern DHB who are: Māori: 82 (0.29%), non-Māori: 215 (0.08%). Due to data availability, data are 3 months in arrears for each quarter. Expectation: Reduce the rate of Māori under s29 of the Mental Health Act by at least 10% by the end of the reporting year.

Southern DHB report:
Following the review of the Southern DHB Maori Directorate Maori health staff are settling into their roles, which we hope will achieve better integration and access to cultural care, particularly where Maori may present in crisis, and in the CMHT settings. Maori health staff recruitment is continuing to provide opportunity for closer working relationship within the existing MHAID structure, with workers aligned to the various Adult and Specialist services.

While this data is subject to ongoing scrutiny and monitoring, the Zero Seclusion strategy group continues to be re-energised, working closely with HQSC. The focus remains on the point of admission through the crisis teams and CMHT's, and emphasis</td></tr>
</table>

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			on the quality of EWS and RPP's being completed with consumers. It is hoped the combination of this focus and increased cultural access may help to reduce use of the MH Act at the point of relapse or crisis and/or during the course of their inpatient stay overall, but inparticular for Maori. The DAMHS is intending to review the number of Maori who have been on section 29's for longer than 5 years in the earlier half of 2022 This will provide a good opportunity to understand the issues that are impacting on the use of compulsion to engage Maori service users in mental health care.
MH06: Mental health output delivery against plan	**A**	**NT**	
MH07: Improving mental health services by improving inpatient post discharge follow up rates	**A**	**GT**	
Better population health outcomes supported by strong and equitable public health services			**Achieving Government's priority goals/objectives and targets**
Care capacity demand management calculation	**No rating**	**JW**	Ministry of Health does not provide ratings or feedback for this measure.
SS01: Faster cancer treatment (31 days)	**P**	**HB**	Results: 84.3% achievement (target 85%) This report is based on patients who received their first cancer treatment (or other management) between Ministry feedback: The achievement of 82.9 percent against a target of 85 percent is noted. Southern DHB report:

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>Tracking of completed records to 31st December 2021, data run on 20th January 2022
<table>
<tr><th></th><th>Health Target
62 Days</th><th>Health Indicator
31 Days</th></tr>
<tr><td>2021/22 Q2</td><td>80.4%</td><td>84.3%</td></tr>
<tr><td>2021/22 Q1</td><td>80.8%</td><td>81.3%</td></tr>
</table></td></tr>
<tr><td>SS03: Ensuring delivery of Service Coverage</td><td>NR</td><td>HB</td><td>Reporting was not completed this quarter which the Ministry has acknowledged.</td></tr>
<tr><td>SS04: Implementing the Healthy Ageing Strategy</td><td>A</td><td>AL</td><td></td></tr>
<tr><td>SS05: Ambulatory sensitive hospitalisations (ASH adult)</td><td>A</td><td>AL</td><td>Results: Non-Standardised ASH rates, 12 months to September 21 for those aged 45 to 64 years
Southern total (2,843/100,000), Southern Māori (4,116/100,000). National total rate: 3,659 per 100,000
ASH target for Southern DHB: <2,865 /100,000 (total rate for 45-64 year olds).

MoH feedback:
Thank you. It is great to read that the call centre is making a difference. Please share some data in your next report Philippa Jones

Southern DHB report:
• "Narrative: The SDHB target for total ASH rate was <2865/100,000. This was achieved, with a total rate of 2843/100,000 recorded. The Maori ASH rate has again reduced this quarter to 4,116/100,000, which is below the target of <4867/100,000.
• To reduce acute admission for Māori, improved and timely coordination of care between secondary, primary and community is needed to better support Māori in health care choices, self-determination and management of health needs to stay well at home.
• Actions that we are undertaking are:
• Continuing on the formation of a Māori Health Clinical Group by the Māori Health Directorate to review and advise on clinical activity that impacts on admissions and readmissions. This group will provide clinical governance for the Māori Health Directorate;</td></tr>
</table>

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td colspan="2"></td><td></td><td></td><td>• Continuing the implementation of the Hauora Wellness Checks for Māori populations (aged 50 years+) using the WellSouth Call Centre with a specific focus on tikanga, manaakitanga and whanaungatanga. The aim is to minimize and reduce admissions to hospital by:
• - Enrolment to General Practice/Designated Practice, for those unenrolled;
• - Re-engaging Māori with their General Practice for self management of care and access to screening programmes.
• This is currently being successfully supported by WellSouth's call centre.</td></tr>
<tr><td>SS07: Planned care measures</td><td>Planned Care Measure 6:</td><td>P</td><td>HL</td><td>Planned Care Measure 6: Acute Readmissions
<table>
<tr><th></th><th>Quarter result</th><th>Target</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>Acute readmissions</td><td>12.3%</td><td>≤11.7%</td><td>Work on readmissions is slowly moving forward with delays due to covid, staff leaving and restructures. However new patient safety work has commenced which is predicted to improve readmission rates. This kicked off in February 2022</td><td>Ongoing</td></tr>
</table>
Ministry Feedback: Kia ora, look forward to hearing in next report about the patient safety mahi that started in Feb 2022 and any improvement on acute readmission rates. Thank you for your report.</td></tr>
<tr><td></td><td>Planned Care Measure 7:</td><td>P</td><td>HB</td><td>Planned care measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)
<table>
<tr><th>FSA DNA by ethnicity</th><th>Result</th><th>Actions to achieve compliance</th><th>When will compliance be achieved</th></tr>
<tr><td>Data quality</td><td>Developmental</td><td>•</td><td>•</td></tr>
<tr><td>Variance</td><td>Developmental</td><td>•</td><td>•</td></tr>
</table>
Ministry Feedback: Kia ora, look forward to hearing in next report about the patient safety mahi that started in Feb 2022 and any improvement on acute readmission rates. Thank you for your report.</td></tr>
<tr><td rowspan="2">SS09: Improving the quality</td><td>Focus Area 1:</td><td>O</td><td>PN</td><td>Focus Area 1: Improving the quality of data within the NHI</td></tr>
<tr><td>Focus Area 2:</td><td>N</td><td>PN</td><td>Focus Area 2: Improving the quality of data submitted to National Collections</td></tr>
</table>

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
of identity data with the NHI and data submitted to National Collections				MoH feedback: Indicator 1: Please let us know how we can assist you to troubleshoot and resolve the cause of data gaps in your NPF reporting. We encourage you to attend the regional online meetings and maintain regular communication with us on your progress. Indicator 2: Thank you for you feedback. The Ministry hopes you can investigate this so there will be an improvement in the coming quarter's data. Indicator 3: Well done on achieving a good result. DHB Report: Indicator 1 – NPF collection has accurate dates and links to NBRS, NMDS and NNPAC for FSA and planned inpatient procedures We continue to have issues with our NPF extract linkages to the other extracts so will continue to develop & trouble shoot the data feeds & extract tool Indicator 2: National Collections Completeness Since the start of the 2022 year, we have experienced issues with our NNPAC extract. This has had a bearing on the NNPAC component of Indicator 1. We are unaware of any issues with the PRIMHD extract so will verify that the numbers have in fact dropped. Anecdotally the Covid19 lockdown knocked back our Mental Health activity for Quarter 2 Indicator 3: Assessment of Data Reported to NMDS SDHB is pleased to get an Achieved rating for this indicator We have had a change in personnel so our current focus for extracts is on familiarisation with our current processes and troubleshooting specific problems before we can do any further development/enhancement work
	Focus Area 3:	**A**	**PN**	Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD) DHB Report: We have a high confidence rating as to the integrity and completeness of this data. Southern DHB PRIMHD data extracts from 1 July 2017 onwards continue to be extracted in full into PRIMHD from our Patient Administration Systems on a regular basis. This is underpinned by a thorough program of data integrity and monitoring, highlighting issues to end users (staff and clinicians) where there are data items the need corrective action. Each of the PRIMHD errors (and many warnings) have, at a local level, an associated end-user component that ensures any national errors and issues are aligned and are highlighted to end users (staff and clinicians) with the expectation that these are attended to and corrective action is taken. Ministry Feedback:

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>Thank you for your report.</td></tr>
<tr><td>SS10: Shorter stays in emergency departments</td><td>P</td><td>HB</td><td>Result: 79.9 % (up 0.2% from 79.7% last quarter) admitted, discharged, or transferred from an Emergency Department (ED) within six hours (target is 95%).

MoH feedback:
Results remain similar to the previous quarter.
It's good to see progress on securing key equipment and personnel - along with a wide range of initiatives.
It is pleasing to see a slight increase in performance for Dunedin hospital this quarter, slightly offset by a slight fall at Southland and Lakes. The improvement in the orthopaedic service performance is encouraging to see. Target performance for Maori is higher, which may hint at reduced access to primary care for minor acute conditions for this group in your DHB, as noted in previous reports.
The ED short stay use and %<15 minutes in ED are appropriate.

Southern DHB report:
Percent managed within 6 hours by facility
<table>
<tr><th>Facility</th><th>% managed within 6 hours</th></tr>
<tr><td>Dunedin ED</td><td>73.43%</td></tr>
<tr><td>Lakes District ED</td><td>95.21%</td></tr>
<tr><td>Southland ED</td><td>81.73%</td></tr>
<tr><td>Southern DHB</td><td>79.94%</td></tr>
</table>
Actions undertaken this quarter to maintain or improve the indicator
• The drop in attendances seen in the 1st level 4 lockdown (March 2020) were not replicated in subsequent level 4 lockdowns (August 2021). Numbers remained at normal/high levels.
• Key developments & improvements in ED Dunedin physical facilities to make them Covid safe
• Dunedin ED Recovery Plan developed to improve efficiency of bed flow and BAU e.g., streamlining bed requests, timely attendance by inpatient registrars, reduce wait times for CT scans, etc.
• Increased RN resource to provide dedicated triage/waiting room (to be termed Front of House, FoH) nurse 11:00-23:30 7 days/week to improve patient safety
• Increased ACNM resource to provide 24/7 cover
• Increased HCA resource to provide additional 24/7 cover
• Patient Flow task force to improve patient flow across hospitals continues
• New equipment portable Ultrasound, interpersonal communication devices</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>
• Refurbishment of Resus spaces
• New generalist model of care implementation 90% underway
• Second scanner in place to provide improved access to CT, reduced wait times
• Generalist admitting model of care in place

Planned work for next quarter
• Patient flow work across the hospital continues
• Continue progress with build and design of MAU in Dunedin hospital
• Continue progress towards additional ED medical staffing

Barriers to achieving or maintaining the indicator
• Traffic light system in place nationally
• Bed pressures, elective delays continue throughout the hospitals with wards closing beds
• Southland ED continues to exceed capacity and overflows into other areas as required.
• Inadequate hospital patient flow pathways contribute to ED access block
• Increasing patient acuity and complexity

What support can the Ministry provide
• Support patient flow work
• Assist SDHB in preparation for Omicron

Data on acutely admitted patients
<table>
<tr><th></th><th>Total Attendances</th><th>In ED over 6 hrs</th><th>% over 6 hrs</th></tr>
<tr><td>Not admitted</td><td>19180</td><td>2313</td><td>12.06%</td></tr>
<tr><td>Admitted</td><td>5143</td><td>2567</td><td>49.91%</td></tr>
<tr><td>Total</td><td>24323</td><td>4880</td><td>20.06%</td></tr>
</table>
For those Admitted to an inpatient ward, provide a separate report of target performance by service
<table>
<tr><th></th><th>Total admitted from ED</th><th>In ED over 6 hrs</th><th>% over 6 hours</th></tr>
<tr><td>Medical (incl. all subspecialties</td><td>2849</td><td>1503</td><td>52.76%</td></tr>
</table>
</td></tr>
</table>

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses

Surgical (all subspecialties excl Ortho and O&G)	1232	664	53.90%
Orthopaedics	603	239	39.64%
O&G	167	78	46.71%
Other	292	83	28.42%
Total	5143	2567	49.91%

Provide data on the number and proportion of patients admitted to an Emergency Department Short Stay Unit (SSU) that are subsequently admitted to an inpatient ward

	Admitted to SSU	Transferred to inpatients from SSU	% transferred
Total	2712	474	17.48%

Provide data on what proportion of patients counted in your denominator that have an Emergency Department stay <15 minutes and where they go (discharged or admitted)

	Total ED attendances	# under 15 mins and discharged	# under 15 mins and admitted	Total stayed under 15 mins	% < 15 mins
Total	24323	274	25	299	1.23%

Acute demand actions from Annual Plan
Acute Data Capturing: Please provide an update on your plan to implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021
The current situation is that the new SNOMED code formats are too long for us to achieve integration with iPM as it will require an upgrade. With the PICS project underway we will not be investing further in iPM as it should only be in place for another 18 months. In the meantime the PICS project will be looking at the interfaces with systems like EDIS and it is at that point we will look to introduce the new

To improve Patient Flow, please report on actions from Annual Plan that:
Improves patient flow for admitted patients
Enhanced generalism, new model of care in place, and MAU project progressing in Dunedin hospital. Work is occurring at Southland ED and approval given for facility upgrade to provide a dedicated short stay units (MAU)

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			Improves management of patients to ED with long-term conditions Supporting patients to remain at home or if an ED presentation or hospital admission is necessary to return home quickly and facilitated by allied health (HOME) Team established across Dunedin and Southland sites. Ongoing Improves wait times for patients requiring mental health and addiction services who have presented to the ED Dedicated SMO liaison holding mental health portfolio and Mental Health Nurse Educator in place Improves Māori patients experience in ED Dedicated FTE Monday to Friday is in Dunedin and Invercargill EDs. At Dunedin Hospital, SMO and Nurse Staff are implementing Te Rautaki Manaaki Mana – ACEM Māori Health strategy
SS11: Faster Cancer Treatment (62 days)	**N**	**HB**	Results:80.4% achievement (target 90%) Ministry feedback: Southern has not achieved the target of 90 percent - has only 80.4 percent achieved Southern DHB report: Heat Map of 62-Day Capacity Breaches

	Brain/CNS	Breast	Gynaecological	Haematological	Head and neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urological
Chemotherapy	0	1	1	3	2	3	3	0	0	0	0	1
Concurrent radiation therapy and chemotherapy	0	0	1	0	0	3	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	2
Palliative care	0	0	0	1	0	0	1	0	0	0	0	0
Radiation therapy	1	0	0	1	0	1	6	0	1	0	1	1
Surgery	0	6	7	0	2	7	2	2	2	9	0	9
Targeted therapy	0	1	0	0	0	0	0	0	0	0	0	1

Southern DHB narrative report

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
				• Patient pathways have started to be developed and/or updated to enable the FCT team to "delay code" correctly, this is a continuing work in progress. • Ethnicity identification is going to be a priority amendment for the FCT tracker to enable easier filtering and auditing. This has yet to be actioned. • At the next South Island Leads meeting a request from SDHB to NMDHB & West Coast DHB to compare & check data for FCT 62 day gynae outcomes for patients going to Christchurch for treatment.
SS12: Engagement and obligations as a Treaty partner		**O**	**GT**	Ministry Feedback: Thank you for your report. Your DHB has received an outstanding rating for this measure. Your narrative report is noted, especially the partnership between the DHB, the Papatipu Rūnaka and WellSouth Primary Health Network. Thank you for also providing the information in regards to the Board and Statutory Advisory Committee membership and training. Your commitment to this deliverable is appreciated.
SS13: Improved management for Long Term Conditions (LTC)	Focus Area 1:	**A**	**AL**	Focus Area 1: Long Term Conditions
	Focus Area 2:	**A**	**AL**	Focus Area 2: Diabetes services
	Focus Area 3:	**P**	**AL**	Focus Area 3: Cardiovascular Health DHB Report: For your PHOs and general practices that do not currently use the national CVDRA tool, what plans do they have to integrate with it? What are the barriers to the Ministry's tool being adopted? WellSouth use the national CVDRA tool implemented through our Practice portal and managed by Karo Data Management What proportion (estimates are expected) of CVDRAs undertaken within your DHB have the patient present? (as opposed to a desktop exercise) We do not collect this data however it is encouraged that GP's conduct these in the practice, otherwise WellSouth Outreach Nurses actively go out to patient's houses or workplaces to conduct these to get this number as close to 100% as possible in the current environment. What other screening, services or assessments are provided alongside CVDRAs (for example, a diabetes annual review)?

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
				Do you mean are done concurrently? If so, this is a decision for general practices on how to manage their workflow. We encourage practices to look at the patient, not the condition, and to manage co-morbidities together and not in isolation. Our long-term condition management programme CLIC is instrumental in this approach and is used in all practices in the network. How does your DHB ensure equitable management of CVD risk following a CVDRA? The DHB through WellSouth have asked practices to assess all Maori and Pacific people over 35 years using the CLIC criteria (a Comprehensive Health Assessment or CHA). WellSouth requires all practices to have a Maori Health Plan and we have prioritised the practices with the highest number of Maori and Pacific patients for our Health Care Home programme. What barriers need to be removed to improve the visibility of CVD risk management in primary and community care, post the completion of a CVDRA? Practices prioritise their efforts where they see the best impact on the patient, and will focus on a programme that will have a benefit for the majority of patients and where their staffing resources can best serve the patients. More community and GP in-reach programmes that connect with NGO groups, especially with Maori and Pasifika NGO's to encourage healthy lifestyles outside of GP practices would be greatly beneficial in making sustainable differences in CVD management at home and in the community. What improvements could be made to increase utilisation of this funding by PHOs? What improvements could be made to the contracting mechanisms of the heart health contracts to improve equitable CVDRA provision and health outcomes? Do you have any other feedback on how the contracting for CVDRA+M services could be improved? Funding for CVD RA+M has not increased for many years and is well behind the cost of delivering the service. Improvements could be made by increasing funding in areas of significant prevention gains by targeting Maori and Pasifika NGO groups to employ community leaders who link in with the PHO's Practices and connects to the community to support programs and education in a culturally safe environment. An example is the Pacific Trust Otago who are very motivated to support the community to lead a healthy life and would like funding to employ a fulltime Pasifika Health and Lifestyle champion that would engage with the PHO and Sport Otago to support healthy living and activity through the already strong community contacts. Ministry Feedback: We appreciate the level of information that many of you have provided. There are some innovative practices going on, and we hope to provide an opportunity to share this great work at a virtual LTC national forum we are proposing for May. We will keep you all posted. The Ministry continues to invest in our CVDRA national tool. We are currently considering developing a wellness plan that would be generated following a CVDRA. The intention of this resource is that it will assist clinicians with facilitating shared care

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
				planning and goal setting discussions. This resource will also support patients to better understand their CVD risk and how they can best lower their risk. The Ministry believes the CVDRA tool is an important vehicle engaging whanau with the health system and beginning conversations about improving their lifestyle and thereby reducing risk factors for CVD and other LTCs. Thank you for your ongoing support to embed the CVDRA tool within your DHB and we look forward to the coming years where the focus of this work will shift to the improved management of patients with moderate to high CVD risk.
	Focus area 4:	**A**	**HB**	Focus area 4: Acute heart services MoH feedback: Your DHB's results: Congratulations on achieving the majority of indicators this quarter. I note and appreciate your comments concerning the indicators not met. Please confirm that you have sent this report to your regional cardiac programme lead. Future direction: It is our understanding that the national and regional networks will continue to be a feature of the new health system. As such, it is important the DHBs are well engaged with their regional networks so issues and opportunities can be escalated appropriately, and knowledge shared. Both clinical and strategic leadership will be very important in this period of interim change until the new entities and structure are well embedded. It is worth aligning our work with the five key system shifts of the reforms which are: 1. The health system will reinforce Te Tiriti principles and obligations 2. People will have more support to help them stay well in their communities 3. High quality emergency or specialist care when it's needed 4. Digital services and technology will provide more care in people's homes and communities 5. Health and care workers will be valued and well-trained Please be cognisant of these when designing, planning and mitigating risk to your acute cardiac services. Ngā mihi nui

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
				Catherine Boyle DHB report:

Indicator	Definition	Performance	Achievement of target
Indicator 1	Door to cath within 3 days for ≥ 70% of ACS patients undergoing coronary angiogram.	125/149 (83.9%)	Target achieved
Indicator 2a	Registry completion- ≥95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge	137/149 (98.6%)	Target achieved
Indicator 2b	99% within 3 months	154/156 (98.7%)	Target not achieved
Indicator 3	ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or Lvgram).	121/126 (96%)	Target achieved
Indicator 4	Composite Post ACS Secondary Prevention Medication Indicator – in the absence of a documented contraindication/intolerance ≥ 85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - ○ Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) and ○ an ACEI/ARB if any of the following – LVEF <50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), and ○ Beta-blocker if LVEF<40% ((5-classes). ○ An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.	91/108 (84.3%)	Target not achieved
Indicator 5a	Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure	55/62 (88.7%)	Target not achieved
Indicator 5b	Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI	2/5 (40%)	Target not achieved

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
				<table><tr><td></td><td>Device ICD forms completed within 2 months of the procedure.</td><td></td><td></td></tr></table> Southern DHB narrative: Where the indicator has not been met, identify the indicator and provide narrative on any barriers/challenges to achieving the indicator and any mitigation strategies for these to be applied over the next quarter. **Indicator 2b:** unable to correct this despite it looking like all completed. No response from ANZAC's regrading this. **Indicator 4:** only narrowly out of range. Escalate to Clinical Lead for further action **Indicator 5 & 5b:** Physiology team short staffing has probably impacted on this work.
	Focus Area 5: Stroke Service	**N**	**AL**	Focus Area 5: Stroke service Ministry Feedback: Thank you for your report. After an encouraging first QTR where the overall target for Indicators #2, #3 and #4 were met it was of concern to see that no Indicators met targets for QTR2. Particularly for Māori. It is clear that staffing is impacting on service delivery which raises patient safety concerns. You have outlined some great positives that are happening at both hospitals, particularly the collaborative working relationships across the care pathways and the education days. As you know promotion of the FAST message needs to be widely circulated to community groups, whanau, schools and so forth to raise awareness of the signs of a stroke and that it is a medical emergency, and to take action straight away. You are encouraged to engage with the Stroke Foundation and local Iwi to identify community networks to assist in promoting FAST messaging, particularly with Māori and Pasifika communities. There is funding available through Te Hiringa Hauora for community groups who wish to run FAST awareness promotions. You have raised two key initiatives that would make a huge difference to delivering an integrated stroke service in your region and you are encouraged to put business cases together aligned to the 'systems shifts' that Minister Little has highlighted as fundamental pillars of the transformed health system. As no further response was received the final rating remains as Not Achieved Please provide further information on the following in your next report: 1. Action plans/timelines to address staffing and resourcing

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
				2. How you will address the barriers in Southland hospital in providing telestroke services Please note: Your reporting has not yet been signed off by the allied health lead. You have provided some information as to the challenges and barriers you are experiencing, and the National Stroke Clinical Lead (Alan Davis) and Senior Advisor Long Term Conditions (Sue Domanski) would like to set up an initial Teams meeting to discuss the issues with your team. We will be in touch. DHB Report: **Indicator 1: 80%** of acute stroke admissions admitted to an ASU or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital

Indicator One - Total

Site	Numerator	Denominator	Percentage
Dunedin	86	110	78.2%
Invercargill	47	63	74.6%
Dunstan	0	23	0.0%
Oamaru	0	8	0.0%
Total	*133*	*204*	*65.2%*

Indicator One - Maori

Site	Numerator	Denominator	Percentage
Dunedin	5	9	
Invercargill	0	2	
Dunstan	0	1	
Oamaru	0	1	
Total	*5*	*13*	*38.5%*

Indicator One - Pacifica

Site	Numerator	Denominator	Percentage
Dunedin	1	2	
Invercargill	0	0	
Dunstan	0	0	
Oamaru	0	0	
Total	*1*	*2*	*50.0%*

Nursing shortages are impacting on bed availability across our hospitals. This is impacting patient flow including admissions, discharges and transfers from the Acute Stroke Units.

At Southland Hospital a revised stroke pathway has been implemented for stroke patients within 24 hours of presentation to hospital. The consult request referral system has been implemented for Stroke CNS input for referrals to be sent by the medical teams.

Indicator 2: **12%** Reperfusion – Thrombolysis /Stroke Clot Retrieval Service provision 24/7

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses

Indicator Two - Total

Site	Numerator	Denominator	Percentage
Dunedin	11	86	12.8%
Invercargill	2	56	3.6%
Dunstan	0	20	0.0%
Oamaru	0	6	0.0%
Total	*13*	*168*	*7.7%*

Indicator Two - Maori

Site	Numerator	Denominator	Percentage
Dunedin	1	8	
Invercargill	0	2	
Dunstan	0	1	
Oamaru	0	1	
Total	*1*	*12*	*8.3%*

Indicator Two - Pacifica

Site	Numerator	Denominator	Percentage
Dunedin	0	2	
Invercargill	0	0	
Dunstan	0	0	
Oamaru	0	0	
Total	*0*	*2*	*0.0%*

Dunedin – A busy quarter for 'code strokes' which meant we were able to meet 12% reperfusion rates.
Telestroke - the system of medical teams contacting Christchurch via phone to discuss potential reperfusion cases is working well, teams are encouraged not to contact Christchurch. until after scans are obtained.
Stroke clot retrieval activity – five patients went forward to Christchurch for potential SCR – 4 had intervention, with varying outcomes.

Southland: Since quarter one 21/22 there has been an updated pathway for "code stroke" to ensure the appropriate people are called to attend, and there has been promotion of the new code stroke pathway in ED. Patients are not presenting in time to receive reperfusion treatments. Patients and families are all educated on the FAST message when in hospital.

There are barriers in Southland Hospital to providing telestroke as we do not have LSP to train up our registrars with our local stroke policies when they start at the hospital. There is still no system to allow for Christchurch neurologists to visually assess the stroke patients, again relying on the untrained Registrars to do the full assessment for the neurologist to make a decision based off this information. It is very rare that patients are sent for Stroke Clot Retrieval however the appropriate scans are being completed in order to make an assessment. Generally there is not a retrievable clot. There have been working relationships built between Southland and Christchurch teams.

Indicator 3: 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission

Measure		Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses

Indicator Three - Total			
Site	Numerator	Denominator	Percentage
Dunedin	20	48	41.7%
Invercargill	13	18	72.2%
Dunstan	0	0	0.0%
Oamaru	0	0	0.0%
Total	*33*	*66*	*50.0%*

Indicator Three - Maori			
Site	Numerator	Denominator	Percentage
Dunedin	*1*	3	
Invercargill	*0*	0	
Dunstan	*0*	0	
Oamaru	*0*	0	
Total	*1*	*3*	*33.3%*

Indicator Three - Pacifica			
Site	Numerator	Denominator	Percentage
Dunedin	*0*	1	
Invercargill	*0*	0	
Dunstan	*0*	0	
Oamaru	*0*	0	
Total	*0*	*1*	*0.0%*

Dunedin: This was a busy quarter with high patient numbers. Chronic staffing challenges unfortunately mean we periodically see delays with our patients accessing rehabilitation beds, particularly for those transferred to Puāwai Rehabilitation Unit (PRU) at Wakari Hospital that takes our younger (<65yrs) patients with stroke.

Southland Hospital: There were delays in patients getting at AT&R due to the rehab beds being at capacity or short staffed. There are more beds being opened up in the rehab ward next month which should support patients being transferred to rehab within 7 days of acute admission.

Indicator 4: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge

Indicator Four - Total			
Site	Numerator	Denominator	Percentage
Dunedin	10	18	55.6%
Invercargill	5	16	31.3%
Dunstan	0	0	0.0%
Oamaru	0	0	0.0%
Total	*15*	*34*	*44.1%*

Indicator Four - Maori			
Site	Numerator	Denominator	Percentage
Dunedin	*0*	*0*	
Invercargill	*0*	*0*	
Dunstan	*0*	*0*	
Oamaru	*0*	*0*	
Total	*0*	*0*	*0.0%*

Indicator Four - Pacifica			
Site	Numerator	Denominator	Percentage
Dunedin	*0*	*0*	
Invercargill	*0*	*0*	
Dunstan	*0*	*0*	
Oamaru	*0*	*0*	
Total	*0*	*0*	*0.0%*

Dunedin: ??
Southland: Percentage wise this is an improvement for Southland, following investment of additional FTE into Rehab. However Physiotherapy vacancies have impacted on waiting times (REACH physio on parental leave and

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			not replaced, utilising contractor as required) and with increasing team size overall (of registered staff) there is also a constraint in Assistant support – this is currently being addressed through additional recruitment. Please Comment on the following 1. Activity during QTR2 that supports the promotion of the **FAST message** for this year's campaign – please include details about your engagement with community groups. a. Promote the FAST message with any patients with stroke and their whanau who are discharged home from our acute stroke unit. 2. What are you most proud of that works well in your DHB's stroke service delivery? a. How the teams/services across the stroke pathway have come together. Relationship have improved and there is a much better understanding of the importance of the collective working together to achieve patient outcomes. i. **Dunedin –** 'Code stroke' responses have improved and have a good system with contacting Christchurch in regard to potential clot retrieval reperfusion candidates. Our MDT work well together. Our Stroke Operational Group has been able to provide 3 stroke related study days within the last 18 months reaching approximately 110 staff from her and around the region. ii. **Invercargill -** The nursing Stroke Workshop is an informative day for staff with great feedback, just need staff to be supported to attend. 3. What whānau focussed, evidenced based approaches are needed to deliver transformational change to stroke services that will ensure improved clinical outcomes, patient experience and patient safety? a. Dunedin – we need dedicated nurses for our acute stroke unit with a decreased nurse / patient ratio so we can increase skills in stroke nursing leading to better patient outcomes, and nurses with dedicated skills in stroke rehabilitation would help. b. Southland – Establishing an integrated stroke unit on the AT&R ward.
SS15: Improving waiting times for colonoscopies	**P**	**HB**	Results: Target: 95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system. Result 100% - exceeded for both sites

Colonoscopy	Target	Results	Comments
Urgent colonoscopy (14 days or less)	90%	100% (both sites)	Exceeded

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Non-urgent colonoscopy (42 days or less)</td><td>70%</td><td>91.9% (Dunedin)
63.0% (Southland)</td><td>Exceeded for Dunedin, not met for Southland. Data as at 17.01.22 shows 32 people who would have waited over 42 days as at 31.12.21 (noting no routine OP scoping over Christmas); only 24 of these are waiting for a flex sig</td></tr>
<tr><td>Surveillance colonoscopy (12 weeks or less)</td><td>70%</td><td>94.4% (Dunedin)
46.7% (Southland</td><td>Exceeded for Dunedin, not met for Southland.
A reduction in the number of Saturday lists coupled with lost sessions due to availability of colonoscopists and loss of nursing staff in Dunedin preventing patients travelling for their procedure has led to the deterioration of performance. An increased emphasis on these patients is being provided in the New Year with additional lists being performed to address the backlog.</td></tr>
</table>

MoH feedback:
Ministry acknowledges the ongoing impact of COVID on the DHB's recovery of colonoscopy wait times and your 17/01/22 performance update. We appreciate that non-urgent and surveillance targets were met in December of Q2 and plans to accommodate people waiting beyond maximum in Q3. Please continue to provide fortnightly updates of your colonoscopy wait time recovery plan to your NBSP contract relationship manager.</td></tr>
<tr><td colspan="2">Improving wellbeing through prevention</td><td></td><td>Achieving Government’s priority goals/objectives and targets</td></tr>
<tr><td>PV01: Improving breast screening</td><td>P</td><td>AL</td><td>Results: BSA coverage of women aged 45-69 years in the Southern district, for the two years ending September 2021: Māori 62.9%; Pacific 58.5%; total 68.4%. Target: 70%.</td></tr>
</table>

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
coverage and rescreening			MoH feedback: We would like more information on what initiatives you have identified to improve the coverage, particularly for Pacific. We look forward to seeing an improvement in the equity and coverage for Q4. Southern DHB report: Breast Screen Otago Southland Pacific Radiology continue to provide Support to Screening and the Regional Coordination Service which supports patient-centred bookings for newly enrolled and priority women who are not participating in screening. This has been challenging during the last 6 months due to internal Pacific radiology issues that have been addressed and reflected in the drop in coverage from Q4. Priority bookings continue to be given to our Maori and Pacifica women in which they are offered an appointment and rescreen in advance of other women. This service also supports data matching at practice level, as well as other community initiatives to support enrolment and participation of women.
Better population health outcomes supported by primary health care			**Achieving Government's priority goals/objectives and targets**
PH01: Improving system integration and SLMs	**A**	**AL**	
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	**P**	**AL**	MoH Feedback: Thank you for your update - this is a very comprehensive summary. I have noted that the EDAT audit was not able to be completed due to COVID-19 response additional pressures on practices. DHB Report: • Has PHO undertaken an audit using EDAT in the past three years? No however practices completed an ethnicity data audit to achieve cornerstone/foundation standard accreditation (indicator 6.2) which all WellSouth practices have achieved. A further audit will be required for reaccreditation in the future to maintain this standard. • PH0's most recent Stage 3 EDAT performance (i.e. level of match in ethnicity data)

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			A stage 3 EDAT was not undertaken recently due to the pressures of COVID-19 pandemic. The WellSouth ethnicity tool for practices does record that 96% of those enrolled have an ethnicity match on the Thalamus data program. • PHO's report on improvement in quality of ethnicity data collection WellSouth continues to assist Practices with their Māori health plans including promoting the objectives below. The following action plan continues to review ethnicity data and ensure the quality assurance systems are regularly reviewed for cornerstone accreditation when it is undertaken: Area of Action Objectives Activities Targets/Monitoring (quarterly) Practice Champion Ethnicity data Primary Care ethnicity data audit toolkit (EDAT) implemented • Primary Care EDAT completed and recommendations implemented (3 yearly) • Monitor register for unknown ethnicity and actively update records • Date due: • Date completed: • Target: No patients with unknown ethnicity Practice enrolment Facilitate and ensure ongoing enrolment for all eligible Maori • Actively facilitate re-enrolment for Maori patients due to drop off the practice register (not seen within 3 years) • Actively facilitate enrolment for any unenrolled Maori into your practice • Target: No Maori patients drop off the practice register (not seen within 3 years) • Target: increase in the number of Maori enrolments in the practice
PH03: Improving Māori enrolment in PHOs to meet	**P**	**AL**	Results: WellSouth PHO enrolment for total population was 92% and was 80% for Māori in the second quarter. National enrolment total was 94% and 84% Maori Target: 95%.

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner initials</th><th>Ministry of Health Feedback and DHB Responses</th></tr>
<tr><td>the national average of 95%</td><td></td><td></td><td>MoH feedback:
Thank you for providing an update

Southern DHB report:
Improvement of Maori enrolment in Primary Care is a priority for the Southern District Health Board and the Community and Public Health Advisory Committee (CPHAC). The CPHAC continues to have a standing agenda item to monitor and assess the improvement plans that have been tabled. The current enrolment rate has increased to 80% in Q2, up from the previous reporting period by 1%.

As the below table demonstrates, there has been a trending small increase in Maori enrolments in primary care across the SDHB region due to the focus WellSouth is placing on this with their practices.

The below table shows Māori enrolment and is based of monthly files from the National Enrolment Service (register of national enrolment and health idendity/demographic data).
<table>
<tr><th></th><th>Feb-21</th><th>Apr-21</th><th>Jun-21</th><th>Aug-21</th><th>Nov-21</th></tr>
<tr><td>Central Otago</td><td>1,877</td><td>1,893</td><td>1,881</td><td>1,918</td><td>1,939</td></tr>
<tr><td>Clutha</td><td>1,838</td><td>1,856</td><td>1,863</td><td>1,855</td><td>1,844</td></tr>
<tr><td>Dunedin</td><td>9,495</td><td>9,530</td><td>9,597</td><td>9,611</td><td>9,655</td></tr>
<tr><td>Gore</td><td>1,821</td><td>1,843</td><td>1,861</td><td>1,854</td><td>1,860</td></tr>
<tr><td>Invercargill</td><td>9,291</td><td>9,356</td><td>9,353</td><td>9,363</td><td>9,363</td></tr>
<tr><td>Queenstown Lakes</td><td>1,932</td><td>1,969</td><td>2,019</td><td>2,062</td><td>2,054</td></tr>
<tr><td>Southland</td><td>1,760</td><td>1,785</td><td>1,817</td><td>1,835</td><td>1,845</td></tr>
<tr><td>Waitaki</td><td>1,924</td><td>1,930</td><td>1,917</td><td>1,941</td><td>1,966</td></tr>
<tr><td>Total</td><td>29,938</td><td>30,162</td><td>30,308</td><td>30,439</td><td>30,526</td></tr>
</table></td></tr>
<tr><td>PH04: Primary health care: Better help for smokers to quit (primary care)</td><td>N</td><td>AL</td><td>Results: 75.8% (total population) were given brief advice and support to quit smoking. 74.9% of Māori and 73.2% of Pacific populations were given brief advice to quit smoking. Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit.

MoH feedback: Please note that the result for Southern DHB's cessation support indicator is 23%. The national result for this indicator is 31%. This indicator shows the % of current smokers who have been given or referred to cessation support services in the last 15 months.</td></tr>
</table>

Measure	Final Rating	Owner initials	Ministry of Health Feedback and DHB Responses
			The cessation support indicator result is for DHB use only and will not be publicly reported. You can use this indicator as a proxy measure of how well the clinicians are engaging with cessation services and how frequently they refer smokers to these services. Thanks for your comprehensive report, Debby. Health targets, now known as Performance measures are constantly under review, however at this stage there is no change to reporting requirements. Do you think you have met the overall target (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? The target will not be met this quarter. WellSouth will achieve approximately 85% for the total population and 82% each for Māori and Pacific populations. WellSouth continue to work on behalf of practices to contact patients and provide them with brief advice at a time when they are under ever-increasing pressure from the coronavirus pandemic (and the usual December workload). Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? The target will not be met this quarter. WellSouth will achieve approximately 82% each for Māori and Pacific populations. WellSouth continue to work on behalf of practices to contact patients and provide them with brief advice at a time when they are under ever-increasing pressure from the coronavirus pandemic (and the usual December workload). The call centre has targeted the district's high needs population – Māori, Pacific peoples and Q5 to increase performance against this measure. Is there any further support you require from the Ministry to achieve the target? If so, what support is required? A review of the effectiveness of this programme at a national level would be useful. While we have put significant efforts into this target over the past five years, we have not seen a significant decrease in the number of coded smokers in our district. WellSouth report having a good understanding of their data however still find themselves correcting information obtained in the quarterly CPI extraction process – in their view this tool is not fit for purpose and adds to their workload. Is there anything else you would like to tell the Ministry? General practice in the Southern district is seeing particularly high levels of patient demand this quarter.

Annual Plan Status Update Reports			Achieving Government's priority goals/objectives and targets
Measure	**Final Rating**	**Owner Initials**	**Ministry of Health Feedback and DHB Responses**
Annual Plan Status Update Reports - Improving wellbeing through prevention	**P**	**AL**	Cross sectoral collaboration - thank you for the updates on progress and acknowledge the comments regarding actions which have not been achieved. Smokefree for Connect Southern Community Laboratory pregnancy data to WellSouth PHO smoking data base to identify all pregnant women who are smokers - Can you provide a date when WellSouth will be responding?
Annual Plan Status Update Reports - Improving Child Wellbeing	**P**	**AL**	Immunisations Can you please update us on all of the actions due in Q2? It looks like you were still waiting on people to provide updates? Please include a response to the questions in our initial feedback in your Q3 report. School-based health services Thank you for your report. Your report is easy to read and informative and having SBHS and Youth Health actions and reporting together is a really good way to show and work towards integration. Congratulations on catching up on assessments for Q2. Noho ora mai. Maternity Care Thank you for your report. Several areas that were meant to be reported on in Q2 were not provided. Please provide an update to these in the next reporting period. Family Violence and Sexual Violence Thank you for your report outlining your achievements and some of the challenges you are facing, I appreciate hearing how things are going in your region. I look forward to reading about your progress in your next report. SUDI NR – No report provided.
Annual Plan Status Update Reports - Improving Mental Wellbeing	**A**	**GT**	Thank you for your report
Annual Plan Status Update Reports - Better population health outcomes supported by primary health care	**P**	**AL**	Thank you for your report and quarter highlight.
Annual Plan Status Update Reports - Better population health outcomes supported by	**P**	**HB**	Thank you for your reporting On FT calcs and note that you quarterly activities are on track - with exception oF recruitment Planned Care initial comment: Thanks for your report. It's great to see the new skin lesions model of care working well. We recognise the issues COVID19 brings to organisational planning and the resulting delays to progress on the Health Needs Analysis work. We look forward to

strong and equitable public health services			seeing how it progresses over the next 2 quarters, along with progress on the 5th Southland theatre. Great to hear the CT scanner is operational which is reflected in improving wait times. Workforce initial comment Can we ask for update on Q1 milestone that was reported amber in last report? I also note that they have marked Q2 milestone "Q2: Diversity and inclusion policy established" as on track - however, in description they say they are still recrutiing for relevant advisor to develop policies. As such, it appears policy not established - can we ask for them to provide further update next quarter? Bowel Screening/colonoscopy wait times initial comment: Ministry appreciates the DHB is continuing to achieve all NBSP participation rates and KPI 306 during COVID. Please refer to SS15 reporting for colonoscopy wait time feedback. Ola Manuia Action Plan initial comment: Thank you for your report. Rural Health initial comment: Thank you for your fulsome update. We note that Equity of Access - Action 2 has not been completed for Q2 and look forward to seeing that update in Q3. Cancer Action Plan initial comment: Te Ahu o Te Kahu hopes to see improvement over Qs 3 and 4 particularly in Lung Cancer Service Improvement Plan and Prostate QPIs Acute Demand initial comment: Thank you for the report. I note that work is also progressing well on the Weekend Discharge pilot which is also identifying opporutnities for other improvements in acute flow. SSED performance remains low and does need continued urgent attention. Delivery of Whanau Ora initial comment: Thanks for your report. Improving Quality initial comment: Hand Hygiene- We note that a draft audit tool has been developed and look forward to this being finalised but no comments for quarter 2 measures. Implementing the New Zealand Health Research Strategy initial comment: Thank you for your report. We look forward to hearing of your progress. Disability Action Plan initial comment: Actions noted and reported progress accepted. Disability initial comment: Are there any Actions 3 and 5 Q1 progress?
Annual Plan Status Update Report –	**P**	**NT**	thank you for your report we note some items are experiencing delays

Improving Sustainability			
Annual Plan Status Update Report – Give Practical Effect to Whakamaua – Māori Health Action Plan	**A**	**GT**	Thank you for your report
Health System Indicators			
Access to planned care	**No rating**	**AL**	We confirm the data is correct for Health System Indicator - Access to planned care .
Acute hospital bed day rate	**No rating**	**AL**	We confirm that the data is correct for Health System Indicator - Acute hospital bed day rate
Ambulatory sensitive hospitalisations for children (age range 0–4	**No rating**	**AL**	We confirm the data is correct for Health System Indicator - Ambulatory sensitive hospitalisations for children (age range 0-4)
Ambulatory sensitive hospitalisations for adults (age range 45–64)	**No rating**	**AL**	We confirm that the data is correct for Health System Indicator - Ambulatory sensitive hospitalisations for adults (age range 45-64)
Immunisation rates for children at 24 months	**No rating**	**AL**	We confirm the data is correct for Health System Indicator - Immunisation rates for children at 24 months
Primary care patient experience	**No rating**	**AL**	We confirm the data is correct for Health System Indicator - Primary care patient experience
Under-25s able to access specialist mental health services within three weeks of referral	**No rating**	**AL**	We confirm the data is correct for Under-25s able to access specialist mental health services within three weeks of referral

Crown Funding Agreements (CFA) Variations

Crown Funding Agreements (CFA) Variations			
Measure	**Final Rating**	**Owner Initials**	**Ministry of Health Feedback and DHB Responses**
CFA Primary Health Care Services	**S**	**AL**	
CFA B4 School Check Services	**S**	**AL**	
CFA Well Child Tamariki Ora Services	**S**	AL	
DHB level service component of the National SUDI Prevention Programme	**S**	AL	
CFA: Health Services for Emergency Quota Refugees	**A (S)**	AL	The Ministry wants to commend Southern DHB its continuing, high-quality and innovative services provided to former refugees. Your reporting is also very comprehensive and provides a comprehensive overview of the work you provide, the challenges you face and your solution-focused approach. We note your comments around language assistance services, and we are still working with MBIE to ensure the national approach they are seeking is implemented, but in a way that won't reduce the quality of services to former refugees. This remains a work in progress. As discussed in recent meetings, as part of our refugee health review and our agreement renewal discussions, many of the issues you raise are common across other regions and we are keen to find ways to improve knowledge, information and innovation sharing nationally. We look forward to 52ontinuing to do this with your involvement. We note that we required current financial reporting. DHB Response: From 2016, a total of 931 former refugees were settled in the Southern DHB district under the MBIE Refugee Resettlement Programme. We are aware that some former refugees have moved to other cities beyond the

<table>
<tr><td></td><td></td><td></td><td>Southern district, but our patient management systems are not designed for the purpose of tracking consumer movement as such.

Our data indicates that there were a total of 1210 appointments for 361 former refugee patients (please see the table below). In consideration of the fact that healthcare delivery for former refugees takes place across multiple agencies beyond SDHB, currently, our best tool for measuring former refugee health engagement is the interpreter appointment register. As there are former refugees who have developed the English skills to no longer require an interpreter, please consider the figures below in columns three and four as being less than actual. I have noted this by placing a “+” sign beside these totals.

<table>
<tr><th>Southern DHB Resettlement City</th><th>Total Former Refugees Settled</th><th>Total Former Refugees who accessed healthcare – Q2 2021-22</th><th>Total Healthcare appointments for Former Refugees – Q2 2021-22</th></tr>
<tr><td>Dunedin</td><td>727</td><td>275+</td><td>915+</td></tr>
<tr><td>Invercargill</td><td>204</td><td>86+</td><td>295+</td></tr>
<tr><td>Total</td><td>931</td><td>361</td><td>1210</td></tr>
</table>
Also, of note, the provision of care reflected in the table above does not include the work of the Cross-Cultural Health Navigators.</td></tr>
<tr><td>CFA: Additional School Based Health Services</td><td>A (S)</td><td>AL</td><td></td></tr>
<tr><td>CFA National Immunisation Register (NIR) Ongoing Administration Services</td><td>B</td><td>AL</td><td>Please supply certification from the DHB Planning and Funding Manager that the DHB has met the Service requirements in clauses 2-8 of the CFA Schedule.

DHB Response to Ministry:
Please see attached report provided by service</td></tr>
<tr><td>CFA Immunisation Coordination Service</td><td>S</td><td>AL</td><td></td></tr>
</table>

Southern District Health Board
Piki Te Ora

Annual Plan Quarterly Report
Quarter two 2021/22

Overview

Southern DHB submits quarterly reports to the Ministry of Health against the actions within the Government Planning Priorities section of the Annual Plan.

Quarter two reports are summarised for the following Planning Priorities:

- Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System
- Give Practical Effect to Whakamaua – Māori Health Action Plan
- Improving Mental Wellbeing
- Improving Sustainability
- Better Population Health Supported by Primary Health Care
- Improving Wellbeing Through Prevention
- Improving Child Wellbeing- Improving Maternal Child and Youth Wellbeing

Each report includes an indication of whether actions are track, according to the RAG Guidelines below. Comments are added where actions have not been achieved for the quarter. Overall progress is also summarised for each Planning Priority.

Reporting RAG (Red Amber Green) Guidelines		
OVERALL STATUS	GREEN	On track
	AMBER	Planned delivery at risk / concern with action underway to resolve
	RED	Significant concern with delivery / intervention required to prevent failure

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Acute Demand		
Acute demand		
Plan for the establishment of an MAU completed with clear timelines for establishment		
Establishment of a dedicated ED SMO for mental health liaison and a dedicated Mental Health Educator		No report received from team member
Dunedin and Southland EDs work collaboratively with Māori to improve cultural appropriateness of the service – education for staff on tikanga Q2		
Commence cultural training for ED staff		
Introduction of Māori signage		No report received from team member
WellSouth to support the Heath Care Home programme through Tranche III. Increase in HCH practices delivering GP Triage and Acute Appointments Q2		

Healthy Ageing		
Improve preparedness for a pandemic outbreak - Scenario tests conducted and feedback communicated		Plans reviewed and now available on DHB website
IPC nurse contacts each facility every 6 months		
Improve identification of factors associated with earl signs of emerging frailty – initial pathways established.		
Participation in mental health review		

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Bowel Screening and Colonoscopy Wait Times		
Surveillance Colonoscopy waiting times indicator is met by end Q2 2021/22 with no patients waiting beyond their maximum waiting times whilst maintaining achievement of the waiting time indicator for symptomatic and NBSP		Predictions are for surveillance wait time indicator to be met by end January 2022
Maintain the current communication and engagement strategy for the National Bowel Screening Programme - Participation rates for priority populations (Māori , Pacifica and Quintile 5) remain above 60%		As at end October (most recent data available) participation for Māori is 76%, Pacifica 70% and Q5 78% versus a target of 60%. Rescreening rates for those first invited in June 2019 are 78% for Maori and Q5, 76% for Pacifica
Participation rates for priority populations will be regularly reviewed and response targeted according to the demographic data that is provided – rates remains above 60% for Māori, Pacific and Quintile 5 (as above)		As at end October (most recent data available) participation for Māori is 76%, Pacifica 70% and Q5 78% versus a target of 60%. Rescreening rates for those first invited in June 2019 are 78% for Maori and Q5, 76% for Pacifica. Rates are monitored regularly

Ola Manuia 2020-2025: Pacific Health and Well-being Action		
Quarterly reporting re increased enrolment of new-borns in general practice and the WCTO programme		Pacific enrolment for 6 weeks of age is 76% and increases to 96.3% for 3 months of age. These are great results that are above the targets of 55% at 6 weeks and 85% at 3months. Pacific 3 month enrolment rates are the highest in the ethnicity data which demonstrates the WCTO service provided by the PTO is delivering great results in connecting Pacific whanau to their GP's.

Delivery of Whanau Ora		
Existing whanau ora navigators across the Otago region support Māori patients admitted with traumatic brain injury, and their whanau. Reporting q2.		
Implementation of Māori COVID-19 Response and Resurgence Plan		

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New Zealand Cancer Action Plan		
New Zealanders experience equitable cancer outcomes		
Process for the capture of ethnicity data is reviewed and changes implemented by end Q2		Various approaches to ethnicity data collection are in place with a major piece of work being undertaken in the lung cancer pathway initially. This will produce the template for other patients and ethnicity data collection
Equity Tracking Tool – Review and commence implementation		The Equity Tracking Tool has been reviewed and refined to widen the capture of target groups. This is working well with patients coming into the Tracker based on the new criteria and scoring system. The rules are noted below which automates patients with these criteria into the Cancer Nurse Coordinator Equity Tracker.
Participation in Te Aho o Te Kahu travel and accommodation project		Much of the NTA project was put on hold in the second half of last year, while the Southern Hub completed some wider service planning work for the Transition Unit. However, they are picking the NTA work up again now and are very interested in connecting with DHBs on the following: • Interviewing NTA coordinators and other staff to understand the NTA process from your perspective • Understanding if/how DHBs capture details about patient diagnosis on any NTA documentation • Understanding if/how DHBs capture details about patients who apply for NTA but are considered ineligible • Understanding if/how DHBs allocate funding for NTA and whether this is monitored and reported
Participation in the national work programme for the delivery of local community-based Māori Hui in partnership with Te Aho o Te Kahu		The Matauranga Maori Cancer Action Report (this will be aligned to NZ Cancer Action Plan) will be made available nationally to all hui participants when completed. The Te Waipounamu, Southern Hub anticipates that distribution will occur within the next few months (March).

New Zealand Cancer Action Plan (continued)		
New Zealanders have better cancer survival, supportive care and end-of-life care		
Report progress against DHB Bowel Cancer Service Improvement Plan		No Report received from team member
Ensure that 31 day and 62 day cancer waiting time measures are met – quarterly reporting		FCT data is continually being reviewed. The achievement rate has been better for the 62-day target over the last 2 quarters where we saw a stable achievement in Q2 at 80.4% - compared to 80.8% % in Q1. 62-day pathway near breaches and those who have breached the target are being flagged to individual services on a regular basis. This allows accurate reason codes to be applied and also to give the service an opportunity to address the near breach. Maori patients who breach the FCT target are being notified to the Maori Leadership Group for investigation. A project is in progress on the lung cancer patient pathway which aims to improve electronic patient capture, tracking, visibility to clinical teams and identify areas for improvement. Along with this there is a new clinical nurse specialist (CNS) position for lung cancer patients with resource in both Otago and Southland. A future project is the gynae patient pathway for those patients who require treatment in CDHB to address bottlenecks and breaches.

New Zealand Cancer Action Plan (continued)		
New Zealanders have better cancer survival, supportive care and end-of-life care (continued)		
Lung cancer service improvement plan written by Q2		Te Aho o Te Kahu has released the Lung Cancer Quality Performance Indicators (QPI) were published in March 2021. A Maori lung cancer audit has been completed and will be presented to the SDHB Clinical Council in 2021 – this has been delayed from August 2021. A project is in progress on the lung cancer patient pathway which aims to improve electronic patient capture, tracking, visibility to clinical teams and identify areas for improvement. Along with this there is a new clinical nurse specialist (CNS) position for lung cancer patients with resource in both Otago and Southland.
Monitor the impact of COVID-19 on cancer diagnostic and treatment services and use this information to plan and manage service volumes		Service plans are in place in the event of a COVID-19 resurgence in accordance with Te Aho o Te Kahu. Plans are continually being revised and updated as the guidance changes
New Zealanders have a system that delivers consistent and modern cancer care		
Work with Te Aho o Te Kahu Regional Hubs to contribute to and implement the recommendations of the national Radiation Oncology Service Plan		No progress on this to date

New Zealand Cancer Action Plan (continued)		
New Zealanders have a system that delivers consistent and modern cancer care (continued)		
Upgrade of stereotactic surgery equipment is completed – fully commissioned by q2		Linear Accelerator bunker, install and commissioning is in progress with a 3-month commissioning Physicist engaged to undertake the work. This includes the stereotactic surgery software Brainlab.
Implement ACT-NOW treatment regimens (national collection) for medical oncology and malignant haematology		This work is ongoing via the Te Aho team.

New Zealand Cancer Action Plan (continued)		
New Zealanders have a system that delivers consistent and modern cancer care		
Work with Te Aho o Te Kahu to plan and implement the adoption of the cancer related Health Information Standards Organisation (HISO) standards		This work is ongoing via the Te Aho team.

Health Quality and Safety (quality improvement)		
Hand hygiene practice		
Undertake audit of high risk areas and analyse results		
Hand hygiene – EDs to have a compliance ≥ 80%		
Improving equity		
Virtual Diabetes Register (VDR) established		
Telehealth service initiated supporting clinical governance		Meeting with Telehealth Manager planned for coming quarter due to extended leave
Diabetic Annual Review programme delivered - DAR to 80%; HbA1c to 90%		
Improving consumer engagement		
Mapping analysis conducted		Feedback has been analysed (and continues to be analysed) and this is assessed against Q1 QSM scores to identify areas where engagement is working well, where it's not and where it is needed. Consumer Experience Manager and Consumer Liaison are meeting with all services during Q3 to discuss QSM scores and increasing and extending Consumer Engagement.

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Health Workforce		
As part of COVID-19 we are reviewing our recruitment processes including calling for volunteers. A database for both volunteers and contingent workforce is in progress. Data base finalised and set up Q2.		Database is being migrated to a better application to ensure security and privacy.
Existing staff who are considered to be vulnerable, have been advised and have been trained where possible in alternate duties (e.g. contact tracing) should the need arise.		Continue to refine the working structure, policies and approach with the arrival of Omicron in NZ.
Engagement with unions as required		Local BAG remains the forum for discussions. Union Leadership Action Group (ULEG) now supports an integrated approach to union engagement on COVID-19 matters.
Implementation of a newly established recruitment system to increase diversity of representation in leadership/decision making		SAP SuccessFactors now implemented as Southern's recruitment system. Work progresses on recruitment policies that support the focus on diversity and Māori candidates.
Diversity and inclusion policy established to ensure diversity in leadership roles as well as decision making within Southern		On track Recruitment for Māori Workforce Development Advisor is in progress. The role will support the development of applicable policies and approaches to support the recruitment of diverse candidates.

Health Workforce (continued)		
Certificate in Bicultural Competency. Course is offered to staff in Otago and Southland, with capacity for 630 staff per annum		Uptake of course has been positive and continues to be provided with the service providers.
Report on numbers enrolled and numbers achieving the Certificate		
Approval of budget for increase in FTE; recruitment and appointment of Welfare Advisor		Request for FTE has been submitted for budget purposes. Awaiting approval.
Provide a digital system to support the operational management of hazards and risks and to track H&S improvement actions. Progressive rollout of Risk Manager modules to H&S Reps and Managers		Progress has been impacted by turnover in the H&S team as well as focus on COVID-19 activities and planning

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Data and Digital Enablement		
Actions to digitally enable health services to support COVID-19 recovery, sustain changes to service delivery models and/or embed key learnings from your COVID-19 response		
iMedx transcription – roll out to our rural hospitals		Planning is ongoing with Clutha and Gore Trust Hospitals
Actions for the upcoming year that Southern DHB considers to be the most important for improving equity of access to health services through digitally enabled means (e.g. telehealth)		
Work with services to assist with adoption of Telehealth		All clinic rooms in Dunedin and Southland Hospitals are now telehealth enabled which has resulted in a further uptake of virtual consults in the services
Increase use of telehealth by Māori providers and runanga -Consultation/ provision of education to Māori providers		Purchase of additional Telehealth Units has been organised with 2 units dedicated to community use. Discussing where to put these units with key stakeholders.
Work with services to assist with adoption of Microsoft 365 and MS Teams		Ongoing

Implementing the New Zealand Health Research Strategy		
Healthcare Homes - Second phase of interviews completed		
Home Team Report - second phase of interviews completed		
Southern DHB report (ED research on lack of presentations during COVID) published and findings disseminated		No Report received from team member
Study undertaken re Improving Outcomes for older people with dementia in Aged Residential Care Facilities		No Report received from team member
Carpal Tunnel Syndrome study – dissemination of findings		

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Care Capacity Demand Management (CCDM)		
Governance		
CCDM Council meets as per the Terms of Reference, with at least one meeting per quarter		Council meetings are bi-monthly
Report on CCDM Programme implementation progress/completion to Health Union Partners, SSHWU/MoH and staff		Via monthly updates; LDC's; CCDM quarterly reporting. Outcome of implementation evaluation visit deemed SDHB to be "fully implemented"
Increase in overall nursing/midwifery CCDM implementation each quarter or <5% decrease in inpatient implementation.		3% increase. Outcome of CCDM implementation evaluation visit deemed SDHB to be "fully implemented". Based on the CCDM ward milestone reporting, SDHB is 85% implemented; this relates to not being able to achieve the FTE calc milestone "New roster model and budgeted FTE are in use"; this is due to nationwide shortages of nurses and midwives and challenges in recruitment.
100% of Local Data Councils / wards have met as per TOR (at least twice per quarter)		Yes & Terms of Reference are under review.
Local Data Council meetings established at Lakes District Hospital. At least two meetings held each quarter.		Meetings scheduled every 6 weeks

Care Capacity Demand Management (CCDM) continued		
Report on key results from evaluation of full implementation by the SSHW Unit- key results and progress reported		Final outcome of CCDM implementation evaluation visit deemed SDHB to be "fully implemented". Standards 1-4 = 100% implementation. Standard 5 = 85% implementation. 21/22 criteria fully attained. Recommendations are being worked through; 3 of the 17 have been addressed since the report was received in mid December.
Patient acuity data		
TrendCare implemented at Lakes District Hospital following 3.6.1 upgrade. Proposal for implementation accepted.		TrendCare implementation scheduled for 29 & 30 March 2022.
100% of wards have completed IRR Testing by end of quarter 4 – progress report		
Report on % IRR testing completed		35% of wards have completed IRR testing.
Core data set		
End of Shift Survey undertaken at least 6 monthly; End of Shift Survey response rate > 65%		A decision has been made to defer undertaking further end of shift surveys on TrendCare until the outcome of a pilot survey conducted by researchers in conjunction with SSHWU is known.
Survey results shared with stakeholders		As above

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Care Capacity Demand Management (CCDM) continued		
FTE calculations		
FTE calculations - Number of completed FTE calculations Q2		A further 11 wards (Queen Mary Maternity wards, MHAID wards & Medical ward) have confirmed new roster models *(bringing the total to 28)* and are actively recruiting. However, the new roster models and FTE are not yet in place for all wards due to nationwide RN & RM shortages. Data entry for 2022 – 23 financial year is complete.
FTE calculations are agreed and budgeted		Outcome of calculations for the 11 wards with confirmed roster models in Q2 = 45 FTE (16.4 RN; 7.6 EN; 10.4 midwives; 10.7 HCA. These are budgeted FTE. Roster testing is in progress to determine the number of FTE required for the 2022-23 budget.
Number of additional FTE recruited		As of 31 December 2021, 'Requests for Recruitment' have been raised for 75.78 FTE & a total of 61 FTE have been recruited (incl Q1 FTE). From the outcome of calculations finalised in the Oct – Dec 2021 quarter (Q2), 2.1 FTE senior midwives have been recruited.
% of total FTE recruited that are Māori		5 staff recruited (RN's & HCA's / mix of casual and permanent staff) but not related to CCDM FTE calculations
Variance response management		
Percentage of time in Red, Orange and Mauve each quarter for all 34 wards.		All DHB Inpatient Wards (excl Lakes): 1.8 % hours in Red VRM 3.2 % hours in Orange VRM 4.3% hours in Mauve VRM
Finalise Allied Health Standard Operating Procedure		The finalisation of the AH SOP is pending completion of a trial of the rehab priority tool.

Health Outcomes for Disabled People		
Disability Working Group reporting to Disability Support Advisory Committee, Community health Council and Iwi Governance		
Action plan, to include specific actions for tangata whaikaha, will be developed with key deliverables for Y1-Y3		Action plan developed and published. Bi-monthly reporting to Disability Support Advisory Committee.
Report on the number of staff who have completed the e-learning training module		131 new staff undertook disability awareness training in Q2, This out of 230 new SDHB employees, representing 57% of new staff. As SDHB is in the process of changing providers, 84 staff completed the Disability Responsiveness module in Ko Awetea Learn, whereas 47 did the HealthLearn Disability Equity training. From 31 January 2022, all new staff with use the HealthLearn module.
Mass media communication relating to COVID information includes captioning, national sign language, high contrast and large print information.		Key messages being produced in accessible formats. Agreements/arrangements in place to be able to provide key messages in NZSL.

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Planned Care		
Supporting COVID-19 recovery		
Skin lesion operations performed in the community - new model of care commences		New model of care working in three practices. Staged increase to include fifteen more practices over next 3-6 months.
Planned care strategic priorities		
Southern district HNA completed with recommendations for follow up actions		Due to staffing resources (COVID) the HNA has not made progress anticipated. Plans have been put in place to ensure the project can continue momentum. Anticipating a launch in the following quarters
Increase in baseline cervical screening coverage for Māori, Pacific and Asian women		Continuing to work with priority groups to increase equity of access and coverage.
Expand and enhance consumer primary care portal access. Patients registered with a portal - target 40%		Below target (32%) but strategies in place to improve
Six monthly reports to evaluate how the specialist nurse-led diabetes clinics are working, using patient and health professional feedback as well as metrics		

Planned Care (continued)		
Planned care strategic priorities		
5th theatre in Southland Hospital. RFP process is completed and a contractor is appointed		The decision was made by the steering group to combine ED redevelopment and 5th construction as they are in the same area. The project is being costed by a Quantity Surveyor and a user group of Engineers and Architects set up. Once they have updated plans the RFP for several contractors will be sent out.
Planned care interventions		
Computed tomography machine. Building work and equipment installation is complete and room cleaned. Patients commence scans in limited numbers.		Training has been completed and the scanner is fully operational
Rheumatology - Nurse led and community based clinics have commenced by Q2		In place

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Rural Health		
COVID responsiveness		
Feedback to and from Rural Hospitals on developments from SDHB relating to COVID-19 management		Weekly meetings with all Rural Trust Hospitals have been established to facilitate information sharing about infrastructure, workforce, clinical pathways, and managing in an endemic. Infection Prevention and Control and Infectious Diseases key staff have assisted Rural Trust Hospitals in their preparation.
Rural participation in SDHB TAB for DOVID-19 Disseminate information to and from SDHB TAG and Rural Hospitals and Community Health Trusts.		Two Rural Hospital Medicine specialists attend TAG. They report to the Rural Hospital Clinical Directors group and also to a combined CD and Chief Executives group to ensure relevant information is shared, and risk is elevated to TAG as necessary.
Equity of access		
Develop pathway to enable population domiciled in Central Lakes to access MRI in Queenstown, to improve equity of access – identify barriers to accessing MRI locally in Q2		
Barriers and opportunities to improve equity of access for Māori identified and reported		

Rural Health		
Equity of access (continued)		
Southern DHB engaged in processes to develop sustainable and affordable after-hours primary care services in the Upper Clutha		
Work with providers in the Central Lakes region to develop plans that reflect the agreed strategic direction.		
Work undertaken with Rural Trust Hospitals to identify a process that meets the goal of a single contractual relationship		

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Minister of Health's Planning Priorities: Give Practical Effect to Whakamaua – Māori Health Action Plan

Māori Health Action Plan 2020-2025		
Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau-centred services		
IGC and Māori health leadership support the review of the Mental Health, Addiction and Intellectual Disability Review with view to increasing service responsiveness to Māori. Report q2.		
Southern DHB to monitor the roll out of the kaupapa Māori primary mental health and addiction service in the establishment phase		
Māori health leadership participation on the district telehealth working party under the GM Medicine, Women's and Children's directorate.		

Māori Health Action Plan 2020-2025		
Engagement and obligations as a Treaty partner		
Review of current kaupapa Māori services and move to high trust contracts		
Procurement processes used to identify providers for delivery of whanau ora contracts.		
Advance tier one services in the community provided by Māori health providers. Reporting q2.		

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Minister of Health's Planning Priorities: Give Practical Effect to He Whakamaua – Māori Health Action Plan

Māori Health Action Plan 2020-2025 (continued)		
Whakamaua Objective: Shift cultural and social norms		
Implementation of an affirmative employment programme into the allied health workforce recruitment programme		
Māori health leadership programme introduced		Progressing in Q3 with meetings planned February
Whakamaua Objective: Reduce health inequities and health loss for Māori		
Review of Māori Health Directorate workplan		
Whakamaua Objective: Strengthen System Accountability Setting		
Engage with Te Runanga o Ngāi Tahu and local Māori communities when developing major business cases across the district, in consultation with Iwi Governance Committee. Reporting q2.		

Māori Health Action Plan 2020-2025		
Whakamaua Objective: Strengthen System Accountability Setting (continued)		
Engage with Kia Ora Hauora (KOH), the national Māori workforce development programme, working with WellSouth PHN and kaupapa Māori Health Providers to grow the number and increase the capacity of Māori working in the health and disability sector. Reporting q2.		
Provide information as required to the national team or systems to ensure that that major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Māori.		

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Minister of Health's Planning Priorities: Improving Mental Wellbeing

Improving Mental Wellbeing		
Psychosocial response to and recovery from COVID		
Central Lakes Wellbeing Recovery Group - communication strategy implemented Q2		
Mechanism implemented to ensure connectivity between Iwi and all stakeholders to support advocacy for Māori and vulnerable populations		
Navigator in the Central Lakes sub region will enhance the integration of primary mental health and addiction services with specialist mental health and addiction services as part of the psychosocial response. Engagement embedded within the local response Q2.		
Activity reports submitted to Governance Group of Central Lakes Wellbeing Recovery Group monthly		
Evidence Based Equity Actions for Improving Mental Wellbeing for Māori		
Prepared an implementation plan for further roll out of Mental Health Advance Preferences/Statements (MAPS) tool across the district		
Prepare an implementation plan for further roll out of MAPS across the District		
Monitor use of seclusion on a monthly basis.		
Development of the Implementation plan for the recommendations of the report from the Independent Review of Southern Mental Health and Addiction System Continuum		

Improving Mental Wellbeing (continued)		
Follow up within 7 days post discharge from an inpatient mental health unit (MH07)		
Data is subjected to quality review after each quarter and errors corrected/ individual follow up is undertaken as required		
Data are shared and discussed		
The Team reviews, identifies and implements measures to manage average length of stay (days) over each quarter.		

Improving Mental Wellbeing (continued)		
Improving mental health services using wellness and transition (discharge) planning (MH02)		
Raise understanding amongst staff of the importance of this KPI at every appropriate opportunity (e.g. team meetings) so that it is embedded as BAU thinking		
Managers actively monitor compliance on a regular basis and target service areas that are below compliance		
Monitoring system established and utilized so that all managers receive and review weekly compliance reports		
Quality audits undertaken on a regular basis. Results are reviewed to determine opportunities for improvement		
Ensure that there is competency and confidence in entering data into IPM through the provision of refresher training to staff		
Meet the programme milestones of the HQSC Programme for Connecting Care, improving service transitions		

Improving Mental Wellbeing (continued)		
Improving mental health services using wellness and transition (discharge) planning (MH02) continued		
Implementation and embedding of the internal DHB review of Transition (discharge) Guidelines. This review identified 4 work streams that will result in improved outcomes for this KPI		
Mental Health and Addiction Service Development – MH04 Focus Area 1 – Primary Mental Health		
Consolidate the Integrated Primary Mental Health Programme (Access and Choice) programme where it has been established in General Practice		
Extend the programme into additional General practice settings.		

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Minister of Health's Planning Priorities: Improving Sustainability

Improving Sustainability - Short term focus 2021/22		
Sustainability funding initiatives Develop district-wide approach to connected and responsive clinical partnerships in relation to • Integrated services for frail elderly incorporating admission avoidance in Mosgiel (DN) • Integrated services for high needs whanau in South Dunedin, incorporating mental health • Primary maternity service configuration in Central Otago • Acute and urgent care incorporating community diagnostics in central Dunedin Q2 – ideas tested		Integrated services for high needs whanau in South Dunedin, incorporating mental health. SDHB, Te Kaika and MSD are collaborating to provide a wellness hub for whānau in South Dunedin. This project is progressing as per timeline, with an expected build completion date planned for December 2023. Other initiatives are all on track
Action initiated from/supported by national analytics – InterRAI analysis Comprehensive analysis of Psychogeriatric Age Related Residential Care cohort to better understand existing levels of Psychogeriatric utilisation and assess for variation against DHB's. Analysis will include: • Clinical and non-clinical characteristics • Inter DHB and Intra DHB (within Southern DHB) comparison Q2 - Analysis completed, reviewed and presented		Analysis completed to be presented in Feb 2022

Improving Sustainability – Short term focus 2021/22 (continued)		
Initiatives developed to strengthen production planning		A production plan model which will assist with acute and elective planning and smoothing of bed demand is in development and will be finished this quarter. We will test the model against actual data to test accuracy. Based on the model results initiative will be developed for the services to improve delivery.

Long Term Conditions		
Six monthly reporting to include referral numbers from Well South's Walking Away programme to Sport Southland and Otago's Green Prescription (GRx) service		
Telehealth MDT service initiated – diabetes service		GM unavailable for meeting due to extended leave – plan to meet in following quarter to action
Diabetic Annual Review (DAR) catch up programme delivered		
HbA1c to 90% for Māori		Still a challenge for the Diabetes team to increase this number from 57% to 90%. Work continues in this area engaging with practices and providing education at a patient and community level.
DAR to 80% for Māori		Exceeds Expectations
Assistance provided to General Practice to support the delivery of the regional hepatitis C work and objectives		Ongoing support provided as required. GP practices have our contact details to contact the hepatology nurses directly. Successfully engaging with WellSouth eg to take on the primary care aspect of the Hep C action plan ie. to provide updates in their GP newsletter. Medical practice education; HCV-POC testing etc. The restrictions associated with covid has had a negative impact on face to face engagement and availability of WellSouth. Engagement is very much a work in progress.
Report on number of practices engaged per quarter		No formal education but many phone conversations with GP's,NP's and practice nurses on HCV education and treatment
Education and advice provided to General Practice across the district in relation to hepatitis C		Advice provided to GP practices on demand. Advice given to one Nurse Practitioner in rural community.
General Practices provided support in the prescribing and monitoring of patients on Maviret		Ongoing support as required; GP practices have our contact details to contact the hep C nurses directly; Maintained established relationships with GP practices; Keeping the Southern Community Pathways in HCS information up to date, based on best practice. A new process map is being developed for HCS to make is easier for GPs to follow- WIP.

Long Term Conditions (continued)		
Report on number of patients being treated for hepatitis C-with Maviret in the southern district		29 patients treated for hepatitis C-with Maviret in the southern district
Initial contact made with Māori health providers to provide education on hepatitis C and the treatments available		Active engagement with WellSouth has been now made to assist in reaching Maori health providers and communities-WIP. This is after unsuccessful attempts when contact was made using the SDHB Maori directorate contacts. Now on hold again due to Covid outbreak.

Reconfiguration of the National Air Ambulance Service Project – Phase Two		
Maintain our commitment to the national plan to achieve a high functioning and integrated National Air Ambulance service and actively participate through the National Ambulance and Retrieval Quality and Safety Group Support		We continue to participate in the national discussions regarding an integrated service
Design a flexible aero-medical workforce model that enables sustainable system improvements and supports service capacity in a COVID impacted health system – ongoing commitment		Our fixed wing service is fully operational for Nurse only transfers, and we are aiming to have the ICU medical team added to the service in the 3rd quarter.
DHB collection of data for KPIs		There has been no formal request for any data to be provided nationally yet, however we are open to discussions at any time

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Minister of Health's Planning Priorities: Better Population Health Supported by Primary Health Care

Pharmacy		
Engagement with Pharmacy Sector to keep them informed of changes/actions re COVID-19		
Number of ICPSA providers who have Flu Vaccination schedule in their ICPSA		60 of 81 ICPSA providers have Flu Vac service in their ICPSA
LTC-CLIC pilot to undergo a redesign of eligibility to closer alight the service to population need. Confirm eligibility change to the pilot. Target is 3500 eligible patients for the Southern District.		
LTC-CLIC pilot -Review the appropriateness of the patient cohort.		
Undertake analysis to understand utilisation and cost drivers of Southern district pharmaceutical use, especially high-cost pharmaceuticals. Outlier pharmacists identified Q2.		Unable to progress due to allocation of resource to COVID-19 immunisation response

Primary Care		
Continue the roll out of the call centre supporting the primary care catch up programme of work. CVD 90% by Q2.		Variance of 6%
HbA1c Māori target 60%		
Flu vaccination Māori 75%		COVID vaccination programme has taken priority this quarter
Māori enrolment 90%		Maori enrolment improved to 80%. Mitigation actions being undertaken
Continue to support the roll out of GP and patient portals to increase access to services. GP practices with portals. Target 80%.		
Patients registered with a portal. Target 40%.		Currently at 32%
WellSouth PHO participation in COVID-19 resurgence planning with the Southern DHB at the Technical Advisory Group and the COVID-19 Steering Group. 100% participation Q2.		

Antimicrobial Resistance (AMR)		
COVID Recovery		
Infection prevention and control (IP&C) meetings scheduled and reporting to Clinical Council, established in line with the revised IP&C and Antimicrobial stewardship (AMS) Committee TOR. Representation and engagement across primary and community care, specifically ARC.		
Development of IP&C and clinical services workflows utilising iCNet		
Advance AMR management across primary care, community (in particular age-related residential care services) and hospital services		
Advance AMR management across primary care, community (in particular age-related residential care services) and hospital services- continue to refine the education programme and determine a sustainable system for q3 and q4		

Smokefree 2025		
Undertake compliance and enforcement activities in relation to the Smokefree Environments and Regulated Products Act 1990. Report measures as required once the implementation process has been made clear. Reporting q2.		Responded to enquiries and complaints. Education and compliance checks coincided with Liquor Licencing inspections. There has been no CPO activity as we are keen to understand the implications of a volunteer who is wearing a mask. All enforcement staff were also responding to Covid-19 following the instruction from the Ministry of Health to cease all BAU in Q2.
Southern DHB clinical staff trained to make referrals into the Southern Stop Smoking Service		Staff are trained and have been doing online referrals to the Southern Stop Smoking Service this quarter.
Systems in place to ensure clinical staff can make referrals.		E-referral system is working well.
Connect Southern Community Laboratory pregnancy data to WellSouth PHO smoking data base to identify all pregnant women who are smokers to enable staff to offer brief advice and referral to stop smoking service as appropriate.		No commentary provided by WellSouth
All pregnant women who smoke are contacted by WellSouth PHO call centre		No commentary provided by WellSouth

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Cross-sectoral Collaboration including Health in All Policies		
Actively work with stakeholders who serve the needs of our most vulnerable groups to facilitate good coverage of the COVID-19 vaccine. Progress report q2.		Processes are in place to work with providers who have close relationships with our vulnerable populations. Work so far has included mental health residential, disability populations, aged residential care facilities, migrant communities, and those requiring outreach.
Complete a Vulnerable Populations Needs Assessment that builds on the Southern DHB Health Needs assessment and provides a basis for future public health intervention planning.		This work has been put on-hold following the instruction from the Ministry of Health to cease all BAU in Q2 to assist the Auckland Covid-19 Delta outbreak. It is likely this may be subsumed by a need to support future locality applications with health needs assessment data.
Evaluate the effectiveness of the multi-agency recreational water programme that has been operating across the Southern District for the past four years. Evaluation complete q2.		This work has been put on hold following the instruction from the Ministry of Health to cease all BAU in Q2 to assist the Auckland Covid-19 Delta outbreak. It is likely that under the new National Policy Statement for Freshwater, we will need to review our participation in this work.
Work collaboratively with Central Otago and Queenstown-Lakes Districts on strategies aimed at ensuring healthy housing is more accessible. Clarify Central Otago's supportive housing policy q2.		CODC responded favourably to a paper that recommended a number of interventions relating to housing at their meeting held on 30 June 2021.

Cross-sectoral Collaboration including Health in All Policies (continued)		
Work with Regional Councils, Local Authorities, the National Institute of Water and Atmosphere (NIWA) and Iwi on strategies aimed at improving air quality in priority airsheds in the Southern District. Intersectoral hui q2. Cromwell air quality study completed and disseminated to key stakeholders.		This work is pending acceptance of the study for publication. The work has been circulated at an informal level, but any progress has been held back following the instruction from the Ministry of Health to cease all BAU in Q2 to assist the Auckland Covid-19 Delta outbreak.
Activity report q2.		A meeting was cancelled in September following the instruction from the Ministry of Health to cease all BAU in Q2 to assist the Auckland Covid-19 Delta outbreak
Actively engage with Māori providers and local Runaka to identify common issues and develop joint work programmes. Activity report Q2.		There has been further work in the context of Covid-19. Next quarter the dialogue will be regarding localities.
Regularly meet with all Southern Local Authorities to look at ways we can effectively support their activity as it relates to their statutory obligation for Community Wellbeing. Two joint projects to be developed in collaboration with local authorities. Activity report Q2.		A zoom meeting was held with Clutha District Council staff in the reporting period. Most of the meeting was a follow-up to activities planned in their 10-year annual plan.

Communicable Disease		
Communicable disease		
Evaluate the roll out of Redcaps® as a means of managing notifications of common notifiable enteric diseases		Redcaps has been rolled out to help manage the notification and investigation process of low risk communicable diseases. Due to the Regulatory and Protection Team doing only non-essential Business as usual since August 2021 there has been no capacity to complete and evaluation of the roll out of Redcaps, all work has been responding.
Respond to any emerging notified outbreaks or cases of disease as per the Communicable Disease manual. Narrative report q2		
COVID-19 response		
Implement a timely response to COVID-19 including assurance around capacity for case management and contact tracing – narrative report		
Ensure that surge response planning is in place for any community COVID cases and contact tracing – narrative report		
Maintain ongoing training for current workforce and any surge workforce – narrative report		Current PHS workforce is receiving ongoing training through supporting national response work. Wider DHB surge staff ongoing training is paused as it is currently being worked through to see what support will be available to us under the new traffic light system.
Support activity at our maritime borders aimed at keeping COVID-19 out – narrative report		The process for managing maritime crew documents has been updated to support Health Protection Officers and Medical Officers of Health to manage maritime crew whilst on-call. Ongoing work continues to support stakeholders at the maritime ports to strengthen their protocols.

Communicable Disease (continued)		
Strengthen engagement and liaison with Māori and Pacific health providers in the Southern District around public health COVID response.		Strengthening and relationships and engagement, support for funding opportunities and clinical oversight has occurred for the Covid-19 programme. There has been an increase in workforce capacity with non-clinical staff trained as vaccinators, additional resources and support for vaccination clinics and Covid-19 monitoring in the community.
Support the roll out of the COVID-19 vaccination programme and in particular advocate for ensuring its accessibility to vulnerable communities		

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Sexual Health		
Access Improvement Project: Conduct a survey to understand barriers for Māori and Pacific accessing sexual health services across the district, considering opening times, locations of clinics and any other opportunities Q2		This continues to be work in progress
Implementation of actions within the Syphilis Action Plan, with oversight by Southern district's Syphilis Group		It has been on hold since former General Manager resigned.
An ELab request process will be developed to include consideration of syphilis testing each time a HIV testing is requested		Work progressed with IT electronic laboratory requests to be finalised.
Review sexual health clinical pathways to understand differences in service delivery across the district		Sexual Planning Day scheduled February 2022.
District wide Sexual Harm Assessment Clinics and services established		
District wide Sexual Harm Assessment Clinics to be available in lockdown events		

Breast Screening		
BreastScreen will fully recruit and retain mammographers to ensure the service has maximum capacity to meet demand and catch up on delays caused by COVID-19.		
Six monthly reports. Target: Māori 70%, Pacific 70%		Improvements made in increasing the Maori screening to 63% though still a long way to go for Pacifika screening rates.
BSA will action a Māori and Pacifica priority booking process where appointments for mammography are held and prioritised for Māori and Pacific women.		
BSA will action a Kaimahi service that supports the wider needs of Māori and Pacific women when accessing the BSA service.		

Environmental Sustainability		
Zero coal use at Southern DHB by 2030 – feasibility study to convert Dunedin Energy Centre to carbon neutral sustainable fuel		No report received from team member
Reduce electricity use through through behaviour education campaign		No report received from team member
Increase use of telehealth by Māori providers and runanga – consultation/provision of education to Māori providers		Providers are aware of the programme, education and training is being developed and will roll out to providers once completed

Drinking Water		
Project to increase compliance of small water suppliers with Drinking Water Standards completed		A tri-agency was formed between Queenstown Lakes District Council, Otago Regional Council and Public Health South to work towards minimising the risk to small supplies. This is ongoing work getting other areas on board.
# investigations related to incidents, complaints and notifications		Public Health South responded to transgressions when we were responsible for responding to these. This is now the responsibility of Taumata Arowai as the new drinking water regulator) since early November 2021).
Communication of key messages developed and available if needed re use of drinking fountains in schools and community settings during any future COVID-19 lockdown events		There were no lockdowns in Q2.
Work with Kati Huirapa Runaka ki Puketeraki as a follow-up to "lead in drinking water" to ensure water quality issues are appropriately addressed from a cultural perspective		This was effectively delivered in Q1 in July. This included a blessing at the marae following the lifting of the do not drink notice.

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Environmental and Border Health		
Work to support Border Agencies as the COVID-19 risks are reduced and current controls are relaxed – narrative report on progress		Health Protection Officers continue to have very good relationships with border agencies at all airport and maritime ports. As the border controls look to relax and the border is opening up there has been work with Queenstown airport stakeholders as to what this will look like and how we will operationalise the multi-agency response at the border.
Implement a quality improvement plan (developed in 19/20 year) for Southern DHB processes for issuing permits pursuant to Section 95 of the Hazardous Substances and New Organism Act 1996 for the use of 1080 and cyanide for the control of vertebrate pests. Evaluate the improvements q2.		The improvements to the processes and protocols for using permits pursuant to Section 95 of the Hazardous Substances and New Organism Act 1996 has made it more aligned to the Ministry requirements. An evaluation of this was done earlier in the year. It should be noted that the Public Health Service has not been doing VTA applications whilst responding to Covid-19 .
Update and renew relationship agreement between Southern DHB, Aukaha and Te Ao Marama for Murihiku environment health issues - draft relationship agreement developed q2		The matter has been raised with staff at Aukaha through our discussions on a joined-up approach to the RFP for the Healthy Homes initiative.

Healthy Food and Drink environments		
Healthy Food and Drink Policy		
Ongoing implementation of the Healthy Food and Drink Policy in all Southern DHB cafeteria		
Monitoring to ensure compliance with the Healthy Food and Drink Policy		Nom Nom café at Southland Hospital 3/08/21 & 26/10/21, Revive Café Dunedin December 2021. The national audit carried out by AUT which was to be scheduled in October, is now due to be completed in March 2022
Healthy Active Learning		
Data collected on the number of up-to-date healthy food and drink policies embedded in priority settings		No changes from the previous quarter – staff continue to be involved in Covid-19 response work.
COVID-19 response		
Identify and quantify food security issues in the community that have become apparent as a result of COVID-19 and work with collaborative partners to design and implement interventions aimed at addressing them. Issues identified and quantified q2. Report written.		(No commentary supplied)

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Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Cervical Screening		
Improve coverage in Māori and Pacific women aged 25-69 years from the baseline as at February/March 2021		
Increase in baseline coverage for Māori, Pacific and Asian women		Achieved the partnership with General Practice to increase participation for those not engaged. Our Southern DHB Asian population target continues to be a challenge. Strategies are in place to work more intensely with practices of high percentages/number of Asian women, eg working with Mornington Health to implement focussed screening events at the practice.
Reducing the equity gap: Pacific		
Six weekly clinics will occur at PIACT in 21/22		
Eight clinics will be held at PTO in 21/22		
Reducing the equity gap: Māori		
Two monthly clinics held in Dunedin		
Six monthly clinics held in Oamaru and Balclutha commencing		
Six monthly reporting utilised to monitor increased participation of Māori women		
Improve equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result		
Review of colposcopy processes across the district for wait times, DNAs and electronic discharge.		Recent resignation of longstanding Service Manager has resulted in reduced progress. Southland GynaePlus has been updated and staff are currently in training.

Reducing Alcohol Related Harm		
Ongoing development of messaging that is able to be assimilated by the audience		Covid-19 response has put this work on hold.
Work with Emergency Departments in the Southern District to standardise the way alcohol harm data is recorded. Standardised data recording established q2.		This is an ongoing piece of work that is rapidly emerging as a national issue in New Zealand's Emergency Departments.
Identify areas of concern to limit liquor licenses q2.		
Develop a process for addressing applications for additional alcohol licences in high deprivation areas		A process has been developed on when we would or would not oppose a licence that does not comply with the object of the sale and supply Act. When addressing applications with high deprivation areas officers take into account the point of density, which would be guided by case law, any alcohol policies and the Act.
Reporting on performance measures (as outlined in the Reducing Alcohol Related Harm: Health Protection Planning/Reporting Template)		Under the Sale and Supply of Alcohol Act a total of 978 licences were received and reported on. Of those reported on, a total of 3 licence applications were opposed.
Review post-COVID alcohol consumption patterns disaggregated by ethnicity in post-COVID Aotearoa New Zealand (Southern district) and devise appropriate evidence-based interventions		This was abandoned following the instruction from the Ministry of Health to cease all BAU in Q2 to assist the Auckland Covid-19 Delta outbreak.

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Minister of Health's Planning Priorities: Improving Child Wellbeing

Immunisation		
Immunisation engagement and communications plan		
Vaccine Preventable Disease, WCTO Steering Groups and the Child and Youth Network meetings meet regularly		WCTO and Child and Youth Network have met in the quarter. All in vaccinations were the main focus of discussion at the Child and Youth Network.
Increased Immunisation at 2 years (CW05)		
Increased collaboration between Māori providers and outreach immunisation services to deliver childhood immunisations within local Māori communities		Working alongside Kaupapa services to increase presence in the community.
Reporting on number of Māori vaccinators		
Increased vaccinations of Pacific children as reflected in national target results		Performing well nationally, currently developing capacity within the Pacific providers. (Southern Pacific Childhood Immunisation milestones: 92.0% for 8-month, 94.3% 24-month and 97.9% for 5-years for Q2)
Increased vaccination of Māori children reflected in national target results		Released one Māori staff member from Te Punaka Oraka – Public Health Nursing to external Māori Health Provider until end of 2022. 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. Looking for further opportunities in this space. SDHB Immunisation Coordinators also working alongside. There is more to do this in this space to embed practice and achieve desired targets. Although MoH targets not reached, SDHB performs highly nationally for these measures. (Southern Māori Childhood Immunisation milestones: 91.7% for 8-month, 85.0% 24-month and 90.4% for 5-years for Q2)
Increased number of Māori vaccinators		All 12 Māori providers have received training and information specific to the vaccination programme. Māori providers are running multiple clinics across multiple sites. The first cohort of the non-regulated Māori provider workforce n=8) is receiving vaccination training in q1.

Immunisation (continued)		
Increased Immunisation at 2 years (CW05)		
Immunisations on the National Immunisation Schedule are received on time for Māori and Pacific children – reflected in national target results.		Utilising MoH QLIK Data, NIR team are beginning to proactively utilised data available to lead action, particular driven by Projected Dashboards. There is a focus on Māori and Pacific children in this space. There is more work to be done in this space. Increased capacity in the team with a focus on complex family/whanau – Māori Pacific providing vaccinations in the home.
Measles Immunisation Campaign for 15 to 29 year olds and active recall of children 5 to 14 years who have not had any or had only one measles, mumps & rubella (MMR) vaccine		
Final reporting of the Southern MMR Campaign completed and submitted to MoH		Continued disruptions due to COVID-19 supporting Childhood vaccination programme as well as recruitment constraints. Pleasing to note that successful recruitment of MMR Coordinator to support this programme and extended to end of June 2022.
COVID vaccine roll out		
Ongoing establishment and assessment of processes for the successful roll out of the COVID-19 vaccine according to the Ministry of Health's COVID-19 Immunisation Programme – narrative reporting		Southern DHB is consistently achieving above national average for vaccination rates
COVID-19 vaccine is delivered to the Southern population according to MoH's COVID-19 Immunisation Programme ensuring equity of outcomes		Project managers work closely with the vulnerable populations (disabled, older people) and work with the providers to ensure their populations have equitable access to the vaccine in a way that is suitable for their needs.

Immunisation (continued)		
Maintain immunisation coverage during the COVID-19 immunisation programme		
NIR produce and use reports to identify children who are close to missing their milestone immunisation; information is used to facilitate immunisation of children through outreach clinics.		Work is being done in this space utilising MoH QLIK Dashboards, particularly projected dashboards to lead action. Although still a challenge for children who are not enrolled to equitable access to immunisations it is pleasing to note with the use of QLIK data in Q2 has enabled easier identification for Outreach to contact this cohort. (Southern Unenrolled Childhood Immunisation milestones: 75.0% for 8-month, 71.4% 24-month and 61.5% for 5-years for Q2, this for the most part an increase on Q1 results: 47.8% for 8-month, 50.0% for 24-month and 76.5% for 5-years).
0800 number used to address enrolment enquiries		As per Q1 Commentary: Creation of an 0800 number to address enrolment enquiries had been created by PHO. Follow up needed to understand demand of this.

Family Violence and Sexual Violence (FVSV)		
Regular attendance at Whāngaia Nga Pa Harakeke (police initiative)		
Collaborate with mental health to ensure safe and appropriate response to SDHB family violence programme, policy and processes		
VIP team engagement with Māori Directorate for policy and programme development		Capacity of Māori Health directorate has limited engagement opportunities.
VIP team engagement with kaupapa Māori services in relation to FV and SV services in the Southern district.		Capacity has limited engagement opportunities

Annual Plan Report Quarter 2 2021/2

Minister of Health's Planning Priorities: Improving Child Wellbeing

Maternity Care		
COVID 19 learnings		
Primary maternity facilities – business plan submitted to Treasury		The Business Case has been approved by the Ministry of Health (DG). An RFP process for the architect Design and Build is due to close today. Land has been identified in Wanaka, and liaison with the Ministry of Health is occurring regarding a proposed purchase. A CAPEX has been raised for land / design and build within SDHB CAPEX system.
Integrated service model		
Pregnancy and Parenting RFP process completed		Decision made not to RFP for this service and the contract was renewed with the existing provider.
Data management systems are in place to support WCTO providers to capture, analyse and report data		Karo Data Management had the system ready to go live but a delay has occurred due to the sudden death of the CE of Maniototo Health Services. Hardware is about to be purchased and data migration has occurred. Project will be completed in Q3.
Reporting of number of babies offered a newborn hearing screening by three months of age and total number of eligible babies		No report received from team member
Reporting of number of newborn babies offered Newborn Metabolic screening at age 48 hours and total number of eligible babies		No report received from team member

Maternity Care (continued)		
Midwifery Accord		
Applications advertised for scholarships to support 2022 second and third year midwifery students who live in Southern and are planning to work as midwives within Southern, to assist them with the on-call costs for students with hardship, with preference for Māori and Pasifika students		No report received from team member
Scholarships awarded		No report received from team member
Recommendations from the Perinatal and Maternity Mortality Review Committee		
New dashboard reporting software displays key quality maternity outcomes by ethnicity – review by maternity clinical governance to identify priorities for improvement		No report received from team member
GROW/GAP programme in place to improve identification of babies at risk for growth-restriction and offer package of care		GAP is still progressing with baseline auditing completed and education rolled out with however chronic midwifery staffing shortages have caused delays in progression of work due to the immediate need to support the services
Maternal morbidity review group formed including community and whānau representatives; Terms of Reference (ToR) agreed		No report received from team member

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Minister of Health's Planning Priorities: Improving Child Wellbeing

Youth Health and Wellbeing		
Additional School Based Health Services		
School nursing services delivered in decile 1-5 schools.		National work has commenced reviewing processes. More work to happen Q2-Q3 around this. Work in progress.
School nurses maintain contact with decile 1-5 schools and priority students		Predominantly caught up with all of the assessments for Q2.
Catch up programme completed in SGHS for year 10 girls who missed the year 9 check		Ongoing additional clinics to see high priority students in decile 1-5 priority schools.
Confidentiality surveys completed in secondary schools receiving SBHS		Reporting Survey disruptions due to COVID-19
Improve the health and wellbeing of priority youth populations		
Enhanced Youth Health Clinics (EYHC) across the Southern district are prioritised so young people, especially in rural areas, can continue to engage and access contraception, especially during any future lockdown events – report q2		
EYHC provide access to chlamydia and other STI testing especially during any future lockdown events		

Youth Health and Wellbeing (continued)		
Improve the health and wellbeing of priority youth populations (continued)		
Ongoing of training of public health nurses on Whakamaua: Māori Health Action Plan 2020-2025 continues		Ongoing training and support provided to staff around this to embed knowledge and practice.
Exploration of youth focussed options e.g. Zoom		

8.5

FOR INFORMATION

Item: SDHB Change Programme Report February 2022

Proposed by: CE

Meeting of: 5 April 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

Background

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

Discussion

This month's change programme update is the fifth 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.

Note that the historic competition column has been deleted for this month's report (this column allowed comparison of this month's report and last month's report). Unfortunately a system-error on the platform caused this column to report incorrect figures; the Cascade development team are amending.

Next Steps & Actions

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

Appendices

1. SDHB Change Programme Total March 2022
2. SDHB Change Programme (NDH Contributing Specific March 2022)

59
GOALS

42%
GOAL COMPLETION

STRATEGIC CHANGE PORTFOLIO PLAN

MĀORI EQUITY

Goal	Owner	Current Completion	Task	Comment
Equity Actions Improvement Programme	Mata Cherrington	**25%** **25 /** 25% ahead		**Greer Harper:** WIP - Programme delayed due to COVID Vaccination/Endemic planning re-directing resource. *Further work to build out this focus area within Cascade needed.* *24/11/2021*
→ **Reducing amenable mortality**	Mata Cherrington	**0%** **0 /** -		**Talis Liepins:** Clinical Council is sponsor; established cardiac group in collaboration with WellSouth to improve screening *21/02/2022*
→ **Appoint equity data analyst role**	Mata Cherrington	**100%** **100 /** -		
→ **Advance Māori workforce development programme**	Mata Cherrington	**0%** **0 /** -	☐ **Recruiting for Māori workforce development specialist role**	**Talis Liepins:** Interviews are being held in week 21 February 2022 *21/02/2022*
→ **Appoint 2x Clinical Nurse Specialist roles - 1x Cancer and 1x Cardiac/Respiratory**	Mata Cherrington	**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*

Goal	Owner	Current Completion	Task	Comment
Pro-equity Recruitment	Tanya Basel	**50%** **50 /** 50% ahead	☐ **Train recruitment team to support this implementation** ☑ **Complete Interview training with AHS&T Managers** ☑ **Develop draft Pro-Equity strategy for Allied Health recruitment** ☑ **Set standards**	**Talis Liepins:** Standards were drafted by Kaye Cheetham, Jayne Jepson and in conjunction with Gilbert and Mat Kiore from the Maori Health Directorate and went to ELT in 2021. Training was held with AHS&T managers early 2021 *24/03/2022*

POSITIONING PUBLIC HEALTH SERVICES FOR THE FUTURE

Goal	Owner	Current Completion	Task	Comment
Southern Strategic Briefing Project (nee refresh)	Andrew Lesperance	**91%** **90.91 /** 9% behind	**Final polishing on full document including Te Reo transalation** ☑ **Community Consultation** ☐ **Web-based environment for strategy** ☑ **Implementation Guidance** ☑ **Detailed Strategic Design** ☑ **Synthesis, design/development Intesive co-design with Working Group** ☑ **Data Analysis** ☑ **Stakeholder Engagement** ☑ **Intensive Engagement with Working Group** ☑ **Document Review** ☑ **Project Set Up** ☑	**Talis Liepins:** Paper for April Board meeting on approaches for consultation to be submitted. *22/03/2022*
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	**81%** **81 /** -	**Automate datastreams for internally held data** ☑ **Collect external data sources** ☑ **Deploy interactive data explorer on the website** ☑ **Soft launch - 40 / 82** ☑ **Formal Launch of Phase One Indicators** ☐ **Remaining indicators live on website (Phase One)** ☐ **Soft Launch of website 8/82 indicators** ☑ **Development of health Indicators** ☑	**Talis Liepins:** Unfortunately we have not made further progress this month beyond reporting to CPHAC. This is due to key staff supporting the ECC data and intelligence workstreams. The intent for Q4 21/22 is to finalise all current indicators and finish the first phase. *22/03/2022*

PRIMARY & COMMUNITY CARE

Goal	Owner	Current Completion	Task	Comment
Implementation of the Primary & Community Strategy	Andrew Lesperance	**18%** **18 /** 36% 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*
Health hubs Implementation: Te Kaika Community Wellness Hub	Andrew Lesperance	**65%** **64.71 /** 35% behind	**Agree co-design process** ☑ **First Floor Plan Complete** ☑ **Ground Floor Plan Complete** ☑ **Create and agree to development agreement** ☐ **Project Initiation, relationship agreement, preparation, RFP won** ☑ **"Go Live" opening date** ☐ **Initiate Co-Design Process (Te Kaika, MSD & SDHB)** ☑ **Heads of Agreement sign off (deferred - did not occur)** ☑ **Lease agreement sign off** ☐	**Talis Liepins:** * Floor plans for Ground Floor and Level One are complete and with Development Board for approval. * Te Kāika co-design of clinical services proposal has been accepted and contract is in draft. * Negotiations of Development Agreement, Lease and Memorandum of Understanding across partners (Te Kāika, SDHB, and MSD) are well underway. *22/03/2022*
Maternity Central Otago	Andrew Lesperance	**25%** **25 /** 4% behind	**Conclude RFP for Architect** ☑ **Build complete of Clyde PBU** ☐ **Build complete of Wanaka PBU** ☐ **Build started on Clyde PBU** ☐ **Build Started on Wanaka PBU** ☐ **Main contractor engagement: award of contract** ☐ **Tender released for main contractor** ☐ **Design complete for Wanaka & Clyde** ☐ **Design Tender** ☐ **Procurement of land in Wanaka** ☐ **Ministry of Health approval of Business Case** ☑ **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. *22/02/2022*
Primary Care in Southland - Hub Build	Andrew Lesperance	**28%** **28 /** 72% behind	**Clinical services co-design complete** ☐ **Stakeholder engagement with iwi and governance groups, and community** ☐ **Due diligence - change, impact and risk assessment developed** ☐ **Discovery Report approved by DHB Board** ☐ **Clinical Discovery Report** ☑	**Talis Liepins:** The clinical discovery report has been drafted and is going for sign-off *24/03/2022*

Goal	Owner	Current Completion	Task	Comment
Wanaka After-Hours Service	Andrew Lesperance	**40%** **40 /** 15% ahead	**Commissioning of services** ☐ **Formalisation of delivery model and assessment of feasibility** ☐ **engagement/co-design with secondary ED teams on possible nurse-led after-hours solutions** ☐ **Engagement with DHB telehealth team to identify possible digital solutions for model of care** ☑ **Early engagement with providers on issues and possible solutions** ☑	**Talis Liepins:** Engagement with both Wanaka practices occurred in February - positive outcome with agreement to work collectively with DHB and WellSouth on innovative solutions. Engagement with Telehealth team occurred in March on options to support models of care digitally. This information will be presented and carried forward in subsequent conversations about models, planned in April. *24/03/2022*

CLINICAL SERVICE REDESIGN

Goal	Owner	Current Completion	Task	Comment
Oncology Sustainability Planning	Hamish Brown	**29%** **28.57 /** 14% behind	**EY report to form basis of sustainability planning for 2022 and beyond** **Reduce Outsourcing for Radiation Services** **Meet with Clincial team to determine priorities from the EY report** **FInalise EY Report for Board**	☐ **Talis Liepins:** Note: I have updated the progress reporting to be based on task ☐ completion, against a stepped increase each month until June 2023. ☐ *24/03/2022* ☑
→ **Address recruitment challenges within the service**	Hamish Brown	**50%** **50 /** 50% ahead	**Meet with CDHB to collaborate on opportunities** **Initiate Haines Attract recruitment campaign**	☑ **Talis Liepins:** Core actions complete. Recruitment to ☑ some roles has been successful. There are gaps outstanding though which will require new and innovative solutions to address *24/03/2022*
→ **Establish outsourcing arrangement to reduce waitlist immediately**	Hamish Brown	**100%** **100 /** -		**Hamish Brown:** Outsourcing arrangements under continuous monitoring to offset clinical risk within services. Outsourcing has increased to offset reduced internal delivery capacity (largely driven by workforce constraints) and is focussed on areas that have significant under delivery in volumes. *13/03/2022*
→ **Development of long term Oncology strategic plan**	Hamish Brown	**100%** **100 /** -		**Hamish Brown:** EY report finalized by the Board and final investment decision handed to HNZ. EY report will be a springboard for determining a long term plan for SBCS. Meeting on the 23rd March to determine next steps. *18/03/2022*
Improving Patient Flow through the Implementation of the SAFER Bundle: A framework for improving patient flow	Jane Wilson	**50%** **50 /** 50% behind	**Discharge before Noon** **Flow from ED to inpatient wards** **Expected Date of Discharge & Clinical criteria for discharge** **Senior Review: Rapid Rounds & Red2Green**	☐ **Talis Liepins:** ☑ Weekend discharge pilot underway to ☐ understand why weekend discharges drop off and implement corrective ☑ actions. The other project to support discharge has been the Medimap trial project where we are training some of the 8 MED teams to be able to prescribe directly into Medimap. This will enable discharge to resthomes later on a

			Friday and over the weekend. Unfortunately this project has been slow to take off but we are about to restart with this round of HO and Regs. Estimated Date of Discharge: All patients are required to have EDDs within 24 hours of admission. However, accuracy of the initial EDD early on in the admission can be variable due diagnostic workup and changing test results. To balance this, EDDs are reviewed daily at the Rapid Rounds and discussed to refine results. Work is still ongoing - focussing on addressing constraints that negatively affect achieving the stated EDD – e.g., access to ARRC. Flow: IOC to be established now the new Patient Manager Flow role has been implemented on the Dunedin site. Southland recruitment is in progress. The early Dunedin focus will be on process-mapping the journey from ED to Wards to improve the timeliness of the steps required for admission. By refining the admitting steps on the ward, patients will be able to be "pulled" from ED Review: Organisational change and staff turnover has presented an opportunity to review where the stranded patient function sits and how it operates as an interprofessional team (such as advancing a multidisciplinary focus and integrating the function either within the Home Team or Integrated Operations Centre). Next steps are: review of resourcing and leadership to be confirmed by Mar 30th; Appoint roles accordingly *22/03/2022*
MHAID Review	Toni Gutschlag	**100%** **100 /** **-**	**Greer Harper:** *Review Complete - Recommendations are being implemented currently.* *25/11/2021*

Goal	Owner	Current Completion	Task	Comment
Embedding Virtual Health	Hamish Brown	**76%** **76 /** -	**Electronic messaging and communication establishment** ☐ **Refine and resource developments** ☐ **Telehealth Hubs** ☐ **Supported Rollout** ☐ **Continue to refine and resource developments** ☑ **Complete supported roll-out to services and support establishment of identified hubs in the community** ☐ **Identify potential hubs in the community for delivery** ☐ **Supported Rollout to services** ☑ **Development of Implementation Plan** ☑ **On-board Project Mgr & technical resource/support** ☑	**Hamish Brown:** Opportunities for exploring virtual health are arising through COVID-19 Omicron response - these are not part of the of the telehealth programme but in many cases represent genuine opportunity *21/03/2022*
Enhanced Generalism Model	Hamish Brown	**50%** **50 /** 11% ahead	**MAU Decant & Build** ☐ **MAU Design** ☐ **Recruitment: PM, SMO & Allied Health** ☐ **GAMA Implementation** ☑ **Communications Plan** ☑ **SLA/Referral Guidelines** ☑	**Hamish Brown:** See attached project dashboard. Currently 1.5FTE of SMO's to recruit. 1.0FTE supporting COVID-19 response for 3 months. Improving performance metrics - 69.8% of admissions now under GM. *21/03/2022*
→ **Recruit pharmacy and nursing roles ahead of new MAU to support model change**	Hamish Brown	**0%** **0 /** -		**Hamish Brown:** CNM recruited *14/02/2022*
→ **Increase general medical admissions.**	Hamish Brown	**65%** **65 /** 65% ahead		**Talis Liepins:** General Medical Admissions are increasing, while in parallel the service is becoming more efficient with reductions in length of stay for both long and short stay patients alike. *24/03/2022*
TCU – Transit Care Units		**0%** **0 /** -		

ENABLING OUR PEOPLE - OUR PEOPLE STRATEGY

Goal	Owner	Current Completion	Task	Comment
H R I S	Tanya Basel	**25%** **25 /** 21% behind	☐ **Undertake tender for implementation partners** ☐ **Business Case approved by FY end 21/22** ☐ **CAPEX approval of business case** ☑ **Draft business case for HRIS modules**	**Talis Liepins:** Note: I have updated tracking to report against a stepped monthly increase from 1 July 2021 to 1 Jan 2023 *24/03/2022*
CCDM Implementation	Hamish Brown	**100%** **100 /** -		**Greer Harper:** *WIP: Further content needed here.* *25/11/2021*
Health & Safety Workplan	Tanya Basel	**0%** **0 /** -	☐ **c. Workforce risk based immunisation** ☐ **b. Implement Hazard and Risk Management System** ☐ **a. Implement effective worker engagement and participation and representation programmes**	**Lu Cox:** **Update task c:** All new employees screened, serology completed and vaccination where relevant offered. Staff influenza campaign scheduled to commence April 2022. Evidence for COVID-19 vaccination order collated. **Update task b:** System go live October 2021, training user group, development of area specific safety plans underway **Update task a:** Training provider and procurement process completed, scheduled in-house training arranged for May, Updated and released associated MIDAS documentation for H&S reps, process and roles and responsibilities *24/03/2022*
Talent Management - Attract, Support, develop & retain the talent we need	Tanya Basel	**8%** **8 /** 92% behind	☐ **Effective retention startegies for each workforce group/location** ☐ **Align budget cycle with Workforce and Service Plans** ☐ **Equity and Diversity recruitment strategies** ☐ **Expand workforce and Service Planning**	**Greer Harper:** Work is progressing in all milestone areas, but not complete. Long term initiatives. *24/11/2021*
Leadership Development	Tanya Basel	**33%** **33.33 /** 20% ahead	☑ **Leadership Development Program for leadership layers: Fit for purpose** ☐ **Align Leadership Development with Health NZ** ☐ **Establish Leadership Framework**	

Goal	Owner	Current Completion	Task	Comment
Diversity and Inclusion	Tanya Basel	**50%** **50 /** 50% ahead	**Support Disability Strategy establishing essential practices** ☐ **Pro-equity recruitment pilot in Allied Health focus on Maori** ☑ **Progress Rainbow Tick (strategy alignment dependent)** ☐ **Implement Pro-Equity Recruitment across all areas** ☐	**Tanya Basel:** Due to competing priorities some of our initiatives to improve diversity and inclusion has been affected by timing and limited resources. *21/02/2022*
→ **Pro-equity Recruitment**	Tanya Basel	**50%** **50 /** 50% ahead	**Train recruitment team to support this implementation** ☐ **Complete Interview training with AHS&T Managers** ☑ **Develop draft Pro-Equity strategy for Allied Health recruitment** ☑ **Set standards** ☑	**Talis Liepins:** Standards were drafted by Kaye Cheetham, Jayne Jepson and in conjunction with Gilbert and Mat Kiore from the Maori Health Directorate and went to ELT in 2021. Training was held with AHS&T managers early 2021 *24/03/2022*
Culture and Engagement	Tanya Basel	**0%** **0 /** -	**Focus on Wellbeing** ☐ **Establish recognition and retention frameworks** ☐ **Refresh Speak-up** ☐	
→ **Wellbeing: Aukaha kia kaha programme**	Tanya Basel	**0%** **0 /** -		**Lu Cox:** For 2022 Aukaha Kia Kaha brings a new focus, using the 5 ways to Wellbeing, AKK is focused on supporting and improving the overall wellbeing of our Southern DHB people. So far in 2022, we are running a 'share your wellbeing' photo competition with the chance to win 1 of 2 e-bikes donated by Toyota and we are in the early stages of designing an implementation plan to lend out 15 other e-bikes to staff. We are also using the funding from the Ministry of Health to thank our people by providing self-selected wellbeing vouchers for our direct employees and organising morning teas for our rural hospitals and wider organisation partners. *24/03/2022*

Goal	Owner	Current Completion	Task	Comment
↳ **Speak Up Programme**	Tanya Basel	**0%** **0 /** -	☐ **Development of Speak Up App** ☐ **Develop e-Learning module**	**Lu Cox:** The wire frame for the Speak Up app has been completed and discussions with IT around integration with internal systems are currently taking place. External provider (Firebrand) advises 3 months for full development implementation (funding in place) Speak Up E-Learning module now with HealthLearn Content National Group for instructional design support. The course outline and content development has been completed internally within OD team. Other DHBs are showing interest in this SDHB initiative and it is anticipated the HealthLearn Content Group can support a module fit for purpose for HealthNZ. *24/03/2022*
Capability Development	Tanya Basel	**33%** **33.33 /** 33% ahead	☑ **Change Cycle Program to support response to change** ☐ **Identify scare skills** ☐ **Establish career programmes**	

SYSTEMS FOR SUCCESS

Goal	Owner	Current Completion	Task	Comment
Specialist Services Operational structure re-design	Chris Fleming	**100%** **100 /** -	**External Recruitment of wider positions** ☑ **Initial Recruitment of Internal Positions** ☑ **Decision Document and Notification To Staff** ☑ **Consult on Proposal For Change** ☑ **Develop Proposal For Change** ☑	**Greer Harper:** Complete. *25/11/2021*
FPIM Implementation	Nigel Trainor	**100%** **100 /** -		
Risk Management Maturity	Hywel Lloyd	**95%** **95 /** 5% behind	**Improve risk identification** ☑ **Roll out the electronic reporting system** ☑ **Embed a risk culture within the organisation** ☐ **Adoption of Safety 1st as digital risk management tool** ☑	**Hywel Lloyd:** 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. The operationalising of the Risk Register is now complete. The Clinical Council have a fixed agenda item to review the high and extreme risks. Directorate Leadership Teams review their risks and organisational wide risks with regular scheduled meetings with the Risk Adviser. 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. *20/02/2022*

Goal	Owner	Current Completion	Task		Comment
Digital Transformation (detailed business case)	Patrick Ng	**88%** **88 /** 70% ahead	**Submission of BC to government** **Board signoff of DBC** **Book DBC Clinic with Treasury** **Confirm & schedule interviewees for Gateway** **Gateway review** **Confirm TQA arrangements** **Confirm IQA of DBC** **Draft version of Detailed Business Case**	☐ ☑ ☑ ☑ ☑ ☑ ☑ ☑	**Jen Pettitt:** Special Board meeting geld on 14/3/2022 to go through the revised DBC and this has now been approved by the Board. Patrick has now submitted it to MoH and possibly be reviewed by Treasury before going to Capital Investment Committee in May. *15/03/2022*
Scanning Project: The digitisation of clinical records	Patrick Ng	**0%** **0 /** 54% behind	**Clinical Engagement** **Bureau Service: Process Design** **Bureau Service: Transition & Training** **Management of Change: Consultation & Response** **Management of Change: Definition of roles & responsibilities**	☐ ☐ ☐ ☐ ☐	**Jen Pettitt:** Nigel Trainor and Patrick Ng are meeting later today (15/3) to brief on the project before its is signed off *15/03/2022*
Establishment of an Integrated Operations Centre	Hamish Brown	**29%** **28.57 /** 29% ahead	**Appoint PM support for 6 month fixed term** **Develop IOC scope document** **SOPs/Regional SOPs** **Requirements** **Identify ands cope physical location** **recruitment PM 6 Months FT** **Define IOC scope and milestones**	☐ ☐ ☐ ☐ ☐ ☑ ☑	**Hamish Brown:** Timeline for IOC Phase one below Project Manager appointed to IOC – 21/2/2022 - complete Project Manager from Building and Property to scope physical location – 15/3/22 - complete, Working through details Indicative drawings of possible locations to be provided – 22/3/22 Design and Estimate for IOC to be completed – 19/4/22 Approval to proceed with building work – 2/4/22 Building work completed 1/7/22 Standard Operating Procedures documented 31/5/2022 Metrics agreed and developed 30/6/2022 *21/03/2022*

SYSTEM IMPROVEMENTS

Goal	Owner	Current Completion	Task	Comment
Discharge Summaries Re-design	John Eastwood	**75%** **75 /** 23% behind	**Pilot of new documentation** ☐ **Pilot group of clincians established to trial NMDHB example** ☑ **NMDHB example shared with clinical leaders** ☑ **upload outline plan** ☑	
Clinical Costing System Implementation plan	Nigel Trainor	**33%** **33.33 /** 33% ahead	**Phase 2** ☐ **Business Case approval by the board** ☐ **Business Case to the board** ☐ **Business Case proposal to ELT** ☐ **Appoint a Project Manager** ☑ **Complete RFP Process** ☑	**Jen Pettitt:** RFP process now completed. Business case to be presented to ELT and Board for approval. - Procurement summary to be submitted to ELT W/C 14th March - BC is being drafted and aiming to submit to the board in early April. *15/03/2022*
ePMO & Project Governance framework	Patrick Ng	**50%** **50 /** 42% behind	**Setting of Project prioritisation criteria with Exec Team.** ☐ **Update & socialise current PM Policy** ☐ **On-Board Portfolio Manager** ☑ **ePMO service offering & governance structures endorsed by ELT** ☑	**Jen Pettitt:** The EPMO Portfolio Manager commenced employment on 21 February 2022. Currently developing a CSO for an EPMO strategy and roadmap. Interim Governance Framework is under development. EPMO is leading on the Business Case for day-forward scanning of physical clinical records. *14/03/2022*
MHAID H&S Review and Improvement Plan	Toni Gutschlag	**67%** **66.67 /** 26% ahead	**Close out implementation plan** ☐ **Develop Implementation Plan** ☑ **External review by Purple Consulting** ☑	**Talis Liepins:** Public release occurred last week and focus is now on implementation *21/02/2022*
Hospital Escalation Planning/Standard Operating Procedures	Hamish Brown	**0%** **0 /** -		**Hamish Brown:** Ops Manager for Southland Hospital in final stages of recruitment. Urgent requirement to develop/adopt escalation plan for Southland Hospital (currently informal actions) *21/03/2022*

Goal	Owner	Current Completion	Task	Comment
PICS implementation: New regional Patient Information System which replaces IPM in Otago & Southland	Patrick Ng	**35%** **35 /** -	**Data Implementation Underway** ☑ **Go Live** ☐ **Initial DM Complete** ☐ **Testing Complete** ☐ **Integration Solutions finalised** ☐ **Operational Processes Defined** ☐ **Enterprise Level Changes determined** ☐ **Data Migration approach agreed** ☑ **Change & Engagement Plan Developed** ☑	**Jen Pettitt:** The PICS programme remains on track for its May 2023 go live, with good progress made on data migration and change and engagement meetings now well underway at all implementation sites. A decision was taken by the Project Board to undertake a gap analysis and determine software and process requirements without mapping current state processes. This is a more expedient way to determine requirements, utilising the subject matter knowledge of key users. A dependency for the project is the identification and implementation of a theatre scheduling and management solution. This will be delivered as a combination of the capabilities in PICS and the regional theatre solution, which is SCOPE. The vendor of PICS (Orion Health) are developing theatre management capabilities in the coming weeks for other PICS clients. We will evaluate these to determine how much of this capability can be implemented with PICS, how SCOPE will be used with PICS and what other development may be required. Decisions will be made on this in the coming months to ensure that implementation does not impact on the critical path towards our May 2023 go-live. *15/03/2022*
Central Decision Support Model		**0%** **0 /** -		
Implementation of MH review recommendations	Toni Gutschlag	**20%** **20 /** 20% ahead		**Greer Harper:** Implementation plan progressing well with Ministry support. Recruitment of Exec. Director MHAID continuing. *25/11/2021*

Goal	Owner	Current Completion	Task		Comment
Rollout of the Performance & Accountability Framework	Andrew Lesperance	**80%** **80 /** 13% ahead	**Rollout of Mental Health Directorate P&AF**	☐	**Talis Liepins:** Note: I have updated the progress tracking to a stepped monthly increase and updated to 80% based on 4/5 directorates active. P&AF is live in Medical & Surgical Directorates. Public and Population Health Directorate is commencing 22 March. Meetings have been had with MHAID regarding establishing. Work underway to align current reporting. Community/ARRC Directorate pending, given current activity with COVID response. *24/03/2022*
			Roll out Strategy, Primary & Community Pack	☑	
			Dry-run of new meeting cadence settled and implemented	☑	
			Agree and define monthly process for pulling together monthly reporting pack	☑	
			Creation of dedicated PowerBI dashboard for one-stop monthly reporting	☑	
			Audit of metrics that will form basis of monthly report pack	☑	
6. Establish a clear clinical governance framework, embed discipline around meeting structure, action follow through and focus	Hywel Lloyd	**0%** **0 /** -	**Service level Clinical Governance implementation planning underway**	☐	
			Detailed investigation of existing clinical governance activity covered by 3 service managers from Perioperative, community and mental health underway	☐	
			Clinical governance baseline survey complete and results reviewed at clinical council	☑	
			Clinical governance policy complete	☑	

FACILITIES FOR THE FUTURE

Goal	Owner	Current Completion	Task	Comment
Right-sizing Southland ED	Nigel Trainor	**25%** **25 /** 25% ahead		**Jen Pettitt:** The Southland ED extension and the Theatre Extension have become intertwined, due to the extension now requiring a second story to accommodate the Theatre extension the costs to the structure has increased. The plan for the Theatres are also outside of the budget and requires some rework, this is happening to enable a business case to go to the Board in May 2022 *15/03/2022*
Security Review	Nigel Trainor	**100%** **100 /** -		
Dunedin Master Site Planning	Bridget Dickson	**90%** **90 /** 7% ahead	**Deliver & Document** **Refine Preferred Scenario** **Explore Spatial Options** **Define Vision & Principles** **Mobilisation/Lead-In**	☐ **Simon Crack:** ☑ 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. *18/01/2022*
CETES – Clinical Engineering, Tech & Equipment Service		**0%** **0 /** -		
Seven-Day Hospital		**0%** **0 /** -		
Acute Assessment & Planning Units		**0%** **0 /** -		
23 Hour Unit		**0%** **0 /** -		
Southland Master Site Planning	Simon Donlevy	**33%** **33.33 /** -		

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

25/03/2022

20
GOALS

35%
GOAL COMPLETION

STRATEGIC CHANGE PORTFOLIO PLAN

POSITIONING PUBLIC HEALTH SERVICES FOR THE FUTURE

Goal	Owner	Due Date	Current Completion	Comment	Task
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	30/06/2022	**81%** **81 /** -	**Talis Liepins:** Unfortunately we have not made further progress this month beyond reporting to CPHAC. This is due to key staff supporting the ECC data and intelligence workstreams. The intent for Q4 21/22 is to finalise all current indicators and finish the first phase. *22/03/2022* **Talis Liepins:** Redeployment of staff resource to support COVID remains a challenge for the project. However, 55 of the indicators have been deployed to the HNA website, and the interactive data explorer is live in parallel. 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. *14/02/2022*	**Automate datastreams for internally held data** ☑ **Collect external data sources** ☑ **Deploy interactive data explorer on the website** ☑ **Soft launch - 40 / 82** ☑ **Formal Launch of Phase One Indicators** ☐ **Remaining indicators live on website (Phase One)** ☐ **Soft Launch of website 8/82 indicators** ☑ **Development of health Indicators** ☑

PRIMARY & COMMUNITY CARE

Goal	Owner	Due Date	Current Completion	Comment	Task
Implementation of the Primary & Community Strategy	Andrew Lesperance	01/01/2024	**18%** **18 /** 36% 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*	
→ **Health hubs Implementation: Te Kaika Community Wellness Hub**	Andrew Lesperance	01/12/2023	**65%** **64.71 /** 35% behind	**Talis Liepins:** * Floor plans for Ground Floor and Level One are complete and with Development Board for approval. * Te Kāika co-design of clinical services proposal has been accepted and contract is in draft. * Negotiations of Development Agreement, Lease and Memorandum of Understanding across partners (Te Kāika, SDHB, and MSD) are well underway. *22/03/2022* **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. Negotiation of the Heads of Agreement has been deferred and will be rolled in to the lease agreement. Ground floor plan design has been completed. *14/02/2022*	**Agree co-design process** ☑ **First Floor Plan Complete** ☑ **Ground Floor Plan Complete** ☑ **Create and agree to development agreement** ☐ **Project Initiation, relationship agreement, preparation, RFP won** ☑ **"Go Live" opening date** ☐ **Initiate Co-Design Process (Te Kaika, MSD & SDHB)** ☑ **Heads of Agreement sign off (deferred - did not occur)** ☑ **Lease agreement sign off** ☐

Goal	Owner	Due Date	Current Completion	Comment	Task
↳ **Health Care Home Collaborative (WellSouth) Supporting the establishment and ongoing development of the health care home model across New Zealand**	Adam O'Byrne	01/01/2023	**50%** **50 /** 8% behind		**Roll out of tranche 5** ☐ **Tranche 1-4** ☑

CLINICAL SERVICE REDESIGN

Goal	Owner	Due Date	Current Completion	Comment	Task
Improving Patient Flow through the Implementation of the SAFER Bundle: A framework for improving patient flow	Jane Wilson	30/06/2022	**50%** **50 /** 50% behind	**Talis Liepins:** Weekend discharge pilot underway to understand why weekend discharges drop off and implement corrective actions. The other project to support discharge has been the Medimap trial project where we are training some of the 8 MED teams to be able to prescribe directly into Medimap. This will enable discharge to resthomes later on a Friday and over the weekend. Unfortunately this project has been slow to take off but we are about to restart with this round of HO and Regs. Estimated Date of Discharge: All patients are required to have EDDs within 24 hours of admission. However, accuracy of the initial EDD early on in the admission can be variable due diagnostic workup and changing test results. To balance this, EDDs are reviewed daily at the Rapid Rounds and discussed to refine results. Work is still ongoing - focussing on addressing constraints that negatively affect achieving the stated EDD – e.g., access to ARRC. Flow: IOC to be established now the new Patient Manager Flow role has been implemented on the Dunedin site. Southland recruitment is in progress. The early Dunedin focus will be on process-mapping the journey from ED to Wards to improve the timeliness of the steps required for admission. By refining the admitting steps on	**Discharge before Noon** ☐ **Flow from ED to inpatient wards** ☑ **Expected Date of Discharge & Clinical criteria for discharge** ☐ **Senior Review: Rapid Rounds & Red2Green** ☑

			Current Completion		
				the ward, patients will be able to be “pulled” from ED Review: Organisational change and staff turnover has presented an opportunity to review where the stranded patient function sits and how it operates as an interprofessional team (such as advancing a multidisciplinary focus and integrating the function either within the Home Team or Integrated Operations Centre). Next steps are: review of resourcing and leadership to be confirmed by Mar 30th; Appoint roles accordingly *22/03/2022* **Greer Harper:** 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. *24/11/2021*	
Embedding Virtual Health	Hamish Brown	31/10/2022	**76%** **76 /** -	**Hamish Brown:** Opportunities for exploring virtual health are arising through COVID-19 Omicron response - these are not part of the of the telehealth programme but in many cases represent genuine opportunity *21/03/2022* **Hamish Brown:** Milestone updates below •Outpatient Site Audits Oct – Nov 2021 •Procurement of equipment Nov 2021	**Electronic messaging and communication establishment** ☐ **Refine and resource developments** ☐ **Telehealth Hubs** ☐ **Supported Rollout** ☐ **Continue to refine and resource developments** ☑ **Complete supported roll-out to services and support establishment of identified hubs in the community** ☐ **Identify potential hubs in the community for delivery** ☐ **Supported Rollout to services** ☑ **Development of Implementation Plan** ☑ **On-board Project Mgr & technical resource/support** ☑

	Owner	Due Date	Current Completion	Comment	Task
				•SI Alliance Telehealth Dashboard launched Nov 2021 •SI Alliance Telehealth RFI completed Nov 2021 •Installation of TH equipment (Southland) Dec 2021 •Carpal Tunnel Telehealth pilot commenced Dec 2021 •Commenced TH specific Staff training – Dec 2021 ongoing •Clinician Telehealth survey Dec 2021 •Installation of TH equipment (Dunedin) Jan/Feb 2022 •1st steps towards community hubs Jan – April 2022 •Lumsden maternity trial pending candidates in the community Monthly telehealth appointments continue to grow however the number of services engaged in telehealth has not seen significant growth. Those services that have increasing numbers of telehealth always have strong clinical engagement. COVID-19 has helped with uptake in early 2022. *21/03/2022*	

Goal	Owner	Due Date	Current Completion	Comment	Task
Enhanced Generalism Model	Hamish Brown	02/01/2024	**50%** **50 /** 11% ahead	**Hamish Brown:** See attached project dashboard. Currently 1.5FTE of SMO's to recruit. 1.0FTE supporting COVID-19 response for 3 months. Improving performance metrics - 69.8% of admissions now under GM. *21/03/2022* **Hamish Brown:** Project Timeline attached. Working to April 2022 date for building works in Frazer Building to begin. Consent has been lodged with DCC. Concept and equipment lists being worked up for MAU and plans with QS for pricing. Note given current market and experience with other projects there is a significant risk of escalation of costs beyond the budget envelop *21/03/2022*	**MAU Decant & Build** ☐ **MAU Design** ☐ **Recruitment: PM, SMO & Allied Health** ☐ **GAMA Implementation** ☑ **Communications Plan** ☑ **SLA/Referral Guidelines** ☑
TCU – Transit Care Units		02/01/2025	**0%** **0 /** -		

ENABLING OUR PEOPLE - OUR PEOPLE STRATEGY

Goal	Owner	Due Date	Current Completion	Comment	Task
Talent Management - Attract, Support, develop & retain the talent we need	Tanya Basel	23/12/2021	**8%** **8 /** 92% behind	**Greer Harper:** Work is progressing in all milestone areas, but not complete. Long term initiatives. *24/11/2021*	**Effective retention startegies for each workforce group/location** ☐ **Align budget cycle with Workforce and Service Plans** ☐ **Equity and Diversity recruitment strategies** ☐ **Expand workforce and Service Planning** ☐
→ **NDH Workforce Modelling**	Bridget Dickson	01/01/2025	**50%** **50 /** 21% ahead	**Greer Harper:** Gap between previous person leaving the DHB and new person moving into role has slowed progress a little. *23/11/2021* **Greer Harper:** Outpatients modelling was presented to ELT/CLG and work is now progressing on completing Inpatients modelling by December. *21/10/2021*	**Inpatients Modelling** ☐ **Outpatients Modelling** ☑
→ **Expand Workforce and Service Planning**	Tanya Basel	01/01/2023	**0%** **0 /** 23% behind	**Talis Liepins:** Recruitment to service planning roles is due to commence early April (after job descriptions are scoped) so this will support this action *23/03/2022* **Greer Harper:** Further development of action plan on this will be informed by the outcomes of the workforce modelling work underway currently. *24/11/2021*	

SYSTEMS FOR SUCCESS

Goal	Owner	Due Date	Current Completion	Comment	Task
Digital Transformation (detailed business case)	Patrick Ng	02/07/2024	**88%** **88 /** 70% ahead	**Jen Pettitt:** Special Board meeting geld on 14/3/2022 to go through the revised DBC and this has now been approved by the Board. Patrick has now submitted it to MoH and possibly be reviewed by Treasury before going to Capital Investment Committee in May. *15/03/2022* **Greer Harper:** Feedback to be incorporated from Gateway review to be ready for the Board review in Feb 2022. *24/11/2021*	**Submission of BC to government** ☐ **Board signoff of DBC** ☑ **Book DBC Clinic with Treasury** ☑ **Confirm & schedule interviewees for Gateway** ☑ **Gateway review** ☑ **Confirm TQA arrangements** ☑ **Confirm IQA of DBC** ☑ **Draft version of Detailed Business Case** ☑
Scanning Project: The digitisation of clinical records	Patrick Ng	31/07/2022	**0%** **0 /** 54% behind	**Jen Pettitt:** Nigel Trainor and Patrick Ng are meeting later today (15/3) to brief on the project before its is signed off *15/03/2022* **Greer Harper:** The change management section of the Business case is in final stages of being drafted ahead of consultation starting but this is slightly behind the desired schedule. *21/10/2021*	**Clinical Engagement** ☐ **Bureau Service: Process Design** ☐ **Bureau Service: Transition & Training** ☐ **Management of Change: Consultation & Response** ☐ **Management of Change: Definition of roles & responsibilities** ☐

Goal	Owner	Due Date	Current Completion	Comment	Task
Establishment of an Integrated Operations Centre	Hamish Brown	01/06/2023	**29%** **28.57 /** 29% ahead	**Hamish Brown:** Timeline for IOC Phase one below Project Manager appointed to IOC – 21/2/2022 - complete Project Manager from Building and Property to scope physical location – 15/3/22 - complete, Working through details Indicative drawings of possible locations to be provided – 22/3/22 Design and Estimate for IOC to be completed – 19/4/22 Approval to proceed with building work – 2/4/22 Building work completed 1/7/22 Standard Operating Procedures documented 31/5/2022 Metrics agreed and developed 30/6/2022 *21/03/2022* **Greer Harper:** 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. *24/11/2021*	**Appoint PM support for 6 month fixed term** ☐ **Develop IOC scope document** ☐ **SOPs/Regional SOPs** ☐ **Requirements** ☐ **Identify ands cope physical location** ☐ **recruitment PM 6 Months FT** ☑ **Define IOC scope and milestones** ☑

SYSTEM IMPROVEMENTS

Goal	Owner	Due Date	Current Completion	Comment	Task
PICS implementation: New regional Patient Information System which replaces IPM in Otago & Southland	Patrick Ng	31/05/2023	35% 35 / -	**Jen Pettitt:** The PICS programme remains on track for its May 2023 go live, with good progress made on data migration and change and engagement meetings now well underway at all implementation sites. A decision was taken by the Project Board to undertake a gap analysis and determine software and process requirements without mapping current state processes. This is a more expedient way to determine requirements, utilising the subject matter knowledge of key users. A dependency for the project is the identification and implementation of a theatre scheduling and management solution. This will be delivered as a combination of the capabilities in PICS and the regional theatre solution, which is SCOPE. The vendor of PICS (Orion Health) are developing theatre management capabilities in the coming weeks for other PICS clients. We will evaluate these to determine how much of this capability can be implemented with PICS, how SCOPE will be used with PICS and what other development may be required. Decisions will be made on this in the coming months to ensure that implementation does not impact on the critical path towards our May 2023 go-live. *15/03/2022* **Greer Harper:** 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	**Data Implementation Underway** ☑ **Go Live** ☐ **Initial DM Complete** ☐ **Testing Complete** ☐ **Integration Solutions finalised** ☐ **Operational Processes Defined** ☐ **Enterprise Level Changes determined** ☐ **Data Migration approach agreed** ☑ **Change & Engagement Plan Developed** ☑

Current Completion	
	systems/implications and integrations is ongoing. *24/11/2021*

FACILITIES FOR THE FUTURE

Goal	Owner	Due Date	Current Completion	Comment	Task
Dunedin Master Site Planning	Bridget Dickson	15/04/2022	**90%** **90 /** 7% ahead	**Simon Crack:** 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. *18/01/2022* **Simon Crack:** ELT session held on 16 Dec to review long-list of options and to refine down to a short-list, based on design principles and agreed evaluation criteria. Two short-listed options selected, which will be worked up for ELT and Board review in late Jan/early Feb 2022. Work to align to NDH planning continues and the team are seeking to connect with the Southland Service Planning activity to ensure alignment. *22/12/2021*	**Deliver & Document** ☐ **Refine Preferred Scenario** ☑ **Explore Spatial Options** ☑ **Define Vision & Principles** ☑ **Mobilisation/Lead-In** ☑
CETES – Clinical Engineering, Tech & Equipment Service		01/01/2027	**0%** **0 /** -		
Seven-Day Hospital		02/01/2026	**0%** **0 /** -		
Acute Assessment & Planning Units		02/01/2025	**0%** **0 /** -		
23 Hour Unit		02/01/2025	**0%** **0 /** -		

FOR INFORMATION

Item: Time for Change Te Hurihanga Programme Update

Proposed by: Toni Gutschlag, Executive Director Mental Health and Addictions

Meeting of: Southern DHB

Date of meeting: 5 April 2022

Recommendation

That the Southern DHB Board note this report.

Purpose

1. The Southern DHB Board note this update
2. Note the Priority Projects indicative timeline and interim progress report (appendix 2)

Specific Implication For Consideration

3. Financial
    - The Southern DHB has agreed that investment is required to support Time for Change – Te Hurihanga implementation. An indicative budget has been endorsed by the Board and we are working with the transition unit and Ministry of Health to confirm 22/23 and 23/24 investment.
    - Principles of investment are attached as Appendix 3.
4. Quality and Patient Safety
    - Quality and patient safety improvement measures are to be developed for inclusion in the programme and project evaluations.
5. Operational Efficiency
    - Operational efficiency measures are to be developed and included in the programme and project evaluations.
6. Workforce
    - The programme is investing in leadership and a learning environment, to support the workforce adjust to the transformational change and be able to sustain the new models of care.
7. Equity
    - Time for Change recommended "by Maori for Maori" investment options, these will be developed alongside health reform planning.
    - The programme budget assumes that future equity investment outside of the 2020/21 and 2021/22 financial years will need support from Health NZ and the Māori Health Authority.
8. Other
    - Significant work has been undertaken by the Cross Sector Group to expand on the recommendations from Time for Change – Te Hurihanga and develop the immediate priorities for resourcing. These align well with the recommended short-term projects

and the "Fix Now" priorities for the next three months. The workplan will be further developed over the next 2-4 weeks.

- A communication plan is also being developed.

Background

9. A review of the Southern District Health Board (DHB) mental health and addiction system was undertaken between January and June 2021 resulted in a document titled Time for Change – Te Hurihanga. Time for Change – Te Hurihanga was accepted in full by the Southern District Health Board and released to the public on the 6th August 2021.
10. Time for Change – Te Hurihanga outlines a vision for the future of the mental health and addiction system based on what many people told the reviewers during the review process. The new vision is *'a reorganised and expanded mental health and addiction system that serves communities through localities with a focus on population health and wellbeing'*. Achieving this vision requires significant change, system and service development and investment.
11. There is strong emphasis throughout Time for Change – Te Hurihanga on the need to develop new services and models of care for an integrated primary, community and specialist mental health and addiction services across the Southern district. There are many recommendations on how to address these.
12. This report provides an update on the first steps to realising this vision and the benefits for the patients/clients and their whanau. The high level "delivery pipeline" is depicted in Appendix 1.

Update

13. The Network Leadership Group has been disestablished. The local community networks continue to operate and to assist coordination across the networks and Southern districts, a Chair of the networks has been established.
14. The Cross Sector Group met on 25th February 2022. This occurred in a workshop format and engaged a range of stakeholders on the priorities for implementation, timelines and the key investment principles.
15. An external consultant has been engaged to undertake an organisational development programme to strengthen the culture and leadership environment within our MHAID services.
16. The priority for by Māori for Māori investment is scoping and development of a Kaupapa Māori Mental Health Service. This has now been added to tranche 1 of priority projects.
17. Organisation development and the role of culture update:
    - Establishment of the Mental Health and Addictions Time for Change Leadership Group
    - Regular collaboration in place with the Inter-agency government group (coordinated by John McDonald)
    - Executive Director of Mental Health and Addictions has been appointed
    - Health and Safety action plan for Wakari located mental health services has been developed, for consideration by SDHB Board
    - Programme Manager has been recruited

- Project Manager/Facilitator roles are currently being scoped by HR.
- Relationship Manager recruitment making good progress

Next Steps & Actions

- Establishment of programme team and refinement of Time for Change work programme
- Commissioning of Dunedin Alcohol and Drugs services
- Selection of preferred provider(s) of services to support Ward 11 patients
- Commissioning of Crisis Response Service for Queenstown/Central Lakes
- Scoping of Kaupapa Māori Mental Health and Addiction Service
- Scoping of Peer Led Wellbeing Services and associated Workforce Development

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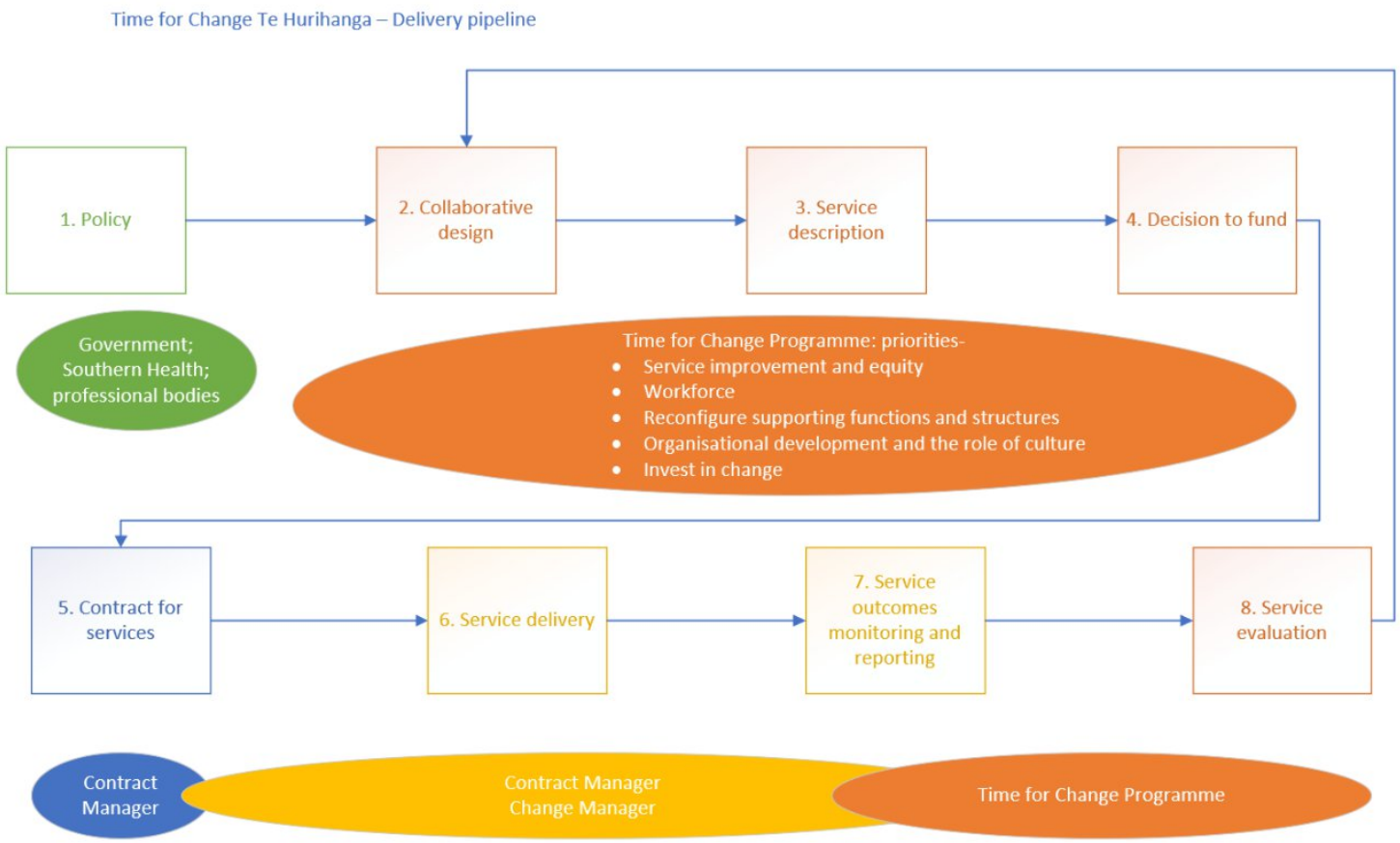
Appendices

Appendix 1: Delivery pipeline (work in progress)



Appendix 2: Tranche 1 Priority Projects indicative timeline and progress report, 13 March 2022

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (13 March 2022)	Reason for investment	Status
1	Long stay patients	short term – 0-3 months	July 2021	June 2023	High level plan in development Public release on closure of ward done EOI for providers of services for people with high and complex needs completed. A closed RFP will be the week beginning 21 March.	Expanded range of community services to meet the needs of people currently stranded in hospital	Underway
2a	Child and youth wellbeing –Central Lakes, Dunedin, all of district	short term – 0-3 months	Jan 2022	March 2023	Commenced, Queenstown, Lakes, Central Otago consultation with providers underway to support improved integration	Support for families, maintain engagement with education	Underway
2b	Crisis respite and response – Queenstown/Central Lakes and Waitaki, all of district - Dunedin	short term – 0-3 months	Oct 2021	March 2023	Extensive engagement has occurred with stakeholders in the Queenstown and Central Lakes communities to explore options for improving local crisis response, to reduce the need to admit into acute service and support people within their preferred communities. Responses are being summarised and 1-2 workshops will be held within the next 2-4 weeks to agree the local model for crisis response. A residential option will be part of the response Start planning for Waitaki over next 6 months Negotiations to increase crisis support services in Dunedin are underway	Development of local services to reduce need for admission/accelerate discharge, support people in their community	Underway
2ci	Alcohol and drug service – Dunedin and Invercargill	short term – 0-3 months	Jan 2022	June 2023	Dunedin AOD providers have agreed the priorities for 5FTE investment: Māori and Pasifika, moderate to severe needs, whanau inclusive, able to support people with corrections backgrounds, use of specialist (DAPAANZ) workforce, adults and under 25s. A draft proposal has been prepared, next step is consumer and whanau engagement on the proposed approach. Once feedback incorporated it will come to CLG for endorsement.	Increase in capacity, service improvement and changes to models of care	getting started
2cii	Alcohol and drug service – Central Lakes and Rural	short term – 0-3 months	October 2022	December 2023			

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (13 March 2022)	Reason for investment	Status
2d	Community support options – primary and community services in Southern	short term – 0-3 months	Jan 2022	March 2023		Increase in capacity of specialist services (to better support community services) through service improvement and changes to models of care	
3	By Māori for Māori investment				The priority for by Māori for Māori investment is scoping and development of a Kaupapa Maori Mental Health Service. This has now been added to tranche 1 of priority projects.		
4	Facilities planning	short term – 0-3 months	Jan 2022	June 2024	Site master planning underway with 2 external contractors for Dunedin (Wakari) and Southland hospital sites, for inpatient facilities	Budget is separate to Time for Change	Underway
5	Develop crisis response options in the Queenstown and Central Lakes (tranche 1) and Waitaki regions (tranche 2).	medium term 3-6 months	Jan 2022	June 2024	Refer project 2b		Underway
6	Develop a peer led crisis/wellbeing café model to be implemented in a range of sites (potentially Invercargill, Dunedin, Oamaru, and Queenstown as starting points).	medium term 3-6 months					getting started
7	Develop a high-level plan to grow, develop and support the peer workforce.	medium term 3-6 months					
8	Begin the supported transition of Ward 11 clients into alternative options.	medium term 3-6 months			Refer project 1		
9	Begin an organisational development programme with external support.	medium term 3-6 months			Organisational development and the role of culture work programme		underway
10	Begin implementation of first by Māori for Māori investment.	medium term 3-6 months			Refer project 3		getting started
11	Implement peer led crisis/wellbeing café plan in at least one location.	longer term 6-			refer project 6		getting started

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (13 March 2022)	Reason for investment	Status
		12 months					
12	Establish dedicated primary/community access and advice telephone help line	longer term 6-12 months			refer project 2d		

Appendix 3: Principles for investment and disinvestment

Slide 5: Cross Sector Group workshop 25 February 2022

Principles of reinvestment

1. The changes will reduce inequity
2. Enable greater numbers of people to be supported
3. Are no less effective (or should be more effective) than other service models
4. Enable earlier intervention
5. Will not disadvantage those with severe and complex need
6. Are in keeping with Time for Change report and recommendations

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Community Health Council**
Report to:	Southern District Health Board
Date of Meeting:	5 April 2022

Summary:

The Community Health Council (CHC) is an advisory council to the Southern DHB and WellSouth PHN. The Council brings together people from diverse backgrounds, ages, health and social experiences to give our communities, whānau and patients a stronger voice into decision-making within the Southern health system.

This report is to provide DHB Board members with an update of activities that have occurred at the Community Health Council from mid-December 2021 to mid-March 2022

Specific implications for consideration (FINANCIAL/WORKFORCE/RISK/LEGAL ETC.):

Financial:	There are financial implications with engaging community members; these expenses should be built into service planning.
Workforce:	There are implications with community engagement work as it is about changing the culture of staff across the organisation and enabling staff/ clinicians, community, whānau and patients to work in partnership.
Other:	The work undertaken by the CHC is focused on quality improvement.
Equity:	One of the principles of the CHC Engagement Framework is a respectful and equal process. Equity in terms of representation, equity in decision-making and underlying the Framework is the Treaty of Waitangi.

Document previously submitted to:	CHC Quarterly Update	**DATE:**
Approved by Chief Executive Officer:	N/A	**DATE:**

Prepared by:	**Presented by:**
Karen Browne Chair of Community Health Council Kathryn Harkin Consumer Liaison **DATE:** 22 March 2022	Karen Browne Chair of Community Health Council

RECOMMENDATION:

That the Board note the content of this paper.

12.1

Overview

The Community Health Council (CHC)[1] was embedded into the Southern health system in February 2018 and has achieved a number of milestones including:

a) The development of the *CHC Engagement Community, Whānau and Patient Engagement Framework and Roadmap*[2] which has allowed staff to have community engagement in projects they are undertaking;

b) Hosting the CHC Symposium for all registered CHC advisors in October 2019 with the purpose of sharing and learning what has been achieved from both staff and CHC advisors through engagement projects;

c) The creation of a CHC database with connections to over 300 persons/ organisations. This is an asset to the Southern health system when it needs to engage and /or communicate with the community on specific issues;

d) The CHC, through processes set up with the CHC Engagement Framework and Roadmap, has empowered CHC advisors to be involved in the new hospital build and contribute to the design process;

e) The CHC proposed the need for community engagement with the hospital build which has been seen positively by both clinical leaders, the Project Management Team for the new build and the wider community;

f) Allowing CHC Members/Advisors the opportunity to feed into multiple projects occurring across the Southern health system;

g) The CHC was also influential with supporting a Disability Strategy to be developed for Southern DHB;

h) The CHC has been instrumental in supporting work to better deliver primary and after-hours primary care in Invercargill, and to the more appropriate use of ED services in Southland;

i) The CHC was instrumental in reviewing the "Unable to Attend" Policy, with significant input into re-writing this to include a better understanding and a more flexible approach as to why some consumers are not able to attend an appointment.

j) The CHC provided over 30 Advisors to multiple FiT Groups which provided valuable advice to the PMO team for the New Dunedin Hospital

Updates for Third Quarter 2022

In February 2022, when CHC re-convened, a discussion around outstanding projects concluded that CHC members showed enthusiasm for ensuring any outstanding work is concluded prior to 1 July 2022, as well as continuing to engage across both the SDHB and WellSouth. The discussion around outstanding or partially completed work has resulted in smaller groups of members taking responsibility for a specific piece of work.

- Three "Select Committees" were formed, each tasked with working on a set project and to report back to the Council as a whole in April, when further recommendations would be included in order to have these concluded by the end of April, ready for next steps. **

[1] https://www.southernhealth.nz/sites/default/files/2019-05/Community%20Health%20Council%20%20ToR%202019.pdf

[2] https://www.southernhealth.nz/about-us/about-southern-health/community-health-council/chc-engagement-framework-road-map

- Continue raising the profile of the CHC Engagement Framework and Roadmap across the Southern health system. Community, whānau and patient engagement may be increasingly seen as the "right thing to do", but without systematic evaluation how do we stop good intentions becoming tick-box tokenism? **
- Continue evaluating what difference engaging CHC advisors on projects is making, and ask the questions are staff genuinely engaging, listening and acting to what CHC advisors are raising on projects? A similar evaluation occurs with staff members.
- The CHC needs to continue to work closely with the Clinical Council and key clinicians across the Southern health system to raise the profile and ensure consistent messaging is going out about the CHC Engagement Framework.
- An on-line Symposium is planned for May 2022, as a way of thanking staff and CHC Advisors who have actively engaged in a variety of ways over the past two years and through some difficult times.
- Profile services where engagement has occurred with CHC advisors, identify what has been learnt, what could have been done better and what improvements have been made to service delivery.
- CHC members have been asked to consider the HQSC "Code of Expectations" as we move forward into Health NZ and the Māori Health Authority, and we will make a submission to this Code.

  Much work across the DHB has already occurred in early 2022 to ensure services are fully aware of HQSC Consumer Engagement Marker, by Consumer Liaison and Consumer Experience Manager. This is a twice-yearly requirement, and as this data is used in part to gauge how well functioning and diverse the Council may be, CHC is determined that truly reflective data is submitted. **Regular meetings are attended by the Chair with both the National Chairs of Consumer Councils and the HQSC and Transition Unit staff to keep abreast of the changes on 1 July 2022. The Chairs network members are working collaboratively to submit to the Transition Unit and HQSC with recommendations about consumer engagement in Health NZ

** in more detail later in this report

What do we know 4 years on?

- The community, through the CHC members' own community networks, feel they have an opportunity to feed into the health system
- Staff working with consumers do need to explain aspects of the project clearly and logically – this can be challenging and does take more time.
- We have had acknowledgement that consumers can bring aspects of some groups into focus. A consumer presence and the consumer lens are bringing about positive change and professional collegiality between group members.
- CHC members understand the responsibilities they have to ensure they represent their community as a whole. They acknowledge that the SDHB has been respectful of any serious concerns brought to the table, and express thanks to the organisation being reactive to these.

Covid -19 and the community

CHC is fully cognisant of the huge efforts and workloads shouldered during this quarter, and members have supported both SDHB and WellSouth in keeping their own community networks up to date and well informed.

We are also kept up to date with monthly reports from the Covid Vaccination Team, who attend CHC meetings. This is valuable and enables up to date and correct information to be disseminated to our communities. This also provides the Team with solid feedback and comment from the community, which the Vaccination Team requested CHC members provide each month.

A CHC member now sits on the Covid 19 Vaccination Steering Group and as well Chair and one member are on the Southern Integrated Covid Care in the Community Oversight Team.

New Dunedin Hospital

Consumer engagement in the build of the New Dunedin Hospital has now reached a new stage, with more "focus" type groups meeting to discuss, in more detail, certain aspects of the project – such as Wayfinding and Digital Transformation. A sound relationship is enjoyed with the PMO team, who also provide CHC with valuable evaluation and comment to ensure consumers understand their role and integrate easily into project groups. The New Dunedin Hospital build has been an avenue for some services to be introduced to the CHC and CHC Advisors. This work will continue to be a priority over the next few months.

HQSC – QSM for Consumer Engagement **

The Health Quality and Safety Commission (HQSC) launched the Quality Safety Marker (QSM) for Consumer Engagement[3] in July 2020, with the first upload of submitted data made in March 2021, and the second in September 2021, and now available to view on HQSC website.

https://www.hqsc.govt.nz/our-programmes/partners-in-care/consumer-engagement-qsm/

HQSC uses the SURE framework for DHBs to collect data. Appendix 3

CHC were very pro-active in 2020/2021 and invited HQSC to attend a meeting at SDHB, for executives and CHC members to have an opportunity to learn about the marker. It was clear from HQSC that an oversight group should be formed which would be 50:50 staff and consumer council members. Staff engagement for the next submission currently looks to eclipse the last submission and both staff and CHC members will be part of the moderation process.

The goal of this QSM is to address 'what does successful consumer engagement look like, and (how) does it improve the quality and safety of services?' HQSC has also stated that the data is a reflection on a Council's level of functioning and its diversity. The data will now be collected bi-annually.

CHC Engagement Framework and Roadmap **

For the mid December 2021 – mid March 2022 period there were ~35 CHC advisors, as well as CHC members, working alongside staff on approximately 30 projects and committees across the Southern health system. - Appendix 1 outlines engagement activities. The majority of these projects are at a strategic partnership level with fewer projects occurring at a service level. Information about the CHC engagement is incorporated into service planning and this will be monitored for progression. Staff are being encouraged as part of the QSM process to look at opportunities for engagement and some have already taken up this opportunity with more

[3] https://www.hqsc.govt.nz/our-programmes/partners-in-care/news-and-events/news/3909/

conversations planned with the Consumer Liaison once pressure on services as a consequence of Covid reduces. Appendix 3 provides a summary of other work the CHC has had involvement.

SDHB Policies

CHC is now engaged with Sam Murray, Policy Advisor, around some specific policies, and also those identified by members as appropriate to have a consumer lens applied. (Note: Some DHBs routinely pass all policies due for review past their Consumer Council for comment). Each quarter policies due to review are sent to CHC for comment and consideration.

Select Committees

CHC had three main pieces of work partially completed at the beginning of 2022, and it was decided that all members needed to have input in order to have these completed by 30 June 2022. Groups are now working on: review of the Staff Information pack (for engaging consumers) and CHC Advisor Welcome pack and feedback requests; Policy for Ending Consumer Engagement; Policy for Recruitment and Recognition of Consumers. While CHC recognises that these may become redundant 1 July 2022 due to new reporting channels, it is felt that these may be of assistance to any new consumer engagement systems instigated in the future. As well this shows the level of commitment our current membership has.

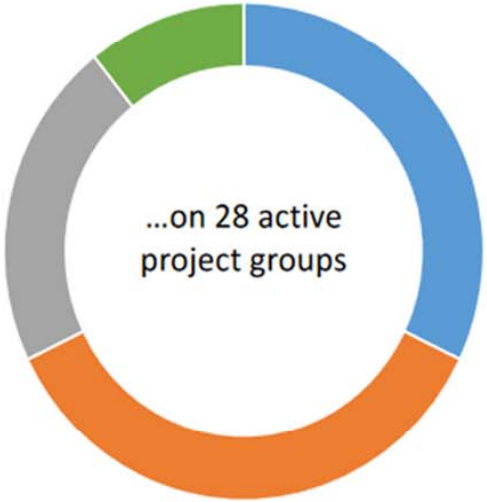
Communication to Consumers

On a semi-regular basis, CHC is asked to review letters and other material sent to consumers for a variety of reasons. This can be a valuable exercise for the service/department and ensures greater understanding and compliance by the recipient. CHC members advise that letters are not always the most appropriate way of communicating, and each recipient needs to be considered individually rather than a bulk mail out – e.g. a blind person receiving written instructions and expected to carry out a pre-treatment RATs test.

CHC Representation on Southern DHB/ WellSouth Committees

	CHC member	**CHC Advisors**
Clinical Council	Karen Browne	
CPHAC/DSAC	Paula Waby	
Central Otago Lakes Locality Network	Jason Searle	
Clinical Leadership Group		Naomi Duckett, Jo Miller
IT Governance Group	Jason Searle	
Integrated Covid Care in the Community Oversight Team	Karen Browne Kelly Takurua	
Covid19 Vaccination Steering Group	Kelly Takurua	
Time for Change Mental Health Review	Toni Huls	
Recognition and Response Committee	June Mills	Rachel Cuthbertson

52 Community Health Council Advisors



- After Hours Southland
- New Hospital FiT Groups
- Recognition and Response Committee

- Long Term Conditions Project
- Evaluation of Primary and Community Care strategy
- Strategic Refresh
- Safer Care for Older People
- Restraint Elimination

- Mental health (Steering Group and ED Space
- Rheumatology
- Telehealth
- Local Diabetes Team
- Shared Goals of Care
- Acute General Surgery
- Endoscopy User Group
- Health Care Homes

- Disability Working Group
- Frailty Steering Group
- Clinical Council
- IT governance group
- Clinical Leadership Group
- Central Otago Localities Network
- Maternity Quality Safety Programme
- Clinical Operations Advisory Group
- Disability Support Advisory Committee
- ED Southland

- 9 Service co-design projects
- 10 Strategic partnership projects
- 6 Evaluation and review projects
- 3 Projects focused on establishing new systems and processes

WellSouth Primary Health Network | Southern District Health Board | Community Health Council

Jan-Dec 2021

Appendix 2. Items the Community Health Council has been updated or consulted on Dec 2021 – March 2022

Month	Topic	Person responsible
Feb	Oncology – department current situation and outsourcing	Phil Witchall
	Disability Working Group	John Marrable
March	Overview of SDHB Audit	Glenda Auton, Sam Murray
	NDH – Digital Business Case	Lance Elder
	Covid Vaccination Team	Demelza Halley, Sophie Glover
	Disability Working Group	John Marrable

Appendix 3: HQSC SURE Framework

Consumer engagement quality and safety marker (QSM) framework **Supporting, Understanding, Responding, Evaluating**				
	1 – Minimal | Te itinga iho	**2 – Consultation | Te akoako**	**3 – Involvement | Te wāhi**	**4 – Partnership & shared leadership | Te mahi tahi me te kaiārahitanga ngātahi**
	What 'minimal' looks like:	**What 'consultation' looks like:**	**What 'involvement' looks like:**	**What 'partnership & shared leadership' looks like:**
Engagement The environment created to support community engagement. **Te Tūhononga** – ko te taiao kua hangaia hei tautoko i te tūhononga hapori.	• Consumers are involved in one of the following areas of the organisation: direct care, service delivery, policy, and governance. Representation and input does not reflect the population served. • Equity is a little known or discussed principle in the organisation. • The consumer council is newly established, with a lack of resources, systems, and processes. • Co-design is not used or understood by the service. • There is limited evidence that the organisation encourages a diverse workforce.	• Consumers are involved at some levels of the organisation in at least two of the following areas: direct care, service delivery, policy, and governance. Representation and input is partially reflective of the population served. Representation is not equitable. • Equity is a well understood principle in some parts of the organisation and there is intent to act upon achieving equity for the population served. • The consumer council is newly established, partially resourced, and evaluation has not yet occurred. • Co-design is a method understood by parts of the service. It has not been used to improve processes at this point. • The organisation encourages a diverse workforce through its recruitment strategy, although the broader population served is not reflected.	**What 'involvement' looks like:** • Consumers are involved at all levels of the organisation: direct care, service delivery, policy, and governance. Representation and input is mostly reflective of the population served, and there is a transparent process for recruiting membership at all levels. Representation is not equitable (e.g. a broader understanding of health care and the wider determinants of health is not possible). • Equity is a well understood principle throughout the organisation and there is intent to act upon achieving equity for the population served. • The consumer council is well established, partially resourced, and occasionally evaluated. • Co-design is a method used and applied by parts of the service. This means using co-design to improve the system for staff and consumers. • The organisation encourages a diverse workforce through its recruitment strategy, reflecting the broader population served.	**What 'partnership & shared leadership' looks like:** • Consumers are involved at all levels of the organisation: direct care, service delivery, policy, and governance. The representation and input reflect the broader population served (e.g. clubs and associations, educational institutions, cultural and social groups, churches and marae), and there is a transparent process for recruiting membership at all levels. Representation is equitable and covers a broader understanding of health care and the wider determinants of health. • Equity is a well understood principle throughout the organisation and achieving equity for the population served is acted upon. • The consumer council is well established, resourced, and regularly evaluated. • Co-design is a method used and applied within the service. This means using co-design to improve the system for staff and consumers. • The organisation encourages a diverse workforce through its recruitment strategy, reflecting the broader population served. Consumers are included on interview panels where appropriate. • Equity is incorporated as part of the recruitment strategy

	What 'minimal' looks like:	**What 'consultation' looks like:**	**What 'involvement' looks like:**	**What 'partnership & shared leadership' looks like:**
Responsiveness Responding to and acting on what consumers are saying about the service and having the right information at the right time for consumers accessing services. **Te Noho Urupare** – ko te urupare, ko te mahi i ngā kōrero a ngā kiritaki mō te ratonga me te whai i te mōhiohio tika i te wā e tika ana mō ngā kiritaki e uru ana ki ngā ratonga.	• There is a lack of systems to a) capture and understand the experiences and views of consumers and whānau, b) respond to them, c) share the results and themes with participants and the wider organisation and, d) involve consumers as partners in any resulting improvement activity. • Community voices are not brought to the attention of senior leaders • Consumers and staff do not have the skills required to make sure consumers are involved in the development and implementation of services (e.g. co-design, listening, behavioural science). • It is difficult for people to find and access what they need, at the right time (e.g. websites are up-to-date and easy to follow, signage is clear for all groups).	• There are emerging systems to a) understand the experiences and views of consumers and whānau, capture and understand the experiences and views of consumers and whānau, b) respond to them, c) share the results and themes with participants and the wider organisation and, d) involve consumers as partners in any resulting improvement activity. • Community voices are brought to the attention of senior leaders within the organisation but not acted upon. • The input of the consumer council is heard, documented, but seldom acted upon. • Consumers and staff have limited skills required to make sure consumers are involved in the development and implementation of services (e.g. co-design, listening, behavioural science). • It is difficult for people to find and access what they need, at the right time (e.g. websites are up-to-date and easy to follow, signage is clear for all groups).	• There are established systems to a) capture and b) respond to them, c) share the results and themes with participants and the wider organisation and, d) involve consumers as partners in any resulting improvement activity. These systems work well for many who access services. • Community voices are brought to the attention of senior leaders within the organisation and sometimes acted upon (i.e. the loop is closed). • The input of the consumer council is heard, documented, and sufficiently linked to be acted upon. • Some consumers and staff have the skills required to make sure consumers are involved in the development and implementation of services (e.g. co-design, listening, behavioural science). • Most people can find and access what they need, at the right time (e.g. websites are up-to-date and easy to follow, signage is clear for all groups). Every interaction builds understanding between patients, whānau, and staff and co-designed health education resources and information are used when needed to support understanding.	•There are established systems to a) capture and understand the experiences and views of consumers and whānau, b) respond to them, c) share the results and themes with participants and the wider organisation and, d) involve consumers as partners in any resulting improvement activity. These systems involve broad representation, and allow for diverse feedback (e.g. different cultures including Māori and Pacific, younger and older, different socioeconomic groups, LGBTQI+) • Community voices are brought to the attention of senior leaders within the organisation and always acted upon (i.e. the loop is closed). • The input of the consumer council is heard, documented, and sufficiently linked to be acted upon. • Most consumers and staff have the skills required to make sure consumers are involved in the development and implementation of services (e.g. co-design, listening, behavioural science). • Everyone can find and access what they need, at the right time (e.g. websites are up-to-date and easy to follow, signage is clear for all groups). Every interaction builds understanding between patients, whānau, and staff and co-designed health education resources and information are used when needed to support understanding

	What 'minimal' looks like:	What 'consultation' looks like:	What 'involvement' looks like:	What 'partnership & shared leadership' looks like:
Experience The systems in place to capture consumer experience, and act upon the results. **Wheako** – ko ngā pūnaha kua whakaritea hei mau i te wheako kiritaki me te whakatinana i ngā mahi i runga i ngā hua.	• There is a lack of metrics in place to support the monitoring of patient experience surveys and patient feedback. • These metrics are reported on. • There are some options for consumers to provide feedback. (e.g. online, face-to-face, meeting). It is not always clear whether feedback is acknowledged.	• There are some specific metrics in place to support the monitoring of patient experience surveys and patient feedback. • These metrics are reported on and shared with relevant stakeholder groups. • There are some options for consumers to provide feedback. (e.g. online, face-to-face, meeting). Certain forms of feedback are acknowledged and responded to.	• There are some specific metrics in place to support the monitoring of patient experience surveys and patient feedback. • These metrics are reported on and shared with relevant stakeholder groups, including consumers involved with the work. • There are a range of options for consumers to provide feedback. (e.g. online, face-to-face, meeting). No matter what form the feedback takes it is acknowledged and responded to.	• There are specific metrics in place to support the monitoring of patient experience surveys and patient feedback. • These metrics are reported on and shared with relevant stakeholder groups, including consumers involved with the work. Reporting is timely, and feedback loops are closed. • There are a range of options for consumers to provide feedback. (e.g. online, face-to-face, meeting). No matter what form the feedback takes it is acknowledged and responded to.

Closed Session:

RESOLUTION:

That the Board move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 32, Schedule 3 of the NZ Public Health and Disability Act (NZPHDA) 2000* for the passing of this resolution are as follows.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Community and Public Health Advisory Committee ▪ Unconfirmed minutes of 1 March 2022 meeting b) Iwi Governance Committee ▪ Unconfirmed minutes of 1 March 2022 meeting c) Finance, Audit & Risk Committee ▪ Verbal report of 4 April 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.
Site Master Planning, Dunedin	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.
Draft Annual Plan 2022/23	Subject to Health NZ/ Ministerial approval	Section 9(2)(f)(i).
Capex Approvals ▪ Building Warrants of Fitness	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.
Contracts ▪ Mainland Cardiothoracic Ltd ▪ Strategy Primary and Community	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
New Dunedin Hospital ▪ Monthly Update	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.
Community Build Projects	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

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

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