Southern DHB Board Meeting

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

03/05/2022 09:30 AM - 12:30 PM

APOLOGIES

Apologies have been received from Prof Sue Crengle and Fiona Pimm, Members, Interim Māori Health Authority.

An apology has been received from Amy Adams, Member, Interim Health NZ, for the first part of the meeting.

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Board, 3 May 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:

- Tuari Potiki – Chair, Te Rūnaka Otākou Ltd, and Member, Independent Whānau Ora Reference Group removed
- Chris Fleming – minor change (nephew's employment)

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~~	Stood down 29.03.2022	
	~~09.12.2019~~	~~*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 (updated 21.04.2022)	Nephew, ~~Tax Advisor, Treasury~~, Senior Treasury Official in Grant Robertson's office.	
	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

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 New Zealand College of Public Health Medicine	Nil
	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	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Minutes of the Southern District Health Board Meeting

Tuesday, 5 April 2022, 9.35 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	*(from 10.30 am)*
	Miss Lesley Soper	*(until 3.00 pm)*
	A/Prof Moana Theodore	
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Dr Ben Pearson	Crown Monitor *(until 3.00 pm)*
	Ms Amy Adams	Member, Interim Health NZ Board *(until 4.00 pm)*
	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 *(until 11.55 am)*
	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
	Dr Hywel Lloyd	Director Quality and Clinical Governance Solutions
	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 Miss Lesley Soper, and for lateness from Mr Tuari Potiki.

Apologies were received from Ms Fiona Pimm, Member of the interim Māori Health Authority, and Mr Andrew Lesperance, Executive Director Planning, Funding and Population/Public Health.

Apologies were received from Ms Toni Gutschlag, Executive Director Mental Health Addictions and Intellectual Disability, for a departure from 10.30 to 11.00 am, and from Ms Mata Cherrington, Chief Māori Health Strategy and Improvement Officer, for an early departure.

3.0 DECLARATION OF INTERESTS

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

The Chief Nursing and Midwifery Officer informed the Board that the line stating her husband was employed by the DHB was omitted from the published copy of the Interests Register but was recorded in the master copy.

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

4.0 PREVIOUS MINUTES

It was resolved:

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

5.0 ACTION SHEET

The Board received the action sheet (tab 5) and the following updates from management.

- *Southland Site Planning* – Sapere had been invited to give the Board an update later in the meeting.
- *Workforce Dashboard* - This was considered by the Finance, Audit and Risk Committee the previous day and continued to be a work in progress.
- *Policies* – This action had been put on hold, given that policies were likely to change under Health NZ.
- *Mental Health Review Implementation* – It was agreed this could be removed from the action sheet, as it was a standing agenda item.
- *Te Kaika Health and Wellness Hub* – This issue was being progressed positively and the Minister of Health had visited Te Kaika.

Mr Andrew Connolly, Board Advisor, joined the meeting at 9.40 am.

6.0 MĀORI HEALTH ACTIONS TO ADDRESS AMENABLE MORTALITY AND CONDITIONS

The Board received a verbal report from the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) on action to address Māori amenable mortality and conditions, during which she advised that:

- The new equity data analyst had provided information and datasets to assist with understanding and measurement of progress. Getting the right dataset to develop dashboard reporting to the Board was currently the CMHS&IO's main consideration.
- A Māori Workforce Development Specialist had been appointed and the workforce strategy was being worked on.
- The CMHS&IO was working alongside the Chief Nursing and Midwifery Officer to secure Māori Clinical Nurse Specialists, with a view to placing them in the

community with a strong connection into the hospital, to make the greatest impact on cardiovascular, cancer and respiratory amenable mortality.

- Consultants had been engaged to develop the equity investment strategy for 2022/23.

7.0 ACTION SHEET (Continued)

- *Productivity* – The Hospital Advisory Committee discussed this issue the previous day.
- *Midwifery* – Further data was still awaited. Core midwifery staffing shortages were an issue.
- *EY Oncology Report* – This was an ongoing set of work and should be included in the Annual Plan for 2022/23.

8.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The unconfirmed minutes of the Community and Public Health Advisory Committee (CPHAC) meeting held on 1 March 2022 (tab 6.1) were taken as read and noted.

Disability Support Advisory Committee

The unconfirmed minutes of the Disability Support Advisory Committee (DSAC) meeting held on 1 March 2022 (tab 6.2) were taken as read and noted.

Hospital Advisory Committee

The Board received a verbal report from Mrs Jean O'Callaghan, Chair of the Hospital Advisory Committee (HAC), on the HAC meeting held on 4 April 2022, during which the Board was informed the Committee:

- Covered the key issues of the ophthalmology and gynaecology waiting lists;
- Received an update on the Resident Medical Officer (RMO) centralisation process;
- Discussed recruitment issues and the need to improve systems and data;
- Received excellent presentations on Orthopaedics and Telehealth;
- Received a report from the Chief Operating Officer, noting that COVID had affected work and caseweight delivery;
- Discussed a report on productivity and workforce trends. This was a starting point and these issues would be discussed further at the next meeting.

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

Margie Apa, CEO, Health New Zealand, and Riana Manuel, CEO, Māori Health Authority, would be visiting on 11 April 2022 to brief key teams, including the Board,

Iwi Governance Committee, tiers 2 and 3 staff, and to hold a hui with Kaupapa Māori health providers.

Ms Apa and Ms Manuel would also receive briefings on Southern issues, including the Mental Health transformation, the New Dunedin Hospital and digital transformation.

COVID – Omicron Outbreak

The Board received an update on the COVID outbreak from the Director of Quality and Clinical Governance Solutions (DQ&CGS), which included modelled case trajectories versus actual case trends, hospitalisation rates, age, ethnicity, and locality distribution data, primary care case monitoring, and vaccination rates.

In summarising the DQ&CGS advised that:

- COVID care in the community was going well, and there was a good relationship with MSD;
- There were good links with Māori and Pacifika NGOs, former refugee communities and translators;
- Community Connectors were being well utilised;
- Primary Care was under pressure but managing their cases with support from the WellSouth Clinical Network;
- Public Health had flexed into exposure event teams supporting Aged Residential Care;
- 62 of the 65 Aged Residential Care (ARC) facilities in the district had COVID positive staff, 25% COVID positive residents, and 12% had active cases;
- It was uncertain whether secondary care admissions had reached their peak. Cases were being transferred from Southland to Dunedin Hospital when required to ease pressure.
- There were significant workforce constraints across the Health sector.

The CEO advised that the system was coping but was under increasing levels of stress, and he was proud of the way the collective system was responding.

The DQ&CGS was thanked for his comprehensive report.

The Board acknowledged the work that had gone into planning for managing the COVID pandemic, the response from the community, and the innovation and commitment of health professionals, which had resulted in a low death rate so far.

10.0 COLONOSCOPY

Mr Andrew Connolly, Board Advisor and Chair of the Endoscopy Oversight Group, was welcomed to the meeting for this item.

Mr Connolly presented an update on the delivery of colonoscopy services (tab 7), during which he highlighted the publicly available graphs included in his report and provided the following national comparisons to illustrate the success of the efforts in Southern DHB:

- There were 3,821 New Zealanders waiting over the recommended time for their surveillance colonoscopy. In Southern there were about 32.

- There were more than 1,544 New Zealanders waiting beyond the recommended maximum waiting time for a colonoscopy. Southern had 2.

Mr Connolly highlighted the effect COVID had on waiting times in March 2020 and the subsequent recovery, which had been achieved by maximising resources and opportunity. He advised that the future focus should be on:

1. Sustaining the current successful position. This did not mean continuing to operate in the same way however, as a considerable amount of success was due to Dunedin based staff travelling to Invercargill on a regular basis. He therefore recommended a modest investment of 0.5 FTE SMO endoscopist in Invercargill.
2. Expanding access further. It was unknown whether there was still a reluctance by some GPs to refer cases, however he did not believe this was widespread, as emergency presentations of bowel cancer had not increased.

Mr Connolly presented a graph showing that Southern DHB was at the national average for the proportion of people diagnosed with bowel cancer following presentation at an emergency department, by district health board of domicile, for the period 2017-2019.

Mr Connolly was thanked for his thorough report, then responded to members' questions. In doing so, he confirmed that he was satisfied symptomatic patients were not currently being declined or delayed because of the introduction of the Ministry's bowel screening programme within the district. A mandatory review process had been introduced for declined referrals whereby any one of three reviewers (a surgeon, gastroenterologist or experienced gastro nurse) could decide a scope should be done.

Delaying the introduction of the screening programme, in Mr Connolly's view, would have resulted in symptomatic presentations and demand for scopes for people with symptoms continuing to rise, as would the demand for surgery, chemotherapy, CTs and MRIs, because there would have been more people presenting with higher stage cancers needing more intensive treatment, follow up and surveillance.

Mr Tuari Potiki joined the meeting at 10.30 am.

It was noted that the Board had accepted Mr Connolly's previous advice to appoint a further 0.5 FTE SMO endoscopist for Southland and recruitment was under way.

11.0 CHIEF EXECUTIVE OFFICER'S REPORT (Continued)

COVID Cold Chain Failure

The CEO reported that good progress was being made in contacting people who had been affected by the vaccine cold chain failure and it appeared that about 10% had decided not to have a replacement dose. An independent review of the failure was being undertaken.

Wellbeing of Staff and Providers

The Chief Allied Health, Scientific and Technical Officer informed the Board that small gifts were being organised for Southern DHB staff and the wider health sector to acknowledge their contribution to the COVID response.

Key Appointments and Recruitment

The CEO informed the Board that the Executive Leadership Team (ELT) recruitment process had gone well and he was pleased with the calibre of the ELT. The Executive Director Communications role was under offer.

Industrial Action - Update

It was expected that the Public Service Association (PSA) would be issuing a notice for industrial action by Allied Health, Public Health and Technical Staff.

Dunedin Roading Network – Shaping Future Dunedin Transport

The CEO reported that a letter had been written to the Minister of Transport regarding the Shaping Future Dunedin Transport Business Case. Southern DHB's bottom line was there must be slow traffic outside the new hospital on Cumberland Street.

Education Perfect Te Ao Māori for Professionals – Engagement and Participation Award

The CEO acknowledged the work of Mathew Kiore, Southern DHB Pou Tāki Educator, which led to Southern DHB receiving an award for the highest engagement and participation in February 2022 of the 50+ organisations involved in Education Perfect's Te Ao Māori course.

Aged Residential Care (ARC) Workforce Shortages

Workforce shortages were impacting ARC Services. The Director of Nursing and Portfolio Manager, Planning and Funding, were providing support and an ethical recruitment agreement between Southern DHB and ARC providers had been signed.

12.0 FINANCE AND PERFORMANCE

Financial Report

The Executive Director Corporate Services (EDCS) presented the financial results for the period ended 28 February 2022 (tab 8.1), highlighting the key drivers of the result.

The EDCS advised that he would be reviewing the year-end forecasted deficit of $32m, as the deficit for the year to date was $14.8m, which if extrapolated would bring the year-end result in on budget.

13.0 PRESENTATIONS

Southland Site Planning

David Moore and Rebecca Rippon from Sapere were welcomed to the meeting and presented an update on the Southland clinical needs analysis (tab 14). This included an overview of the key parts of the process to date and feedback from site visits, population and baseline hospital volume projections, the impact of ageing on services, and the key 'strategic configuration' questions for consideration and/or modelling.

Mr Moore and Ms Rippon then responded to questions on the configuration of secondary and tertiary hospitals within the district, demographic changes for Māori and Pasifika populations, and the interface between secondary and primary care.

Mr Moore advised that the next steps were to finalise the forecasts, then go through a process of moderating them to give a base capacity forecast. A more substantive report would be provided in June 2022.

The Chief Māori Health Strategy and Improvement Officer left the meeting at 11.55 am.

Community Health Council

Karen Brown, Chair of the Community Health Council (CHC), and Kathryn Harkin, Consumer Liaison, were welcomed to the meeting.

The Board received a presentation from Ms Browne on CHC activities from mid-December 2021 to mid-March 2021 (tab 12.1), during which the following achievements were highlighted.

- Three subcommittees had been formed to address several workstreams to ensure they were closed off by 30 June 2022. There had been good engagement from members to achieve this.
- The work of Kathryn Harkin, Consumer Liaison, was acknowledged, in particular her attendance at service planning meetings to talk about the consumer engagement marker and raise the profile of the CHC throughout the DHB.
- An on-line symposium was being planned for 19 May 2022 and invitations to that had been accepted by Interim Health NZ and Māori Health Authority staff charged with managing the consumer and whānau voice.
- The CHC submitted to the Health Quality and Safety Commission (HQSC) on their draft Code of Expectations for Engaging with Consumers/Whānau.
- The CHC was assisting services by reviewing and commenting on their letters to patients.
- The CHC had been approached to assist WellSouth recruit a community representative to their Board.
- The paper *Southern Health Systems Community Health Council: the establishment and processes to engaging with communities, whānau and patients* that had been accepted by the New Zealand Medical Journal would be published in their 6 May 2022 edition. This was the second paper accepted for publication that the CHC had co-written, one of which had won a global award.

Ms Browne thanked the Board Chair, Members and staff for the opportunities provided, and their encouragement and support of the CHC.

The Board expressed its gratitude to Ms Browne and the CHC for their work over the years, which had exceeded expectations.

The Chair advised that thought needed to be given to retaining the services of the CHC during the Health transition, particularly in the absence of Locality Networks. The CEO informed the Board that he had asked the CHC to continue until they were asked to stop. Ms Adams endorsed the Chair and CEO's comments, noting that it would take a while for the new structures to be built.

14.0 FINANCE AND PERFORMANCE (Continued)

Volumes Report

The volumes report for the year to 28 February 2022 (tab 8.2), was noted.

Quality Dashboard

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

- Just under 50% of the Executive Quality Dashboard targets were green, 25% orange and 25% red.
- Hospital acquired complications and infections, particularly in Dunedin, continued to be an issue. A considerable amount of work was going into improving clinical governance processes and the Clinical Council had been focusing on hospital acquired infections.
- Medication complications were also a focus. This related to complications from medication, not medication errors.

The DQ&CGS then responded to questions on mental health restraints and the length of stay trend.

Performance

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

Performance and Annual Plan Reporting, Quarter 2 2021/22

A report on performance and progress against the Annual Plan for Quarter 2, 2021/22 (tab 8.5) was taken as read. It was noted that five measures had not been achieved, which was concerning.

15.0 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.

The CEO informed the Board that:

- Due to a technical issue, the historic completion column had been omitted from the report;
- The report continued to be a work in progress and the new Planning and Accountability Manager was placing an emphasis on it.

It was agreed that a workshop would be arranged on how to interpret the Strategic Change Portfolio Plan report.

16.0 MENTAL HEALTH - TIME FOR CHANGE TE HURIHANGA PROGRAMME

The Executive Director Mental Health and Addictions (ED MHAID) presented an update on the *Time for Change, Te Hurihanga, Programme* (tab 10) and provided the following updates.

- Chris Crane had been appointed Programme Manager for *Time for Change* and a Relationship Manager would be starting in mid-May 2022. The MHAID General Manager role would be advertised that week.

- There were several pieces of work under way to address the gaps in the service continuum. This included :
  - Extensive engagement with the Queenstown/Central Otago communities to inform the development of a crisis response model. This was almost complete, and a workshop would be held in April to refine the model, following which the services would be commissioned.
  - A model to expand the capacity of alcohol and drug services in Dunedin and Otago was being developed, and a consultation process was about to commence on that.
  - Preparations were under way to scope a Kaupapa Māori mental health and addictions service model.
  - Work was about to commence on crisis respite services in Dunedin.
  - Communications and engagement with stakeholders was being improved.
  - The Request for Proposal (RfP) to transition Ward 11 clients into alternative options was due to close on 29 April 2022.

The ED MHAID responded to questions on the process for Kaupapa Māori services, child and youth wellbeing, workforce issues, and her general impressions of the potential and problems within the MHAID service, and how the Board could assist with those.

The Board thanked the ED MHAID for her report and the progress made under her leadership.

PUBLIC EXCLUDED SESSION

***At 12.30 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 ▪ 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.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
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.

L Soper/K Crowther

The meeting closed with a karakia at 4.20 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 26 April 2022

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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	Update provided at the April Board meeting.	
March 2022	(Minute 13.0)	Southland Clinical Needs Analysis to be submitted to May Board meeting.	COO	On board agenda.	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.
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
Oct 2021	**Te Kaika Health and Wellness Hub** (Minute 9.0)	Lease approval to be sought from the Minister.	CMHS&IO CEO	On board agenda, public excluded.	
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	CMHS&IO		

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		equity across the organisation (incl. to Quality Directorate, Clinical and Community Health Councils).			
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	Due to the complexity of data collection (e.g. significant manual data collection required from LMCs), not all data has been able to be collected as yet. Data sources include TAS, Midwifery Council, PBUs, LMCs and DHB. Data analysts assisting but more time is needed to finish collection from various sources and analyse the data.	June 2022
April 2022	**Strategic Change Programme** (Minute 15.0)	Workshop to be arranged on how to interpret the Strategic Change Portfolio Plan Report.	CEO	To be held in May, yet to be scheduled.	

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING

2 May 2022

- Verbal report from A/Prof Moana Theodore, Deputy Chair, Community and Public Health Advisory Committee

DISABILITY SUPPORT ADVISORY COMMITTEE MEETING

2 May 2022

- Verbal report from A/Prof Moana Theodore, Chair, Disability Support Advisory Committee

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 4 April 2022, commencing at 9.00am via zoom

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

1.0 WELCOME AND OPENING KARAKIA

Mrs Jean O'Callaghan, Chair of the HAC welcomed everyone to the meeting. Associate Professor, Dr Moana Theodore, provided an opening Karakia.

2.0 APOLOGIES

Apologies were noted from Mr Andrew Lesperance, Executive Director, Planning, Funding and Population/Public Health and Professor John Eastwood, Chief Medical Officer. An apology was also noted from Crown Monitor, Mr Roger Jarrold, who advised he would need to leave the meeting between 9.30 and 10.00am.

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES (tab 4)

It was resolved:

"That the minutes of the meeting held on 1 February 2022 be approved and adopted as a true and correct record of the meeting."

5.0 MATTERS ARISING

There were no matters arising from the minutes that were not covered in the Agenda. The Chief Operating Officer (COO), Mr Hamish Brown, responded to members queries in relation to:

- The Outpatient Clinics for General Medicine.
- Direct admissions by General Medicine Physicians, by-passing the Emergency Department (ED). The admissions have risen from 59% to 69%
- Re-appointment of staff impacted by the COVID vaccination pass mandate.
- Neurosurgery recruitment.

Mr Chris Fleming, CEO, joined the meeting at 9.05am.

6.0 REVIEW OF ACTION SHEET

The Committee considered the action sheet (tab 6) and attached information papers and the verbal update from the COO, Mr Hamish Brown.

Centralisation of RMO Rostering

An update was included with the action sheet (tab 6.1) providing a brief on the centralisation of RMO Rosters. The COO advised that the Omicron COVID outbreak has slowed progress. A further update will be included in the COO Report for the June 2022 meeting.

Ophthalmology Wait Times

Members considered the report on the risk associated with Ophthalmology patients being overdue for a follow-up appointment (tab 6.2). The COO advised on the work done to significantly reduce the waitlist and success with recruitment. An update was also provided on the barriers to recruitment due to difficulty with getting people into the country as most District Health Boards have lost their preferred provider status with Immigration New Zealand.

Ms Tanya Basel, Executive Director People and Culture (EDPC) joined the meeting at 9.10am.

The EDPC, Ms Tanya Basel, advised that the preferred provider status lapsed due to the long delay with the borders closed and Southern DHB now needs to go through a process to reapply for that. The lack of pathway for residency at the current time is a further barrier.

The Chair acknowledged the progress made with Ophthalmology wait times and the assurance that it should continue to reduce. The Board Chair commended the COO and the team on the effective response and progress made within a short period of time and advised he would like to have seen the progress reflected in the wider Board papers.

Gynaecology Waiting List and Surgical Thresholds

Members considered the update on the Southland Gynaecology Outpatient Waiting List and the updated table of actions for recovery and sustainability (tab 6.3). The COO noted the positive progress with the urgent case numbers and advised that he would like to have seen more progress on the overall numbers, which have increased slightly. The COO noted the pressure on the Senior Medical Officer (SMO) team and the impact with the shortage of Midwives.

Associate Professor, Dr Moana Theodore, noted the increase in waiting times and the impact of that on women. The COO acknowledged the impact on women and outlined actions being taken, but advised that compliance is a long way off. The COO concurred with comments from Crown Monitor, Mr Ben Pearson, in relation to the referral boundaries and scope for a centralised system across the district. The HAC Chair reflected the need for the system to provide what works best for the patient and advised the need for change under the pending new health system. In response to concerns around the Oncology Service wait list, it was noted that additional funding will be provided by the Ministry of Health (MoH) from September 2022. The Dunedin figures are not included in the report and the COO provided an update on the district view in relation to gynaecology.

Recruitment

Members considered the report on recruitment included with the action sheet (tab 6.4). The COO raised concern around the accuracy of the figures provided and advised reconciliation work is ongoing to ensure accurate information is provided in future reports. A forensic analysis of the Registered Nurse and Registered Midwife workforce was undertaken, which indicated 60 vacancies rather than the 400 reported. The EDPC advised on work being undertaken to clean up the recruitment system and the Request for Recruitment (RFR) may be driving some of the numbers. There are challenges with no correlation between the financial and the recruitment system and the lack of a position control system. Work will be done over the next three months to clear historical vacancies out of the system. The Board Chair advised the need for management to provide a paper for the Board advising of the concerns with the system and what is being done to identify and mitigate the issues. The EDPC is to provide a report as outlined and include information related to the Human Resource Information System (HRIS). The CEO advised that the system issues experienced also existed in other DHBs he has worked in. Further work will be done prior to the next meeting to improve the data available to assist with regional and national convergence in the future. The HAC Chair noted the paucity of information around workforce and advised the need to look at a different model of care for services where recruitment has been an ongoing issue for a number of years. Discussion was held on the impact of staff being paid more than one FTE and candidates turning down job offers for more highly paid positions elsewhere.

7.0 PRESENTATION – ORTHOPAEDIC SURGERY SOUTHERN DHB 2022

The following staff joined the meeting at 9.45am:

- Dr Janine Cochrane, General Manager (GM), Dunedin Surgical Services and Radiology, Dunedin Hospital.
- Ms Sharon Jones, Director of Nursing, Dunedin Surgical Services and Radiology, Dunedin Hospital.
- Mr Michael Chin, Clinical Director, Orthopaedics, Dunedin Hospital

Members received the presentation (tab 7.1) highlighting key issues and proposed solutions and the following highlights were noted in discussion following the presentation:

- Members thanked the team for the presentation, noting it provides them with a better understanding of what is happening within the area of Orthopaedics and why.
- The barriers to achieving a Saturday list were noted and there is currently no date for commencement of acute theatre as recruitment is not yet complete. The full complement of Anaesthetic Technicians is not available and there is a shortage nationally.

- Mr Chin advised that the Day Surgery facilities in Dunedin are marginal, particularly for more complex surgery. There is a definite move to short stay surgery and there is ability to manage people as outpatients if well prepared.
- There is an increase in the use of Outpatient Arthroplasty overseas, particularly in the UK and USA.
- There is the potential for more Day Surgery to be done with good facilities.
- Other services are currently using the main Operating Theatres, due to the poor state of the current Day Surgery Theatres. The dire shortage of nursing staff is impacting and the current recruitment into Nursing Programmes across the district are insufficient to keep up the current level of nursing staff. Changes to the Nursing Programme are likely to further impact on the shortages.
- There is no immediate solution around recruitment to the final Spinal Surgeon vacancy in Southland and it is a challenge to get somebody with the appropriate skills to complement the team.
- The Spinal Surgeon vacancy is not currently advertised and it is challenging for the Surgeons travelling from Dunedin to Southland as they are often limited in what they can do due to bed closures.
- The Chief Allied Health, Scientific and Technology Officer (CAHSTO), Kaye Cheetham, provided a comprehensive update on the work being done to recruit to and mitigate the shortage of staff in the areas of Anaesthetic Technicians and Physiotherapists. The CAHSTO is to provide a paper for the next HAC meeting on providing Scholarships to attract Anaesthetic Technicians to the Southern district and retain them.
- The Chief Nursing and Midwifery Officer and the Director of Nursing, provided an update on the challenges with the Ward 3 situation at Dunedin Hospital, where Wards were consolidated into one large Ward to make room for ICU.
- The COO provided a brief update on progress with the Central Sterile Services Department (CSSD) and the work being done with the Building and Property team. Further discussion is to take place at the Finance Audit and Risk Committee.
- Crown Monitor, Mr Ben Pearson, advised that South Canterbury DHB has the capacity to deliver around 130 joints per year, but no contracts have been issued beyond July 2022. The GM Surgical and Radiology Services is to investigate this.
- Mr Chin responded to a query from the Board Chair around work on Enhanced Recovery after Surgery (ERAS), acknowledging the need to reduce length of stay and noting the need to have the staff to support the process.
- The HAC Chair commended and thanked the team for their presentation and the initiatives being taken to address the key areas of concern and noted the hard work going in to make a difference despite the challenging times.

Dr Janine Cochrane, Ms Sharon Jones and Mr Michael Chin left the meeting at 10.27am.

A brief five minute break was held commencing at 10.27am.

8.0 PRESENTATION – TELEHEALTH

The following staff joined the meeting at 10.30am:

- Simon Donlevy, General Manager, Southland/Deputy Chief Operating Officer
- Matthew Pettersson, Project/Change Manager - Telehealth

The COO introduced the team and members received the presentation (tab 7.2), highlighting key issues and the following was noted in discussion following the presentation:

- Members noted their thanks for the excellent presentation.
- The Project/Change Manager Telehealth, is to provide information for the next meeting showing the number of patient contacts that have traditionally been face to face that could be via telehealth.
- The Board Chair acknowledged the standard of the presentation and the attention to patient time. As the DHB with the largest geographical area in the country, Southern DHB should be leaders in Telehealth.
- The main challenges with advancing Telehealth within Southern are attitudes and staff change and a willingness to accept feeble objections to it.
- The system currently captures clinician location, but not specifics of clinician time saved by using Telehealth.
- The National Health Service (NHS) in the UK has overcome the challenge of integrating the clinical information systems to the Telehealth Technology. However, it is more of a challenging for NZ currently with 20 individual DHBs.
- The team responded to concerns raised by Associate Professor, Moana Theodore, relating to ethnicity data captured on page 62 of the agenda papers. The team have reached out to the Māori Health Directorate to address the findings and further work is being done to identify Māori participation and barriers. Research is being undertaken and initiatives looked at by digital service providers to address digital inequity.
- Advice was received on the limitation of Telehealth in specialties such as ENT, Ophthalmology and Oncology and the need for first specialist appointments (FSA) to be face to face. In some cases Telehealth can take more clinician time.
- Advice was received on the growing public awareness of telehealth and WellSouth Primary Health Network (PHN) are about to launch an advertising campaign that will further raise awareness.
- Crown Monitor, Mr Roger Jarrold, urged Southern DHB to embrace Telehealth and promote it, given the substantial amount of money required for the new information technology business case. He noted the value of hubs for people to Telehealth from.
- The COO thanked the team for the presentation and acknowledged the significant opportunities for Telehealth across Southern DHB. He noted the learnings from COVID and the need to have the right clinical workflows and business rules in place, along with the resources to support Telehealth.
- The HAC Chair acknowledged the progress made and advised she would like to see a move to having no option for a face to face appointment for any appointments that can be done by Telehealth.

Mr Simon Donlevy, General Manager, Southland/Deputy Chief Operating Officer and Mr Matthew Pettersson, Project/Change Manager – Telehealth left the meeting at 11.12am.

The HAC Chair advised that there are to be no presentations to the final Southern DHB HAC meeting, scheduled for 7 June 2022, as the time is needed to discuss where the Committee is to leave the various issues being considered.

9.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Chief Operating Officer's (COO) Report

The COO report (tab 8.1) was taken as read and the COO, Mr Hamish Brown, drew the Committee's attention to the following items:

- The complex operating environment that management and staff have been working in with the complexities of COVID, vacancies and COVID absenteeism, whilst juggling acute flow and care within the environment. The COO noted his thanks to the Senior Leadership Team, across both sites, for their support over the past couple of months, noting the achievements, despite the difficult environment.
- Of the 82 Nursing Entry to Practice (NETP) Nurses who joined the team, 68 are now out of their time.
- The increased number of beds that have been open across the district.
- The installation of the new Magnetic Resonance Imaging (MRI) machine in Dunedin.
- The reduction in ESPI 2 and ESPI 5 cases.
- There are still significant challenges across the hospitals, but the team are working hard to address those challenges.
- An update on case weight delivery (cwd), finishing 180 cwd behind for the month of February 2022.
- The improved position overall despite the challenges.
- Outsourcing has continued, despite the providers facing many of the same challenges as Southern DHB.
- The increased number on the Orthopaedic Outpatient Waitlist, with an aging population and the burden of disease being significant.
- The increasing presentations to ED and high acuity. There is potential for Geriatricians to do Emergency Medicine to help reduce acuity, discharge more or work with people in their home to prevent the presentations. The CMO is keen to use the Medical Assessment Unit (MAU) as part of a virtual care pilot to help reach out to Rest Homes and General Practice to keep the frail elderly from having to come in to the ED setting.
- The Board Chair commended the COO on the modestly positive changes, achieved under the current challenging circumstances. An update was provided on the discrepancy in the data for Ophthalmology, noting that the activity is not captured in the discharges as a lot of it is Outpatient or coded under different activity. Most of the improvement in the area of Ophthalmology is in the Outpatient area.
- The recruitment campaign, with the final video and material almost ready for sign-off by the recruitment agency.
- The business case for increased bed capacity is reliant on involvement by the Southern Institute of Technology. In the interim more beds have been opened on the surgical floor, using a team based model. Conversations are in progress and students are in place, but there are insufficient registered staff to cover the night shift and weekends. There are a number of Enrolled Nurses graduating from SIT in April 2022. The employment of Health Care Assistants is working well in Surgical and a number of other areas, enabling Registered Nurses to work to the top of scope. A request was made for an update to be provided for the June 2022 meeting.
- In response to concerns raised regarding surgical performance and cwd compared to 2021, the CEO advised he would arrange for an update to be provided for the Board meeting to be held on 5 April 2022. The COO advised that work is being done to actively lift elective performance after 25 April 2022.
- Clarification was provided on the recovery approach for long waiting patients on the waitlists outlined on page 15 of the COO report and discussion was held on the treatment of these patients into the future. Members expressed concern at the lengthy waiting lists, with one example noted of a person advised of a wait time of 40 weeks for a FSA. ELT members will keep working to address this issue.

Southern DHB Output Trends, FTE Trends and Productivity

The Southern DHB Output Trends, FTE Trends and Productivity report (tab 8.1.1) was taken as read and the COO, Mr Hamish Brown, drew the Committee's attention to the following:

- The Business Analyst team provided the report in response to a paper from the Technical Advisory Service (TAS) that looked at overall productivity of all DHBs.
- The table on page 94 of the agenda and reports compares Southern DHB's productivity to the national productivity growth.
- A follow up report will be provided showing a more in depth analysis.

Financial Performance Summary

The COO presented the Specialist Services financial results (tab 8.2) for the period ended 28 February 2022 and highlighted the following:

- The adverse result of $950K for the month, with the main contributor being outsourcing ($600K).
- The year-to-date result is unfavourable by $7,352K.
- Further discussion on the finances will take place at the Finance Audit and Risk Committee (FARC) meeting on 4 April 2022.
- The HAC Chair queried what action management is taking in relation to the high Annual Leave Liability, particularly in relation to the Resident Medical Officers (RMOs), with leave taken at 68% of levels budgeted. The COO acknowledged the concerns and noted the challenges with balancing the ongoing operational need against future service delivery. The National COO group has discussed the approach to annual leave with a view to having a consistent approach nationwide. With the borders opening, there are now more CME and other leave requests coming through and these are being monitored carefully.

It was resolved:

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

10.0 NEXT MEETING

The final meeting of the Southern DHB HAC is to be held on 7 June 2022.

11.0 CLOSING KARAKIA

Associate Professor, Dr Moana Theodore, provided a closing Karakia and the meeting closed at 11.43am.

Confirmed as a true and correct record:

Chair: _____ Date: _____

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 3 May 2022

Recommendation

That the Board:

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

Purpose

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

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

1. Organisational Performance

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

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

The operating environment has remained highly complex in March dominated by workforce issues as COVID-19 absenteeism has continued 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 (BAU) functions. Flow through the hospitals has continued to remain manageable, however at the expense of a reduction in planned care especially for those patients requiring inpatient beds, and there has been significant staffing issues in some areas.

Financial performance for the month of March was adverse to plan as expected. The result was an operating deficit of $5.982 million compared to a planned deficit of $5.346 million, so $0.636 million adverse to plan. The year to date deficit is now $20.858 million compared to a budgeted deficit of $10.903 million, a variance of $9.955 million.

The BAU budget (which excludes COVID related revenue and expenditure) is a year to date deficit of $19.865 million against a plan of $10.903 million, so $8.962 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 $1.193k for the month
- Pharmaceuticals which relates to phasing, the underlying budget issues, and increased Pharmac forecasts of $1.783 million
- Air Ambulance Services $227k
- ICT and Software exceeding budget $292k.
- Inter District Flows $685k which included a single patient from Starship costing $800k
- Offset by
  - net elective revenue increase of $1.777 million which is recognising year to date performance along with Improvement Action Plan funding
  - other additional revenue streams $1.281 million.

From a volumes perspective:

- Total case weighted discharges were adverse to plan at -487 or -9.6% for the month compared to the plan, and down 267 or 5.3% on the same month last year. Year to date case weighted discharges are adverse 600 or 1.41% year to date against plan and down 1,359 or 3.1% against last year
- Medical case weights are up 660 or 4.25% year to date on plan, and down 302 or 1.83% compared to last year
- Surgical case weights are down on plan 1,533 or 6.6% with acutes down 400 or 3.66% and electives down 1,132 or 9.22%. Compared to last year, surgical acute case weights are down 340 or 3.1% and electives are down 696 or 5.9%
- Raw discharges (actual number of patients) are down 189 or 3.6% for the month against plan, which is down 301 or 5.7% compared to the same month last year. Year to date raw discharges are down 1.124 or 2.4% compared to last year
- Mental Health bed days are 842 or 25.6% below planned levels for the month (indicating a 74.4% bed occupancy) and 942 or 4.1% 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 385 or 4.9% compared to March 2021, with Dunedin down 2.2%, Southland down 11.8%, and Lakes up 8.1%. On a year to date basis ED presentations are down 2.2% with only Lakes having a 2.5% 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

Fepulea'i Margie Apa, Chief Executive of the Hauora Aotearoa, interim Health NZ, and Riana Manuel, Chief Executive of the Te Mana Hauora Māori, interim Māori Health Authority, visited Southern DHB on Monday 11 April. While here they met with Board members, Iwi Governance Committee members, Executive Leadership Team, Tiers 2 and 3 staff, Māori Providers, visited Ward 10A and the New Dunedin Hospital Programme Office, and attended presentations on Mental Health and Addictions, the New Dunedin Hospital and the Digital Programme.

On 21 April the Minister of Health announced the nine communities where the locality approach to guiding health and wellbeing planning will be rolled out first. Our application for Southland to be one of the locality prototypes was not one of the nine announced, but Health NZ have said that they are keen to work with us to progress towards establishing a locality in Southland as soon as possible.

3. CEO Departure

As announced last month I have made a decision to pursue business opportunities outside of the Health Sector along with pursuing some governance or part-time consulting opportunities, and so will be finishing in my role on 30 June 2022. It has been a privilege to be entrusted with the leadership of Southern DHB over the past six years along with the other Chief Executive positions I have held prior to commencing in Southern.

The Interim Chief Executive of Health New Zealand has advised that she will be appointing an Interim Chief Executive to oversee the services currently led by Southern DHB for the period 1 July 2022 to 30 September 2022, with the possibility of being extended to 31 December 2022. This is consistent with how all former DHBs are to be lead over this time period. The Interim Chief Executive is going to be selected by Margie from within the existing Executive Leadership Team as she has identified that there needs to be a degree of stability over this transition period. As soon as this person has been appointed, I will commence a hand over / transition process with this individual to ensure a smooth transition over the next two months.

4. COVID – Omicron Outbreak

Public Health Response

Public Health South continues to have two COVID-19 response teams working over a seven day roster. There are still increasing numbers of cases across the district, in particular in Southland, which informs us that we haven't reached our peak yet (as of the time of writing). We are now working under phase 3 of the COVID-19 Protection Framework which has seen a significant shift in where we focus our work. This has meant that our response teams have now moved away from the case and contact investigation and management to now predominantly focusing on outbreak management of the following high-risk settings:

- Aged Residential Care Facilities
- Faith based places of worship
- Marae and Tangihanga
- Residential housing.

The majority of our work has been in the aged residential care space; however, we are still receiving exposure events to investigate in the faith-based places of worship as well as residential housing settings. We are moving towards a lighter touch response for faith-based places of worship due to the cases coming from the community rather than the setting itself causing an outbreak. This setting is being provided advice on what public health measures they need to follow to reduce further risk to their community. There are some additional settings that we offer to support if they require it as well, for example freezing works across the district.

Our Public Health South cultural liaisons continue to proactively reach out to our Māori and Pasifika cases across the Southern district to make sure that any manaaki and welfare needs are addressed appropriately. This team is also supported by a small team at WellSouth to make sure that everyone is being reached. This also ensures that they are connected in with a General Practice for clinical support.

Work is underway to start looking at what beyond Phase 3 means and looks like for the teams. In addition, we have been advised that COVID-19 funding will continue into the 2022/23 year. A number of staff are employed on fixed term contracts. A priority is to review our current COVID Response Team workforce, ensure the position descriptions are fit for purpose for expectations moving forward, and have a process to extend contracts.

Quarantine Free Travel

The Queenstown Airport Health Team continue to be utilised in the Case and Contact Management Teams and as a vaccinator at the vaccination clinics.

From 11:59pm on 12 April the borders opened up further to allow the return of Australian and then other tourists. There is still an expectation from the Ministry of Health that there is a health presence at the border, but potentially not to the same extent as what previously has been required. This will involve Public Health staffing to assist with completing health assessments of those who arrive symptomatic, or those who arrive on specific quarantine free travel pathways from certain countries. Staff will also provide guidance to those who need to be re-directed if they have arrived on an incorrect pathway. Travellers entering New Zealand will need to be fully vaccinated and self-test on arrival. There is no requirement for these travellers to isolate.

This will have implications for our Covid-19 response workforce as we balance staffing to support both COVID-19 response and the airport border response work.

Community Supported Isolation/Quarantine (SIQ)

There was a steady demand for supported isolation/quarantine during March in Dunedin, Invercargill and Queenstown. The National Contact Tracing System (NCTS) has been updated to include questions on whether cases require support with accommodation. The questions currently ask if someone can safely self-isolate in their current accommodation. If the answer to this question is no, then a prompt will ask them why this is. The options that can be selected include overcrowding or someone with serious health conditions resides in the house, nowhere to safely self-isolate, do not have basic facilities e.g., toilet, power, water; or other where they can provide their own answer. This change now requires resource to monitor a queue in NCTS for any cases that provide this information so that it can be actioned in a timely manner. These questions continue to be revised but it is expected that this will cause a large amount of work for the Community Care Hub team who must navigate this new component and the added pressures that this will put on SIQ in the Southern district.

A manager has been hired for Aaron Lodge which makes this site operational. Two staff have been recruited to co-ordinate the transport and accommodation arrangements for COVID-19 cases.

Software issues and flow of information is making it difficult to track a large influx of cases. Rapid Antigen Tests (RATs) mean positive results are received at all hours of the day, so we are often receiving referrals after 5:00pm to manage from Emergency Departments, Ministry of Social Development (MSD), and Community Connectors.

The future of supported isolation/quarantine with the borders reopening to tourists is yet to be determined and the expectations of whether we are to assume responsibility for travellers is unknown at this stage.

COVID Resiliency

Public Health South have had a COVID resiliency project in operation since October 2021. At that time the aim was to reach underserved populations with a view to try to encourage processes aimed at managing COVID-19 in their communities, including access to services and limiting the spread of infection. Our work involved aligning with high-risk premises where these populations are located e.g., boarding houses, camping grounds, other specialist residential services (e.g., intellectual disability, mental health, older persons) as well as collaborating with organisations serving the needs of these populations. Some collaborators/premises were easy to engage while others were either hard to find or challenging to communicate with.

Now that we are in Phase 3 many of these organisations are being contacted by our COVID-19 Response Team. Given that multiple staff are interacting with these organisations, as well as an expectation that future Public Health services will be focused on these

underserved populations, it is becoming increasingly necessary to track our interactions with these premises/organisations. A relationship management system has been developed and tested. We are currently in the process of identifying how it will need to be applied and what business rules need to be developed so that we can maximise the benefits offered by this application. This will all come under the COVID-19 Response Team that in effect joins the approaches of the resilience function and the reactive response function.

Aged Residential Care (ARC) Workforce Shortages and Omicron Readiness

Relationships across the ARC sector and teamwork paid off in March as the Omicron outbreak rapidly evolved.

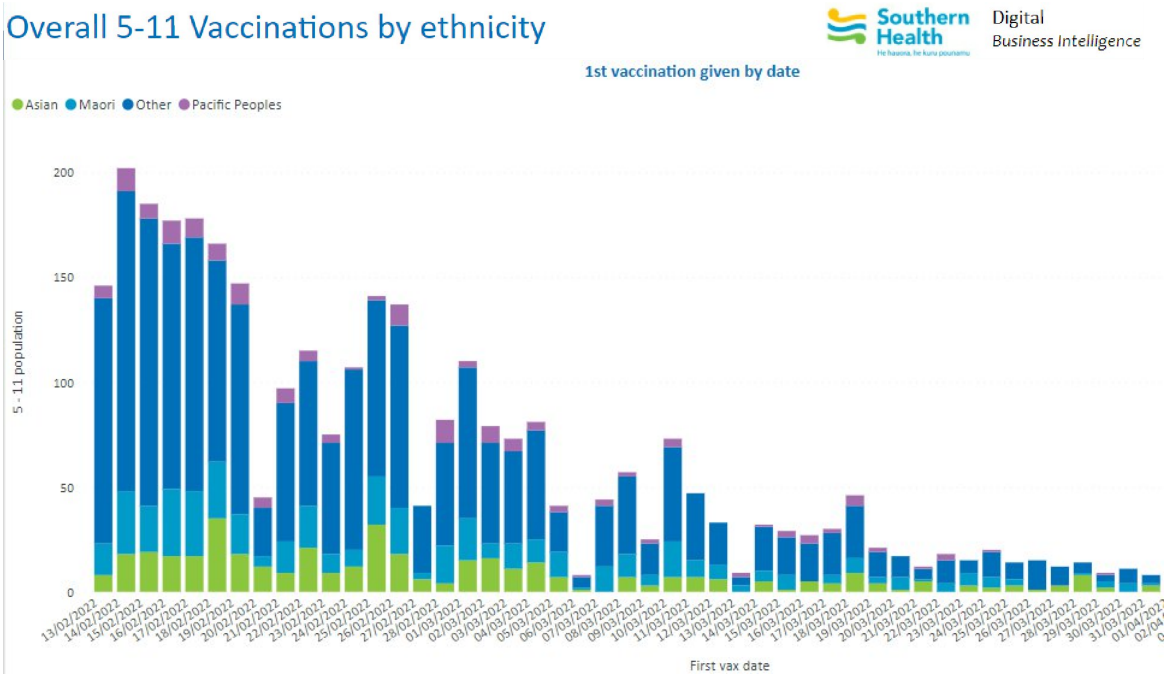
The DHB was providing guidance and support to as many as a dozen facilities simultaneously. Support included site visits from Infection Prevention and Control (IPC) team to assess the situation and provide guidance, recommendations, education, and training. The DHB has also provided Registered Nurses (RNs) and Health Care Assistants (HCAs) to several facilities where there were significant clinical risks due to increased clinical requirements or extreme workforce shortages. Our ARC Daily Reporting Survey gave us an overview and identified where concerns were. The quick development of a Notifications Form and dedicated email and phone number allowed us to manage the increasing volumes of notifications, including knowing when to seek support from Public Health South. Again, groundwork creating a cooperative culture across facilities has paid off as facilities are getting support from each other in locality networks. This also has provided us with a rich data source to understand the COVID outbreak in ARC.

This required a rapid creation of a team to support the sole Health of Older People Portfolio Manager. There is now a team of five working to support ARC seven days a week. However, this is placing strain on other services and responsibilities for both the General Manager and Director of Nursing who have limited capacity during the week for work outside ARC plus also working weekends. As the Omicron outbreak now appears to have a long tail, this is not sustainable.

Workforce Shortages continue to plague aged residential care, often resulting in staffing that does not meet requirements. It is a credit to the remaining staff how they are managing to, in most cases, continue to provide services to residents seamlessly. However, the stress on staff is enormous. Pay parity for RNs and pathways for internationally qualified nurses and their families to enter NZ must be addressed urgently.

5. COVID-19 Vaccination Programme

The month of March 2022 saw a significant drop in the number of daily covid-19 vaccinations across all areas, mirroring the national vaccination uptake rates. Southern DHB remains above the national average for the proportion of booster doses and paediatric doses administered. Over 91.9% of Māori are double-dosed. As of 30 March 2022, 74.8% of the eligible population have been boosted, and 55.0% of the paediatric population have been partially vaccinated. The chart on the following page shows the breakdown of COVID-19 vaccinations for 5 to 11-year-olds by ethnicity across the Southern District daily from 13 February 2022 through to 31 March 2022.



Cold-Chain Breach

Following the identification of a potential cold-chain breach on 2 March 2022, and subsequent confirmation on 4 March by IMAC that there had been a cold-chain failure and the number of affected doses, the Southern DHB COVID-19 Vaccination Programme began contacting the 1,571 affected individuals on 7 March. These individuals have been advised to have a replacement dose.

964 (62%) of the replacement doses have been completed.

A team from the Meridian Vaccination Centre are actively contacting the remaining 240 people who have not had a replacement dose yet.

An independent review has been undertaken, including a documentation review and interviewing of relevant Southern DHB staff members. We are expecting the draft report imminently which will be reviewed by those who participated in the review to provide any factual corrections prior to finalising. We are expecting that there will be some shortcomings identified on both the Public Health process as well as the operator and we are therefore committed to address any feasible recommendations that are made.

Pharmacies

Two new pharmacies (1 in Riverton and 1 in Wanaka) are being onboarded to deliver COVID-19 vaccinations. They are only now coming on board as a need for more vaccinating providers was identified to meet demand in these areas. When approached a second time, they were interested in starting vaccinations. Aspiring Pharmacy in Wanaka will be doing both adult and paediatric vaccinations, and Riverton Pharmacy will begin with only adults, but they hope to progress into delivering paediatric vaccines.

One more pharmacy in Invercargill has come on board to offer 5 to 11-year-old vaccinations this month. As a result, vaccinations in the 5 to 11 years age range are more accessible.

Māori and Pacific Providers

There have been multiple clinics held by Māori and Pacific providers this month to respond to community needs. These have been in Oamaru, Balclutha and Southland, and all have reached a number of people for boosters and 5 to 11-year-olds.

Disability Residential Facilities and Aged Residential Care

Onsite booster clinics at Disability Residential Facilities were completed in February 2022. In addition, processes and relationships are in place to support vaccinations for new arrivals as required.

Mental Health and Addictions

Onsite booster clinics at Mental Health and Addictions Residential Facilities were completed in February 2022. As required, processes and relationships are in place to support vaccinations for new arrivals. In addition, the Ministry of Health has released funding this month to enable organisations to provide peer support to those who may benefit from additional support to access vaccinations. The COVID-19 Vaccination Programme will work in partnership with any organisation that is successful in applying for this funding from the Ministry of Health.

5 to 11-year-old Vaccinations

Demand continued to decrease in line with a national trend, and the vaccination programme is ensuring capacity is maintained across the Southern District.

Low sensory clinics were held in Queenstown with the support of Five Mile Pharmacy and the Pivotal Point Trust. These clinics offered a low sensory environment for 5 to 11-year-olds as an alternative to their families travelling to Dunedin or Invercargill for hospital-based clinics.

Specialist Paediatric COVID-19 Vaccination Clinics have been organised at Dunedin Hospital and Southland Hospital to assist tamariki unable to receive their COVID-19 vaccination through community clinics or home visits. This may be due to extreme needle phobia, neurodevelopmental needs such as intellectual disability / Autism Spectrum Disorder or other complex health needs. Play Specialists, Paediatricians (for sedation where necessary) and Psychologists are available for input alongside the COVID-19 vaccinators.

Measles, Mumps and Rubella (MMR) vaccination in mass vaccination clinics

The two mass vaccination clinics have begun vaccinating against MMR. The Dunedin site has so far administered ten and the Invercargill site 4.

Influenza vaccination in mass vaccination clinics

Work is underway to ensure flu vaccinations will be able to be administered at the mass vaccination clinics for both staff and eligible members of the public.

COVID-19 Vaccination Outreach Service

The COVID-19 Vaccination Outreach Service continues home visits throughout the Omicron outbreak with additional safety precautions. Since the launch of the Outreach Service, the service has administered 6,272 vaccinations to hard-to-reach individuals and health care workers.

Novavax

There are three Novavax vaccination clinics across the Southern district: Dunedin, Invercargill and Cromwell. In addition, to ensure service equity, the COVID-19 Vaccination Outreach Service is also delivering Novavax to individuals unable to access a Novavax clinic.

6. 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 capital expenditure and operational expenditure 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.

7. Industrial Action

On 20 April 2022, Southern DHB along with other DHBs, received two strike notices from the Public Service Association (PSA) Union. The industrial action is for the periods 08:00hrs on Monday 9 May to 23:58hrs on Sunday 15 May and 00:01hrs Tuesday 17 May to 18:00hrs Friday 20 May 2022. Both strike notices involve bans on working before and after agreed finish times and stopping work to take all entitled breaks.

On 26 April, Southern DHB along with other DHBs, received a strike notice for a complete withdrawal of labour from 11:59hrs on Sunday 15 May to 11:59hrs on Monday 16 May 2022.

8. Hospital Operations Update

March 2022 was dominated by the response to COVID-19 Omicron and the subsequent surge in community cases and hospitalisations. Hospitalisations have continued to ramp up as the month has progressed and are forecast to peak in Mid-April. There have been daily challenges with regarding to resourcing of clinical areas, requests for support for areas outside the hospital, management of exposure events and ensuring that non deferable and urgent planned care activity continues to occur and to capitalise on opportunities for innovation (such as pivoting into high throughput day cases). The team has faced into this extremely well and the leadership team and the Board should be proud of the response within Southern DHB hospitals.

No doubt a significant contributor to this success was the on boarding of 82 New Entry to Practice (NetP) staff who through March have gradually moved out from their load sharing orientation phase and enabled more beds to be opened on both sites than in the previous six months. This has enabled a more robust response within the nursing teams, greater flow from the Emergency Departments and more opportunities to better manage elective and acute surgical patients. Despite the challenges presented by COVID we have achieved more planned care activity in March than in February. It is worth pointing that although our variance from target is greater than in February (due to the production target lifting) we have delivered more care than in the previous month to the people of the Southern district.

Recruitment to Tier 3 Vacant Positions

Craig Ashton commenced in the role of General Manager Dunedin Medicine, Women's and Children's Health on 16 March.

An appointment has been made to the Patient Flow/Ops Manager Invercargill role and the successful candidate commences in May. This was the last role from the November 2021 structure changes to be recruited to. and this now completes the roles changed from the November 2021 restructure.

Midwifery and Obstetrics and Gynaecology Services

Midwifery and Obstetrics and Gynaecology (O&G) services remains critical despite mitigations. There is ongoing work with the service to ensure risk is addressed as able. the O&G waitlist remains a focus for the planned care and service delivery team. A report is due to the final Hospital Advisory Committee (HAC) Meeting in June.

Planned Care Improvement Action Plan

Progress against the Planned Care Improvement Action Plan (IAP) has been positive, and the planned care team is pushing hard for further recovery into April and ongoing into May and June. Forecasts for April and May see beds remaining open.

It is expected that full funding will be achieved in ESPI 5 and diagnostics.

The risk of not achieving full funding in ESPI 2 and Ophthalmology follow-ups is low and dependent on clinic volumes, additional clinics and locums. Plans are in place for these to happen and performance against the plans is being monitored.

The risk of not achieving in colonoscopy is higher with work being completed internally rather than outsourced. Outsourcing options are being considered.

Recruitment

Despite recruitment successes – vacancies across all professional groups however particularly nursing remain challenging, for example, Southland has 36 nursing vacancies.

Winter Planning

Winter-planning has commenced with a review of the current plan and interrogation of the data. Previous plans which have relied on doing what we normally do but better have been unsuccessful. The team has reached out to Primary care as well.

9. Tourism Recovery Fund – Psychosocial Mental Wellbeing Recovery

A range of wellbeing initiatives have been supported. In particular, the second round of the Connecting Communities initiative has been completed and 50 initiatives have been funded. These are ideas developed at a 'grassroots' level which are being resourced with a plan to follow up. The response has been very positive. In addition, a Community Co-ordinator has been appointed in Fiordland with this role being based at Great South. Further funding has been approved for an activities co-ordinator who will be based at Queenstown Lakes District Council.

10. Time for Change – Te Hurihanga

The implementation of Time for Change is progressing.

The Ward 11 work-stream is awaiting closure of the date for Request for Proposals (RFPs) from the three preferred expression of interest applicants. A project manager has been employed to oversee this work programme.

The process to expand Alcohol and Other Drug Services in Otago is being adapted in response to feedback from the Change Leadership Group. A broader approach to service design is required.

11. Co-Response Team (CRT)

The trial of this new way of working is continuing to go well. Since commencement the team has been involved in 318 jobs up until 25 February 2022.

12. Early Intervention Psychosis Team

Building work is completed and the team is scheduled to move to Albany Street on 7 and 8 April 2022. Official opening to be delayed for a couple of weeks so that area can be set up and staff settle in.

13. Organisational Development

Work currently underway by the Organisational Development (OD) team under the four areas of focus identified in the 2020 staff engagement survey include:

- Change
  - The team have secured agreement with Family Planning NZ regarding the development of Diversity and Inclusion Workshops for non-clinical staff which will be government funded. Workshops will commence on 2 and 3 May
  - A 12 month Accessibility Game programme (in support of the Disability Strategy) has been agreed and sessions are being run monthly
- Performance
  - Further Essential Corporate Training Workshops continue – Appraisals, Performance Management and Having Courageous Conversations. This programme continues with good levels of engagement via virtual delivery

- Work began in March on the development of a ECT payroll training workshop for managers and also an interview skills module
- Revised senior medical officer (SMO) performance review templates and SMO mandatory training framework completed for the Deputy Chief Medical Officer. Further support is available including training been support

- Leaders
  - An Emerging Nursing Leaders Programme has been developed and further support is now being provided regarding talent conversations and career planning for individual leaders (using new accredited skills/tools within the OD team). The first of these sessions due in April
  - A leadership development programme for Clinical Directors has been developed and will commence in April. Further work is also being undertaken regarding developing a clinical leadership competency framework similar to that used by the National Health Service (NHS) in England
  - Agreement reached this month for virtual delivery of LEADS cohort for 2021/22 in May. This programme places more emphasis on the leadership and management gaps highlighted in the staff engagement survey, including leading through change and performance management
- Wellbeing
  - Wellbeing pilots for ED and ICU staff have been progressing well. Work is currently underway to evaluate the pilots with a view to further implementation of this app
  - Speak Up app is now with external developer after wire frame completed
  - Speak Up e-learning module passed to Healthlearn Content Review group for further instructional design support -the module has attracted the attention of other DHBs and there may be an opportunity for economies of scale and scope with this initiative
  - OD team have provided support to Aukaha Kia Kaha Committee and plans are being drawn up for sending out staff wellbeing gifts in April, aligned to the 5 Ways to Wellbeing (a resource sourced and facilitated via workshops by the OD team).

Chris Fleming
Chief Executive Officer

26 April 2022

Hon Michael Wood

Minister of Transport
Minister for Workplace Relations and Safety

Chris Fleming
Chief Executive Officer
Southern District Health Board

21 APR 2022

Hon Pete Hodgson
Board Chair
Southern District Health Board

Bridget Dickson
Programme Director
New Dunedin Hospital Project Management Office

Dr Sheila Barnett
Chair
Clinical Leadership Group
New Dunedin Hospital Project

By email: NewDunedinHospital@southerndhb.govt.nz

Dear Mr Fleming, Mr Hodgson, Ms Dickson and Dr Barnett

Thank you for your letter of 30 March 2022 regarding the Shaping Future Dunedin Transport Business Case and its implications for the New Dunedin Hospital. Building a new hospital in Dunedin is a huge opportunity to change healthcare in the region, and I am proud to have been part of the Government supporting this project.

While the funding decisions and design details are an operational matter for Waka Kotahi NZ Transport Agency, I recognise the strategic importance of the project and have had extensive dialogue with Waka Kotahi about the issue. I have outlined my expectation that we recognise the generational opportunity to create a more sustainable, healthy, and people-friendly transport system for Dunedin, and for the Agency to work closely with yourselves and other important stakeholders including Dunedin City Council.

Waka Kotahi have advised me that while the Waka Kotahi Board has endorsed the Shaping Future Dunedin Transport Programme Business case, which retained the one-way system in an enhanced form, Waka Kotahi staff continue to work collaboratively with Dunedin City Council to remodel the one-way and two-way SH1 options to confirm functionality and refine cost estimates.

Waka Kotahi is also looking closer at the urban design improvements that could be made to both options to improve the attractiveness, safety and access requirements for pedestrians

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particularly in the central core of Dunedin. A review of speed limits on State Highway 1 through Dunedin will also be carried out by Waka Kotahi in the coming financial year.

Waka Kotahi will continue to work closely with the New Dunedin Hospital team on this issue, as well as the Waka Kotahi-led SH88 project, to ensure the new Dunedin Hospital has appropriate levels of service and access through a slower, safer and less trafficked solution that enables improved pedestrian access and increased amenity.

If you would like to discuss this matter further with Waka Kotahi, you are welcome to contact James Caygill, Director Regional Relationships, by email at james.caygill@nzta.govt.nz. I have asked to be kept up to date with developments.

7

Yours sincerely

Hon Michael Wood
Minister of Transport

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FOR APPROVAL

Item: Financial Report for the period ended 31 March 2022

Proposed by: Nigel Trainor, Executive Director Corporate Services

Meeting of: Board Meeting, 3 May 2022

Recommendation

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

Purpose

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

Specific Implications for Consideration

2. **Financial**

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

Next Steps & Action

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

Appendices

Appendix 1 Financial Report for the Board

Appendix 1: Financial Report for the Board

Southern DHB Financial Report

Financial Report for:	31 March 2022
Report Prepared by:	Finance
Date:	14 April 2022

Report to Board

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

The March 2022 result was a deficit of $6.0m, being $0.6m unfavourable to budget.
The year to date result is a deficit of $20.9m which is $10.0m 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, Community Care, Endemic 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 March 2022

	Month Actual Total $000	Month COVID-19 Vaccination $000	Month COVID-19 Resurgance $000	Month COVID-19 Community Care $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	117,263	2,555	1,317	4,218	595	85	-	106,235	102,236	3,999	F	2,258	500	1,758	F
Non-Government & Crown Agency	752	-	-	-	-	-	-	752	847	(95)	U	-	-	-	
Total Revenue	118,015	2,555	1,317	4,218	595	85	-	106,987	103,083	3,904	F	2,258	500	1,758	
EXPENSES															
Workforce Costs	48,099	541	1,154	-	488	16	-	45,900	44,679	(1,221)	U	-	-	-	
Outsourced Services	5,210	16	-	-	-	-	-	5,194	4,011	(1,183)	U	-	-	-	
Clinical Supplies	10,173	10	-	-	29	5	-	10,129	9,398	(731)	U	-	-	-	
Infrastructure & Non-Clinical Supplies	6,272	197	87	-	78	64	-	5,846	5,408	(438)	U	-	-	-	
Provider Payments	51,152	1,791	72	4,218	-	-	-	42,813	41,430	(1,383)	U	2,258	500	(1,758)	U
Non-Operating Expenses	3,091	-	-	-	-	-	-	3,091	3,503	412	F	-	-	-	
Total Expenses	123,997	2,555	1,313	4,218	595	85	-	112,973	108,429	(4,544)	U	2,258	500	(1,758)	
NET SURPLUS / (DEFICIT)	(5,982)	-	4	-	-	-	-	(5,986)	(5,346)	(640)	U	-	-	-	

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 31 March 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 Community Care $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	999,925	15,103	33,198	4,550	4,218	713	445	94	931,325	920,769	10,556	F	10,279	4,500	5,779	F
Non-Government & Crown Agency	7,134	-	-	-	-	-	-	-	7,134	7,626	(492)	U	-	-	-	
Total Revenue	1,007,059	15,103	33,198	4,550	4,218	713	445	94	938,459	928,395	10,064	F	10,279	4,500	5,779	
EXPENSES																
Workforce Costs	398,617	16,096	6,857	3,659	-	570	72	75	371,288	371,517	229	F	-	-	-	
Outsourced Services	39,914	-	518	-	-	-	-	-	39,396	34,778	(4,618)	U	-	-	-	
Clinical Supplies	86,759	-	103	132	-	29	15	-	86,480	80,285	(6,195)	U	-	-	-	
Infrastructure & Non-Clinical Supplies	54,176	-	1,532	660	-	114	358	19	51,493	48,169	(3,324)	U	-	-	-	
Provider Payments	419,632	-	24,188	99	4,218	-	-	-	380,848	374,959	(5,889)	U	10,279	4,500	(5,779)	U
Non-Operating Expenses	28,819	-	-	-	-	-	-	-	28,819	29,590	771	F	-	-	-	
Total Expenses	1,027,917	16,096	33,198	4,550	4,218	713	445	94	958,324	939,298	(19,026)	U	10,279	4,500	(5,779)	
NET SURPLUS / (DEFICIT)	(20,858)	(993)	-	-	-	-	-	-	(19,865)	(10,903)	(8,962)	U	-	-	-	

Drivers of the result:

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

Driver variance	**Month Variance 000's**	**YTD Variance 000's**
Planned Care reduction for volumes not achieved (Oct-Mar)	(2,649)	(2,649)
Pharmaceuticals – Budget lower than Pharmac forecast, incr dispensing	(1,783)	(7,669)
Outsourced clinical services – related to Surgical services	(1,193)	(4,894)
Air Ambulance mix usage and 10% price increase	(227)	(2,046)
ITC & Software	(292)	(2,299)
IDFs (net) (includes one Starship patient $800k)	(685)	(2,456)
Sub Total	**(6,829)**	**(22,013)**
Offset by		
Unbudgeted Improvement Action Plan Funding	4,426	4,426
Additional Public Health, Mental Health, Primary Care Funding	467	4,298
Other Government Revenue – ACC back pay & price increase	693	2,243
Capital Charge – Budget set before final June 21 adjustments	121	565
Total Variance	**(1,122)**	**(10,481)**

Pharmaceuticals:

000's	2021/22 SDHB Budget	Oct 2020 Pharmac Forecast	Feb 2021 Pharmac Forecast	Dec 2021 Pharmac Forecast	Feb 2022 Pharmac Forecast
Total Pharms Budget – per Pharmac Forecast	$108,347	$108,347	$113,572	$115,000	$112,884
Savings Target	$2,000				
SDHB Net Budget	**$106,347**				

The SDHB Pharms budget was set using the Oct 2020 forecast, however as the forecast has since increased significantly, in hindsight the budget should have used the Feb 2021 Pharmac forecast.

The YTD cost of the Pharmaceuticals including dispensing fees is $87.7m ($62.1m Community and $25.6m Provider), a crude extrapolation gives a full year spend of $117m. The Pharmaceutical forecast has two unknowns remaining, the rebate level & additional revenue to offset cost increases.

The estimated increase to dispensing fees, due to COVID in the community, is estimated at $1m for which we are not funded.

Month detail:

Consolidated Revenue was $14.4m favourable to budget.

Variance area	**Variance**
Covid related	
Unbudgeted COVID-19 Community Care Funding	$4.22m
Unbudgeted COVID-19 Vaccination Funding	$2.56m
Unbudgeted COVID-19 Incremental Costs Funding	$1.32m
COVID-19 Surveillance & Testing Funding	$1.76m
Non-Covid related	
Unbudgeted Improvement Action Plan Funding	$4.43m
Nursing Pay Equity Funding	$0.82m
Planned Care reduction for volumes not achieved (Oct-Mar)	$(2.65)m
IDF Funding	$(0.24)m
Reduction PBF – Pharms COVID-19 Funding	$(0.15)m
Total	**$12.07m**

Expenses were $15.1m unfavourable to budget.

Workforce costs were $3.4m unfavourable including $2.2m for unbudgeted Vaccination, Resurgence and Endemic costs and ongoing (funded) post-settlement Nursing MECA costs of circa $0.8m.

Variance area	**Variance**
SMOs – 1.85 FTE favourable with continued vacancies, offset by additional overtime and outsourced in a number of areas for cover	$(0.45)m
RMOs – 9.6 FTE unfavourable with low rates of leave being taken plus overtime	$(0.33)m
Nursing – 61.8 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.	$(2.09)m
Allied Health – 56.3 FTE favourable in a number of areas including Dental Therapists, Occupational Therapists, Physiotherapists, Psychologists & Technicians, largely driven by continued unfilled vacancies.	$0.23m
Management/Admin – 62.3 FTE unfavourable of which 65 are unbudgeted relating to Covid response, reflecting $0.51m unbudgeted Covid activity covered by revenue.	$(0.70)m

Outsourced Services is $1.20m unfavourable with additional surgical activity, being Ophthalmology, Orthopaedics and Plastics funded from Improvement Action Plan revenue.

Clinical Supplies are $0.8m unfavourable. This includes higher than budgeted costs in Treatment Disposables, Instruments & Equipment, Air Ambulance and Pharmaceuticals, offset by an underspend in Implants & Prostheses (Cardiac, Hips, Knees) due to increased outsourcing.

Provider Payments were $9.2m unfavourable, reflecting COVID-19 $1.8m Vaccination and $4.2m Community Care expenses (both offset by additional revenue). Other costs unfavourable to budget include Community Pharmaceuticals $1.4m, Primary Health Care $0.3m and Mental Health $0.1m. In addition, the IDF costs for a single long-term patient in Auckland Starship Hospital have come to charge this month at circa $800k higher than previously provided.

Year To Date

Revenue is $74.2m favourable to budget. This includes:

Variance area	**Variance**
Nursing Pay Equity Funding, settlement and ongoing	$17.57m
Unbudgeted COVID-19 Vaccination Funding (incl Māori)	$33.20m
Unbudgeted COVID-19 Incremental Costs Funding	$4.55m
Unbudgeted COVID-19 Community Care Funding	$4.22m
Unbudgeted COVID-19 Endemic & MIQ Funding	$1.16m
COVID-19 Surveillance & Testing Funding	$5.78m
Unbudgeted Improvement Action Plan Funding	$4.43m
Unbudgeted Public Health core contract uplift	$1.75m
ACC Contract backpay and increase	$2.24m
Mental Health Funding	$1.05m
Primary Care Funding	$1.49m
Planned Care reduction for volumes not achieved (Oct-Mar)	$(2.65)m
Reduction PBF – Pharms COVID-19 (net)	$(2.52)m
IDF Funding	$(1.32)m
Ineligible Patients	$(0.92)m
Total	**$70.03m**

The additional funding above fully or partially offsets additional expenditure incurred.

Expenses are $84.1m unfavourable to budget.

Workforce costs are $27.1m unfavourable including $11.1m unbudgeted Vaccination, Resurgence and Endemic 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 9.0 under budget but is offset by increased overtime payments of $3.4m against a budget of $0.3m, comprising 4.9 FTE	$(1.99)m
RMOs – remain unfavourable with low rates of leave being taken, increased overtime, relocation costs and FTE's over budget by 9.2.	$(1.65)m
Nursing – remains complex as there are three main areas that need separating, these are: • Nursing MECA settlement – pay equity partial settlement cost $18.6m and was offset by revenue of $17.6m • Unbudgeted Nursing FTE of 68.4 YTD at a cost of $5.6m for COVID response covered by unbudgeted revenue • BAU Nursing FTE for the YTD is just under budget at 1,941 (Budget 1,949), the BAU Nursing costs are also under budget.	$(21.28)m
Allied Health – remains favourable in a number of areas including Occupational Therapists, Physiotherapists, Psychologists & Technicians, 49.4 FTE overall, largely driven by continued unfilled vacancies.	$1.99m
Management/Admin - unfavourable driven by: • Unbudgeted Vaccination programme costs $3.3m and 67 FTE	$(3.76)m

Outsourced Services is $5.1m unfavourable with additional surgical activity including ENT, Plastic Surgery, Urology and Ophthalmology, partially funded from Improvement Action Plan revenue. 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. The Radiation Oncology was $1m favourable with lower than budgeted volumes through St Georges.

Clinical Supplies are $6.5m unfavourable. This includes higher than budgeted costs in Treatment Disposables, Instruments & Equipment, Air Ambulance and Pharmaceuticals.

Infrastructure and Non-Clinical Supplies are $6.0m unfavourable in a range of areas, including COVID-19 expenses $2.7m, Patient Meals, Cleaning, Facilities, Transport & Travel, IT Services and Microsoft Licenses.

Provider Payments are $40.2m unfavourable, reflecting $0.4m ARRC back-payments, $4.1m Community Pharmaceuticals, $2.1m Primary Care, $24.2m COVID-19 Vaccination expenses and $4.2m Community Care expenses (both offset by additional revenue).

Financial Summary Reports

Financial Performance Summary

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

8.1

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						
117,263	102,736	14,527	F	Government & Crown Agency	999,925	925,269	74,656	F	1,187,928	1,233,735
752	847	(95)	U	Non-Government & Crown Agency	7,134	7,626	(492)	U	12,489	10,168
118,015	103,583	14,432	F	*Total Revenue*	1,007,059	932,895	74,164	F	1,200,417	1,243,903
				EXPENSES						
48,099	44,679	(3,420)	U	Workforce Costs	398,617	371,517	(27,100)	U	481,291	502,352
5,210	4,011	(1,199)	U	Outsourced Services	39,914	34,778	(5,136)	U	47,821	46,095
10,173	9,398	(775)	U	Clinical Supplies	86,759	80,285	(6,474)	U	111,249	107,947
6,272	5,408	(864)	U	Infrastructure & Non-Clinical Supplies	54,176	48,169	(6,007)	U	62,476	64,693
51,152	41,930	(9,222)	U	Provider Payments	419,632	379,459	(40,173)	U	489,958	506,799
3,091	3,503	412	F	Non-Operating Expenses	28,819	29,590	771	F	37,059	40,324
123,997	108,929	(15,068)	U	*Total Expenses*	1,027,917	943,798	(84,119)	U	1,229,854	1,268,210
(5,982)	(5,346)	(636)	U	**NET SURPLUS / (DEFICIT)**	(20,858)	(10,903)	(9,955)	U	(29,437)	(24,307)

Financial Position Summary

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

Actual 30 June 2021 $000		Actual 31 March 2022 $000	Budget 31 March 2022 $000	Actual 28 February 2022 $000	Budget 30 June 2022 $000
	CURRENT ASSETS				
7,582	Cash & Cash Equivalents	5,805	7	13,692	7
61,439	Trade & Other Receivables	74,197	49,655	68,911	48,474
6,159	Inventories	6,670	5,148	6,545	5,235
75,180	*Total Current Assets*	86,672	54,810	89,148	53,716
	NON-CURRENT ASSETS				
325,558	Property, Plant & Equipment	328,101	348,630	326,721	358,043
6,258	Intangible Assets	10,033	21,967	10,898	25,118
331,816	*Total Non-Current Assets*	338,134	370,597	337,619	383,161
406,996	**TOTAL ASSETS**	424,806	425,407	426,767	436,877
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	19,877	-	33,663
72,840	Payables & Deferred Revenue	96,341	66,660	93,487	69,492
235	Short Term Borrowings	110	1,458	109	1,979
82,596	Holidays Act 2003	87,361	88,221	86,786	90,146
95,374	Employee Entitlements	103,376	85,822	103,207	88,211
251,045	*Total Current Liabilities*	287,188	262,038	283,589	283,491
	NON-CURRENT LIABILITIES				
856	Term Borrowings	773	8,680	782	10,754
19,411	Employee Entitlements	18,706	20,182	18,706	20,144
20,267	*Total Non-Current Liabilities*	19,479	28,862	19,488	30,898
271,312	**TOTAL LIABILITIES**	306,667	290,900	303,077	314,389
135,684	**NET ASSETS**	118,139	134,507	123,690	122,488
	EQUITY				
486,579	Contributed Capital	489,892	493,782	489,468	495,164
108,500	Property Revaluation Reserves	108,500	108,500	108,500	108,500
(459,395)	Accumulated Surplus/(Deficit)	(480,253)	(467,773)	(474,278)	(481,176)
135,684	*Total Equity*	118,139	134,509	123,690	122,488
	Statement of Changes in Equity				
165,991	Opening Balance	135,684	138,188	135,684	138,189
(30,933)	Operating Surplus/(Deficit)	(20,858)	(10,903)	(14,881)	(24,307)
1,333	Crown Capital Contributions	3,313	7,224	2,887	9,313
(707)	Return of Capital	-	-	-	(707)
135,684	Closing Balance	118,139	134,509	123,690	122,488

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 March 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	990,320	935,537	54,783	1,240,738	884,966
Non-Government & Crown Agency Revenue	6,664	7,374	(710)	9,832	8,024
Interest Received	403	252	151	336	270
Cash was applied to:					
Payments to Suppliers	(588,138)	(546,422)	(41,716)	(719,719)	(545,258)
Payments to Employees	(380,983)	(373,341)	(7,642)	(498,453)	(339,234)
Capital Charge	(3,368)	(3,507)	139	(7,142)	(4,124)
Goods & Services Tax (net)	479	(620)	1,099	(2,604)	751
Net Cash Inflow / (Outflow) from Operations	25,377	19,273	6,104	22,988	5,395
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	64	-	64	-	4
Cash was applied to:					
Capital Expenditure	(30,322)	(53,468)	23,146	(71,902)	(22,291)
Net Cash Inflow / (Outflow) from Investing Activity	(30,258)	(53,468)	23,210	(71,902)	(22,287)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	3,313	7,224	(3,911)	8,556	1,145
Cash was applied to:					
Repayment of Borrowings	(209)	(479)	270	(879)	(718)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	3,104	6,745	(3,641)	7,677	427
Total Increase / (Decrease) in Cash	(1,777)	(27,450)	25,673	(41,237)	(16,465)
Net Opening Cash & Cash Equivalents	7,582	7,582	0	7,582	31,011
Net Closing Cash & Cash Equivalents	5,805	(19,868)	25,673	(33,655)	14,546

Cash flow from Operating Activities is favourable to budget by $6.1m. Government revenue received includes the Nursing Pay Equity funding receipt in December and ongoing unbudgeted COVID-19 funding. Payments to Suppliers is unfavourable in line with the Statement of Financial Performance, adjusted for movements in working capital. Payments to Employees is unfavourable by $7.6m with the unbudgeted Nursing Settlement payments of $17.6m being mostly offset by the budgeted expected pay out for Employee Entitlements $11.8m.

Cash flow from Investing Activities is favourable to budget by $23.2m. The Capital Expenditure cash spend reflects project delays although several larger projects are expected to reduce this variance. Cashflow from Financing Activities is $3.6m unfavourable with delays in Capital project drawdowns. Overall, Cash flow is favourable to budget by $25.7m.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 31 March 2022

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	8,614	22,055	13,441	U	5,195
Clinical Equipment	17,649	14,911	(2,738)	O	11,281
Other Equipment	586	1,095	509	U	521
Information Technology	2,302	2,438	136	U	2,671
Motor Vehicles	-	30	30	U	14
Software	1,171	12,938	11,767	U	2,609
Total Expenditure	30,322	53,467	23,145	U	22,291

At 31 March 2022, our Financial Position on page 6 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $338.1m, which is $32.5m less than the budget of $370.6m.

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

SERVICE PROVIDER CASEWEIGHTED DISCHARGES

As at: 7/04/2022 5:33:15 ...

1/07/2021 31/03/2022

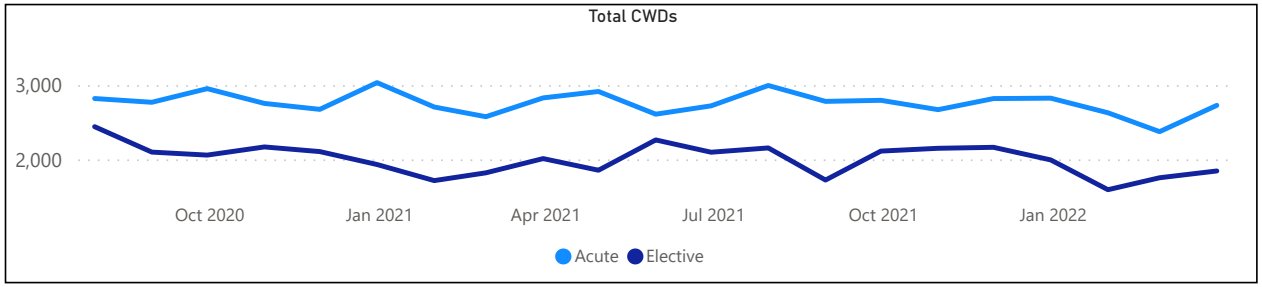
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Medical Caseweights												
Medical Acute	1,375	1,506	-131	-9%	1,491	-116	13,214	12,904	310	2%	13,373	-160
Medical Elective	326	315	11	4%	352	-26	2,960	2,610	350	13%	3,102	-142
Total	**1,701**	**1,821**	**-120**	**-7%**	**1,844**	**-143**	**16,174**	**15,514**	**660**	**4%**	**16,476**	**-302**
Surgical Caseweights												
Surgical Acute	1,265	1,296	-31	-2%	1,250	15	10,536	10,936	-400	-4%	10,875	-340
Surgical Elective	1,162	1,479	-316	-21%	1,222	-60	11,148	12,280	-1,132	-9%	11,844	-696
Total	**2,427**	**2,775**	**-348**	**-13%**	**2,473**	**-45**	**21,684**	**23,216**	**-1,533**	**-7%**	**22,719**	**-1,036**
Maternity Caseweights												
Maternity Acute	88	95	-7	-7%	86	1	863	803	61	8%	860	3
Maternity Elective	356	368	-12	-3%	436	-80	3,378	3,166	211	7%	3,402	-24
Total	**444**	**463**	**-19**	**-4%**	**523**	**-79**	**4,241**	**3,969**	**272**	**7%**	**4,262**	**-21**
Total	**4,572**	**5,059**	**-487**	**-10%**	**4,839**	**-267**	**42,099**	**42,699**	**-600**	**-1%**	**43,458**	**-1,359**

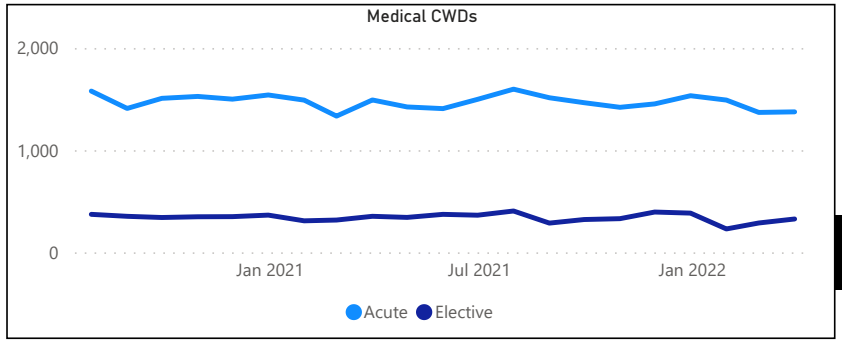
TOTALS

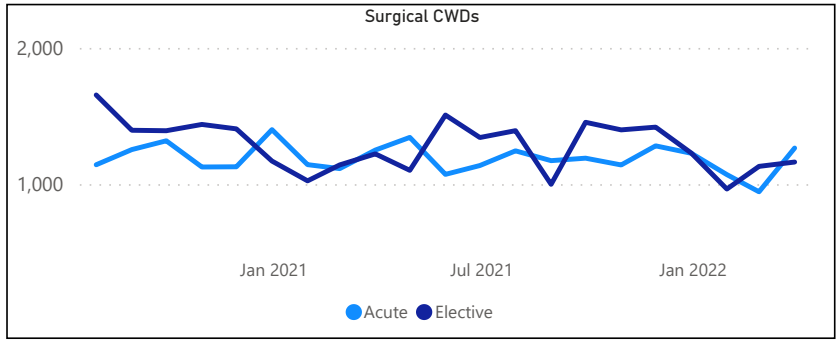
Acute	2,728	2,897	-170	-6%	2,828	-100	24,613	24,642	-30	-0%	25,109	-496
Elective	1,845	2,162	-317	-15%	2,011	-166	17,486	18,057	-571	-3%	18,348	-862
Total	**4,572**	**5,059**	**-487**	**-10%**	**4,839**	**-267**	**42,099**	**42,699**	**-600**	**-1%**	**43,458**	**-1,359**

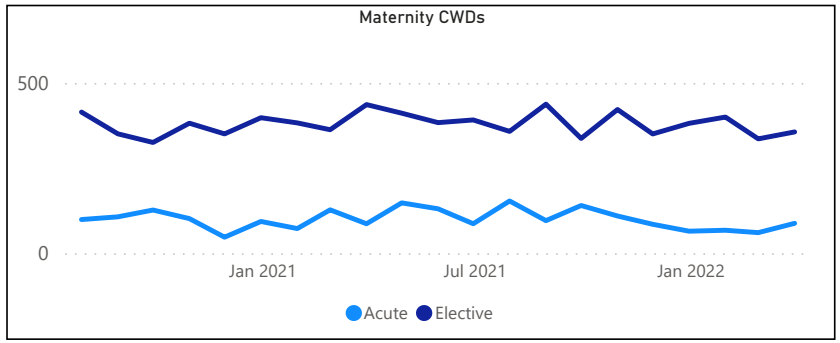
TOTALS excluding Maternity

Acute	2,640	2,803	-163	-6%	2,741	-102	23,749	23,840	-90	-0%	24,249	-500
Elective	1,489	1,794	-305	-17%	1,575	-86	14,108	14,891	-782	-5%	14,946	-838
Total	**4,128**	**4,596**	**-468**	**-10%**	**4,316**	**-188**	**37,858**	**38,730**	**-873**	**-2%**	**39,195**	**-1,338**









8.2

SERVICE PROVIDER RAW DISCHARGES

As at: 7/04/2022 5:33:15 ...

1/07/2021 31/03/2022

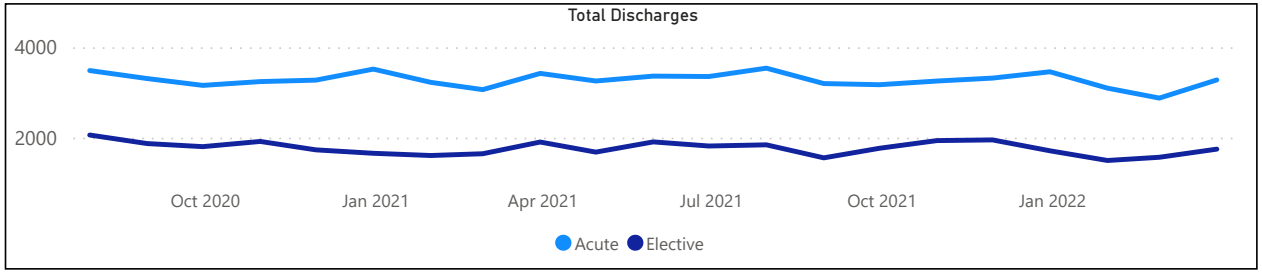
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Medical Discharges												
Medical Acute	2,475	2,401	74	3%	2,497	-22	21,823	20,628	1,195	6%	21,601	222
Medical Elective	425	363	62	17%	433	-8	3,525	3,018	507	17%	3,539	-14
Total	**2,900**	**2,763**	**137**	**5%**	**2,930**	**-30**	**25,348**	**23,646**	**1,702**	**7%**	**25,140**	**208**
Surgical Discharges												
Surgical Acute	735	840	-105	-12%	849	-114	6,653	7,085	-432	-6%	7,309	-656
Surgical Elective	826	1,035	-209	-20%	902	-76	7,408	8,574	-1,166	-14%	8,198	-790
Total	**1,561**	**1,875**	**-314**	**-17%**	**1,751**	**-190**	**14,061**	**15,658**	**-1,597**	**-10%**	**15,507**	**-1,446**
Maternity Discharges												
Maternity Acute	68	84	-16	-19%	76	-8	710	716	-6	-1%	780	-70
Maternity Elective	496	491	5	1%	569	-73	4,636	4,235	401	9%	4,452	184
Total	**564**	**576**	**-12**	**-2%**	**645**	**-81**	**5,346**	**4,951**	**395**	**8%**	**5,232**	**114**
Total	**5,025**	**5,214**	**-189**	**-4%**	**5,326**	**-301**	**44,755**	**44,255**	**500**	**1%**	**45,879**	**-1,124**

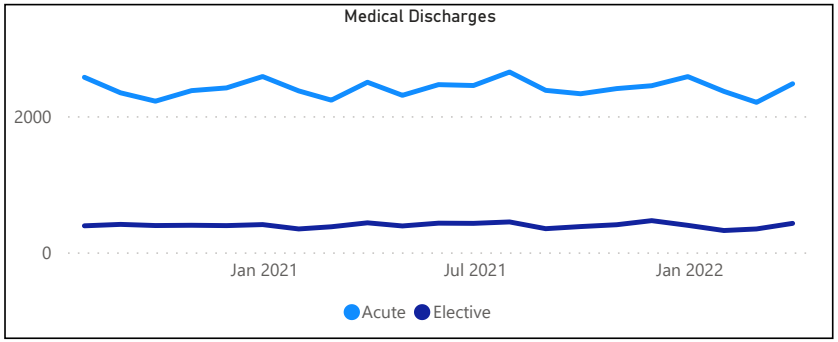
TOTALS

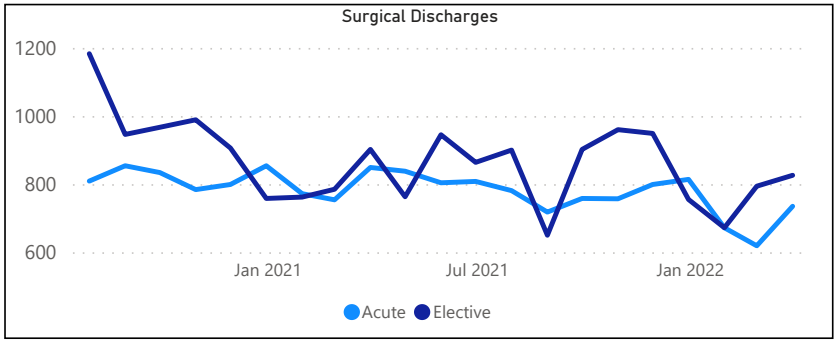
Acute	3,278	3,325	-47	-1%	3,422	-144	29,186	28,428	758	3%	29,690	-504
Elective	1,747	1,889	-142	-8%	1,904	-157	15,569	15,827	-258	-2%	16,189	-620
Total	**5,025**	**5,214**	**-189**	**-4%**	**5,326**	**-301**	**44,755**	**44,255**	**500**	**1%**	**45,879**	**-1,124**

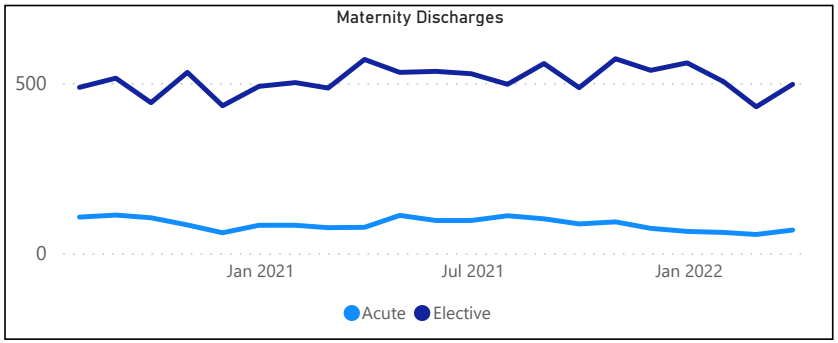
TOTALS excluding Maternity

Elective	1,251	1,398	-147	-11%	1,335	-84	10,933	11,592	-659	-6%	11,737	-804
Acute	3,210	3,241	-31	-1%	3,346	-136	28,476	27,712	764	3%	28,910	-434
Total	**4,461**	**4,638**	**-177**	**-4%**	**4,681**	**-220**	**39,409**	**39,305**	**104**	**0%**	**40,647**	**-1,238**



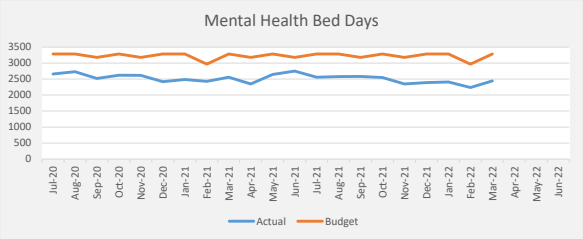




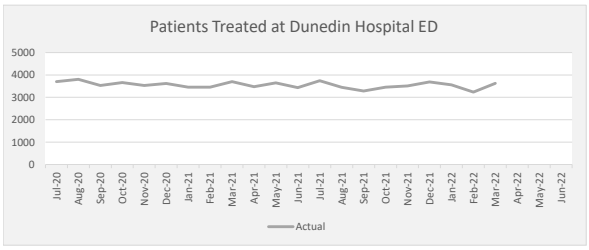


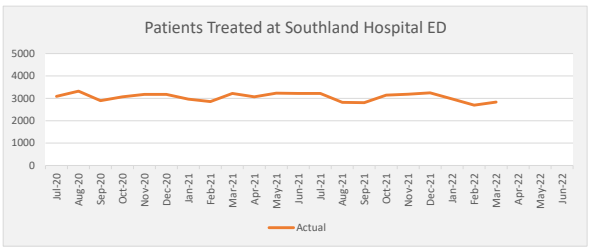
OTHER ACTIVITY

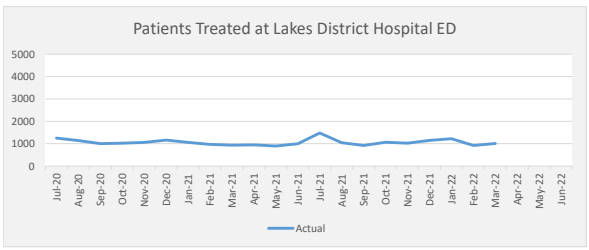
Mar-22				Mar-21	YEAR ON YEAR		YTD 2021/2022				YTD Mar-21	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,444	3,286	(842)	-26%	2,558	(114)	**Mental Health bed days**	22,104	29,044	(6,940)	-24%	23,046	(942)

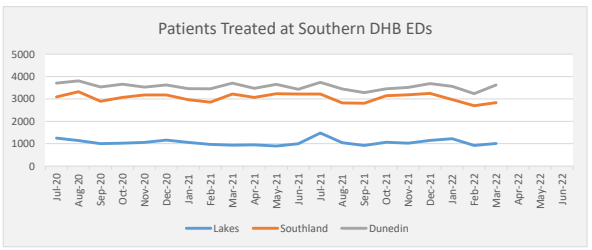


Mar-22	Mar-21	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2021/2022	YTD Mar-21	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,625	3,705	(80)	Dunedin	31,540	32,473	(933)
1,007	931	76	Lakes	9,830	9,593	237
2,836	3,217	(381)	Southland	26,920	27,761	(841)
7,468	7,853	(385)	**Total ED presentations**	68,290	69,827	(1,537)









8.2

FOR INFORMATION

Item: Quality Dashboard – March 2022

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

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – May 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

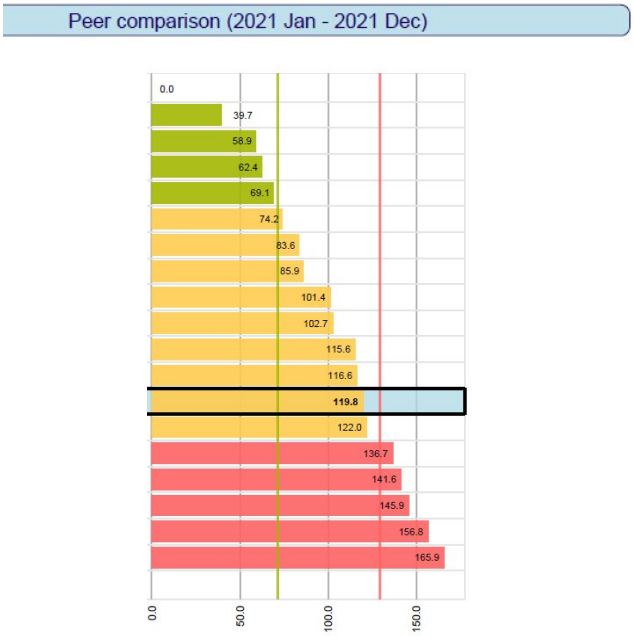
Background

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
9. Please see commentary for further details on measures
10. 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

Discussion

11. Southern's hospital acquired complications have been trending down steadily over the last 4 years. As have our peers. However, we are above the 75-centile compared to our NZ DHB peers. Dunedin Hospital remains above the 75-centile compared to its peers.

12. There has been an improvement in Dunedin Hospital's healthcare associate infections. They have changed from red to amber. The bar chart below is our Southern DHBs NZ DHB comparator bar chart provided by the HRT. This includes Southland and Dunedin hospitals and compares us to other New Zealand DHBs. Southern is highlighted with the black surround.



13. There has been a change in the Invercargill Hospital average length of stay graph. There appears to be a gradual increase in length of Stay from about June 2021. However, this was not apparent on previous Board Reports. We are looking into the data to understand why this graph is so different from previously reported graphs.

Next Steps & Actions

14. 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

Appendices

Appendix 1	**Executive Quality Dashboard – Southern Region, Dunedin Hospital and Invercargill Hospital**
Appendix 2	**Executive Quality Dashboard – Māori**
Appendix 3	**Guide to Interpreting the Executive Quality Dashboard**
Appendix 4	**Commentary and data definitions**

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 % of episodes of care				3.5	2.9		2.2	2.2	
2 Healthcare Associated Infections per 10k episodes of care				124	97		88	77	
3 Medication Complications per 10k episodes of care				12	25		20.2	19.3	
4 Readmissions within 7 days %				2.5	3.4		4.1	3.2	
5 Mental Health Seclusions no	33	32							
6 Mental Health Restraints no	162	125		73	48		21	13	
7 Deaths no	53	58		29	28		12	14	
8 ED Wait Time - % patients discharged within 6 hours				73	95		79	95	
9 Vulnerable Patients (Aged 70 and over; Triage Category 1 2 3) in ED > 6 hours				185	162		162	146	
10 Falls resulting in fracture or intracranial injury per 10k of episodes of care				0.03	0.03		0.09	0.02	
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	87	82		48	42		33	30	
15 Complaint response target met %	53	100		52	100		42	100	
16 Short Notice Postponments no				46	44		50	28	
17 Short Notice Postponments %				5.8	5		13	7	
Operations									
18 Referrals Declined %				12	15		6	14	
19 Length of stay days				3.5	4.5		3.6	3.3	
20 Patients with stay > 7 days no				328	384		151	169	
21 Patients with stay > 21 days no				70	87		45	42	

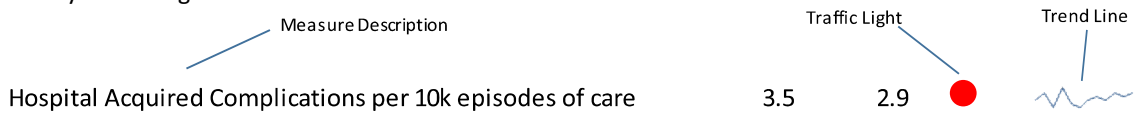
Appendix 2 Executive Quality Dashboard – Māori

		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 % of episodes of care				3.8	3.4		1.5	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	4	3							
8	ED Wait Time - % patients discharged within 6 hours				77	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	37	38							
21	Patients with stay > 21 days no	14	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	Based on the HRT data the rate of infections in Dunedin Hospital continue to drop and is now benchmarked as orange against peers. Infections in Invercargill Hospital have dropped quite dramatically in the last quarter after a rising trend for the last 6 quarters. Invercargill is now rated orange against peers. Maori infections continue to be in line with non-Maori	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 Benchmark: HRT
3	Medication Complications per 10k episodes of care	Dunedin continues to be an outlier in medication complications after a major spike in the quarter Jul to Sep 21. Although medication complications have returned to lower levels in the latest quarter and continue an overall downward trend further investigation will be undertaken to try and identify any issues of concern. Complications have spiked in Invercargill this latest quarter and have	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 disorders due to psychotropic medication, 10.5 Serious alteration to conscious state due to psychotropic medication

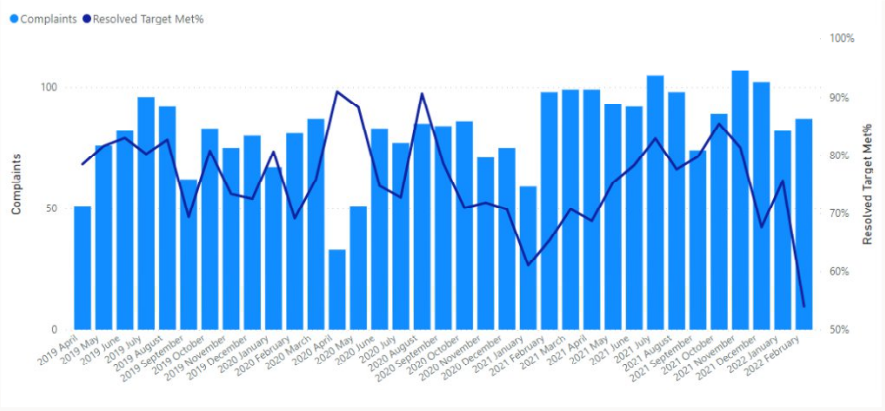
		been benchmarked red against peers. If this continues next month then further investigation will be required.	Benchmark: HRT
4	Readmissions within 7 days %	Readmissions continue to be stable across both hospitals however Invercargill was slightly higher than the long term average this month Māori readmissions 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 once again 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 continuing to work on a number of mitigations 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. Māori deaths in hospital are in the low single figures so it is difficult to draw meaningful conclusions from this data	Deaths Number of patients deceased by discharge month. 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	Monthly 6 Hour %

		Maori ED Wait Time figures are in line with the rest of the population	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. The rising trend continues 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 8th out of 20 peers Invercargill is newly red after a spike in the latest quarter. However caution is needed here. Invercargill averages approx. one serious fall a month and had two months with two falls in the latest reported quarter.	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 green via HRT and is 5th 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.	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 although Invercargill postponements spiked somewhat in the last month. 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 showing a slightly rising trend. We continue to monitor	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 with Dunedin showing a dropping trend. Invercargill remains stable 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

Executive Dashboard – Patient Experience (Southern)



Safety 1st data.

Complaints

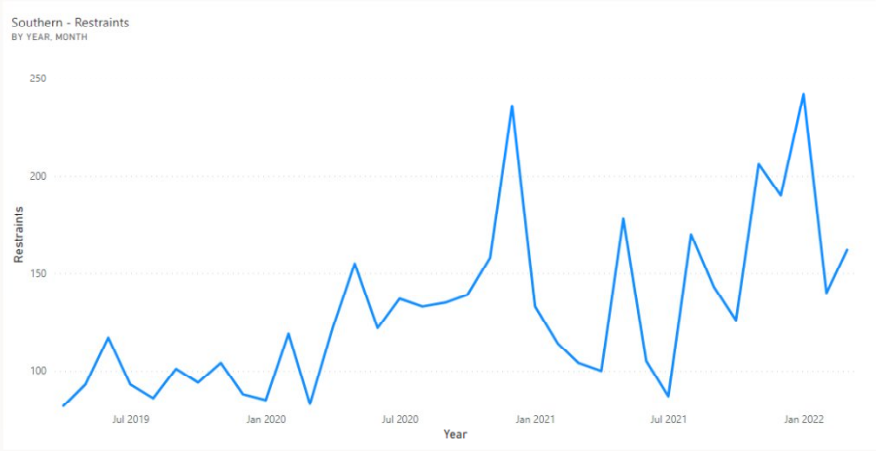
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

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.

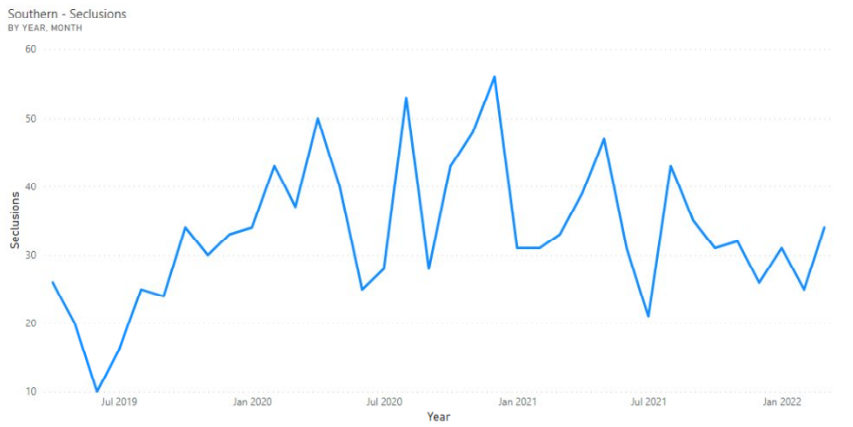
Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.

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

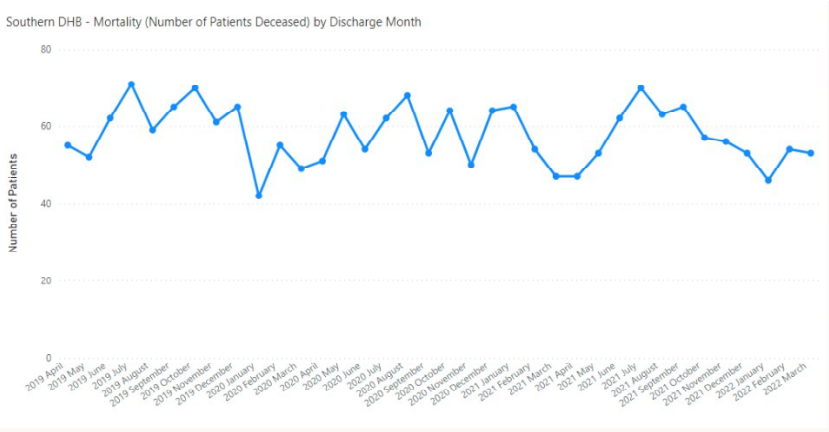
Safety 1st data. The number of restraint events per month. Restraints data includes Dunedin, Invercargill, Wakari and Lakes



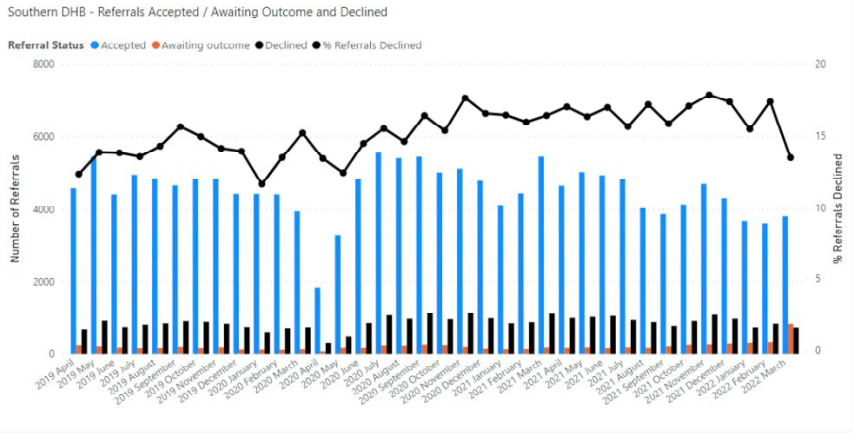
Seclusions

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

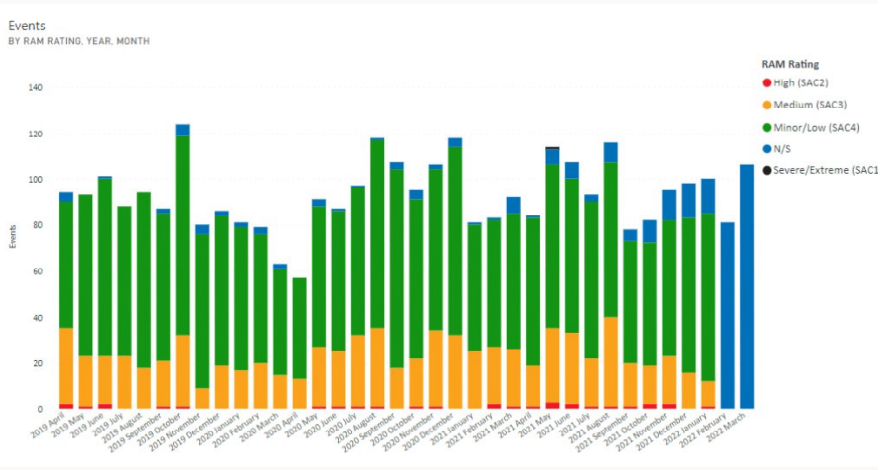
Executive Dashboard – Experience (Southern)



Deaths
Number of patients deceased by discharge month



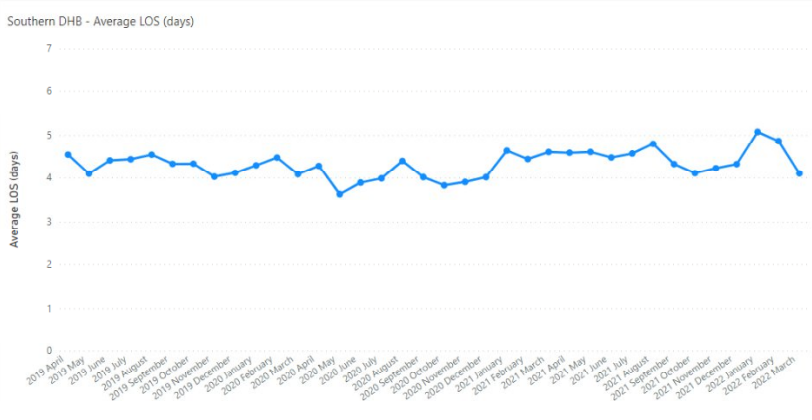
Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



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

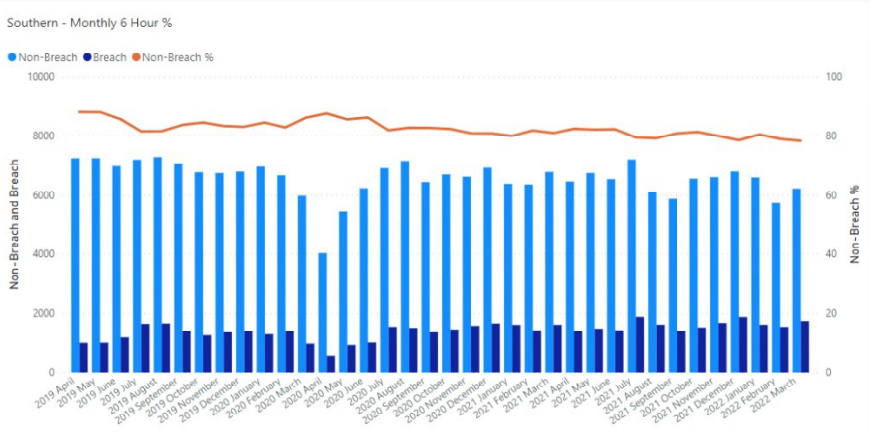
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls form (visitor falls) which were not associated with clinical practice. These events are not assessed in the same way as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

Executive Dashboard – Efficiency (Southern)



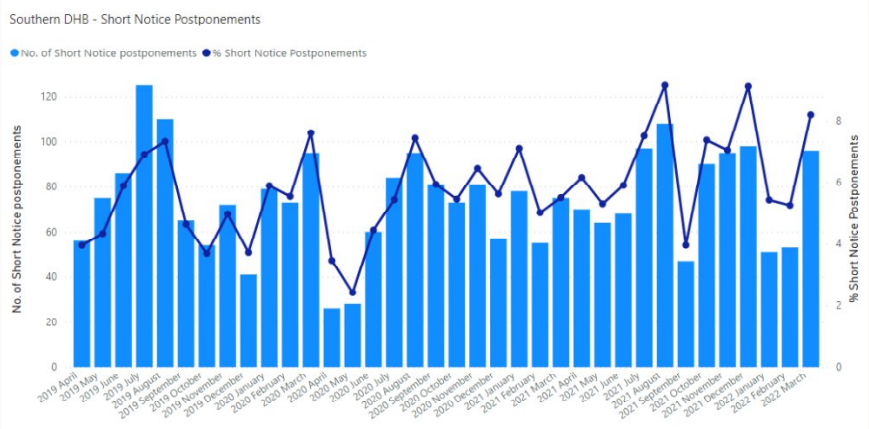
Average Length of Stay

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.

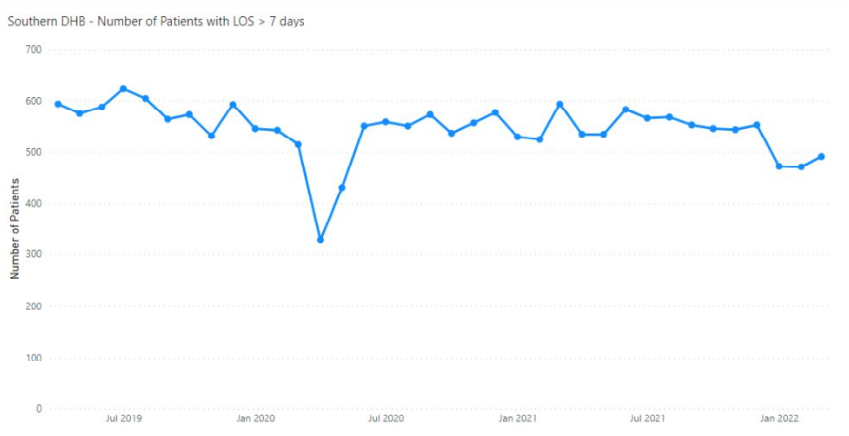


Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure.

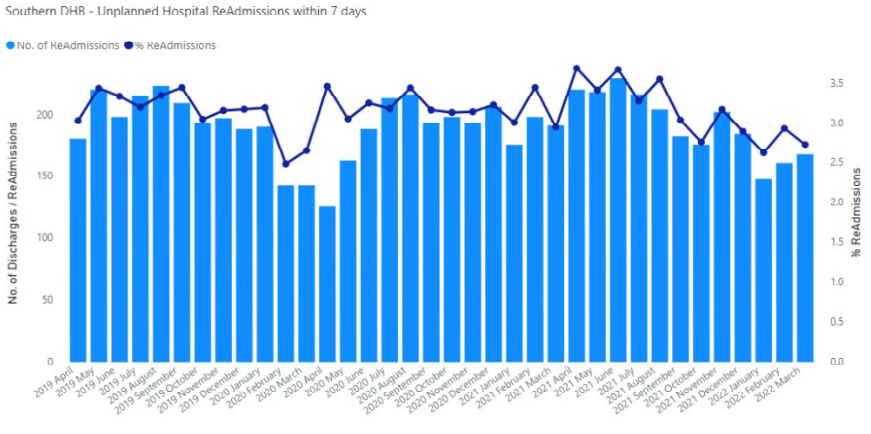
Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

Executive Dashboard – Timely (Southern)



Number of Patients with LOS > 7 days

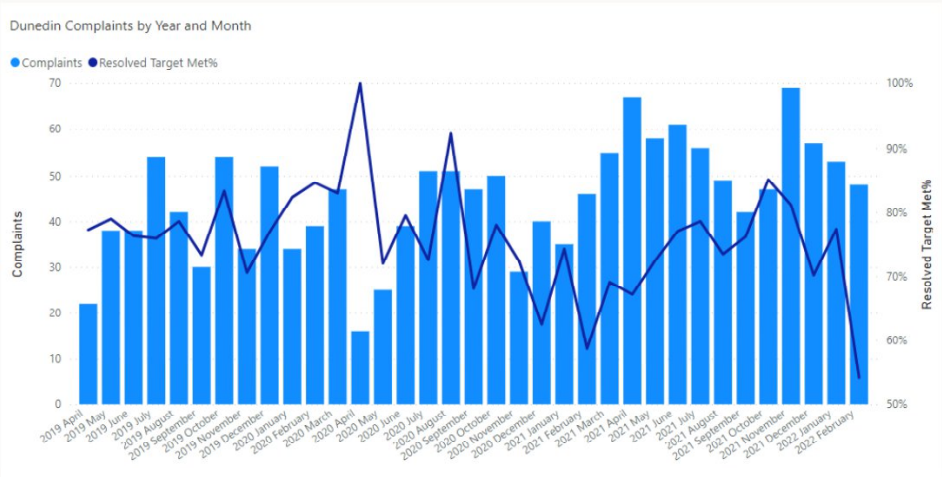
Number of patients in hospital at any point of time when they have exceeded 7 days since admission.



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

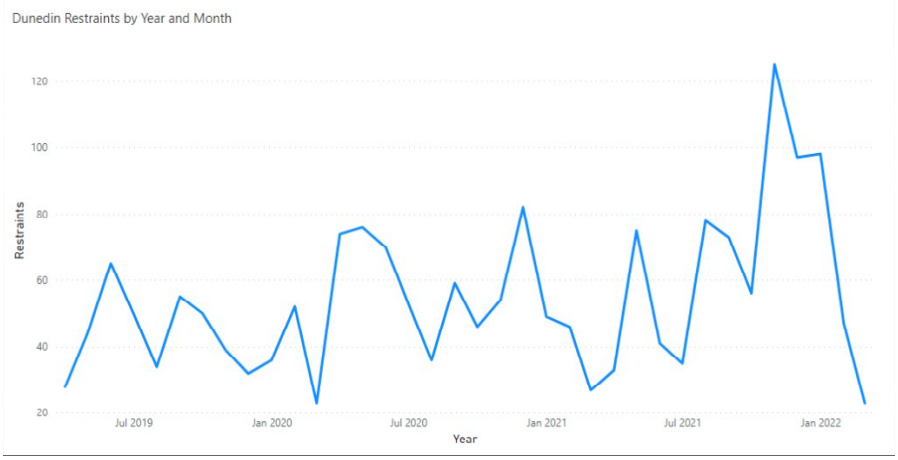
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

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.

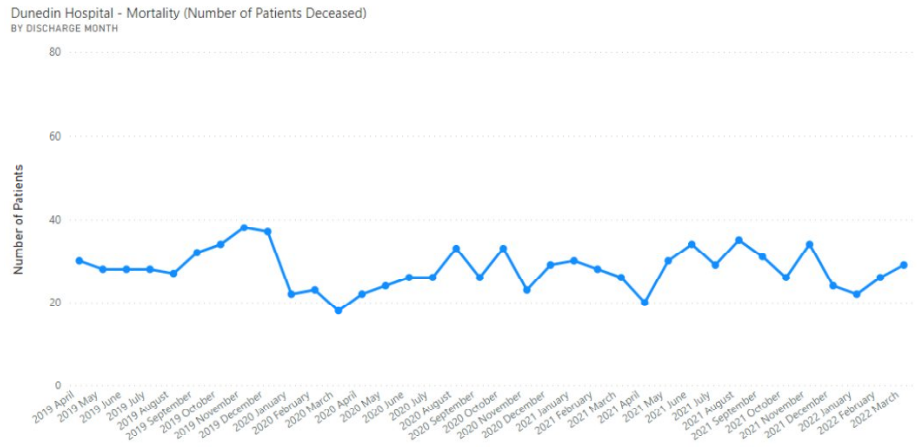


Restraints

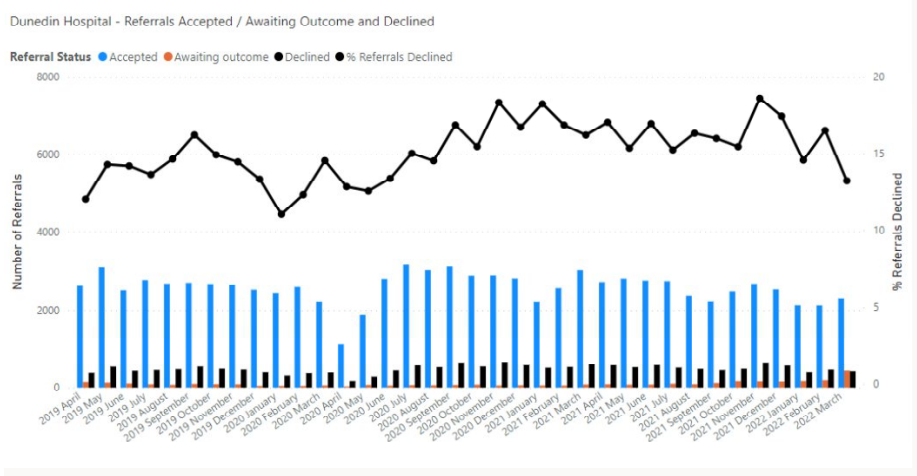
Safety 1st data. The number of restraint events per month.

8.3

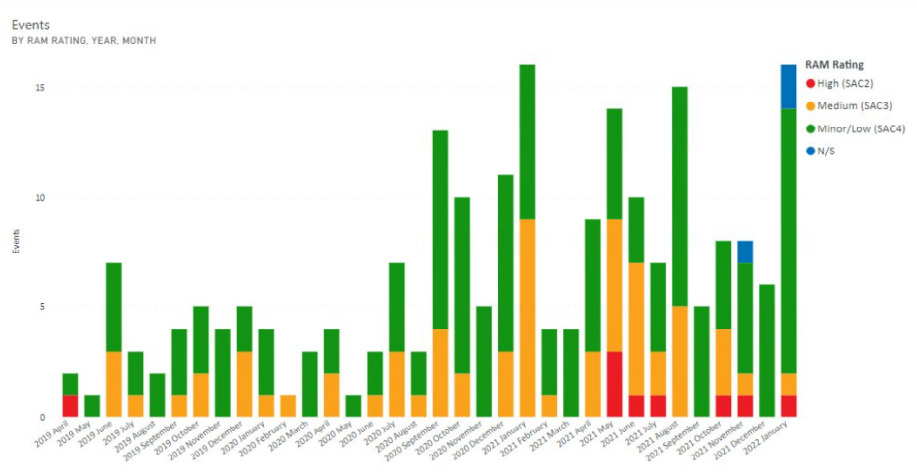
Executive Dashboard – Effectiveness (Dunedin)



Deaths
Number of patients deceased by discharge month.

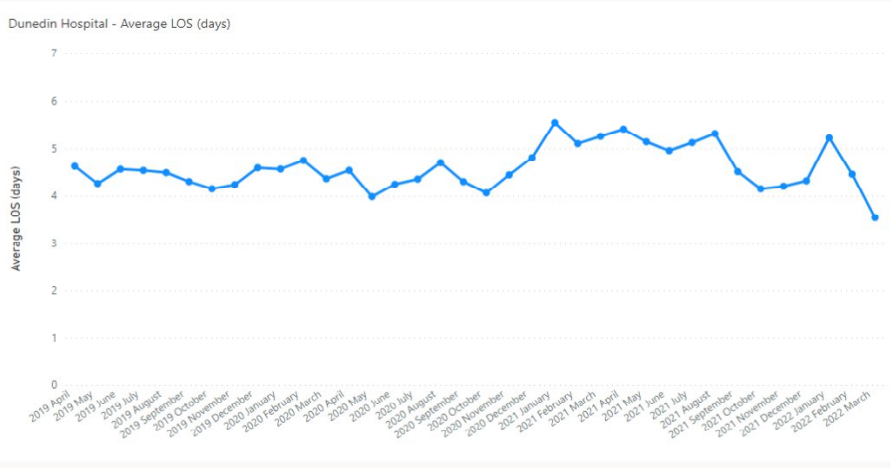


Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



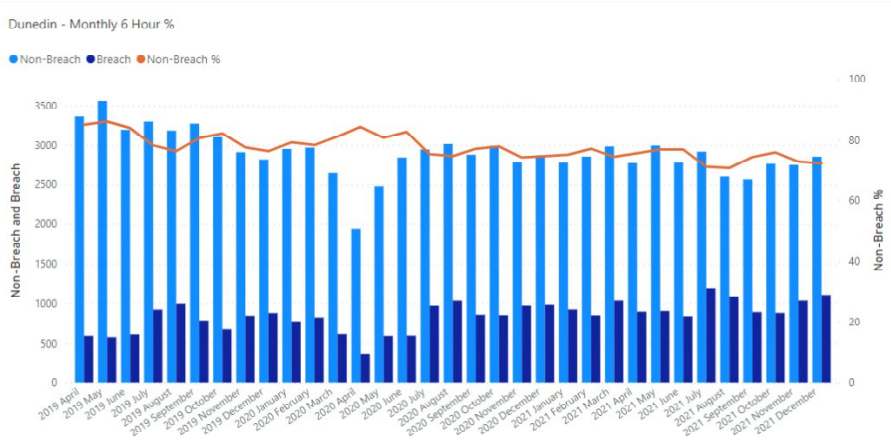
Safety 1st data.
The monthly number of reported staff adverse events Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

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.



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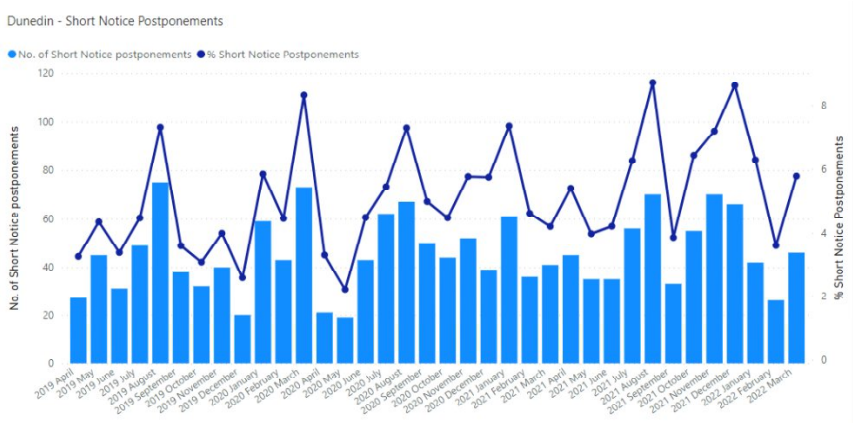

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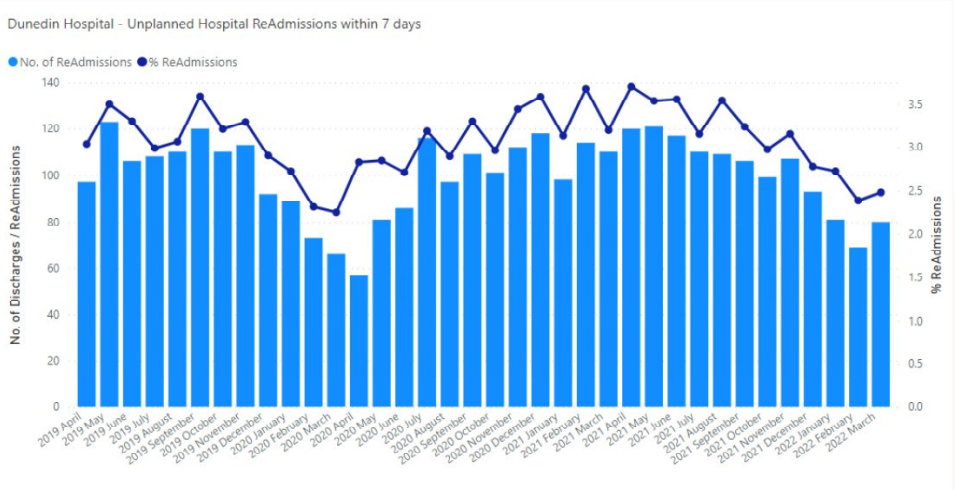
Executive Dashboard – Timely (Dunedin)

Number of Patients with LOS > 7 days

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



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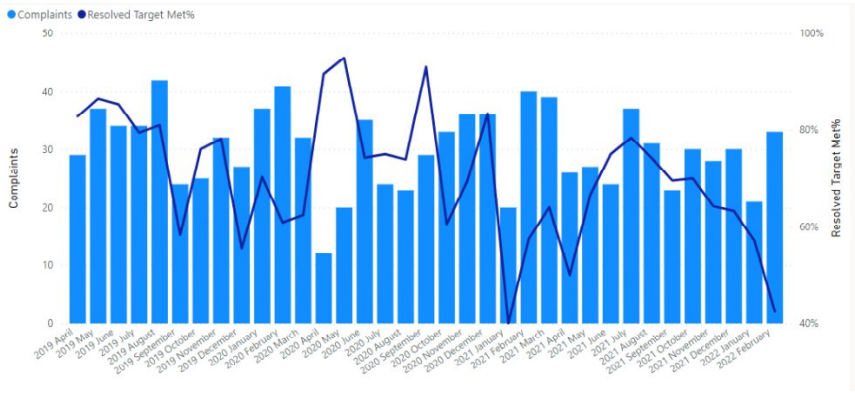
Executive Dashboard – Patient Experience (Invercargill)



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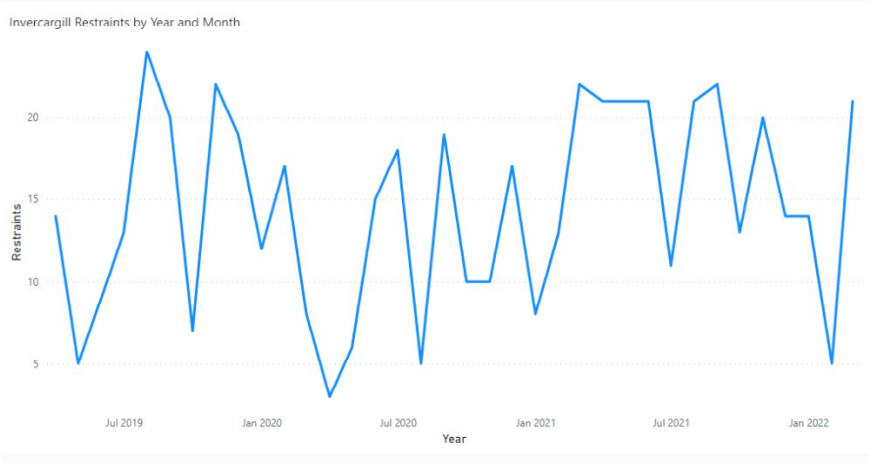
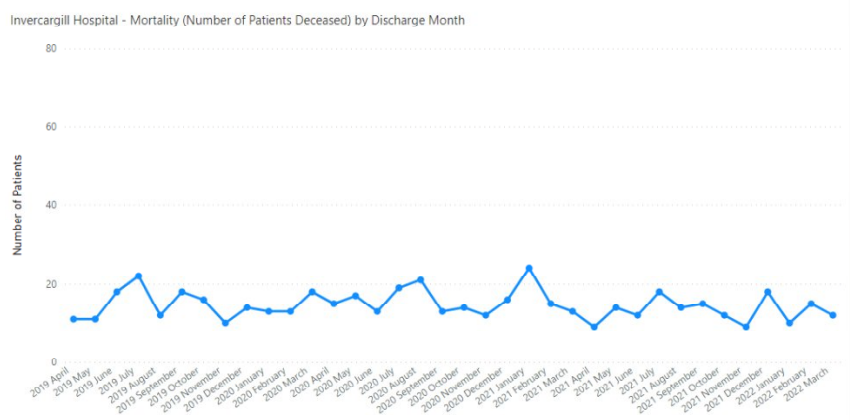


Restraints

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

Executive Dashboard – Effectiveness (Invercargill)



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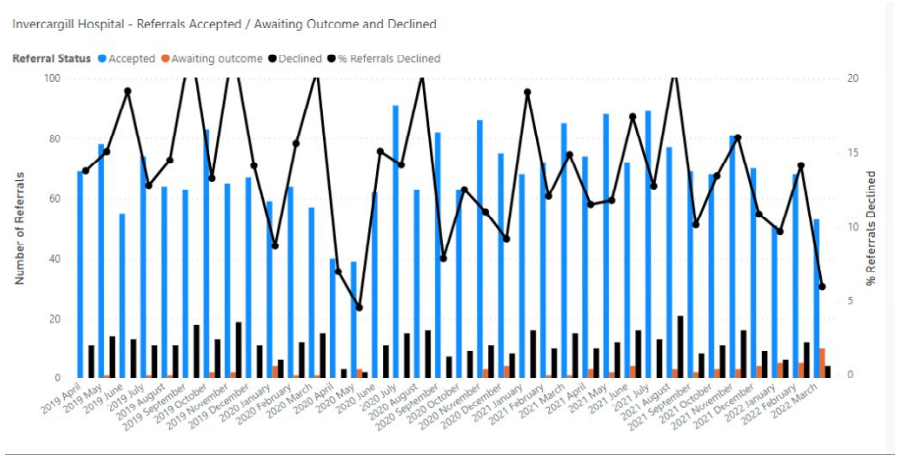

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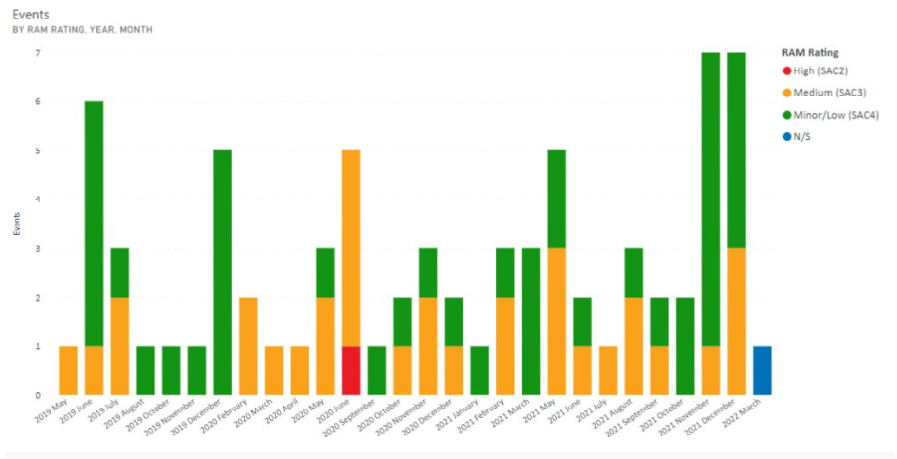

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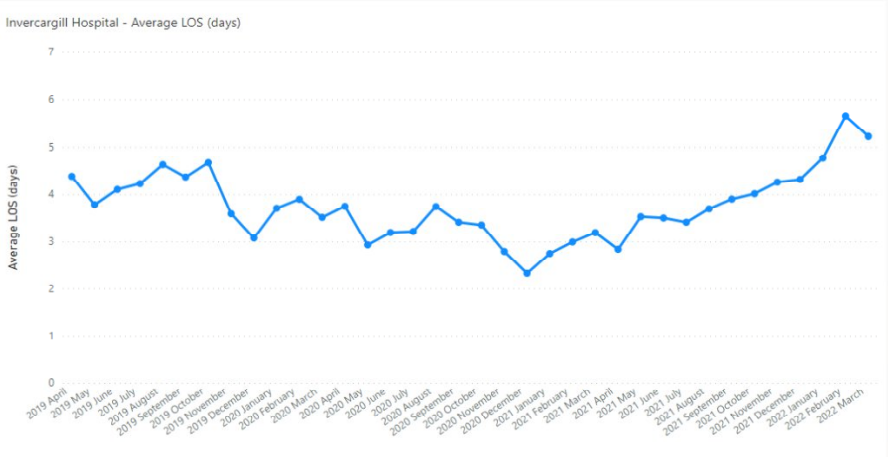
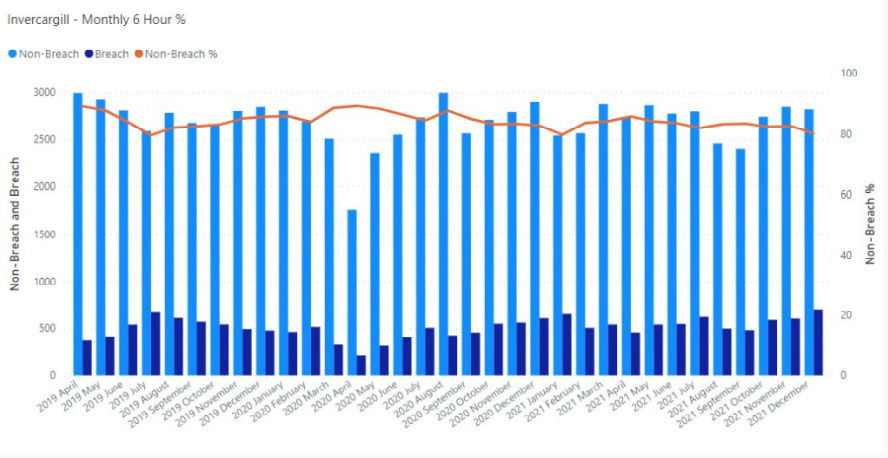


Average Length of Stay

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



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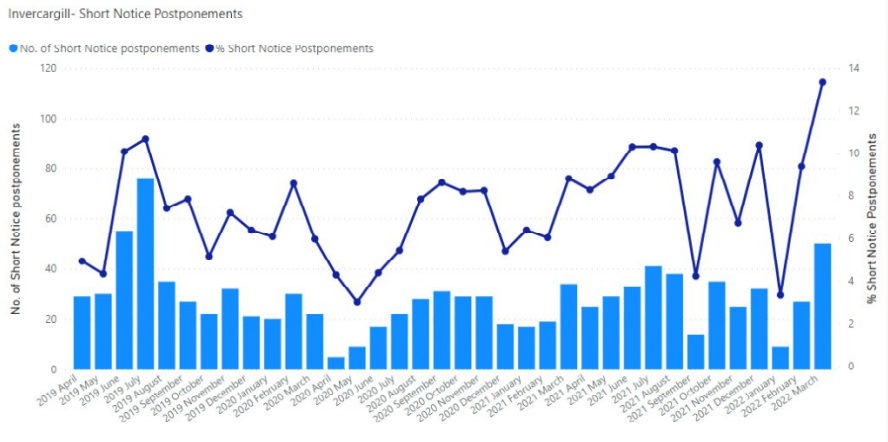

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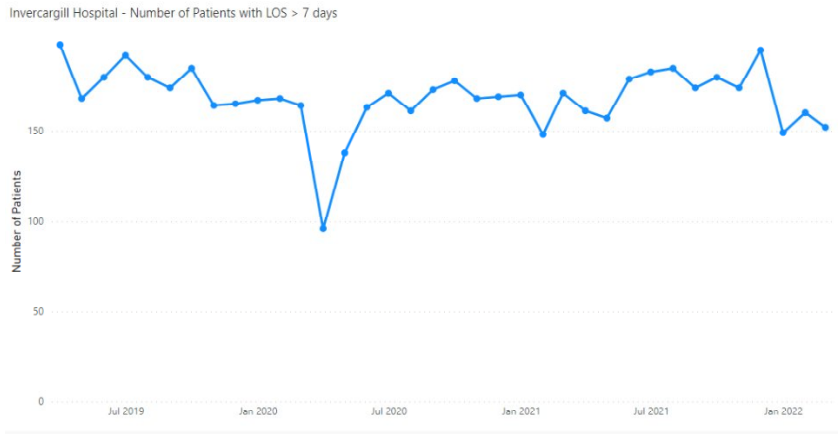
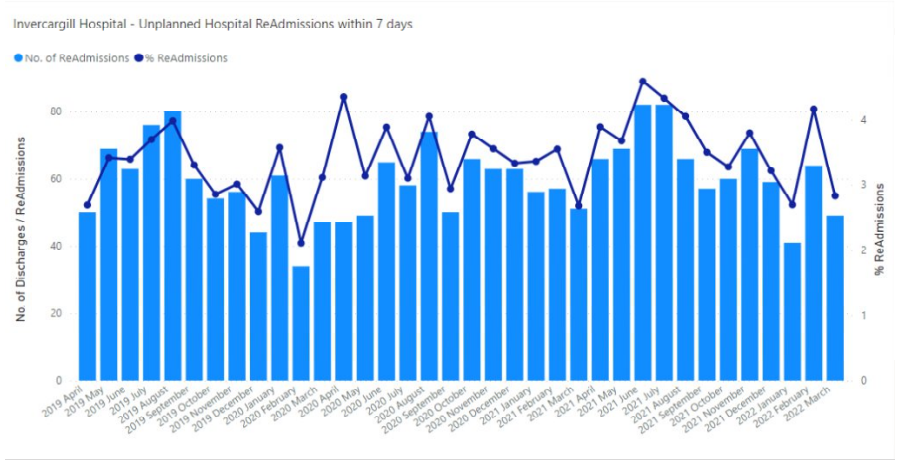


Number of Patients with LOS > 7 days

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 Manager

Meeting of: Board, 3 May 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

Monthly Snapshot of current metrics as of 13/04/22:

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 March data because they have been extracted in April.

Figure 2

ED Presentations KPI Mar 2022

Southern	Mar	Feb	
ED Presentations This Month	ED Presentations Prev. Month	% Change	
7954	7280	9.3%	▲
Cat 1&2 This Month	Cat 1&2 Prev. Month	% Change	
1447	1266	14.3%	▲
Dunedin Hospital			
ED Presentations This Month	ED Presentations Prev. Month	% Change	
3835	3463	10.7%	▲
Cat 1&2 This Month	Cat 1&2 Prev. Month	% Change	
913	839	8.8%	▲
Southland (Kew) Hospital			
ED Presentations This Month	ED Presentations Prev. Month	% Change	
3084	2878	7.2%	▲
Cat 1&2 This Month	Cat 1&2 Prev. Month	% Change	
450	341	32.0%	▲

8.4

Figure 3.


Resourced Occupancy Last Complete Month Mar 2022
Occupancy from IPM midnight census, Resource beds from CaaG
Information Systems
Business Intelligence
Southern
Mar
Feb
Occupancy %
Occupancy % Prev. Mth
% Change
93%
94%
-1%
Dunedin Hospital
Occupancy %
Occupancy % Prev. Mth
% Change
94%
95%
-1%
Southland (Kew) Hospital
Occupancy %
Occupancy % Prev. Mth
% Change
92%
92%
-0%
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 %
Occupied Beds
Resourced Beds
Resourced Occupancy %
10K
5K
0K
95%
90%
2021 April
2021 May
2021 June
2021 July
2021 August
2021 Septe...
2021 October
2021 Nove...
2021 Dece...
2022 January
2022 Febru...
2022 March

Figure 4.

Hospital VRM Status Last Complete Month Mar 2022

Variance Response Management - data manually entered in CaaG

Mar	Feb	
% Green This Month	% Green Prev. Month	% Change
69%	58%	12% ▲
Red/Black This Month		
1		

Dunedin Hospital

% Green This Month	% Green Prev. Month	% Change
74%	58%	15% ▲
Red/Black This Month		
0		

Southland (Kew) Hospital

% Green This Month	% Green Prev. Month	% Change
41%	33%	8% ▲
Red/Black This Month		
1		

8.4

Figure 5.


Average Length of Stay Mar 2022
Discharged Patients Average Length of Stay calculated daily, measured in days
Southern District Health Board
Piki Te Ora
Information Systems
Business Intelligence
Southern
LOS Previous Month
3.51
LOS Last Complete Month
3.65
Total Change
0.14
Highest Avg
Geriatric Residential (Hospital -...
179.78
Longest Stay
Surgical Services
366.11
7 Day Stays
General Medicine
156
Dunedin Hospital
LOS Previous Month
3.40
LOS Last Complete Month
3.46
Total Change
0.06
Highest Avg
Geriatric
24.34
Longest Stay
Psychogeriatric
195.90
7 Day Stays
General Medicine
61
Southland (Kew) Hospital
LOS Previous Month
3.10
LOS Last Complete Month
3.57
Total Change
0.47
Highest Avg
Rehab Geriatric Active
41.07
Longest Stay
Surgical Services
366.11
7 Day Stays
General Medicine
43
Average Length of Stay Analysis and Narration
Average LOS (days) by month
3.76
4.04
3.80
4.46
4.05
3.70
3.34
3.71
3.72
3.51
3.65
3.82
2021 May
2021 June
2021 July
2021 August
2021 Septe...
2021 October
2021 Nove...
2021 Dece...
2022 January
2022 Febru...
2022 March
2022 April

FOR INFORMATION

Item: SDHB Change Programme Report February 2022

Proposed by: CEO Southern DHB

Meeting of: Board, 3 May 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 and focus areas. To also focus on those initiatives that contribute directly to the New Dunedin Hospital.

Background

This update aims to provide a high-level portfolio overview of our 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 sixth iteration generated out of the Cascade platform. There are 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

Please note:

1) 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.

2) The format for providing monthly updates has been changed, to ensure a consistent approach to providing feedback.

Next Steps & Actions

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

Appendices

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

SDHB CHANGE PORTFOLIO TOTAL

26/04/2022

54	59%
GOALS	GOAL COMPLETION

STRATEGIC CHANGE PORTFOLIO PLAN

MĀORI EQUITY

Goal	Owner	Monthly Update	Task	Current Completion
Equity Actions Improvement Programme	Mata Cherrington			0% -
→ **Reducing amenable mortality**	Mata Cherrington	**NEW** **Talis Liepins:** **Key Accomplishments:** *No value* **Challenges:** Accessing relevant data to inform decision-making Longitudinal nature of metric means system changes won't translate to improvement in outcomes data for many years. **Next Steps:** Working with Equity Analyst on producing insights in a workplan that will be oriented around primary/community actions (rather than secondary services) *13/04/2022*		10% 10% ahead
→ **Appoint equity data analyst role**	Mata Cherrington			100% -

Goal	Owner	Monthly Update	Task	Current Completion
Advance Māori workforce development programme	Mata Cherrington	**NEW** **Talis Liepins:** **Key Accomplishments:** The workforce development advisor role has been recruited to **Challenges:** *No value* **Next Steps:** Working with HR and Maori Health Directorate on development of plan. Ensuring the role maintains its speciality and focus on workforce recruitment and equity. *13/04/2022*	**Workforce development plan produced** ☐ **Recruiting for Māori workforce development specialist role** ☑	**50%** 50% ahead
Appoint 2x Clinical Nurse Specialist roles - 1x Cancer and 1x Cardiac/Respiratory	Mata Cherrington	**NEW** **Talis Liepins:** **Key Accomplishments:** EOIs complete for registered nurse and clinical nurse specialist roles. Roles reoriented to be based in the community with a whole of system view. Seeking to embed in established services and advance nurse leadership in the community. **Challenges:** *No value* **Next Steps:** Maori Health Directorate working with procurement to determine recruitment approach. In parallel, working on methods to provide the support around the nurses to ensure there's integration across the sector. *13/04/2022*	**Appointment of successful candidates** ☐ **Undertake procurement/commissioning of the role** ☐ **Develop ROI** ☑	**33%** 33% ahead
Pro-equity Recruitment	Tanya Basel	**NEW** **Lu Cox:** **Key Accomplishments:** 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 **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**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** ☑	**50%** 50% ahead

POSITIONING PUBLIC HEALTH SERVICES FOR THE FUTURE

Goal	Owner	Monthly Update	Task	Current Completion
Southern Strategic Briefing Project (nee refresh)	Andrew Lesperance	**NEW** **Talis Liepins:** **Key Accomplishments:** Board direction provided on April 5 regarding the direction and approach for the launch. **Challenges:** *No value* **Next Steps:** Team to commence planning and campaign preparation materials, video scripts etc. *12/04/2022*	**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** ☑	**93%** 1% ahead
Health Needs Analysis: Development of Tō Tātou Pūkete/Our Health Profile	Talis Liepins	**NEW** **Talis Liepins:** **Key Accomplishments:** Reinstating project team and weekly progress meetings Deployment plan for completing outstanding indicators Setting end of Q4 21/22 deadline for completion Work underway on indicators **Challenges:** Competing priorities for staff **Next Steps:** Continued deployment and updating of indicators and narratives *11/04/2022*	**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** ☑	**88%** -

PRIMARY & COMMUNITY CARE

Goal	Owner	Monthly Update	Task	Current Completion
Establish locality networks to improve planning and delivery of well coordinated local services	Andrew Lesperance	NEW **Talis Liepins:** **Key Accomplishments:** Exec Dir Māori Health working with Rūnanga and Iwi on developing localities. DHB-WellSouth-Māori Health Directorate working group set up to develop shared thinking and progress for development **Challenges:** *No value* **Next Steps:** *No value* *13/04/2022*		**1%** 1% ahead
Implementation of the Primary & Community Strategy	Andrew Lesperance			**18%** 38% behind

9

Goal	Owner	Monthly Update	Task	Current Completion
Health hubs Implementation: Te Kaika Community Wellness Hub	Andrew Lesperance	**NEW** **Andrew Lesperance:** **Key Accomplishments:** Third person assigned from DHB to be on the governance group Mental Health GM engaged in project and scope of work as it significantly impacts on this service Te Kāika Wellbeing Hub floorplans have been approved by all three partners' (Te Kāika, SDHB, MSD) Health & Safety managers. Te Kāika Wellbeing Hub floorplans have received final approval by Te Kāika Development Board, which consists of voting membership across the three partners. Te Kāika has released the Colliers valuation. **Challenges:** Determining monthly rental payment process (yield vs m2) discussion continues The Development Agreement, License (to lease) Agreement, and Memorandum of Understanding is taking time. There is a potential that this will cause a delay in ordering steel and other building materials, and thus breaking ground. Security – MSD has strict prescribed security policies and protocols for their workplaces. Service design has commenced after the agreement of floor plans; though this was unavoidable as SDHB has entered the build and service partnership at a later date. **Next Steps:** Meet with CEO's and legal team to determine pathway forward and get agreement signed Progress with Development Agreement, License (to lease) Agreement, and Memorandum of Understanding. Come to an agreement on security in shared meeting spaces. Continue to progress service design. *12/04/2022*	**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** ☐	**65%** 14% ahead

Goal	Owner	Monthly Update	Task	Current Completion
↳ **Maternity Central Otago**	Andrew Lesperance	**NEW** **Talis Liepins:** **Key Accomplishments:** Workshops with architect for Clyde build are scheduled for mid-April. Identification of a suitable Wanaka primary birthing facility and paperwork is underway. Tender documents for construction RFP are written (but not yet released). **Challenges:** Escalating construction costs. Availability of appropriate/affordable land in Wanaka. **Next Steps:** Sale and Purchase agreement for identified Wanaka property Sign-off for architect contract Stakeholder design workshops Resource consent application *12/04/2022*	**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 site in Wanaka** ☐ **Ministry of Health approval of Business Case** ☑ **Business case for the Primary Birthing Units completed and to CEO for sign off** ☑	**33%** 2% ahead
Primary Care in Southland - Hub Build	Andrew Lesperance	**NEW** **Adam O'Byrne:** **Key Accomplishments:** No updates **Challenges:** *No value* **Next Steps:** To provide the respective boards with an update of the progress of the development of the community health hub in Invercargill, which is being led by Te Hau o Te Ora, including the opportunities for the inclusion of SDHB services. *13/04/2022*	**Clinical services co-design complete** ☐ **Stakeholder engagement with iwi and governance groups, and community** ☐ **Due diligence - change, impact and risk assessment developed** ☐ **Discovery Report presented to DHB Board** ☐ **Clinical Discovery Report** ☑	**20%** 20% ahead
Wanaka After-Hours Service	Adam O'Byrne	**NEW** **Adam O'Byrne:** **Key Accomplishments:** *No value* **Challenges:** Resourcing pressure due to unsustainable after-hours model of care in Wanaka (lack of GP's participating putting pressure on the few that do) **Next Steps:** *No value* *13/04/2022*	**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** ☑	**33%** 2% ahead

9

CLINICAL SERVICE REDESIGN

Goal	Owner	Monthly Update	Task	Current Completion
Oncology Sustainability Planning	Hamish Brown	**NEW Hamish Brown:** **Key Accomplishments:** First tranche of recommendations from the EY report are being worked up by the services. Critically as the services continue to hold SMO vacancies which we are unable to recruit to the focus has shifted to what resources are required to offset immediate pressures and risks. It is clear that tis means additional admin and nursing staff and details are being worked up. An increase in booking staff FTE will help improve clinic efficiency. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**Investment decision for 22/23 reached** ☐ **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** ☑	**80%** 34% ahead
→ **Address recruitment challenges within the service**	Hamish Brown	**NEW Hamish Brown:** **Key Accomplishments:** Material has been completed and is now live both static media and video. A programme is in place for delivery across a variety of platforms and channels and response will be monitored. ☐ SDHB Standout Fit in Final.mp4 The task will remain incomplete until recruitment is successful. Also note that SDHB has funded (on an PBFF basis) a national programme for nursing recruitment which is currently active **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**Staff recruited to and in place** ☐ **Meet with CDHB to collaborate on opportunities** ☑ **Initiate Haines Attract recruitment campaign** ☑	**75%** 25% behind

Goal	Owner	Monthly Update	Task	Current Completion
→ **Establish outsourcing arrangement to reduce waitlist immediately**	Hamish Brown			100% -
→ **Development of long term Oncology strategic plan**	Hamish Brown			100% -
Improving Patient Flow through the Implementation of the SAFER Bundle: A framework for improving patient flow	Jane Wilson	**NEW** **Talis Liepins:** **Key Accomplishments:** The SAFER bundle has been rolled out across all medical and surgical wards with a range of methods to support understanding of the framework and best practice for patient flow (such as the rapid rounds). **Challenges:** Sustaining the behavioural / system changes to achieve the flow. Without ongoing maintenance or engagement with all components of the SAFER bundle it is easy for performance to slide. **Next Steps:** The actions associated with the introduction of SAFER bundle have been marked as complete because the rollout is complete. Next steps will involve working through the identified initiatives to enable flow (e.g., IOC) or address constraints (e.g., delayed discharge summaries) and ongoing embedding of the SAFER programme components. This embedding of SAFER becomes BAU as part of ward management, with the expectation that wards drive improvement in the performance metrics. *14/04/2022*	**Discharge before Noon** ☑ **Flow from ED to inpatient wards** ☑ **Expected Date of Discharge & Clinical criteria for discharge** ☑ **Senior Review: Rapid Rounds & Red2Green** ☑	100% -
MHAID Review	Toni Gutschlag			100% -

Goal	Owner	Monthly Update	Task	Current Completion
Embedding Virtual Health	Hamish Brown	**NEW** **Hamish Brown:** **Key Accomplishments:** Update provided to the HAC as attached. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**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** ☑	**76%** 3% behind
Enhanced Generalism Model	Hamish Brown	**NEW** **Hamish Brown:** **Key Accomplishments:** Frazer Building 6-8 week delay due to Chorus fiber delay. See attached project update **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**MAU Decant & Build** ☐ **MAU Design** ☐ **Recruitment: PM, SMO & Allied Health** ☐ **GAMA Implementation** ☑ **Communications Plan** ☑ **SLA/Referral Guidelines** ☑	**50%** 8% ahead
→ **Recruit pharmacy and nursing roles ahead of new MAU to support model change**	Hamish Brown	**Hamish Brown:** **Key Accomplishments:** CNM seconded into role and beginning to drive change. Connection (Service Manager and CNM) with CDHB AMAU established. Site visit in Feb. Policies/protocols and documentation shared. **Challenges:** *No value* **Next Steps:** *No value* *25/01/2022*		**100%** -

Goal	Owner	Monthly Update	Task	Current Completion
↳ **Increase general medical admissions.**	Hamish Brown	NEW **Hamish Brown:** Key Accomplishments: An April update on Enhanced Generalism. **The highlights of the current metrics are:** **· A 71.5% admissions rate by the General Medicine team** **· An additional 2.2% reduction in number of Outliers for General Medicine, although the total for the hospital increased by 39.4% from February's numbers.** **· A 3% improvement in LOS < 1 day. Our goal is to continuing the trend <7 days, although that overall number decreased during March.** Challenges: *No value* Next Steps: *No value* *14/04/2022*		**65%** 65% ahead

9

ENABLING OUR PEOPLE - OUR PEOPLE STRATEGY

Goal	Owner	Monthly Update	Task	Current Completion
Human Resources Information System (HRIS)	Tanya Basel		**Undertake tender for implementation partners** ☐ **Business Case approved by FY end 21/22** ☐ **CAPEX approval of business case** ☑ **Draft business case for HRIS modules** ☑	**25%** 29% behind
CCDM Implementation	Hamish Brown	**Hamish Brown:** **Key Accomplishments:** CCDM fully implemented. Calculations occurring to inform 22/23 budget process **Challenges:** *No value* **Next Steps:** *No value* *14/02/2022*		**100%** -
Health & Safety Workplan	Tanya Basel	**NEW** **Talis Liepins:** **Key Accomplishments:** Risk Manager system rollout is underway. ~25 hazard plans developed to address identified risks. **Challenges:** *No value* **Next Steps:** Health and Safety Policy update MHAID action plan in progress - continue to make progress *26/04/2022*	**HSW Policy Update** ☐ **EAP Contract extension** ☑ **ACC Audit** ☑	**50%** 50% ahead
Talent Management	Tanya Basel	**Tanya Basel:** **Key Accomplishments:** Workforce Planning and HR Analyst started in role in January 2022. **Challenges:** *No value* **Next Steps:** *No value* *21/02/2022*		**8%** 17% behind
Leadership Development	Tanya Basel		**Leadership Development Program for leadership layers: Fit for purpose** ☑ **Align Leadership Development with Health NZ** ☐ **Establish Leadership Framework** ☐	**33%** 16% ahead

Goal	Owner	Monthly Update	Task	Current Completion
Diversity and Inclusion	Tanya Basel	**Tanya Basel:** **Key Accomplishments:** Recruitment for a Maori Workforce Development Specialist is being concluded. Work continues to encourage staff to update their personal records including their ethnicity data. Focus is on recruitment practices and the training of leaders/vacancy managers to adopt diversity friendly recruitment practices. **Challenges:** Systems are not well interfaced and does make accessing personal information challenging. More work needs to be done to update the ease of access for staff. Staff survey on diversity and ethnicity did not yield significant results and broadly aligned with data we already had. **Next Steps:** *No value* *21/02/2022*	**Pro-equity recruitment pilot in Allied Health focus on Maori** ☑	**50%** 50% ahead
→ **Pro-equity Recruitment**	Tanya Basel	**NEW** **Lu Cox:** **Key Accomplishments:** 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 **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**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** ☑	**50%** 50% ahead
Culture and Engagement	Tanya Basel			**0%** -

Goal	Owner	Monthly Update	Task	Current Completion
Wellbeing: Aukaha kia kaha programme	Tanya Basel	**NEW** **Lu Cox:** **Key Accomplishments:** 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. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**Well-being care packages rollout** ☑ **e-Bike competition complete** ☑ **Wellbeing pilots in ED and ICU using CHNNL app complete** ☑ **Five ways to well-being workshops rollout** ☑ **Wellbeing Sharepoint developed and deployed** ☑	**80%** 80% ahead
Speak Up Programme	Tanya Basel	**NEW** **Lu Cox:** **Key Accomplishments:** 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. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**Refresh Speak Up programme content** ☑ **Development of Speak Up App** ☐ **Develop e-Learning module** ☐	**75%** 75% ahead
Capability Development	Tanya Basel		**Change Cycle Program to support response to change** ☑ **Establish career programmes** ☐	**50%** 50% ahead

SYSTEMS FOR SUCCESS

Goal	Owner	Monthly Update	Task	Current Completion
Specialist Services Operational structure re-design	Chris Fleming		**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** ☑	**100%** -
Project Governance framework	Patrick Ng	**NEW** **Jen Pettitt:** **Key Accomplishments:** The ePMO Manager has completed her review of the scanning business case and it is now complete. The case is going forward to ELT and then Board for approval and we anticipate starting the project in May. The CSO seeking project management methodology support is live in the marketplace and we anticipate appointing a partner to work with in the next 2 weeks. **Challenges:** *No value* **Next Steps:** *No value* *11/04/2022*	**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** ☑	**50%** 42% behind
FPIM Implementation	Nigel Trainor			**100%** -
Risk Management Maturity	Hywel Lloyd		**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** ☑	**100%** -

Goal	Owner	Monthly Update	Task	Current Completion
Digital Transformation (detailed business case)	Patrick Ng	**NEW** **Talis Liepins:** **Key Accomplishments:** We have had a progress meeting with the MOH on 7.04.22. We have been advised that the review and questions for responding on will be made available to us next week and we will start compiling responses to questions next week. We have also been advised that the process that we will be required to follow to draw down the funding for the stage 1 will be simpler than it might have been. We will be required to submit an assurance plan but we will not be required to develop a separate implementation case which is standard practice and adds the additional burden of having to develop another business case. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**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** ☑	**50%** 30% ahead
Scanning Project: The digitisation of clinical records	Patrick Ng	**NEW** **Jen Pettitt:** **Key Accomplishments:** Completion and approval of scanning business case. Assigned to: Jen Pettitt Start Date: 01/02/2022 Due Date: 13/05/2022 Weight: Top Priority Description: The scanning business case has now been finalised and is in the ELT papers for consideration on 8.04.22. Upon approval by ELT this business case we are planning to submit the business case to the SDHB Board in early May. Upon receiving approval, the project will be initiated in May and the remaining tasks will be systematically closed as part of project initiation. **Challenges:** **Next Steps:** *No value* *11/04/2022*	**Completion and approval of scanning business case.** ☐ **Clinical Engagement** ☐ **Bureau Service: Process Design** ☐ **Bureau Service: Transition & Training** ☐ **Management of Change: Consultation & Response** ☐ **Management of Change: Definition of roles & responsibilities** ☐	**50%** 13% behind

Goal	Owner	Monthly Update	Task	Current Completion
Establishment of an Integrated Operations Centre	Hamish Brown	**NEW** **Talis Liepins:** **Key Accomplishments:** *No value* **Challenges:** *No value* **Next Steps:** 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 *14/04/2022*	**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** ☑	**29%** 29% ahead
EPMO Strategy and Roadmap	Sara Kidd	**NEW** **Talis Liepins:** **Key Accomplishments:** A direct, closed tender was released to x3 Business Change consultancies from the AOG panel. The tender closed on 14 April 2022. Decision will be made by panel on 26 April 2022. Consultancy will proceed from May to 1 July 2022 (in line with available funding). **Challenges:** Staff absence due to COVID-19 and Easter / ANZAC break. **Next Steps:** *No value* *14/04/2022*		**0%** 29% behind

SYSTEM IMPROVEMENTS

Goal	Owner	Monthly Update	Task	Current Completion
Discharge Summaries Re-design	John Eastwood		**Pilot of new documentation** ☐ **Pilot group of clincians established to trial NMDHB example** ☑ **NMDHB example shared with clinical leaders** ☑ **upload outline plan** ☑	**75%** 23% behind
Clinical Costing System Implementation plan	Nigel Trainor	**NEW** **Jen Pettitt:** **Key Accomplishments:** Business case is being drafted and aiming to submit to the Board in April - stakeholder meting scheduled for 14th april to align on project timeline and resource requirement. **Challenges:** *No value* **Next Steps:** *No value* *13/04/2022*	**Stakeholder meeting** ☐ **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** ☑	**46%** 46% ahead
MHAID H&S Review and Improvement Plan	Toni Gutschlag	**NEW** **Talis Liepins:** **Key Accomplishments:** Plan has been refreshed, and updates provided to FARC, Board and Quality/Clinical Governance group. **Challenges:** *No value* **Next Steps:** The process will be ongoing and iterative to improve patient safety and workforce wellbeing. However the plan has been approved so marking as complete. Actions will to roll and be carried out. *12/04/2022*	**Close out implementation plan** ☑ **Develop Implementation Plan** ☑ **External review by Purple Consulting** ☑	**100%** -
Hospital Escalation Planning/Standard Operating Procedures	Hamish Brown			**0%** -

Goal	Owner	Monthly Update	Task	Current Completion
PICS implementation: New regional Patient Information System which replaces IPM in Otago & Southland	Patrick Ng	**NEW** **Jen Pettitt:** **Key Accomplishments:** A proposal for the theatre module requirements, using the newly developed PICS theatre capabilities will be considered by the project board on 8.04.22. The board will also consider software development requests before these are submitted into the Orion Health software development cycle in May 2022, which will be the last software development cycle before our go live date. Consultation with key users is ongoing and the SRO and PSA Project Board representative recently made a collaborative video which is being used to introduce the project to our key users. **Challenges:** *No value* **Next Steps:** *No value* *11/04/2022*	**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** ☑	**39%** -
Rollout of the Performance & Accountability Framework	Talis Liepins	**NEW** **Talis Liepins:** **Key Accomplishments:** P&AF is rolling in all directorates, except MHAID, - however work is underway to stock take existing reporting and assess existing alignment with P&AF. **Challenges:** *No value* **Next Steps:** As P&AF has been approached as a standalone reporting structure, work is underway to consider the opportunities for integration with existing reporting structures - such as Cascade, or existing Monthly reporting. By this approach, we embed P&AF. *11/04/2022*	**CEO and Board reporting mechanism complete** ☐ **Rollout of Mental Health Directorate P&AF** ☐ **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** ☑	**80%** 5% ahead
Establish a clear clinical governance framework, embed discipline around meeting structure, action follow through and focus	Hywel Lloyd	**NEW** **Talis Liepins:** **Key Accomplishments:** Investigation of clinical governance activity in services for initial case study complete, finding complex variation in activity . These findings are informing CG implementation planning and recommendations. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*	**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** ☑	**75%** 75% ahead

FACILITIES FOR THE FUTURE

Goal	Owner	Monthly Update	Task	Current Completion
Right-sizing Southland ED	Nigel Trainor	**NEW** **Jen Pettitt:** **Key Accomplishments:** Hamish and Simon confirmed that the design can proceed for the 2 storey building option. Preliminary design complete. Detailed design 50% complete. Discussions with local council was successful and they have agreed to a staged consenting process to fast track consents on the project. Nigel has asked us to proceed with the relocation of Biomed, there is 800k (DAP 22-16027) available on the capex to complete this work. Nigel and Hamish requested for staging options for the project to manage cashflow. And the following staging has been proposed. QS estimate for the staging expected to be complete by 14/4/22 • ◦ **Stage 1**- ED plus 2nd level ◦ **Stage 2**- 5th Theatre, sterile storage, 6th theatre area as storage ◦ **Stage 3**- SSU and sleep area, offices ◦ **Stage 4**- 6th theatre **Challenges:** *No value* **Next Steps:** *No value* *13/04/2022*		**25%** 25% ahead
Security Review	Nigel Trainor			**100%** -

Goal	Owner	Monthly Update	Task	Current Completion
Dunedin Master Site Planning	Bridget Dickson	**NEW** **Simon Crack:** **Key Accomplishments:** SDHB Board endorsed the Site Masterplan at their 5 April 2022 (Public-Excluded) session. Work to develop a more condensed report suitable for public release is underway, with the draft due before Easter. Following internal review, it will be released alongside a media pack and FAQs. An update will be provided at the all-staff forum on 27 April, followed by service-specific sessions with those services named in the plans. The Site Masterplan will also be helpful to inform upcoming activity in the Health and Education Precinct, starting with the upcoming design process for the Interprofessional Learning Centre (ILC). **Challenges:** *No value* **Next Steps:** • Complete condensed report for public release (by 22 April), including a media pack and FAQs • Deliver All-Staff Presentation/update (27 April) • Service-specific sessions with affected services (from early May) *08/04/2022*	**Deliver & Document** ☐ **Refine Preferred Scenario** ☑ **Explore Spatial Options** ☑ **Define Vision & Principles** ☑ **Mobilisation/Lead-In** ☑	**95%** 1% ahead
Southland Master Site Planning	Simon Donlevy	**NEW** **Hamish Brown:** **Key Accomplishments:** This has not yet commenced as it is a dependency of the Southland needs assessment. **Challenges:** *No value* **Next Steps:** *No value* *14/04/2022*		**90%** -

FOR THE BOARD'S INFORMATION

Item: Māori Health – Amenable Mortality Update

Proposed by: Mata Cherrington, Chief Māori Health Strategy & Improvement Officer

Meeting of: Southern DHB – 3 May 2022

Recommendation

That the Board notes the update report on Māori Health Actions that support Māori amenable mortality service improvement.

Purpose

1. To provide the Board an update on amenable mortality actions specific to the recruitment of dedicated Māori positions as previously directed by the Board. This paper follows on from the February Board report and will provide the Board with additional developments since the previous meeting.

Specific Implication For Consideration

2. Financial

    - There are financial implications associated within budget expectations previously approved by the Board.

3. Quality and Patient Safety

    - The appointment of community-based roles will build on existing, high quality nursing services providing exemplar standards of care and safety to whanau.

4. Operational Efficiency

    - The allocation of resource will be built on an existing service and operational model of care that has been successfully implemented but requires further investment.

5. Workforce

    - The reallocation of nursing roles from secondary/tertiary to community/Māori providers will build the capacity within the community that will better integrate health care from community to secondary/tertiary and follow whanau back into the community.

6. Equity

    - The model of care has been developed to reach whanau Māori and rural communities who are challenged by the lack of accessibility to health care – including lower socio-economic whanau and Pasifika.

7. Other

    - Localities Networking – builds opportunities to share the model with other providers across the island which will ensure integration into the future Health NZ/Māori Health Authority systems.

Background

8. **Clinical Nurse Specialist Roles (see paragraphs 9 to 10):**

Southern DHB has agreed to use Māori health equity investment for community nursing services focused on prevention, early intervention and addressing amenable mortality for Māori whanau. Within this, stronger collaboration, peer and cultural support, and strengthened clinical pathways across community, primary care and hospital settings will occur.

There is targeted funding available for three Māori Clinical Nurse Specialists (CNS) with interests in cardiac, cancer and child health and three Māori Registered Nurses. To ensure these nursing positions meet timely procurement and contracting services, ensure nurses will be based within the community to work with Māori whānau and communities, the nursing investment will be used to strengthen existing services across Māori providers in the Southern district.

In 2014, the Ministry of Health (MOH) funded the "Te Kākano Nurse Led Clinics" for three years as a pilot programme. The contract was held by two providers; Kai Tahu ki Otago and Awarua Whānau Services with the expectation Southern DHB would continue with future investment.

In 2017, an evaluation was commissioned which advised for greater Southern DHB investment to further enhance the current service with clinics held across the Southern district in both rural and urban centres.

In 2021, a report was commissioned by Awarua Whānau Services, Invercargill, which identified greater development, training and further investment opportunities. During this time, Kai Tahu ki Otago (Aukaha) decided not to re-sign their contract.

Discussion

9. **Extension of Nursing Services Investment**:

Southern DHB has identified the Te Kākano Nurse Led Clinics, as the model for the Māori health equity investment – nursing services.

Te Kākano - Nurse Led Clinics is led by Awarua Whanau Services which is a kaupapa Māori service, shaped by local Rūnanga and the Māori communities they serve. Te Kākano - Nurse Led Clinic model align with "Pae Ora" and the NZ Health Strategy and include objectives to:

- Advance Whānau Ora and affirm positive Māori approaches which improve Māori health outcomes.
- Promote Māori service delivery systems that value health and social service collaboration and use whānau centred interventions.
- Recognise service models that address the needs of whānau, hapu, Iwi and Māori communities.
- Enhance physical, spiritual, mental and emotional health and wellbeing, allowing whānau to determine their own pathways.

10. **Southern DHB Expectations:**

Southern DHB's expectation is Te Runaka o Awarua Charitable Trust (Awarua Whānau Services) will be the lead provider due to being the only current Te Kākano Nurse Led Clinic contract holder. The lead provider will collaborate and work in partnership with the other Māori health providers to build on the existing Te Kakano Nurse Led Clinics held in communities and determine a shared model of nursing care across the Southern district.

The model will reach into the hospital to advocate and support the early discharge and management of care in the home or community for Māori particularly with cancer, cardiac and child health. Identify and agree objectives and outcomes that mitigate amenable mortality; the model will work in partnership with other General Practices; the model will improve low health literacy, improve poor medication adherence, work with or refer to organisations to address social, economic and housing issues with the expectation of improving health outcomes. Collectively, the providers will determine location for services with a focus on Māori and those Māori not enrolled or unable to enrol due to shortage of GP services.

There will be benefits of employing nurses collectively within one organisation to have oversight and build community Māori nurses across the district. These will include a stronger sense of collegiality, strengthening models of nursing care, peer and cultural support to ensure best practice and Te Ao Māori models of care for Māori whānau.

Next Steps & Actions

30 May 2022 – Respond to Request of Interest and work with the Māori Provider to integrate the nurses within their organisation and build on the community to secondary care relationships.

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:	Board, 3 May 2022

Recommendation

That the Southern DHB Board note this report.

Purpose

1. The Southern DHB Board note this update
2. Note the progress report (appendix 1)

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
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 recruiting for Project Managers and a part-time Programme Administrator. The Senior Leadership Team is a critical component for the success of the Programme to ensure the change benefits are realised.
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 Maori Health Authority.
8. Other
    - The workplan continues to be developed. Refer Appendix 1 for update on actions
    - 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 programme's progress and next steps

Update

13. The programme team is in the process of being established – a Clinical Project Manager has been seconded; Communications expertise is now in place (and planning to add to this over the next few weeks), recruitment process underway for a lived-experience project Manager and another Project Manager.
14. Proposal for rapid expansion of Dunedin Alcohol and Drugs services is in development.
15. RFP process for selection of preferred provider(s) of services to support Ward 11 patients underway (end 29 April 2022), and work has commenced on a deep understanding of the community services that will be required
16. Model of Care for Crisis Response Service for Queenstown/Central Lakes draft almost complete, and commissioning phase will start once the model of care is finalised
17. Scoping of Kaupapa Maori Mental Health and Addiction Service has been received; to be submitted to the Iwi Governance Board for their consideration and decision
18. Scoping of Peer Led Wellbeing Services and associated Workforce Development will commence once a project manager has been appointed

Next Steps & Actions

- Recruitment of project managers and administration
- Baseline data compilation
- Enhancement of communications – website, social media
- Selection of preferred provider(s) of services to support Ward 11 patients
- Commissioning of Crisis Response Service for Queenstown/Central Lakes

Appendices

Appendix 1: Tranche 1 Priority Projects indicative timeline and progress report, 7 April 2022

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (7 April 2022)	Reason for investment	Status
1	Long stay patients	short term – 0-3 months	July 2021	June 2023	Clinical Project Manager engaged. Work started to provisionally identify long stay patients on Wards 11 and 9b Wakari and explore what may be required for successful transition to the community. Unit managers advised and involved. Preliminary information identifies a total of 18 current long-stay inpatients; 13 in Ward 11 and 5 in Ward 9b. Early in this process there are already some emerging themes both in terms of patient characteristics and the challenges/ risks involved in best helping the individuals achieve quality of life outcomes. It is anticipated that more detailed information gained now will help inform the level of service provision required in the community as these aspects directly tie into the needs and challenges identified. It is also anticipated that more detailed information gathered now will help expedite planning for individuals later. Time frame for completing case reviews is estimated to be within the next 1-2 weeks. A closed RFP (3 providers) for intensive community services was issued 21 March and closes on 29 April.	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 Child and Youth Services, Clinical Network Group, Queenstown, Lakes and Central Otago: Progressing to a more integrated	Support for families, maintain engagement with education	Underway

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (7 April 2022)	Reason for investment	Status
					model of care – draft project plan in the process to be sent to Clinical network group for the child and youth services for consultation. Next steps to be discussed with the Networks and the MHAID SLT , and if this is a component of Integration of Care between Specialist Services and Community Providers		
2b	Crisis support 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. Phase 1: Responses have summarised (Developing Crisis Response Options for Queenstown, Central Lakes: Towards a Shared Vision), from the first clinician workshop to scope up a model of care has been held. COMPLETED Phase 2: A workshop for clinicians is scheduled for 13 April to work through the service model of care details. COMPLETED Phase 3: The draft model of care will be shared with the community for their feedback (workshop), and identification of any serious misalignment. IN PROGRESS Phase 4: Commence commissioning. Timeframe and approach to be formalised. Project Manager resource likely to be needed; recruitment process underway Planning for Waitaki scheduled over next 6 months	Development of local services to reduce need for admission/accelerate discharge, support people in their community	Underway

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (7 April 2022)	Reason for investment	Status
					Negotiations to increase crisis support services in Dunedin continue		
2ci	Alcohol and drug service – Dunedin and Invercargill	short term – 0-3 months	Jan 2022	June 2023	Collaborative process for rapid expansion of Alcohol and Other Drug Services in Dunedin continues. Consultation with whanau and lived experience via Consumer Focus group meetings scheduled for 13 and 19 April in Dunedin and Oamaru. Oamaru has been completed – informal feedback is that whilst not as well attended as hoped, the discussion, process and information gathered has been excellent Once feedback incorporated it will come to CLG for endorsement. The Dunedin Network has signalled a desire to improve the Alcohol and Drug services in Otago. They have provisionally proposed to form a group to work on a submission to the Programme under the Collaborative Design parameters, and seek project support for the work (facilitator, communications)	Increase in capacity, service improvement and changes to models of care	underway
2cii	Alcohol and drug service – Central Lakes and Rural	short term – 0-3 months	October 2022	December 2023			
2d	Community support options – primary and community services in Southern	short term – 0-3 months	Jan 2022	March 2023	Discussions with a local provider for establishment of crisis respite services in Dunedin have progressed.	Increase in capacity of specialist services (to better support community services) through service improvement and changes to models of care	Underway

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (7 April 2022)	Reason for investment	Status
3	By Māori for Māori investment				Scoping for Kaupapa Mental Health and Addiction Services Model of Care has been prepared and will be submitted to the Iwi Governance Group for consideration and decision		Underway
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. Engagement with Health Infrastructure Unit in Health New Zealand has commenced.	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 centre model to be implemented in a range of sites (potentially Invercargill, Dunedin, Oamaru and Queenstown as starting points).	medium term 3-6 months			This concept has been discussed at a high level with the Network Chairs and with Dunedin Network Will progress quicker once a project manager has been recruited		getting started
7	Develop a high-level plan to grow, develop and support the peer workforce.	medium term 3-6 months			Will discuss and progress with the Networks once a project manager (Lived Experience) has been recruited Plan will be to identify fast-track solutions to address workforce shortages with emphasis on resourcing the development and growth of the peer workforce, across the district and connected to the Peer Led Wellbeing Centres.		getting started

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (7 April 2022)	Reason for investment	Status
					The initial scoping will include supply, competency, development, supervision and training requirements		
8	Begin the supported transition of Ward 11 clients into alternative options.	medium term 3-6 months			Refer project 1		underway
9	Begin an organisational development programme with external support.	medium term 3-6 months			Externally contracted. Needs to be scoped – working with DLT and OLT	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		underway
11	Implement peer led crisis/wellbeing centre plan in at least one location.	longer term 6-12 months			Refer project 6		getting started
12	Establish dedicated primary/community access and advice telephone help line	longer term 6-12 months			Refer project 2d		

FOR INFORMATION

Item:	Reaffirming Clinical Governance
Prepared by:	Tui Smith, Quality & Performance Improvement facilitator Patrick O'Connor, Quality Improvement Manager James Goodwin, Patient Safety & Risk Manager Hywel Lloyd Interim Director of Quality & Clinical Governance Solutions
Meeting of:	Board, 3 May 2022

Recommendation

The Board notes the attached plan for implementing clinical governance capability through our locality

Purpose

1. This paper details a plan for implementing improved quality and safety in our hospitals.

2. The focus of the paper is to step through the plans and actions we are taking to reaffirm clinical governance through the organisation. It talks to the processes of clinical governance (CG). i.e., What needs to be in place so that good governance can occur. This paper does not outline the plans and actions to address specific clinical governance issues such as hospital acquired complications.

3. Any activity that is aimed at reducing harm in our hospitals will be significantly harder to implement and embed without a robust process of joined up clinical governance within the organisation.

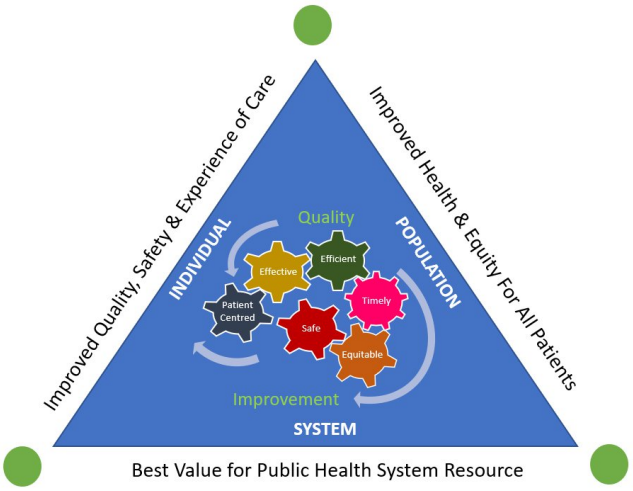
Specific Implications for Consideration

4. **Financial**
   - The Financial position of the organisation is inextricably linked to the quality of the care the system delivers. High quality and safe care reduces rework and waste and reduces cost.
5. **Workforce**
   - A high-quality organisation improves recruitment and retention of staff. We need to bring our staff with us with a relatable simple message of what clinical governance means for us as a collective.
6. **Equity**
   - Equity is one of the six domains of quality and is of particular focus with the change to our health system through the establishment of Health NZ and the Māori Health Authority.

Background

7. Safer and better-quality care occurs when consumers, health care workers, non-clinical staff and those in management and governance work together at all levels of the organisation with a common purpose. This common purpose is expressed through the New Zealand Triple Aim:

Figure 1: New Zealand Triple Aim (Modified from the HQSC publication' From Knowledge to Action' 2016)



8. When we have focus on 'The Triple Aim' during every interaction and at every level of a health system the right outputs will be achieved. The outputs must be simultaneously balanced and consist of:

- Improving the patient experience of care (including quality, safety and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

9. Clinical Governance was defined initially by Scally & Donaldson, the then chief nurse and chief medical officer for the NHS in 1998. The HQSC published its definition in 2017:

> "Clinical governance provides a means for clinicians, managers and other staff to work together to improve and be held accountable for the quality and safety of the health and disability services they provide" *HQSC 2017*

10. In essence clinical governance is the implementation of quality and safety capability, with an accountability process to ensure that all activity is undertaken, measured, and refined by improvement methodologies. The organisation will then fulfil its shared purpose, The Triple Aim.

11. The quality and safety activity undertaken by wards, services and departments is collated and compared across different areas to understand and identify good practice for shared learning. External benchmarking is provided through the Health Round Table (HRT) via their peer comparator reports and their NZ DHB reports. The HQSC dashboard of health system quality provides additional measures and again benchmarked to other DHBs.

12. The quality dashboard captures the quality and safety activity in a similar way to the HRT data but in a much timelier fashion. These metrics are discussed as part of the Performance and Accountability Framework for operational oversight. Integrated Governance, the joined-up conversation between clinical, quality, human resources, and management occurs within the Performance and Accountability meetings.

13. The clinical governance oversight is provided by the Clinical Council with all the professional lines represented and governance is also provided, when applicable, by the council's sub-committees.

14. The quality and safety methodology are outlined in the Quality Framework and are now mandated through the Clinical Governance Policy.

15. It is important that there are clear connections between the clinical teams quality and safety activity, the quality dashboard, the performance and accountability framework and the clinical council and its sub committees' agendas.

16. To ensure the whole governance system is joined up the Quality and Clinical Governance Solutions directorate are undertaking a desk top exercise to ensure that all the above interconnections are present and there are no gaps. The desk top review will ensure that all quality and safety activity have both a joined up operational accountable oversight as well as clinical governance oversight.

17. We have a well-functioning Clinical Council, we have performance and accountability meetings for most Directorates, some services have regular performance discussions, we do deep dives into some issues and there are various committees looking at aspects of care across the organisation.

18. We have a very good Community Health Council. The chair of the community Council has been championing the HQSC QSM for consumer engagement. Services have completed a consumer engagement maturity matrix which makes clear the tasks and actions services need to follow to trigger the benefits of well-established consumer engagement.

19. As described in the Clinical Governance Policy we undertook an assessment of our level of Clinical Governance knowledge and implementation. We used the Clinical Governance Development Index (CGDI) developed by Robin Gauld (*https://doi.org/10.1186/s12913-014-0547-8*). We found variability in clinical governance activity, with varying degrees of knowledge on clinical governance agendas.

20. When we triangulate the results of the CGDI with the stubborn red HRT hospital acquired complications and the complaints we receive, there is significant room for improvement. We need to tighten our clinical governance processes and broaden their reach.

Discussion and recommendations

21. **The Vision**: It may seem obvious why we should all do clinical governance and do it well, but our survey indicates areas for improvement. Our HRT data suggests we have areas to improve. The complaints we receive indicate we don't have good clinical governance processes. We need a simple statement that illustrates the 'why' we need clinical governance and link it to the 'how' we work and then to 'what' we do as a healthcare organisation. Such as:

22. The vision must resonate with everyone in our organisation. It must be simple, as clean as a whistle and relatable, and our staff must also believe in it and feel it, for example:

We believe in Caring.	We put caring into care.	We care for you.
The Why	The How	The What

23. There is a significant opportunity to incentivise clinicians through a joined-up conversation involving clinicians, management, quality and HR around quality and safety that has consistent threads right across the organisation.

24. Where clinicians are involved in these conversations and affect change and improvement, they will become incentivised to become more involved.

25. The mechanisms of clinical governance need to be simple and easy to implement. The tools to achieve progress must be straight forward to use.

26. We need to ensure that performance relating to quality and safety outcomes are included in position descriptions and individual appraisal processes for key leaders such as General Managers, Service Managers and Clinical Leaders. The process of reviewing progress and re-affirming the importance and praising success incentivises further success.

27. When adverse events occur, the care reviews should be thorough and follow a set methodology. The identified root causes should be systems focused to avoid a culture of blame. Staff involved should feel supported and managers with the review team should be alongside our staff when they have been involved when situations have not gone well. We must ensure we promote an environment where sharing our experiences during adverse events is to encourage learning and improvement, a normal feature of our system and clinical governance processes.

28. **The Plan:** Ownership by services of how services undertake clinical governance is fundamental. However, some aspects are not negotiable, as we all believe in caring for our patients. Following the points discussed above the services will pull together their own plans for clinical governance based on the Quality Framework, the Clinical Governance Policy and this paper.

29. **Resources:** Ensuring we have the right resources available to undertake the reaffirming of Quality and safety is a key success factor for implementing change. This represents an ambitious plan of work which can drive change. The directorate will utilise current vacancy to adjust the make up of the team to create the position of Clinical Governance Facilitator.

Next Steps & Actions

Clinical Governance plan agreed and endorsed

Appendices

Appendix 1	**Quality Framework**
Appendix 2	**Clinical Governance Policy**
Appendix 3	**Clinical Governance Maturity Matrix (draft)**
Appendix 4	**Current Clinical Governance Service Activity**

Appendix 3 Clinical Governance Maturity Matrix

Key notes for understanding the intent and purpose of the Maturity Matrix:

The maturity matrix for each domain provides a continuum of key Clinical Governance activities, using scoring of 1 (low maturity) to 4 (high maturity) for each indicator, with 4 being the target on the continuum, i.e. what best practice looks like for Clinical Governance. The core measures relate to Clinical Governance structures and process, quality improvement, system integration, and workforce capability and development. More broadly, this refers to people, process, and systems. It may also include service-specific performance measures following consultation.

The focus on these domains is based on the premise that they are key drivers of service efficiency and innovation, and provide mechanisms for change to be sustained. In fully realising these changes, improvement can be expected in patient safety, consumer engagement, workforce engagement, clinical effectiveness, and equitable outcomes. A maturity matrix approach has been used to recognise that services are on a continuous improvement journey.

What it is for:

- **Creating shared understanding of what Clinical Governance maturity looks like in your service**
- **Providing focus for service development areas related to Clinical Governance**
- **Being used with honesty, psychological safety, and a continuous improvement mindset as guiding principles**

What it is <u>not</u> for:

- **Any punitive discussion or action related to services' current level of maturity**
- **Implying that many Clinical Governance characteristics within a service need improvement focus simultaneously**
- **Being used as a tool to dictate what improvements a service must focus on**

Note: this is presented as a minimum viable product, and will likely require refinement following service input

Service elements	Characteristics	1	2	3	4
1. Clinical Governance structures and processes are embedded	1.1 Clinical Governance meetings	… do not occur	…occur on and ad-hoc basis, or are often deferred in place of other priorities, or do not regularly result in actions	…have a regular cadence, terms of reference and include representatives from most professional groups with actions	…occur monthly, with terms of reference, representatives from consumers, all professional groups and tier 3 management

				and persons responsible frequently being identified in an attached action list	present, and a comprehensive action list that is updated monthly with new actions
	1.2 Clinical Governance reporting	…does not occur routinely	…includes some relevant measures, but is not routine or widely circulated	… occurs routinely, includes some financial information and most relevant clinical measures, is widely disseminated, and often discusses why clinical outcomes have/ have not changed	…occurs routinely, includes all relevant financial and clinical measures, is disseminated to service teams, GMs and Clinical Council, and routinely discusses why clinical outcomes have/ have not changed
	1.3 Clinical Governance planning	…is ad-hoc	…occurs as part of the annual service planning process	…is a key aspect of annual service planning processes, involving all leaders within the service	…is integral to annual service planning processes, involving all leaders within the service coming together for a dedicated planning day annually
	1.4 Clinical Governance activity prioritisation and decision-making	…processes are not well-defined	…is led by one individual, with some consensus building taking place	…is a collaborative process, with most decisions made by majority consensus based on the best available evidence	…is a collaborative process, with all decisions made through a democratic system and are based on a shared

					understanding of the best available evidence
	1.5 Clinical Governance Authority	…is limited to areas that do not require investment	…has some influence on service investment decisions, but no clear framework for this exists	…often dictates service investment decisions within budget, with an agreed process for this and mechanisms for escalating identified needs over budget	…routinely dictates service investment decisions, as part of a system-wide framework that evaluates cost and benefit of all investment requirements against and agreed framework such as the triple aim
	1.6 Information on quality and safety risks, targets and outcomes between clinical services and the board	…is only provided when requested	…is provided through reporting, but does not regularly identify related plans or resources	…is provided through reporting and live dashboards, often accompanied by plans and resources required to address issues with an equity focus	…is provided through reporting and live dashboards, routinely accompanied by plans and resources required to address issues with equity as the priority
2. Quality Improvement methodology is used to improve outcomes	2.1 The service uses a structured methodology to improve quality and reduce waste	…in response to an event	…to proactively identify areas for improvement. Some staff are trained in improvement methodologies	…to address all clinical governance-related service improvement opportunities, with training completed by most staff	…as a routine part of operations and daily business. Quality improvement training is completed by all staff and a Quality Improvement champion is identified.
	2.2 Clinical Governance service level data	… is collected ad-hoc	… is often collected, but incomplete and has minimal equity-focussed segmentation	… has strong integrity, is routinely collected and analysed, most items are segmented	… has strong integrity, is routinely collected and analysed, all items are stratified with all

			and stratification, and is only understood by a few team members	or stratified with equity considerations, and is understood by most of the team	relevant equity considerations, and is understood by the whole team
	2.3 Consumer experience and feedback	…is collected ad-hoc	…is regularly sought, but no processes are in place for acting on it and the feedback loop is often not closed	…is routinely sought, with some processes in place for acting on it, occasionally involving consumers and feeding back changes made	…is routinely sought, with defined processes for acting on feedback which regularly prompt co-design activities and close the feedback loop
	2.4 Clinical Governance benchmarking	…is reviewed when this information is provided by others	…is accessed by the service and used to compare core metrics of service delivery	…is routinely accessed by the service from key sources to compare most core metrics for service delivery and often leads to quality improvement work with an equity focus	…routinely uses HRT, HQSC and MoH data and guidance to systematically compare all service elements with peers through an equity lens, and routinely leads to improvement work with an equity focus
	2.5 Credentialling and auditing	…does not lead to quality improvement activity for the service	…often lead to quality improvement initiatives, but are often isolated from other improvement work streams	…routinely lead to quality improvement initiatives, and usually links in with other service improvement work streams	…is integrated into services' quality improvement workplan, anticipating development requirements and addressing these prior to audit and credentialling
	2.6	…is ad-hoc	…is part of regular schedules for leaders,	…is part of regular schedules for most of	…is part of regular schedules for the

	Time allocation for Quality improvement work		but often postponed or cancelled	the team, usually allows enough time for the work to be done and is rarely cancelled	whole team, always allows enough time for the work to be done, and is virtually never cancelled
3. System integration	3.1 Collaboration between provider arm services on improvement work	…rarely happens	…happens sporadically, with a limited mix of professionals in Southern DHB services	…happens regularly between a broad mix of professional groups sharing formal QI projects, with some inter-regional collaboration	…happens routinely between all professional groups working on QI projects, with mentoring systems in place and significant inter-regional collaboration
	3.2 Collaboration with funder arm services and other disability, primary, and community health providers	…rarely happens	…sometimes happens when external providers request support or guidance	…happens proactively, focussing on improving the patient journey across the whole continuum of care	…happens systematically and in partnership for all improvement work that relates to referral, case management, and care transitions
	3.3 Formal feedback processes for funder arm services and other disability, primary, and community health providers	… do not exist	…are in place, but are not widely shared across the sector and most actions taken in response to feedback are not transparent	…are in place and widely shared across the sector. Feedback is acknowledged and actioned in a timely manner and changes are routinely communicated back	…are in place and widely shared across the sector. Services proactively seek feedback on service delivery and co-design solutions with providers
4.	4.1 Staff engagement	…is not measured	… is occasionally measured and reviewed with related	…is frequently measured and reviewed, with improvement plans	…is regularly and routinely measured and reviewed, with improvement plans

Workforce capability and development			improvement actions sometimes happening	often enacted in response, showing some improvement	routinely enacted in response, showing regular improvement
	4.2 Staff wellbeing	…is informally asked about occasionally. EAP is advertised but service use patterns unknown	…is on some meeting agendas, EAP service use patterns are known, but wellbeing improvement actions are uncommon	…is measured regularly, with 'check-ins' and karakia often offered at meetings. EAP service use patterns sometimes trigger improvement actions.	…is measured routinely, karakia and 'checking-in' with colleagues is part of the service's culture and all meetings. EAP is one of many service wellbeing offerings and routinely triggers service improvement
	4.3 Education and training	…is rarely offered or undertaken by most of the team	…opportunities are available and completed by most team members, but little is known about their value to the service	…opportunities are routinely advertised and completed by most of the service to expand service capabilities	…is systematically undertaken and co-designed with staff preferences shaping content, leading to a variety of service-based champions and passionate learning culture
	4.4 Staffing levels	…are only reviewed in response to crises	…are regularly reviewed, but corrective actions are infrequent	…are regularly reviewed, with frequent corrective actions and some communication to the team	…are systematically reviewed and forecast, with a defined escalation pathway and communication plan to address issues
	4.5 Annual professional development	…meetings are ad-hoc	…meetings occur regularly, but little is known on themes or actions that result	…meetings occur regularly as part of a more frequent 1:1 meeting schedule.	…meetings occur regularly within a monthly or more frequent 1:1 meeting

				Themes are recorded and reviewed. Action from themes is unclear	schedule. Themes are recorded and reviewed across the service and changes result


Southern Future
It's up to us
Southern DHB
Quality Framework
Southern
Health
He hauora, he kuru pounamu
Southern District
Health Board
Piki Te Ora

Mihi

Karanga atu rā ki ngā tangata o te taitonga;

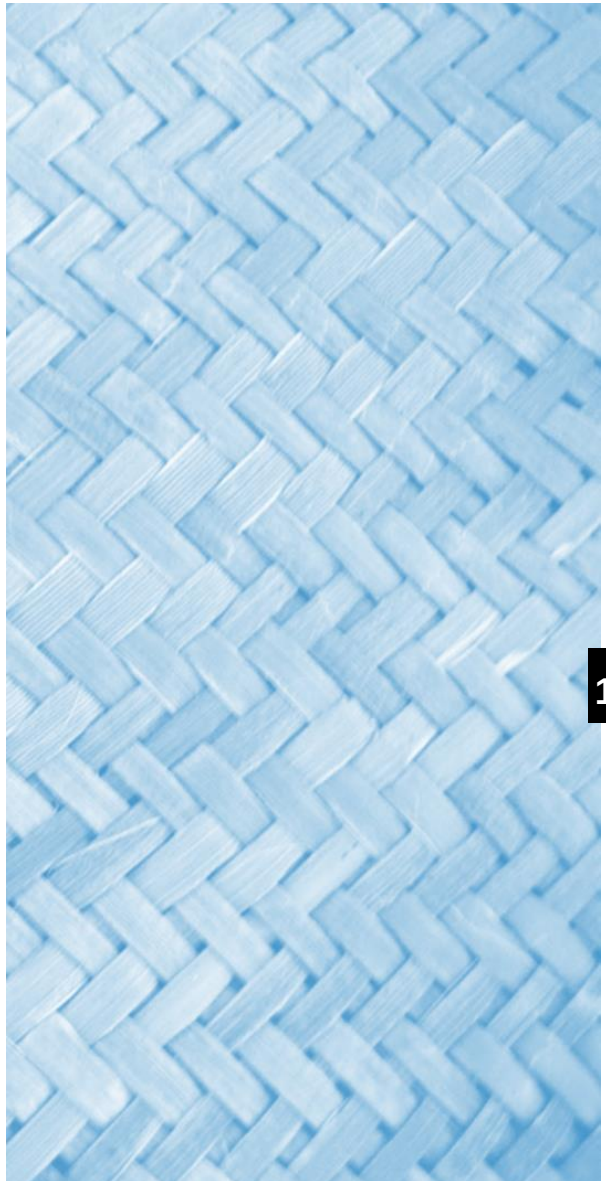
Nei rā mātou, e mihi kau ana ki ā koutou tīpuna kua wehe atu ki tua o Paerau.

Tēnā koutou katoa!

We call to you, the people of the south;

We greet and acknowledge all of our ancestors who have passed beyond the veil.

Greetings to you all!



12.1

In this document

- Foreword
- Linkages
- Development
- The Framework is made up of four components:
- **Component 1 – Ways of Working**
- **Component 2 – Clinical Governance**
- **Component 3 – Quality Dashboard**
- **Component 4 – Enablers for Success**

Foreword

Chris Fleming
Chief Executive
Southern DHB

Dave Cull
Board Chair
Southern DHB

The Southern Health Quality Framework describes our vision and goals through which our organisation will be accountable for continuously improving the quality of services and safeguarding high standards of care.

The ultimate goal is to transform healthcare services across the Southern Health System by creating an environment in which clinical care will flourish.

This Southern Quality Framework describes the strategic drivers, dimensions, and tools that support our quality movement.

The framework recognises that in a changing health environment, long-term planning for quality improvement needs to become a part of everything that we do. It will outlive any changes in organisational structure, service delivery or delivery location. The framework identifies the key components that will drive its success and ensure clear steps forward are clearly aligned to the Triple aims: Experience of Care, Population Health and Cost per Capita.

Message from the Chiefs & Clinical Council

Kaye Cheetham

Chief Allied Health, Scientific and Technical Officer

Nigel Millar

Chief Medical Officer

Gilbert Taurua

Chief Maori Strategy & Improvement Officer

Jane Wilson

Chief Nursing & Midwifery Officer

The words of Don Berwick, CEO IHI, in response to the events of Midstaffordshire 2008, succinctly state what healthcare organisations should be doing. These sentiments align to our frameworks 4 key components which we recognise and support as being fundamental to continually improving healthcare and outcomes for our communities.

- Place the quality and safety of patient care above all other aims for the organisation. (This, by the way, is your safest and best route to lower cost.)
- Engage, empower, and hear patients and carers throughout the entire system, and at all times.
- Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
- Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

… to tackle our future challenges

Aging population

Increasing Co-morbidities

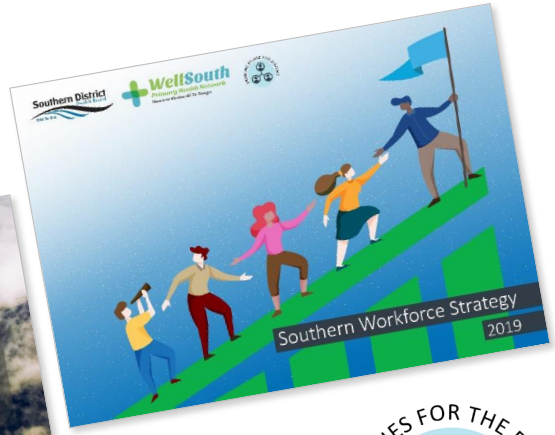
Inequities

Rising cost of Secondary care

12.1

Links to strategies

- The Southern Strategic Health Plan – Piki te Ora
- The Primary and Community Care Strategy
- The Southern Workforce Strategy
- Southern Digital Strategy



Our pathway towards enabling

Better health, better lives, Whānau Ora

What have our people asked for?*

Southern Future

It's up to us

- better coordinated care across providers, with less wasted time
- care closer to home
- communication that makes sense and is respectful
- a calm, compassionate and dignified experience
- high quality, equitable health services.

*Southern Future listening sessions, 2016

THE SOUTHERN STRATEGIC HEALTH PLAN

How will we get there?

Improving experience and outcomes:

Creating an environment for health
The environment and society we live in supports health and wellbeing.

Primary & Community Care
Care is more accessible, coordinated and closer to home.

Clinical service re-design
Primary and secondary/tertiary services are better connected and integrated. Patients experience high quality, efficient services and care pathways that value their time.

Enabling success:

Enabling our people
Our workforce have the skills, support and passion to deliver the care our communities have asked for.

Systems for success
Our systems make it easy for our people to manage care, and to work together safely.

Facilities for the future
Including Dunedin Hospital, Lakes District Hospital redevelopment and community health hubs to accommodate and adapt to new models of care.

By 2026:
We work in partnership to create a truly integrated, patient-centred health care system

A health-enabling society, within which we deliver:

More accessible, extensive primary and community care with the right secondary and tertiary care when it's needed.

So that our people:

- are healthier and take greater responsibility for their own health
- stay well in their own homes and communities
- with complex illness have improved health outcomes.

Southern Health
He hauora, he kuru pounamu

Kind - Manaakitanga | Open - Pono | Positive - Whaiwhakaaro | Community - Whanaungatanga

12.1

Developing the framework

Workshops – *Discovery*
- Where have we come from?
- Defining Service Excellence vs quality improvement models
- International best practice

Workshops – *Creating our Vision*
- Alignment to strategic direction
- Broad engagement across Southern DHB & Wellsouth

Workshops – *Testing the theory*
- Feedback on key themes, testing assumptions
- Clinical & Community Health Councils

Workshops – *The framework*
- Presentation of draft, completing feedback loop
- Executive and Board teams workshops

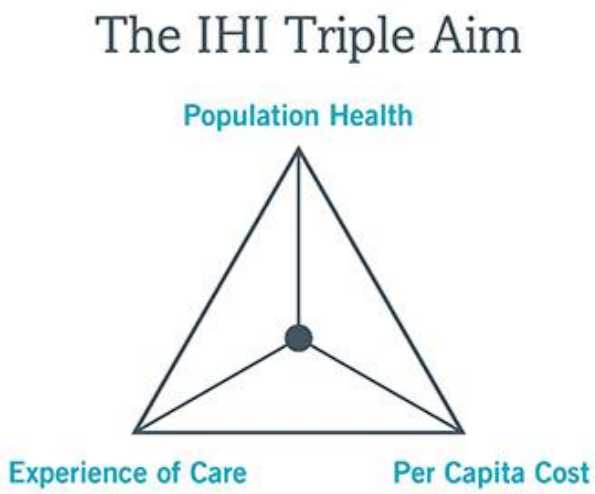
Desktop Analysis
- International literature & best practice
- National research on models used
- Strategic alignment to National, Regional and Local priorities
- Review of demographic information

Framework
- QF 1: Quality dimensions that are relatable, relevant 7 our way of working
- QF 2: A culture of safety & continuous improvement
- QF 3: Bring people & data together by providing clinical insights
- QF 4: Tools & capability to empower & enable transformation

Clinical Council
Oversees implementation and monitors improvements

Quality Improvement models

- Very few models exist to enable optimisation of health system performance
- The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement
- It was designed specifically to contribute to overall health outcomes while being responsible stewards
- http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

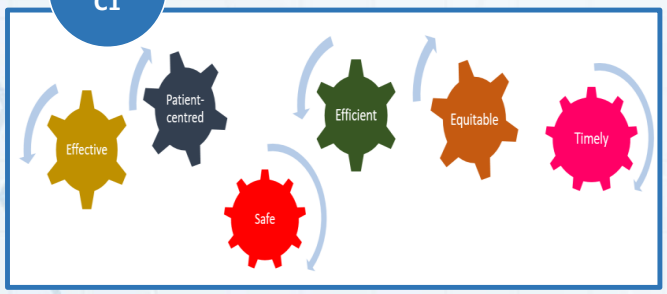


12.1

The Framework, our four components

QF C1

Ways of Working



Laying the foundations, providing a sustainable framework to create an environment in which clinical care can flourish.

QF C2

Clinical Governance

Bringing our people together with the right information to drive a culture of safety and continuous improvement.

QF C3

Quality Data

Enabling the people of Southern Health to access data and dashboards to have the right conversations at a service and governance level

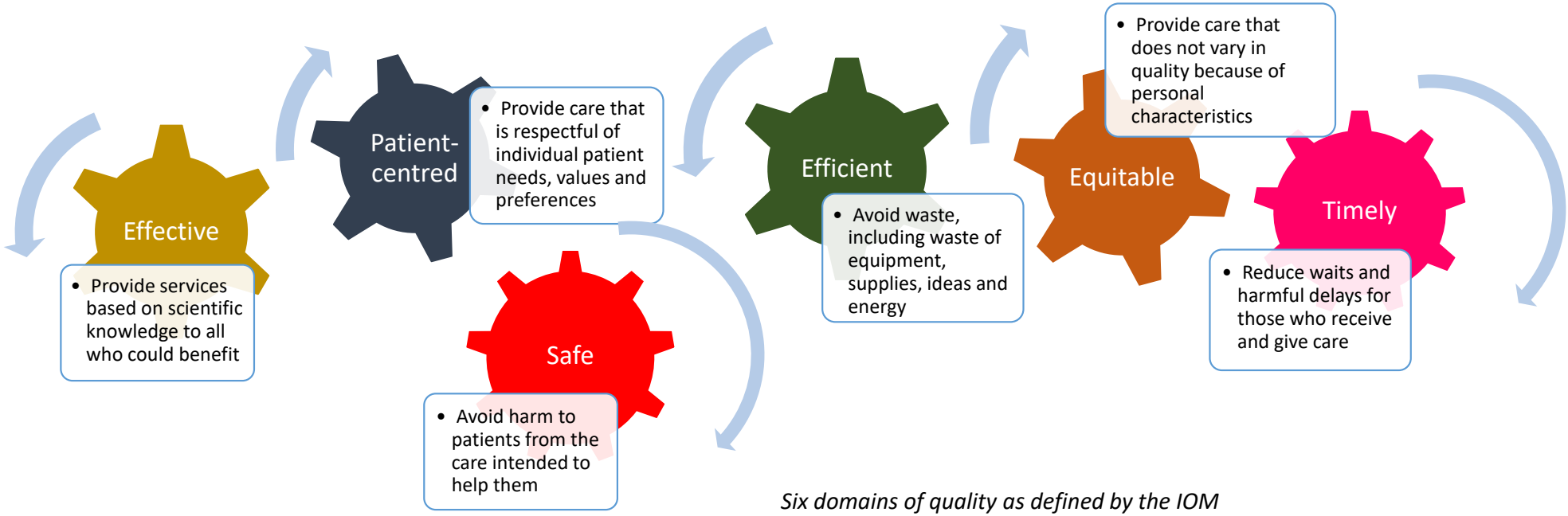
QF C4

Enablers for Success

Strengthening our workforce capability and giving our people the tools to empower them to transform their services.

QF
C1

The six domains of Quality



Six domains of quality as defined by the IOM

12.1

QF C1

The six domains of Quality - our way of working

- Become part of everything we do:
  - every conversation
  - when assessing risk
  - In work prioritisation and service planning
  - when writing a business case
  - Or even a Board paper
- We challenge ourselves to ask of the domains:
  - How do I know (its safe, equitable…)
  - How often do you check?
  - How do we compare to peers?

QF C2

Definition of clinical governance

a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, creating an environment in which excellence in clinical care will flourish

Scally & Donaldson, NHS 1998

Clinical governance provides a means for clinicians, managers and other staff to work together to improve and be held accountable for the quality and safety of the health and disability services they provide

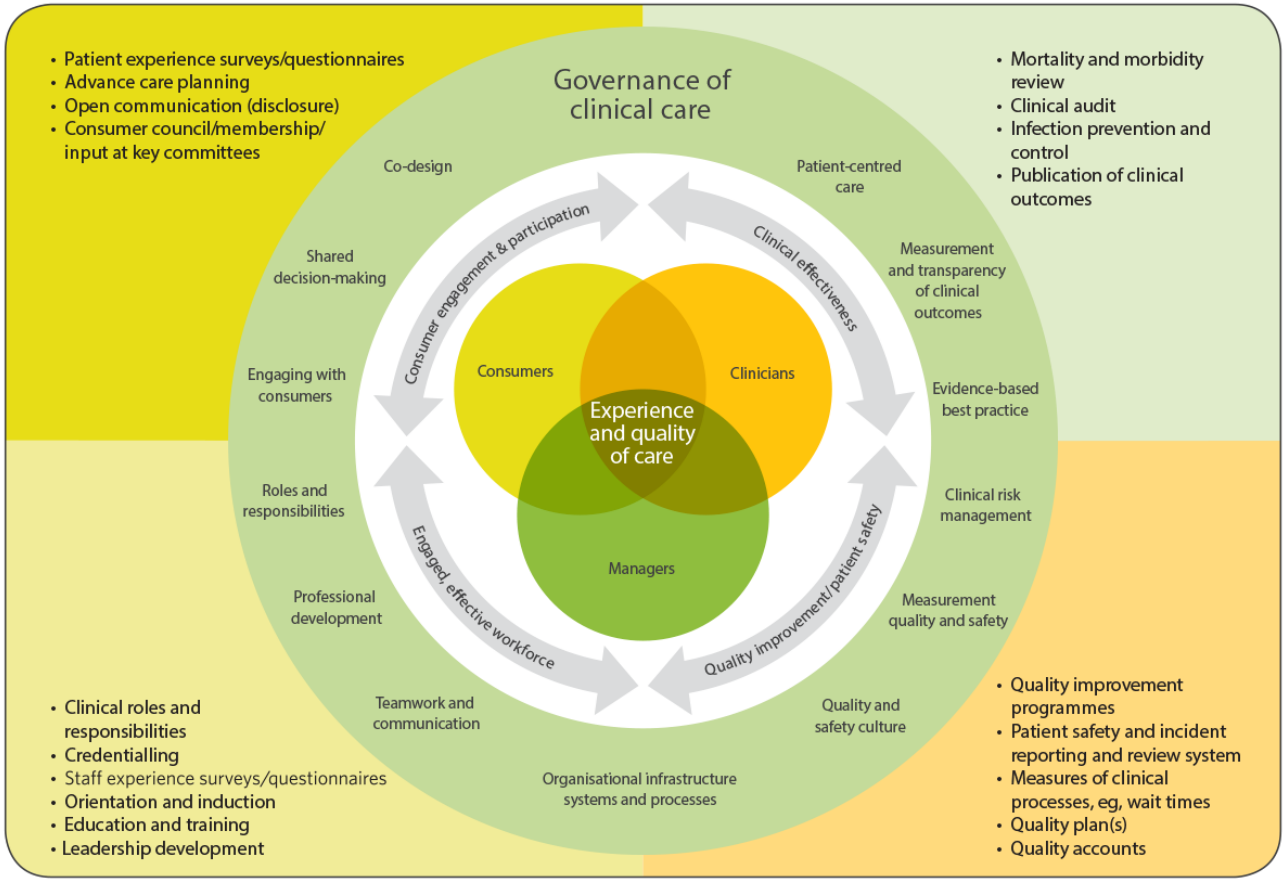
HQSC 2017

It is larger in scope than any single quality improvement initiative, committee or service.

12.1

QF C2

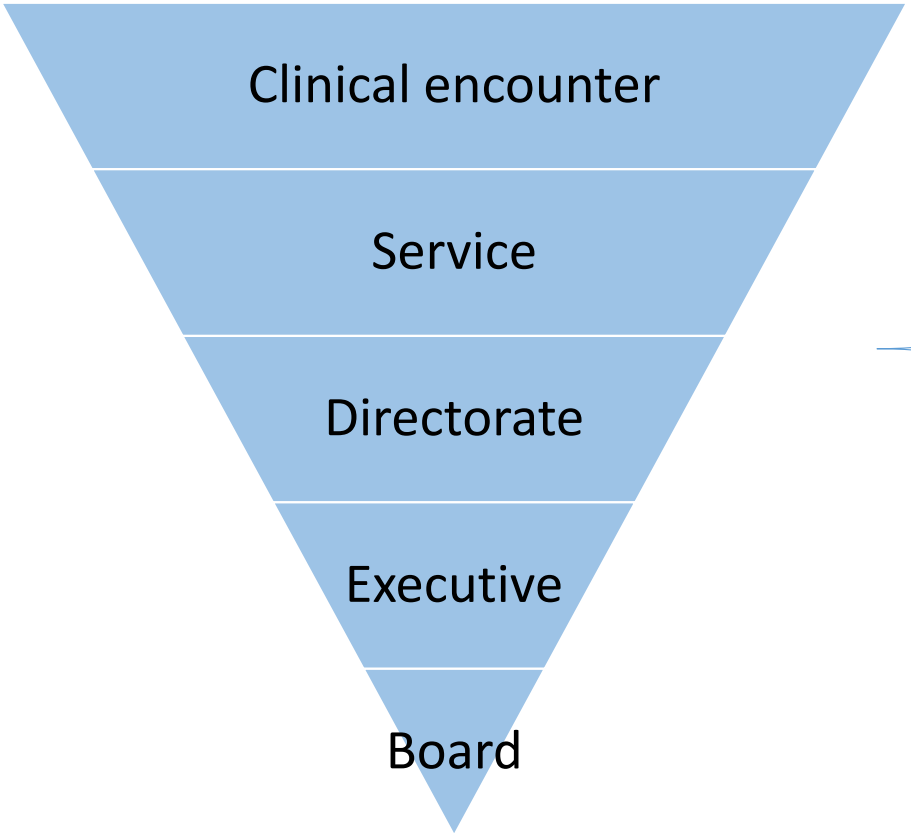
The Southern DHB quality framework aligns to the HQSC* clinical governance framework



*Health Quality & Safety Commission 2017

QF C2

Ward to Board accountability



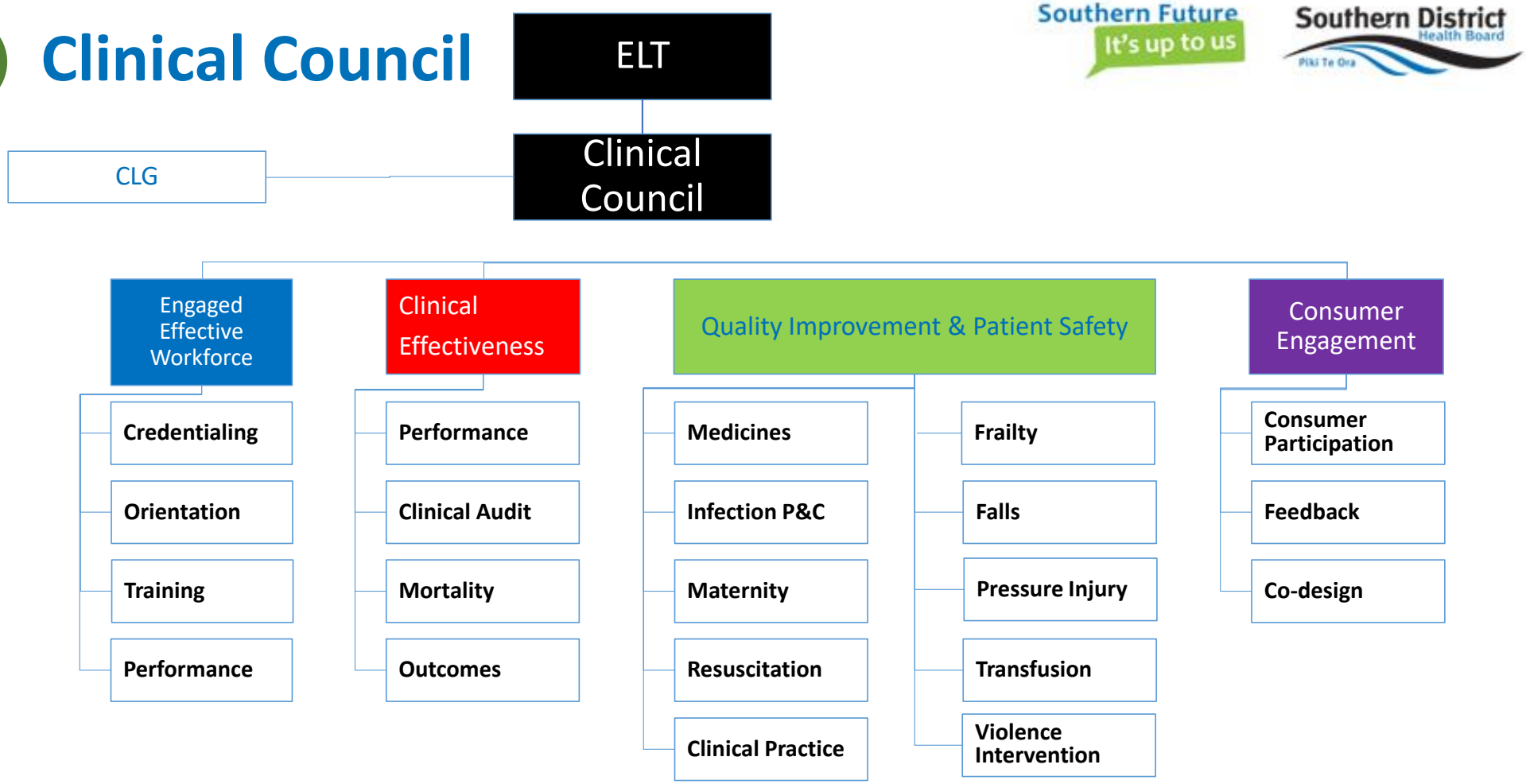
Taking action:

- Promote clinical standards
- Clinical risk management
- Continuous improvement
- Ethical clinical decisions
- Cultural safety
- Capability development
- Customer voice
- Strategic investment & prioritisation
- Improve Health Outcomes

12.1

QF C2

Clinical Council



Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

QF C2

Service level accountability

Consumer engagement & participation:

- Feedback – Complaints/suggestions/compliments
- Patient Experience – National & Local Surveys
- Consumer Involvement with Service Development
- Consumer Information

Engaged, effective workforce:

- Mandatory Training Attendance
- Credentialing – Service & Individual
- Education & Training
- Appraisals/Performance Reviews
- Staff Engagement Surveys (organisation)
- Workforce Development & Succession Planning
- Recruitment & Retention (turnover)
- Sickness & Absence
- Models of Care conversations

Clinical effectiveness:

- Clinical Outcomes
- Risk Management
- Equitable Access – wait times, follow ups, volumes, ESPI, $$, Māori, Pacifica, Disabled etc
- Benchmarking – Health Round Table/AROC/HQSC
- Quality Dashboard
- Mortality & Morbidity
- Clinical Audit
- Infection Prevention & Control
- External audits (colleges, accreditation e.g. IANZ, HDSS)

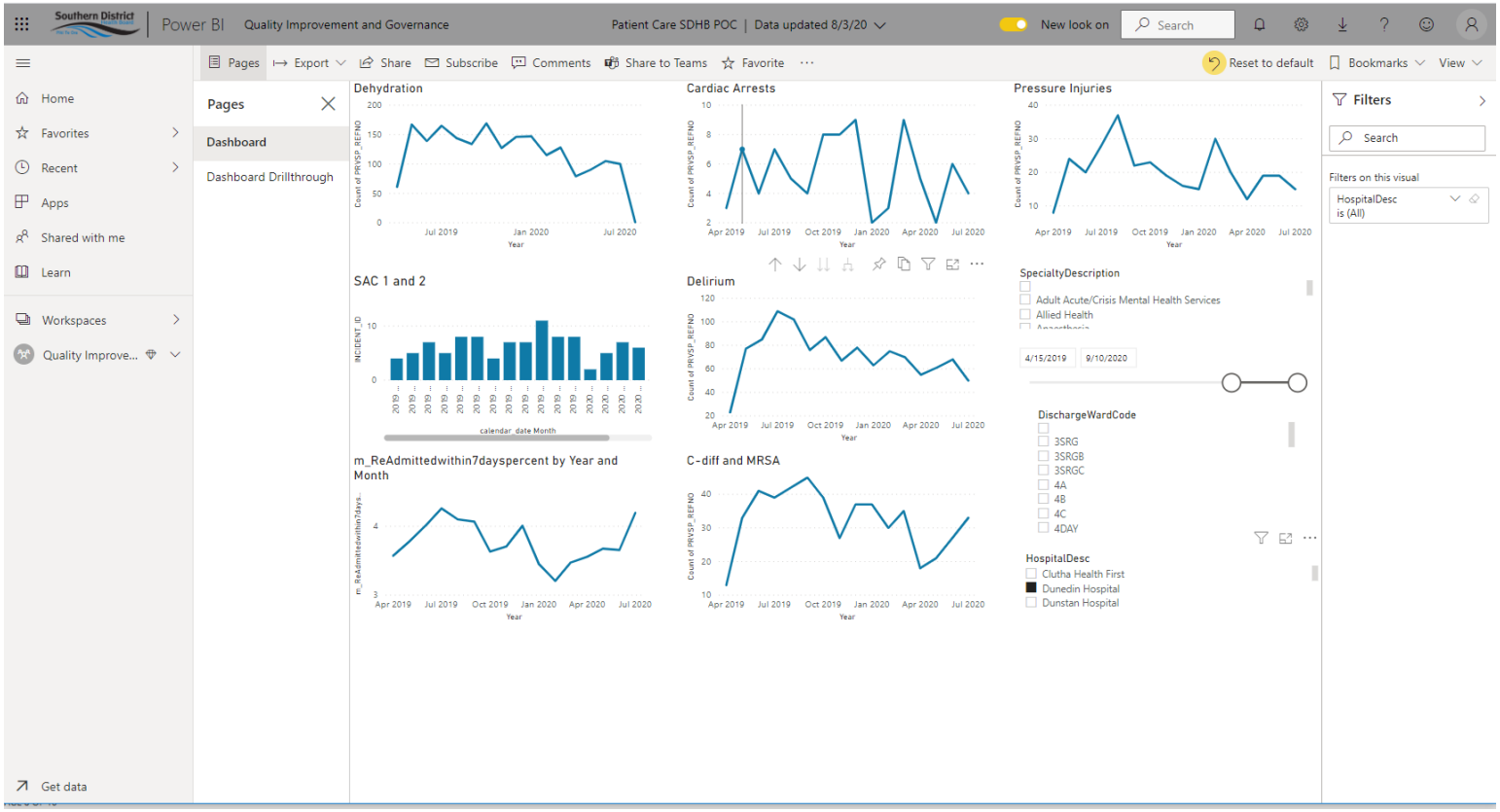
Quality improvement/Patient safety:

- Adverse Events – Patient Safety Markers
- Health & Safety
- Local & System Quality Improvements
- Patient Flow
- Health Pathways

QF C3

Quality dashboards

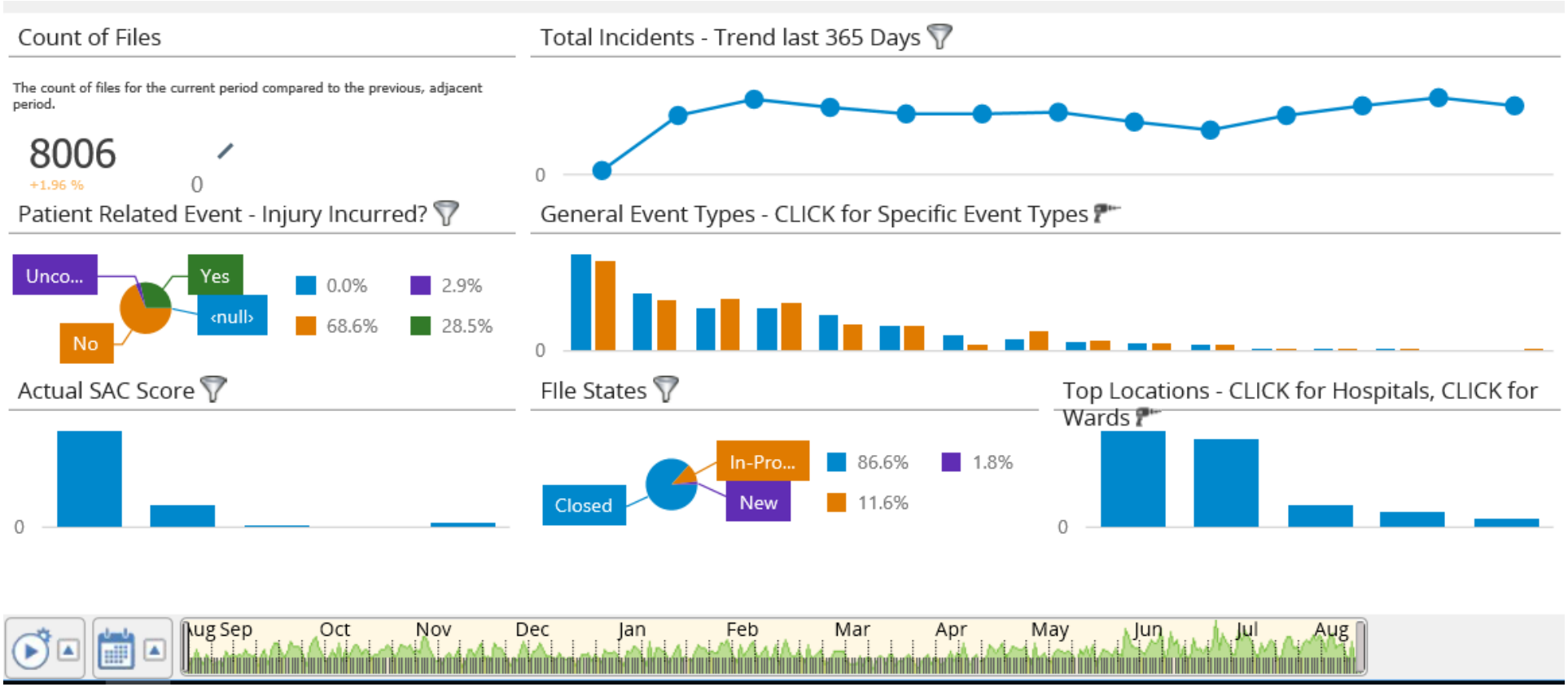
- Quality Indicators in Power BI



QF C3

Quality dashboards

- Quality Indicators in Safety First



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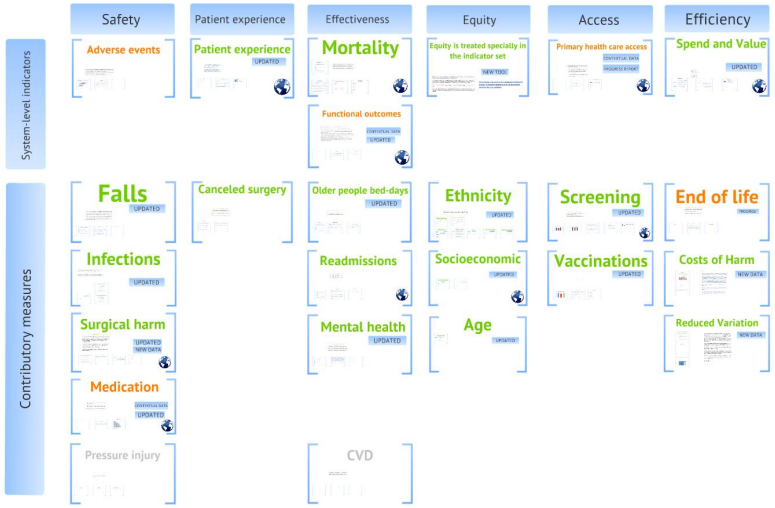
QF C3

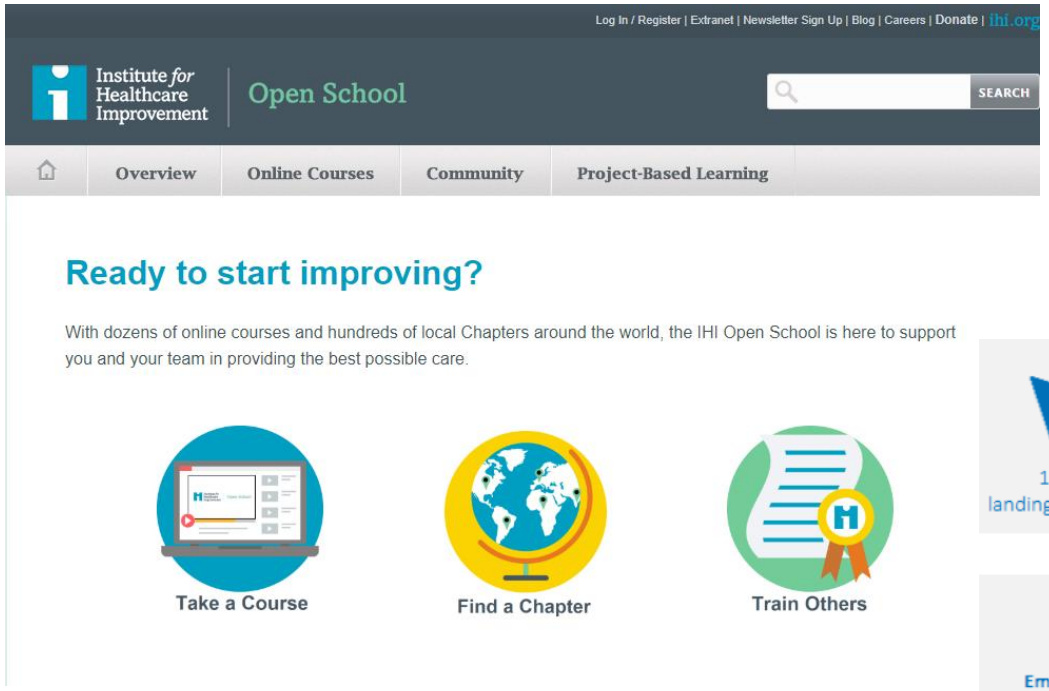
Quality dashboard

- Being developed at organisation wide and service levels
- Designed to be self service
- Support service level quality / clinical governance meetings supporting service level accountability
- Include benchmarks where available such as Health Round Table, HQSC Quality & Safety Markers
- Will continue to develop

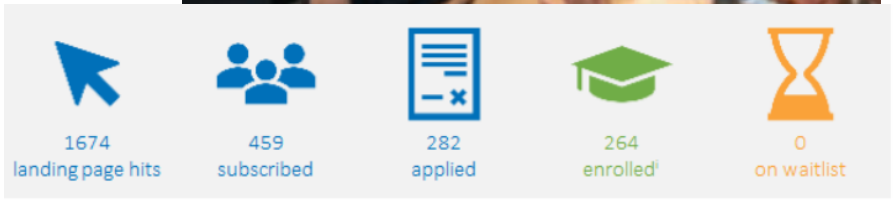


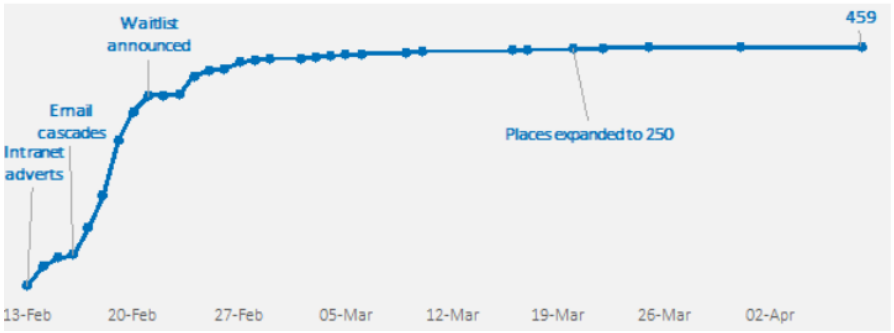
QF C4

Tools to enable & empower - education



- Improvement Movement





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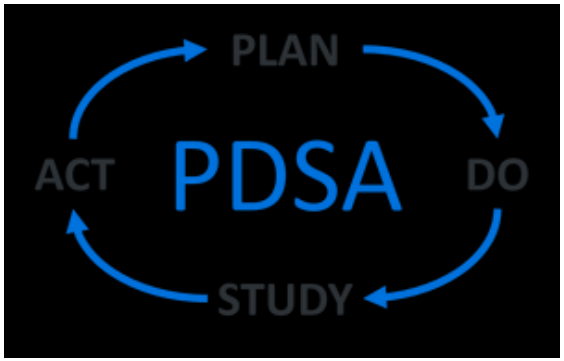
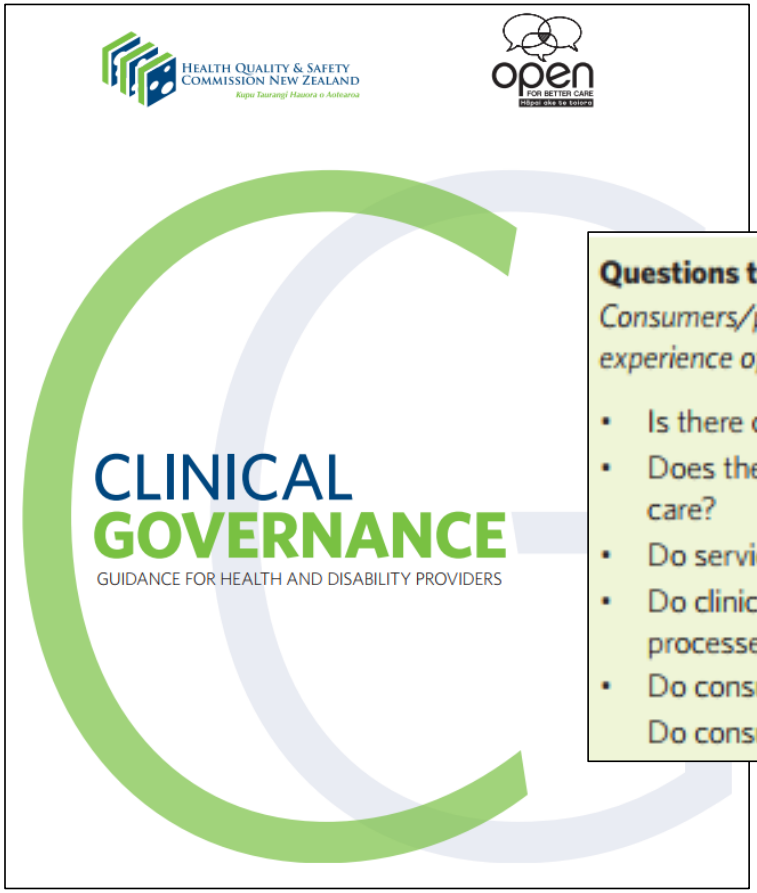
QF C4

Tools to enable - improvement



QF C4

Tools to enable – self assessment



Questions to consider

Consumers/patients should be at the centre of any clinical governance system. Their health outcomes and experience of care should be transparent to all and used to continuously improve services.

- Is there clear, open and respectful communication between our organisation and consumers?
- Does the board engage with consumers, and proactively seek their feedback on their experience of care?
- Do services learn from that feedback?
- Do clinicians participate and partner with consumers/patients in designing quality systems and processes of care?
- Do consumers/patients participate in the planning and evaluation of services for improvement?

  Do consumers/patients participate in key committees?

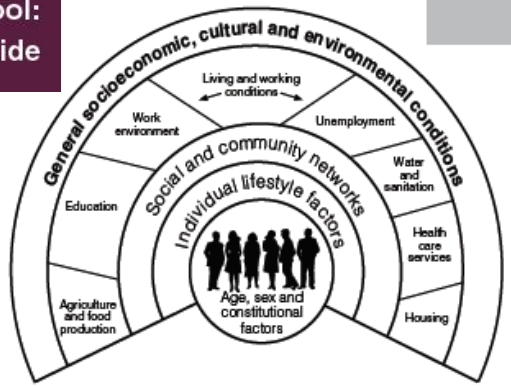
12.1

QF C4

Tools to enable – HEAT

The Health Equity Assessment Tool:
A User's Guide

1. The main determinants of health



Source: Dahlgren and Whitehead 1991.[33]

Type of inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. How did the inequality occur?
Consider the range of inequalities.	What do you know about inequalities in relation to this health issue?	Who is advantaged in relation to the health issue being considered and how?	What causal chain(s) leads to this inequality?
Ethnic			
Gender			
Socioeconomic			
Geographical			
Disability			

Naku te rourou nau te rourou ka ora ai te iwi

With your basket and my basket the people will live

12.1

Clinical Governance Policy

Purpose

This policy establishes the clinical governance framework and responsibilities for Southern District Health Board (SDHB) services which are foundational to Health Excellence, the Health and Disability Services Standards 2008, and professional practice requirements. This process will respect the responsibilities of Te Tiriti o Waitangi at every stage.

Policy

The pursuit of excellence and continuous improvement is vital to every part of SDHB. Throughout the organisation quality and safety must be the top priority. Clinical governance is not an isolated sperate process. As outlined by the Health Quality and Safety Commission (HQSC) in their 2016 publication "Governing for Quality": Quality of health care is inextricably linked to ensuring the financial health of an organisation. It is imperative that management roles work in partnership with the clinical leadership roles, to bring the business side together with quality and clinical governance and to get the correct shared outcomes of a high quality safe and efficient service.

The quality conversation together with management, finance and human resources in a joined-up forum at all levels of the organisation will create a reliable, resilient and distributed shared leadership to safeguard patients and service provision, while enabling staff to thrive. Teams should ensure core programmes, processes, standards, functions, and professions' activities are monitored, and networked across the organisation, to sustain alignment and consistency in how we do things. We will be data driven, monitoring core processes and functions, and are guided by the Health Quality and Safety Commission Clinical Governance Framework (2017) to assure, improve and enhance the quality of care. These processes and results combined with quality assurance and continuous improvement activity undertaken by corporate and support services will contribute to overall Health Excellence.

Applicability

Applies to all staff and teams within SDHB.

Roles and Accountabilities

Our People

- Communicate in a way that demonstrates mutual trust, openness, respect, and empathy.
- Partner and engage with patients and their family/ whanau and customers, stakeholders, and teams for best outcomes.
- Continue to learn and develop.
- Support colleagues to do the 'right thing'.
- Work collaboratively within teams and across services in the best interests of patients and the system.
- Use the provided systems to manage and report on practice, quality and risk.
- Participate in continuous improvement activity in teams, services, and professions.

Service, Ward & Unit Managers

For the purposes of this policy service, ward and unit managers have department, area, ward or unit team members reporting to them. In addition to Our People's responsibilities they:

- Provide leadership, foster a team culture, plan, co-ordinate and evaluate clinical governance and Health Excellence in their teams, continuously improving care and services.
- Operate robust quality and risk management systems.
- Work across the system to improve the patient journey, connecting, standardising to reduce variation, waste and waits while retaining patient centred care.

In addition, **Professional, Clinical and Service Leaders** agree the allocation of responsibilities for multi-professional clinical governance at service cluster or Directorate level. They:

- Champion a quality and safety culture across the organisation and provide direction to improvement effort.
- Ensure key indicator measurement processes are agreed, robust, and the results are regularly reviewed and actioned.
- Link with and bring together service teams, creating and making the connections and highlighting the links.
- Enable teams, Services, and Directorates to engage consumers in planning, design, and evaluation of improvements, sharing learnings.
- Monitor and evaluate governance processes and outcomes to ensure teams are meeting their Clinical Governance Agenda and are prepared and enabled for success.
- Maintain and socialise a risk register with regular review to identify risks and promote timely mitigation or escalation.

Directorate Leadership Teams

- Bring together interdisciplinary teams:
    - Communicating the strategic direction and goals, translating how these apply to services and improvements.
    - Planning, design, improvement, and evaluation of processes and outcomes.
    - Assuring service quality and performance, risk management and health and safety.
- Use the Quality Framework and Clinical Governance Policy, to guide continuous improvement.

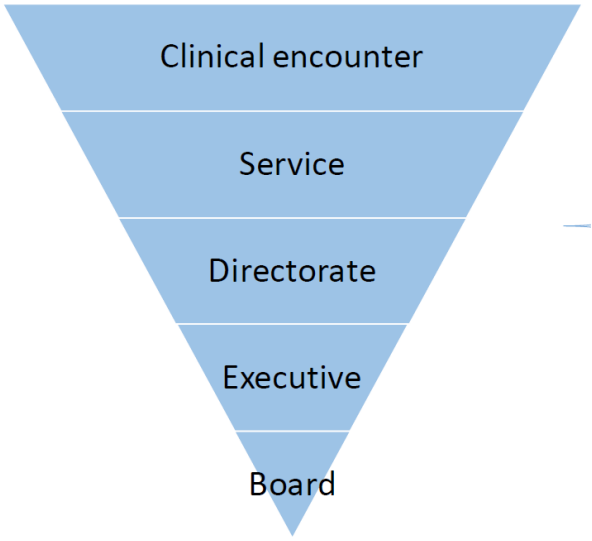
- Make sure the Directorate's Governance Groups in services and teams are fully functioning and achieving their Clinical Governance Agenda.
- Enable dissemination of information, enabling sharing of progress, learnings, setting improvement priorities, tracking progress, and quickly adjusting for success.

Quality & Performance and Patient Safety & Risk Managers and Teams

- Provide quality, patient safety, and clinical risk management leadership across the organisation, linking with external agencies such as the Health Quality and Safety Commission and Health Round table to align direction.
- Ensure the ongoing prioritisation, development, implementation, monitoring and evaluation of quality and patient safety measures, systems, and frameworks.
- Actively promote a 'whole of system' approach across services for quality and patient safety initiatives.
- Providing locally relevant, timely and digestible metrics to allow services to understand and be accountable for their outcomes.

Service Level Clinical Governance Meetings

The Team, Service, Department, and Directorate Clinical Governance Groups share a common agenda for a joined-up approach. Each service aligns their team's and professions' clinical governance activity. This is integrated at Directorate level. The SDHB Clinical Council has oversight of clinical governance in health care services provided by the Southern District Health Board. The Clinical Council is to deliver the objectives laid out in the Terms of Reference set by and agreed with the CEO. The Clinical Council has sub-committees (Standing Committees) that support the core clinical functions and have agreed Terms of Reference with key performance indicators related to their objectives. They are established by the SDHB Clinical Council and feedback regularly.



Corporate Services

All corporate services maintain active risk, quality assurance and improvement system. Quality Domains guide leadership, planning, monitoring, reporting and is evidenced in Health Certification processes.

Strategy & Planning

Strategy & Planning work alongside managers, senior leaders and partners to plan our strategic direction and determine how resources are allocated across the health system. Strategy & Planning

engage throughout the system to design health services to meet population need, integrating the patient journey and supporting leaders to drive system improvement using data.

People and Capability

People and Capability supports, enables and empowers the people of our health system to achieve its vision and strategic goals. Ultimately, it impacts patient care by supporting the development of an enabling environment in which the patient is at the very centre of everything we do.

Executive Leadership Team

The Executive Leadership Team (ELT) is responsible for the overall performance of our health system, for providing leadership and has overall accountability for results. ELT members lead the planning, assurance, and improvement programmes for SDHB and enable and empower distributed leadership for results. The Quality Framework encompasses the full organisation continuous improvement programme, with Clinical Governance a key building block.

Board.

The role of the Board is to embrace the principles set out in "Governing for Quality", HQSC, 2016.

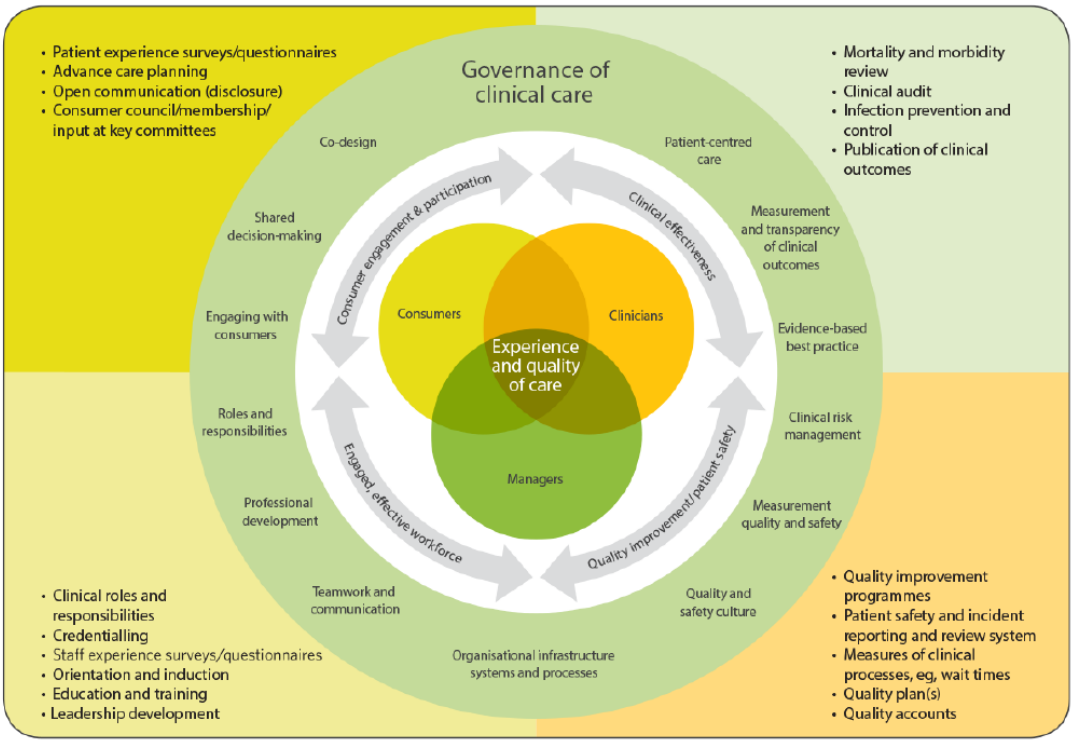
- Setting direction
- Ensuring accountability
- Shaping organisational high quality and safety culture
- To create the right environment for organisational learning

The Board ensures the quality of health care is inextricably linked to ensure the financial health of the organisation. That the consumer voice is listened to and heard and equitable outcomes are achieved for all. The Board, with the senior leadership team, sets the organisation's strategic quality direction and goals for improvement. The board and senior leaders model the desired attitudes and values that drive quality improvement from a firm foundation of compassionate, patient-centred and high-quality care. This approach centralises the quality and safety of consumer care at the heart of everything we do

Definitions

Clinical Governance

Clinical governance provides a means for clinicians, managers, and supporting staff to work together to improve and be held accountable for the quality and safety of the health and disability services they provide (HQSC 2017).



Process for Improvement

The Process for Improvement (also known as quality improvement) is vital to SDHB as it is the methodology by which we achieve less avoidable harm and waste, foster bottom-up innovation, improve patient flow, reduce inefficient variation, and build a better health care system. Upskilling and enabling improvement for each member of staff will make their jobs easier and open the door to an engaged and empowered workforce with ownership and pride over the organisation's future.

The science of improvement is an applied science that emphasises innovation, rapid cycle testing in the field, and spread in order to generate learning about what changes, in which contexts, produce improvements. It is characterized by the combination of expert subject knowledge with improvement methods and tools. It is multidisciplinary — drawing on clinical science, systems theory, psychology, statistics, and other fields. The SDHB's process for improvement is aligned to the Institute for Health Improvement (IHI). IHI's methodology traces back to W. Edwards Deming (1900-1993), who taught that by adhering to certain principles of management, organizations can increase quality and simultaneously reduce costs. Based on Deming's work, the Model for Improvement was created by Associates for Process Improvement (API) as a simple, effective tool for bringing about positive change.

The Model for Improvement asks three questions — What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement? — and then employs Plan-Do-Study-Act (PDSA) cycles for small, rapid-cycle tests of change.

Building the Capability to Improve

Southern DHB employees to have two roles. One is their daily role within the DHB in helping deliver care to our community. The other is to help improve the system around them. Thus, to realize our ambitions as a progressive organisation, we need to provide better improvement training and support. In response to this need the Quality & Clinical Governance Solutions Directorate set up the *Improvement Academy*.

The Improvement Academy

The Improvement Academy's mission is to make improvement everybody's second job. Its aims are:

- To disseminate improvement ethos and methodology throughout the frontline staff
- To enable bottom-up innovation and improvement: the 'Improvement Movement'
- To provide a home and a platform for improvement projects
- To identify future leaders for the Leadership Development Pathway

The IHI Open School is a key enabler the program is designed to be easy for busy frontline staff to fit the learning in and around their busy work/home schedules. The 13 modules lead to a recognised qualification, Basic Certificate in Quality and Safety, and include PDSA, statistical process control, preventing errors, human factors, teamwork, and communication.

Quality

The right care or service and support, by the right person, at the right time, in the right place, with the right patient or customer experience. The dimensions of quality definitions inform measurement:

Safe: Avoiding injuries to patients from the care that is intended to help them.

Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse). Doing the right thing for the right person at the right time.

Patient/Whanau-centred: Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. It can be thought of as respectfully involving the patient in a way that helps practitioners provide care that is concordant with their patients' values, needs and preferences while better enabling patients to actively provide input and participate in their healthcare.

Timely: At the time prescribed by the agreed standard. Reducing waits and unfavourable delays for both those who receive and those who give care.

Efficient: Avoiding waste, such as waste of supplies, equipment, time, and effort.

Equal/Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status (Institute of Medicine, 1999).

Quality Risk Management System

Established, documented, and maintained quality and risk management system includes data for and full quality improvement cycle (includes audit), consumer participation, policy and procedure with control, quality and risk plan, event reporting (incidents), feedback system (experience surveys, complaints management, compliments, suggestions), infection prevention control, health and safety and restraint minimisation (NZ HDSS 8134.0:2008 - 2.3).

Policy measures

- Teams: 100% use a set of key performance indicators that cover Leadership, Patient Safety, Patient Experience, Efficiency, and follow the Clinical Governance Agenda.
- 100% of Team key performance indicator results that do not meet requirements have action plans.
- 100% of SDHB Quality Improvement activity is visible in the Learning and Sharing library.
- Health and Disability Services Standards Certification is maintained.

Appendix 1	Quality Framework
Appendix 2	Clinical Governance Departmental and Service Level Implementation
Appendix 3	Clinical Governance Agenda
Appendix 4	Reporting Schedule Clinical Council
Appendix 5	Benchmarking of organisational Clinical Governance
Appendix 6	Service Level Clinical Governance Self-Assessment

Appendix 2

Departmental and Service Level Clinical Governance

Clinical Governance

Clinical governance provides a means for clinicians, managers, and supporting staff to work together to improve and be held accountable for the quality and safety of the health and disability services they provide (HQSC 2017).

Therefore, Clinical Governance is an implemented process, a series of interlinking activities, that if carried out within a quality framework will lead to improvement in outcomes for our patients.

The success of the implementation will be enhanced by the review of individual and service metrics (performance), through a framework of accountability.

Implementation at Departmental and Service Level

Clinical Council has agreed on a standardised clinical governance (CG) approach to be rolled out in the organisation. A Clinical Governance Agenda has been reviewed by council (appendix 3).

To embed Departmental and Service Level Clinical Governance across the DHB. We propose the following implementation plan

1. A pre-implementation benchmark of the current level of Clinical Governance awareness and status within SDHB based on the Clinical Governance Development Index (CGDI).
2. Self-assessment of services current CG activities. To allow prioritisation of input, self-grading of governance literacy and desired dataset. (Appendix 4)

3. Identification of a minimum set of clinical governance metrics for each Department and Service. To include:

    a. Annual Professional Development (Appraisal) compliance
    b. Mandatory training compliance
    c. Patient Experience
    d. Local hand washing data
    e. Cancelled outpatient/theatre/procedure data
    f. Adverse events
    g. Compliments
    h. Complaints, themes, and rates
    i. Risk register

Ward-based disciplines:

a. Pressure injury
b. Falls
c. Length of stay
d. Day 7 and 28 readmission rates
e. Antibiotic stewardship
f. VTE metrics to ensure compliance with policy
g. Line associated infections
h. Urinary Catheter associated infections

4. Each department and service will review the data available from the Health Round Table, the HQSC or other collaborative data sharing forum specific to their service to include additional quality metrics reported by these organisations to enable national and international benchmarking to their peers. The actual metrics will be agreed to and collated by the department, ward or service and directorate. The metrics may well vary and change and are therefore not included as part of the policy.

5. Engage with Senior Leaders Clinical Directors, Service Managers, Charge Nurse Managers and Allied Health leaders to implement the Clinical Governance Policy and Departmental and Service level. Each directorate will incorporate the department, ward or service clinical governance agendas and metrics to their Performance and Accountability Frameworks.

- Structure the meetings to ensure team inclusivity and participation
- Create the culture of positive improvement
- Have open, kind discussion on the agreed clinical governance metrics.
- Set the expectation of an Annual Clinical Governance Report as per the report template for Clinical Council. Rotational Clinical Council Annual reporting (appendix 5)

6. Promote an environment of shared learning between services and departments where more advanced clinical governance advocates explore methodology and learnings with less progressed services.

5. The improvement trajectory to be measured by repeated CGDI assessment, the Service Level Metrics (in point 3 above), HRT datasets relating to patient safety and hospital related harm, reviewed on yearly basis by clinical council.

6. Implementation to be staged with full uptake in departments being anticipated by June 2022.

Key stake holders:

Clinical Chiefs

Clinical Council Membership

ED Q&CGS

General Managers

Medical, Nursing and Allied Health Scientific and Technical l Directors

Clinical Directors and professional leads

SMO, Charge Nurse Managers and Senior Allied Health.

Departmental champions Nurse/Allied Health/RMOs

Appendix 3

Quality & Clinical Governance
MEETING AGENDA

Date:

Service	
Time:	
Venue:	
Attendees:	
Attendance:	
Apologies:	

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

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

12.1

Appendix 4 Reporting Schedule Clinical Council

To be Confirmedon basis of self assessment exercise .

Appendix 5

Clinical Governance Development Index (CGDI)

Item	Scoring	CGDI item from 2010 survey	CGDI item from 2012 survey
1	Yes = 1, No = 0	To your knowledge, has your DHB board established a governance structure that ensures a partnership between clinicians and management?	To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management?
2	A great extent = 2, Some extent = 1, No extent = 0	To what extent are clinicians in your hospital involved in a partnership with management with shared decision making, responsibility and accountability?	To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?
3	A great extent = 2, Some extent = 1, No extent = 0	To what extent are clinicians in your hospital involved as full active participants in all governance decision making processes?	To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes?
4	A great extent = 2, Some extent = 1, No extent = 0	To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB hospital?	To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB?
5	A great extent = 2, Some extent = 1, No extent = 0	To what extent do you believe that quality and safety is a goal of every administrative initiative in your DHB hospital?	To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB?
6	A great extent = 2, Some extent = 1, No extent = 0	To what extent has your DHB sought to give you responsibility for clinical service decision making in your clinical areas?	To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas?
7	A great extent = 2, Some extent = 1, No extent = 0	To what extent has your DHB leadership sought to identify clinical leaders?	Not included.

Gauld, R., Horsburgh, S. Measuring progress with clinical governance development in New Zealand: perceptions of senior doctors in 2010 and 2012. BMC Health Serv Res 14, 547 (2014). https://doi.org/10.1186/s12913-014-0547-8

Clinical Governance Development Index (CGDI)			
	No (score = 0)	Yes (score = 1)	
To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management?			
	No Extent (score = 0)	Some Extent (score = 1)	A Great Extent (score = 2)
To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?			
To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes?			
To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB?			
To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB?			
To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas?			
To what extent has your DHB leadership sought to identify clinical leaders?			

Gauld, R., Horsburgh, S. Measuring progress with clinical governance development in New Zealand: perceptions of senior doctors in 2010 and 2012.

BMC Health Serv Res 14, 547 (2014). https://doi.org/10.1186/s12913-014-0547-8

Appendix 6

Clinical Governance Self-Assessment Template for Service Leaders.

Please complete in collaboration with your service manager

Department Name:

Date _ _/_ _/_ _ _ _

Does your department have a clinical governance meeting?

Y N

Frequency of Clinical Governance Meetings:

Monthly bi-monthly 6-Monthly Annually

Does it have a set agenda? (If yes please append to reply)

Y N

Who attends the meeting? Highlight attendees

SMO DON CNM NS RN AH Registrar Interns Consumer

Does your department have a specified inpatient location?

Y N

Is your department part of a National or International Governance benchmarking programme

Y N if Yes please describe:

Does your department have a local risk register?

Y N

How often is it reviewed?

Monthly bi-monthly 6-Monthly Annually

Does your department have a regular mortality and morbidity meeting?

Y N

Do you use the suggested DHB process for this?

Y N

What is the frequency?

Monthly bi-monthly 6-Monthly Annually

How would you assess your departmental clinical governance literacy?
(1 little or none, 5 highly skilled)

1 2 3 4 5

Please see attached indicative agenda, what support do you envisage you may need to achieve this?

Are there any specific additional metrics you think you would benefit from access to?

Do you have anything further you would like to highlight to us?

Thank you for your contribution towards Patient Safety

Please email response to ClinicalCouncil@southerndhb.govt.nz

FOR INFORMATION

Item:	Reducing Hospital Acquired Complications
Prepared by:	Patrick O'Connor, Quality Improvement Manager
	Hywel Lloyd Interim Director Quality & Clinical Governance Solutions
Meeting of:	Board – 3 May 2022

Recommendation

The Board notes the attached plan for reducing hospital acquired complications (HACs).

Purpose

This paper details a plan for reducing hospital acquired complications in the Southern DHB

Specific Implications for Consideration

1. **Financial**
   - HACs introduce additional cost into the hospital system as they require additional treatment and resource. Patients with HACs typically require more days in hospital
2. **Workforce**
   - HACs place additional stress on our already stressed workforce
3. **Equity**
   - Based on the limited data we have available there do not appear to be major inequities for our Māori patients
4. **Other**
   - None

Background

5. Hospital acquired complications are a concern for all hospitals, patients, and staff. They cause harm to patients, additional workload, and stress to staff, as well as these patients occupying much needed bed days
6. We follow the Australian model where HACs fall into the following categories: pressure injuries; falls; healthcare associated infections; surgical complications; respiratory complications; venous thromboembolism; renal failure; gastrointestinal bleeding; medication complications; delirium; incontinence; endocrine complications; cardiac complications; perineal laceration during delivery; neonatal birth trauma
7. We provide clinical coding data to the Health Round Table who provide benchmarking services, as well as self-reporting some categories of HACs through our safety1st system, and to the HQSC through point prevalence audits which involve sampling.
8. The work to reduce the number of HAC has to flow on top of robust structures of clinical governance. The paper, Reaffirming Clinical Governance, outlines our approach to strengthen our structures, improve our understanding of clinical governance, and lift the conversation quality within services, wards and departments. The paper also describes the importance of an accountability framework wrapped around our clinical governance work to ensure good outcomes are shared and where improvements are required, they happen.
9. Our clinical governance processes are of mixed maturity with some specialities having regular discussions about patient safety and HACs and others less so.

10. The Quality and Clinical Governance Directorate has a number of initiatives underway to reduce the prevalence of HACs

11. **Patient Safety Walkabouts**
    - This is a ward based and clinician focussed approach to patient safety. It involves patient safety discussions based on a safety theme. The themes covered so far are healthcare associated infections and falls with pressure injuries and medication errors to follow. The aim of these walkabouts are to raise awareness of HACs and what is required to reduce them.

12. **Early Warning Scores & Shared Goals of Care**
    - The recognition and Response committee is providing the oversight of these two quality and safety programmes. While both are in their early stages. They are being supported by the Korero Mai HQSC work to encourage whanau to speak up when they have concerned for their relatives' condition. We have posters and education of juniors to encourage them to call there Senior Medical Officers for support and a change in management plan when EWS scores deteriorate.

13. **Patient Safety Dashboard**
    - One of the issues we have is presenting HAC information in a meaningful way to clinicians. Most of the data we have is at hospital or DHB level, is difficult to access or is sometimes up to six months old
    - With IT's help we have developed a Patient Safety Dashboard. This is modelled on the clinical coding used by the Health Round Table and displays the number of HACs over time. This can be segmented by ward or speciality, is up to date and is based on the DHBs standard reporting platform
    - The Patient Safety Dashboard will provide the key metrics for services, wards, and departments to support their quality and safety work to reduce their HACs.

14. **Ward Round Safety Check Lists**
    - Check lists have been implemented on 6 ATR and the general medicine ward rounds are the next site for expanding the trial. These are to ensure there is increased awareness of the possibility of a hospital acquired complication and for interventions to be made to reduce the likelihood of complications occurring.

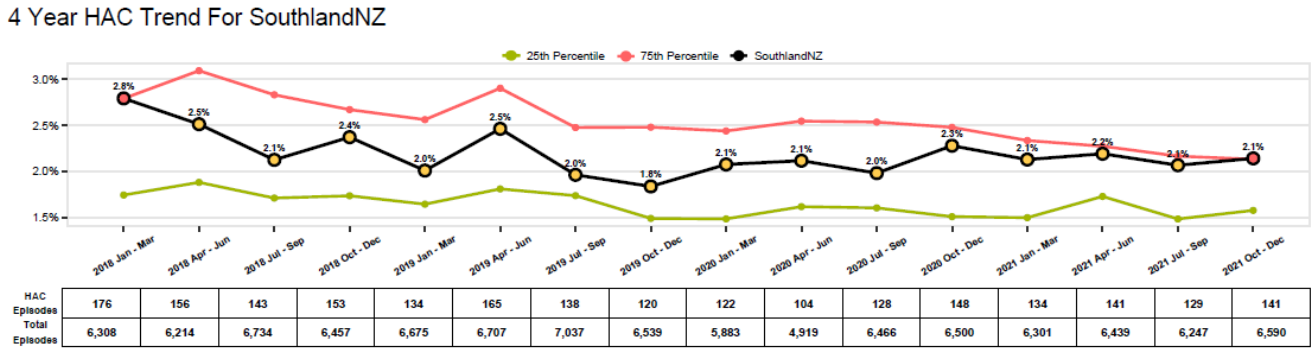
15. **Infection Prevention and Control**
    - Significant investment has already been made to increase the IPC resource. With the expectation of reducing HAIs.

Discussion and recommendations

16. **Hospital Acquired Complications**
    The HRT data provides two types of reports a New Zealand DHB comparison report and a hospital peer group report which predominantly compares our hospitals to Australian peer equivalents.

    Southland Hospital historically has compared favourably to its HRT peers, though the last quarter Oct-Dec 21 Southland was red for HAC for the first time since Jan-= Mar 18. Graph 1

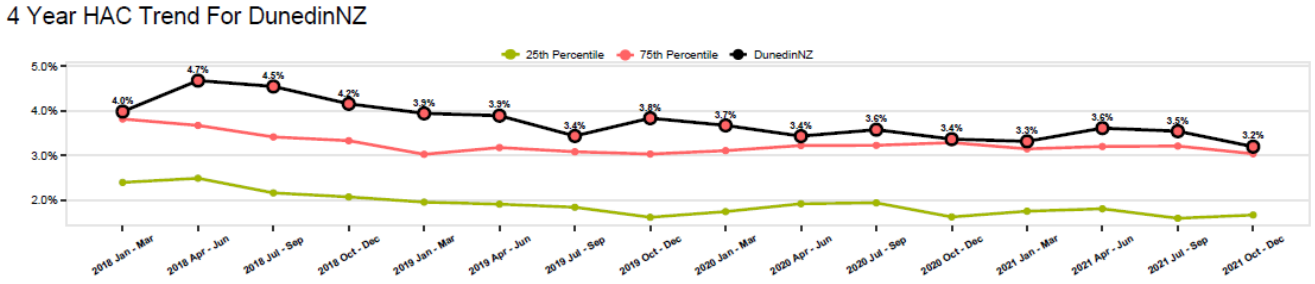
Graph 1



	2018 Jan - Mar	2018 Apr - Jun	2018 Jul - Sep	2018 Oct - Dec	2019 Jan - Mar	2019 Apr - Jun	2019 Jul - Sep	2019 Oct - Dec	2020 Jan - Mar	2020 Apr - Jun	2020 Jul - Sep	2020 Oct - Dec	2021 Jan - Mar	2021 Apr - Jun	2021 Jul - Sep	2021 Oct - Dec
HAC Episodes	176	156	143	153	134	165	138	120	122	104	128	148	134	141	129	141
Total Episodes	6,308	6,214	6,734	6,457	6,675	6,707	7,037	6,539	5,883	4,919	6,466	6,500	6,301	6,439	6,247	6,590

Graph 2

Dunedin Hospital has been stubbornly red compared against its HRT peers.



	2018 Jan - Mar	2018 Apr - Jun	2018 Jul - Sep	2018 Oct - Dec	2019 Jan - Mar	2019 Apr - Jun	2019 Jul - Sep	2019 Oct - Dec	2020 Jan - Mar	2020 Apr - Jun	2020 Jul - Sep	2020 Oct - Dec	2021 Jan - Mar	2021 Apr - Jun	2021 Jul - Sep	2021 Oct - Dec
HAC Episodes	396	468	480	417	395	407	382	407	362	296	391	356	340	378	368	340
Total Episodes	9,953	10,016	10,571	10,043	10,030	10,471	11,129	10,622	9,865	8,632	10,943	10,589	10,266	10,474	10,398	10,647

Southern DHB when we take Southern DHB and compare ourselves to other DHBs in the HRT reports we sit at the lower end of the middle tertile. We are ranked 8th out of 13 DHBs who are part of HRT.

17. **HACs, where should we focus our attention**? When you take the HRT Dunedin and Southland hospital reports the following areas stand out as areas for improvement (Red indicates a Southland, issue too):
    a) Pressure injury
    b) Healthcare associated Infections
    c) Surgical complications
    d) Respiratory complications
    e) Venous thromboembolism
    f) Medicine complications
    g) Delirium
    h) Incontinence
    i) Cardiac complications
    j) Perineal lacerations

18. When we utilise the HRT Southern DHB comparator data to other DHBs see Appendix 1. The priority areas for improvement are identified as:

    a) Surgical complications
    b) Respiratory complications
    c) Venous thromboembolism
    d) Medicine complications
    e) Delirium

f) Incontinence
g) Cardiac complications
h) Perineal lacerations

Next Steps & Actions

19. Implement the steps described in the companion paper 'Reaffirming Clinical Governance'

20. Re prioritise the work of the Quality Improvement team to align with the priority areas above.

21. Explore with the clinical teams the data from the HRT reports. Undertake deeper dives into the coding and utilise additional quality data to verify the areas of concern.

22. Explore with the teams, services, wards and departments the causes of the high levels of HACs.

23. Implement PDSA cycles of agreed interventions based on the identified causes and international best practice to reduce the levels of complications.

24. Monitor progress and work success via the Patient Safety Dashboard

25. Through the Performance and Accountability framework highlight success and work through barriers to quality and safety improvement.

Appendices

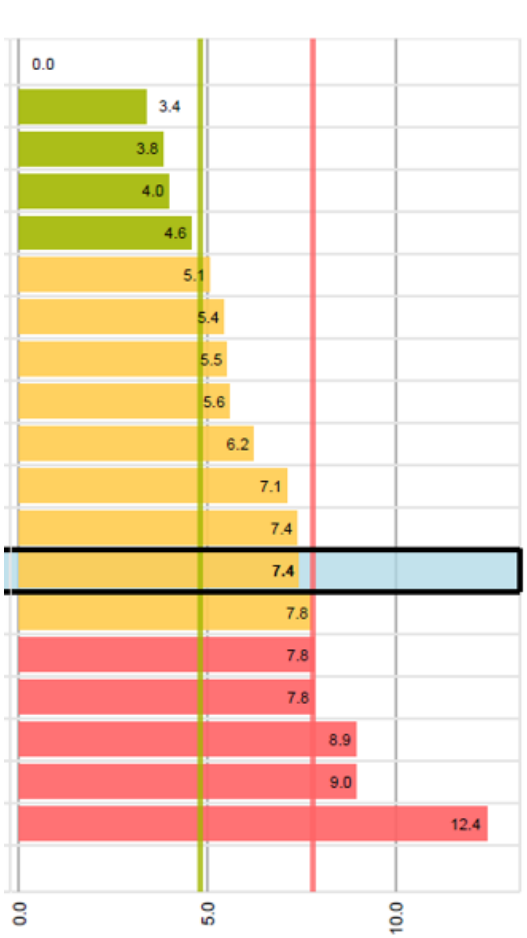
Appendix 1 HRT DHB Comparator Reports

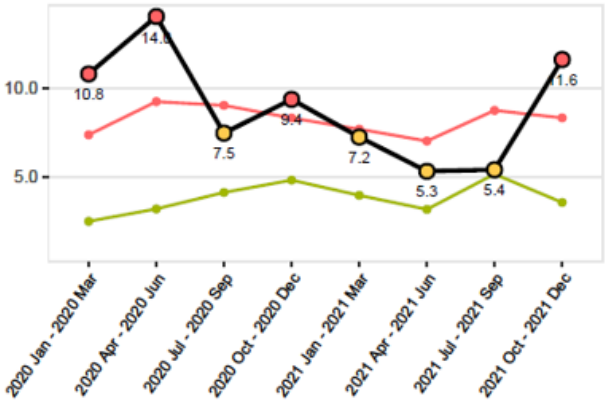
Appendix 1 HRT DHB Comparator Reports

SouthernNZ+ | Jan 2021 - Dec 2021 | Hospital-Acquired Complications Report |

1 - Pressure injury per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec) | Newly Red





Formula: [Pressure injury episodes]/[total episodes] *10,000

Source: Casemix

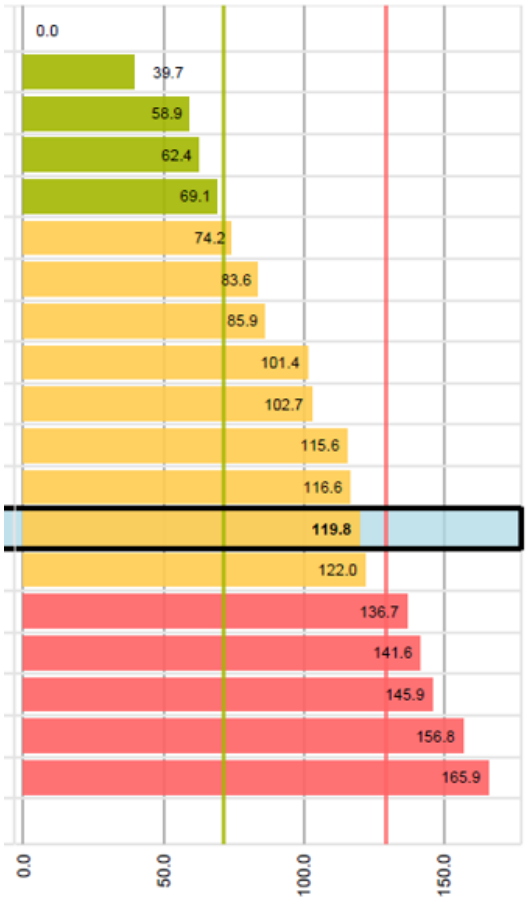
Description: Includes the diagnosis groups: 1.1 Stage III ulcer, 1.2 Stage IV ulcer, 1.3 Unspecified decubitus and pressure area, 1.4 Unstageable pressure injury, 1.5 Suspected deep tissue injury

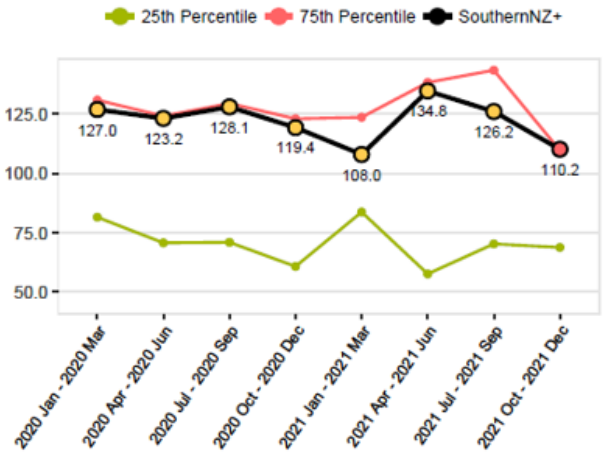
Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for stage III pressure injury (L892x), stage IV pressure injury (L893x), unspecified pressure injury (L899x), unstageable pressure injury (L894x) and suspected deep tissue injury (L895x) with onset in the hospital.

3 - Healthcare associated infection per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec) | Newly Red





Formula: [Healthcare associated infection episodes]/[total episodes] *10,000

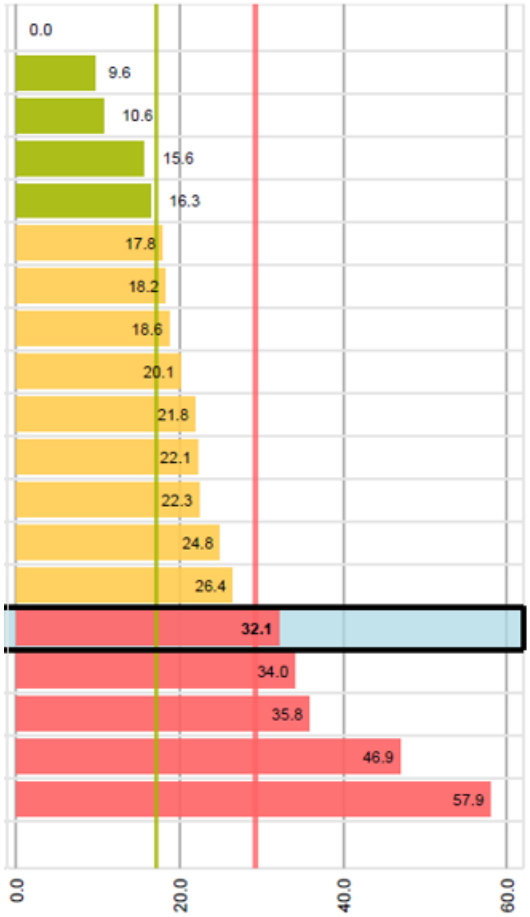
Source: Casemix

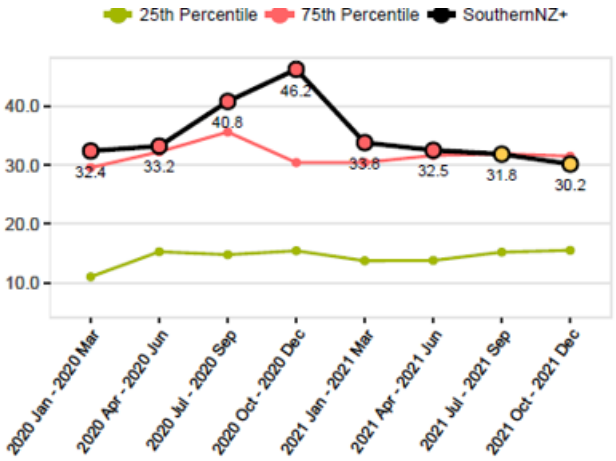
Description: Includes the diagnosis groups: 3.1 Urinary tract infection, 3.2 Surgical site infection, 3.3 Pneumonia, 3.4.Blood stream infection, 3.5 Central line and peripheral line associated bloodstream infection, 3.6 Multi-resistant organism, 3.7 Infection associated with prosthetics/implantable devices, 3.8 Gastrointestinal infections, 3.9 Other high impact infections

Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 11.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.
Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for the above mentioned diagnosis groups with onset in the hospital. Click here for more details: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31

4 - Surgical complications per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec)





Formula: [Surgical complications episodes]/[total episodes] *10,000

Source: Casemix

Description: Includes the diagnosis groups: 4.1 Post-operative haemorrhage/haematoma requiring transfusion, 4.2 Surgical wound dehiscence, 4.3 Anastomotic leak, 4.4 Vascular graft failure, 4.5 Other surgical complications requiring unplanned return to theatre

Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.
Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for the above mentioned diagnosis groups with onset in the hospital. Click here for more details:
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital

4 - Surgical complications details by diagnosis

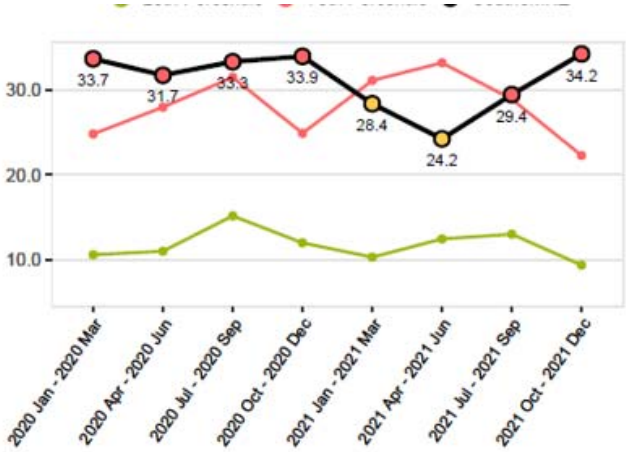
Trends at SouthernNZ+ (2021 Jan - 2021 Dec)

Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
4.1 - Post-operative haemorrhage/haematoma requiring transfusion per 10,000 episodes	12.5	6.2	14.6 14.8 14.9 22.2 12.1 14.2 13.2 10.4	10.4
4.2 - Surgical wound dehiscence per 10,000 episodes	4.9	4.9	5.7 3.8 8.6 4.7 3.6 4.7 5.4 5.8	5.8
4.3 - Anastomotic leak per 10,000 episodes	2.5	1.0	1.3 1.5 1.7 3.5 3.0 3.0 2.4 1.7	1.7
4.4 - Vascular graft failure per 10,000 episodes	0.3	0	1.3 0 0.6 1.2 0 0 0.6 0.6	0.6
4.5 - Other surgical complications requiring unplanned return to theatre per 10,000 episodes	14.3	9.9	10.8 15.5 19.5 17.0 19.9 12.4 11.4 13.3	13.3

2020 Jan - Mar | 2020 Apr - Jun | 2020 Jul - Sep | 2020 Oct - Dec | 2021 Jan - Mar | 2021 Apr - Jun | 2021 Jul - Sep | 2021 Oct - Dec

6 - Respiratory complications per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec)



Formula: [Respiratory complications episodes]/[total episodes] *10,000

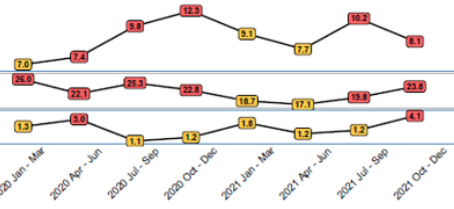
Source: Casemix

Description: Includes the diagnosis groups: 6.1 Respiratory failure including acute respiratory distress syndrome requiring ventilation (invasive and/or non-invasive), 6.2 Aspiration pneumonia, 6.3 Pulmonary oedema

Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.
Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for respiratory failure including acute respiratory distress syndrome requiring ventilation(J80, J9600, J9601, J9609, J9690, J9691, J9699), aspiration pneumonia(J690, J698, J954, J9582), and pulmonary oedema (J81) with onset in the hospital.

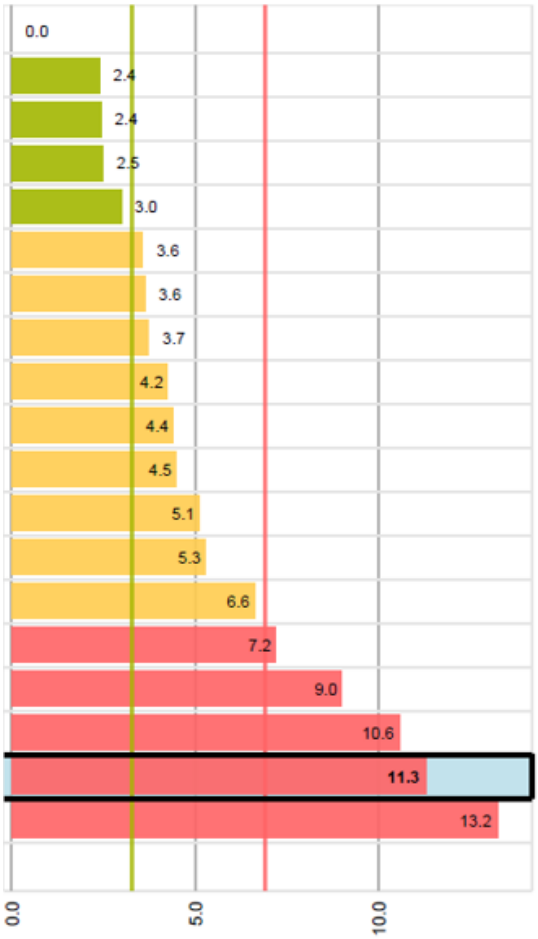
6 - Respiratory complications details by diagnosis

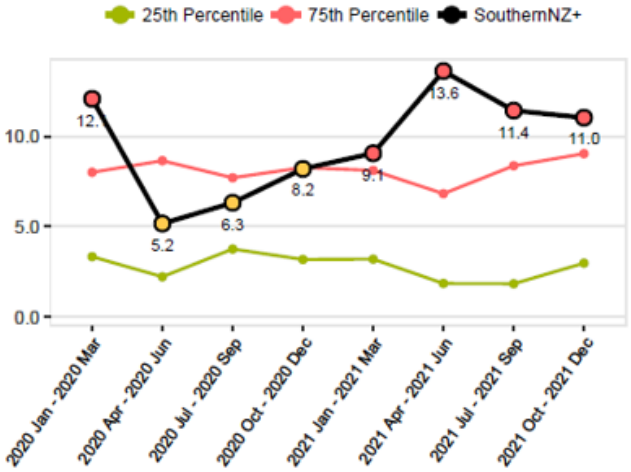
Trends at SouthernNZ+ (2021 Jan - 2021 Dec)

Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
6.1 - Respiratory failure including acute respiratory distress syndrome requiring ventilation per 10,000 episodes	8.8	4.1		8.1
6.2 - Aspiration pneumonia per 10,000 episodes	19.9	13.3		23.8
6.3 - Pulmonary oedema per 10,000 episodes	2.1	1.6		4.1

7 - Venous thromboembolism per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec) | Stubborn Red (last 4 periods)





Formula: [Venous thromboembolism episodes]/[total episodes] *10,000

Source: Casemix

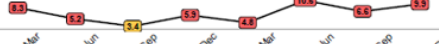
Description: Includes the diagnosis groups: 7.1 Pulmonary embolism, 7.2 Deep vein thrombosis

Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for pulmonary embolism(I260, I269) and deep vein thrombosis(I801, I8020, I8021, I8022, I8023, I8042, I808) with onset in the hospital.

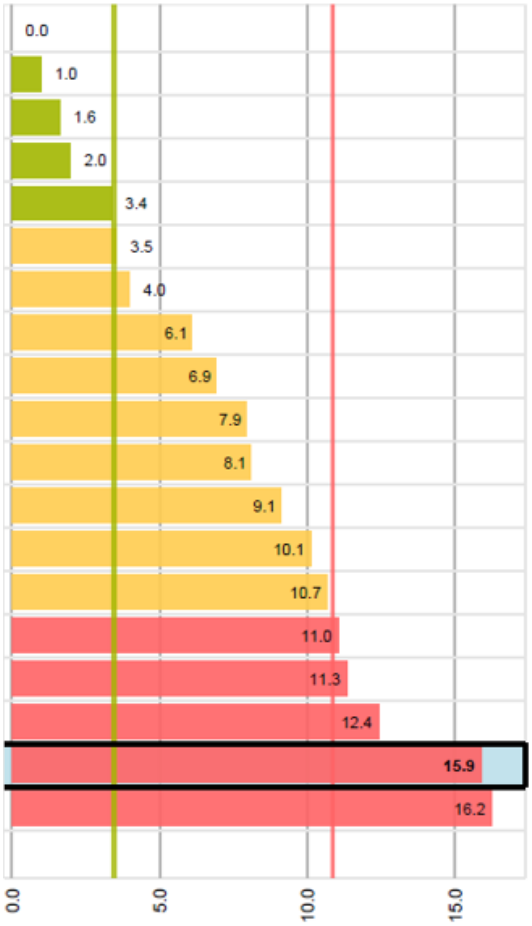
7 - Venous thromboembolism details by diagnosis

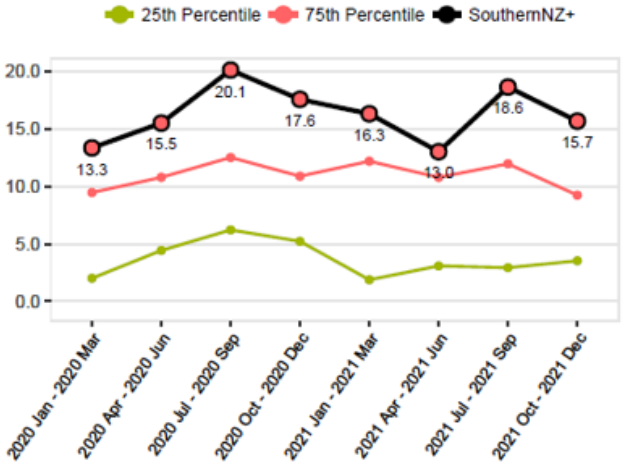
Trends at SouthernNZ+ (2021 Jan - 2021 Dec)

Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
7.1 - Pulmonary embolism per 10,000 episodes	4.0	2.5		1.2
7.2 - Deep vein thrombosis per 10,000 episodes	8.0	1.9		9.9

10 - Medication complications per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec) | Stubborn Red (last 4 periods)





Formula: [Medication complications episodes]/[total episodes] *10,000

Source: Casemix

Description: Includes the diagnosis groups: 10.1 Drug related respiratory complications/depression, 10.2 Haemorrhagic disorder due to circulating anticoagulants, 10.4 Movement disorders due to psychotropic medication, 10.5 Serious alteration to conscious state due to psychotropic medication

Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.
Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for the above mentioned diagnosis groups with onset in the hospital. Click here for more details:
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31

10 - Medication complications details by diagnosis

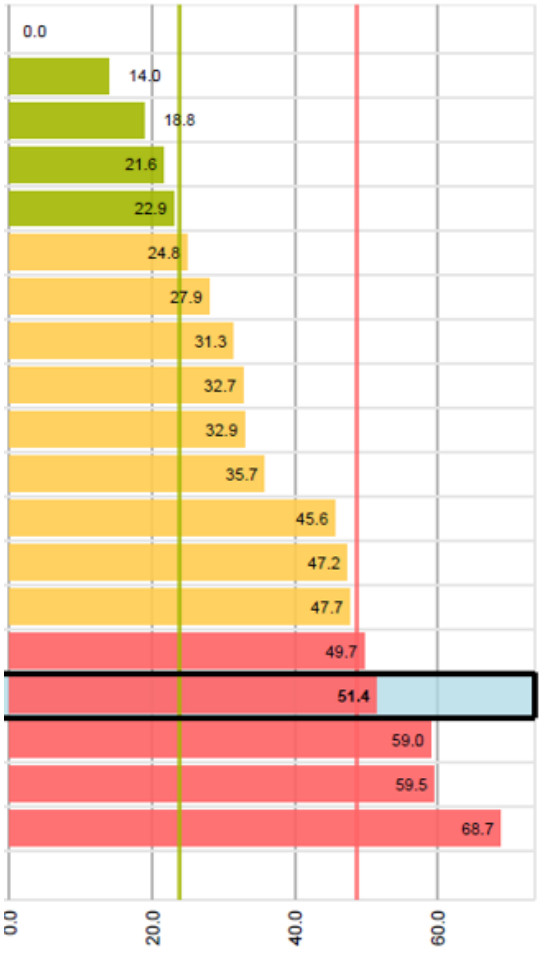
Trends at SouthernNZ+ (2021 Jan - 2021 Dec)

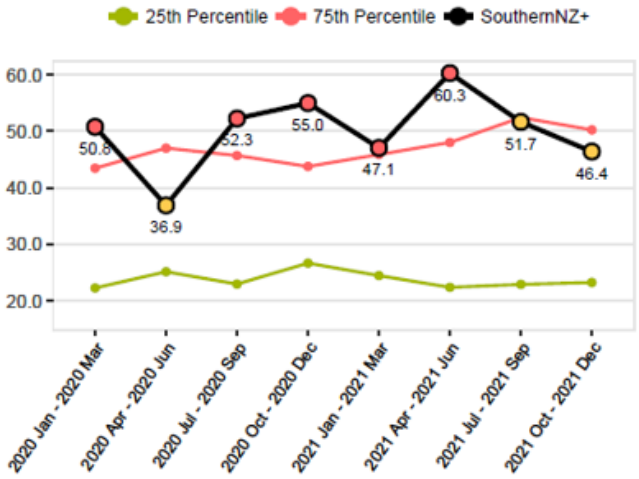
Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
10.1 - Drug related respiratory complications/depression per 10,000 episodes	2.2	0.3	1.5 1.5 2.3 2.3 2.4 1.2 1.8 3.5	3.5
10.2 - Haemorrhagic disorder due to circulating anticoagulants per 10,000 episodes	6.5	3.3	5.7 5.2 8.0 5.5 4.8 5.9 10.2 5.2	5.2
10.4 - Movement disorders due to psychotropic medicati per 10,000 episodes	2.1	0.8	1.3 2.2 5.2 2.3 1.2 3.0 1.8 2.3	2.3
10.5 - Serious alteration to conscious state due to psychotropic medication per 10,000 episodes	5.5	2.1	4.4 6.5 4.0 7.0 7.8 3.0 5.4 5.8	5.8

2020 Jan - Mar | 2020 Apr - Jun | 2020 Jul - Sep | 2020 Oct - Dec | 2021 Jan - Mar | 2021 Apr - Jun | 2021 Jul - Sep | 2021 Oct - Dec

11 - Delirium per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec)





Formula: [Delirium episodes]/[total episodes] *10,000

Source: Casemix

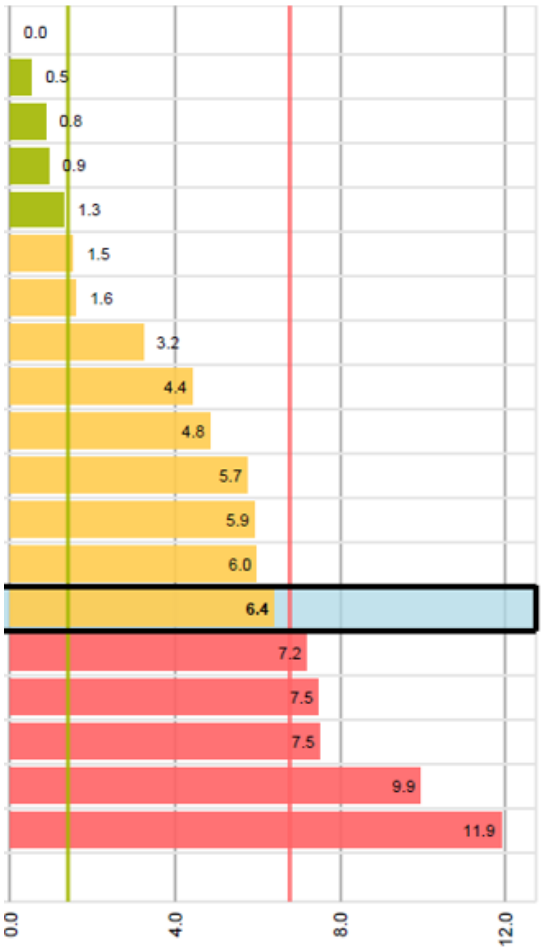
Description: Includes the diagnosis groups: 11.1 Delirium

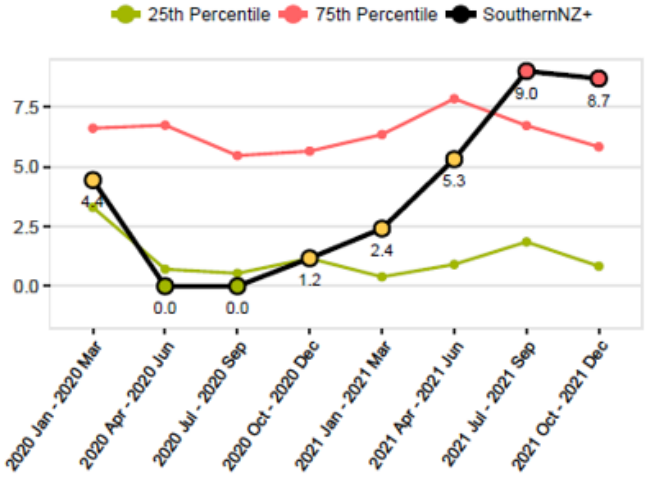
Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for delirium (F050, F051, F058, F059, R410) with onset in the hospital.

12 - Incontinence per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec)





Formula: [Incontinence episodes]/[total episodes] *10,000

Source: Casemix

Description: Includes the diagnosis groups: 12.1 Urinary incontinence, 12.2 Faecal incontinence

Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for urinary incontinence(R32, N393, N394) or faecal incontinence (R15) with onset in the hospital.

12 - Incontinence details by diagnosis

Trends at SouthernNZ+ (2021 Jan - 2021 Dec)

Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
12.1 - Urinary incontinence per 10,000 episodes	4.2	3.6	3.8 0 0 0.6 1.8 3.0 6.0 5.8	5.8
12.2 - Faecal incontinence per 10,000 episodes	3.4	1.5	0.6 0 0 0.6 1.2 3.0 5.4 4.1	4.1

2020 Jan - Mar | 2020 Apr - Jun | 2020 Jul - Sep | 2020 Oct - Dec | 2021 Jan - Mar | 2021 Apr - Jun | 2021 Jul - Sep | 2021 Oct - Dec

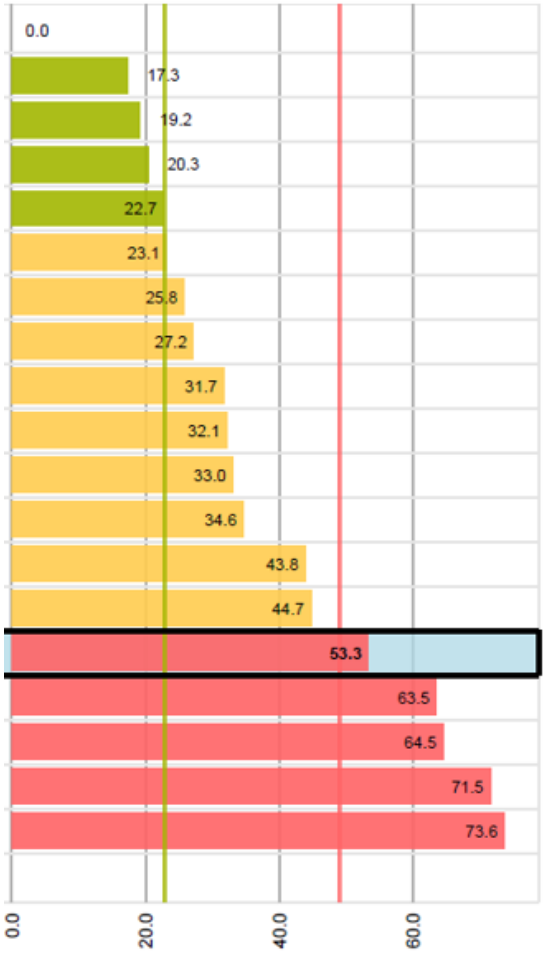
Count of episodes (2021 Jan - 2021 Dec)

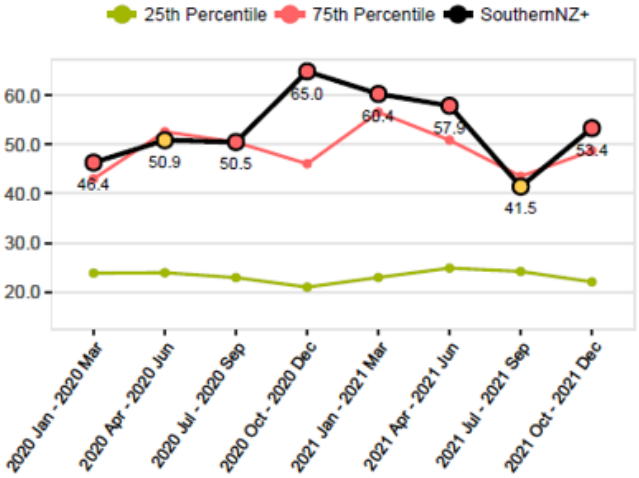
	Low Complexity	Moderate Complexity	High Complexity	Total
12 - Incontinence	**40**	**3**	**0**	**43**
12.1 - Urinary incontinence	25	3	0	28
12.2 - Faecal incontinence	22	1	0	23

* The sum of episodes from all diagnosis is different from the count of total episodes in that HAC category, due to the possibility that one episode might have multiple HACs

14 - Cardiac complications per 10,000 episodes

Peer comparison (2021 Jan - 2021 Dec) | Newly Red





Formula: [Cardiac complications episodes]/[total episodes] *10,000

Source: Casemix

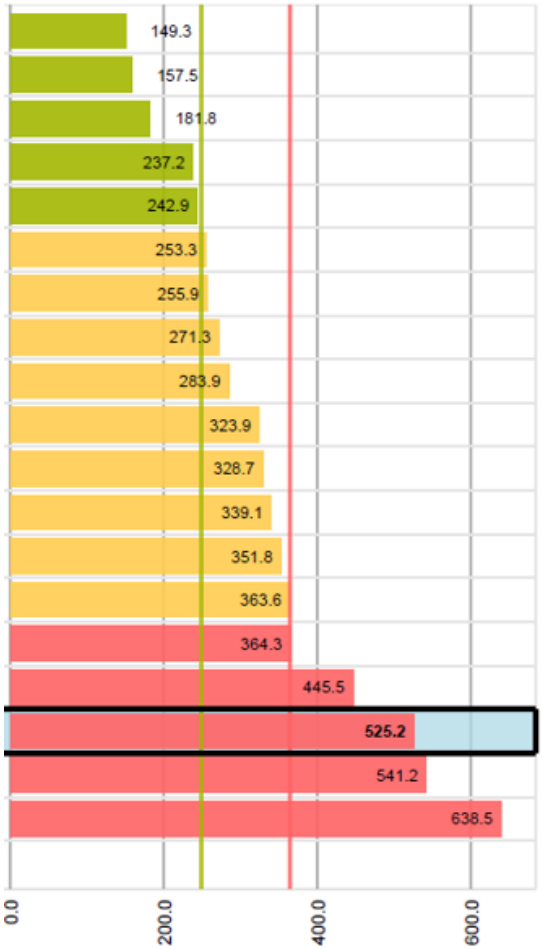
Description: Includes the diagnosis groups: 14.1 Heart failure and pulmonary oedema, 14.2 Arrhythmias, 14.3 Cardiac arrest, 14.4 Acute coronary syndrome including unstable angina, STEMI and NSTEMI, 14.5 Infective endocarditis

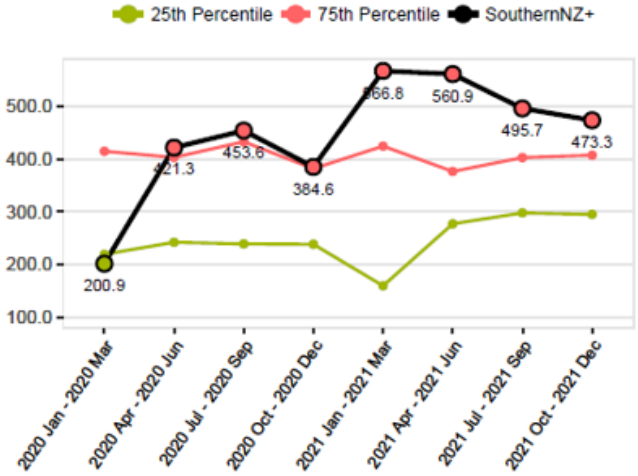
Denominator: Count of episodes, excluding episodes with ANY of the following conditions: 1.Same-day chemotherapy (DRG V10: R63Z and admission date = separation date) 2.Same-day haemodialysis (DRG V10: L61Z and admission date = separation date) 3.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for heart failure and pulmonary oedema(I500, I501, I509, J81), arrhythmias(I470, I471, I472, I479, I48x, I49x), cardiac arrest(I460, I461, I469), acute coronary syndrome including unstable angina, STEMI and NSTEMI (I200, I21x, I22x), and infective endocarditis (I330) with onset in the hospital.

15 - Perineal laceration during delivery per 10,000 vaginal delivery episodes

Peer comparison (2021 Jan - 2021 Dec) | Stubborn Red (last 4 periods)





Formula: [Perineal laceration during delivery episodes]/[total vaginal delivery episodes] *10,000

Source: Casemix

Description: Includes the diagnosis groups: 15.1 Third degree perineal laceration during delivery, 15.2 Fourth degree perineal laceration during delivery

Denominator: Count of vaginal delivery episodes excluding episodes with ANY of the following: 1.Episodes with caesarean delivery recorded. 2.Admission mode =1 (Admission mode is 'Admitted patient transferred from another hospital'). 3.Healthy newborns (P68) 4.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for third degree perineal laceration during delivery (O702) or fourth degree perineal laceration during delivery (O703).

FOR INFORMATION

Item: Southland Clinical Needs Analysis

Proposed by: Hamish Brown, Chief Operating Officer

Meeting of: Board, 3 May 2022

Recommendation

That the Board notes the interim 'current state' paper on the Southland Clinical Needs Analysis.

Purpose

To update the Board on current progress on the Southland Clinical Needs Analysis

Specific Implications For Consideration

1. Financial
2. Quality and Patient Safety
3. Operational Efficiency
4. Workforce
5. Equity
6. Other

Background

The Southland Clinical Needs Analysis project was commenced in October 2021 with the aim to create a clear pathway for the development of Southland Hospital over the next 10+ years considering the anticipated needs of the population across the Southern DHB region and changes in models of care over this period.

Sapere have been engaged to undertake this work including collecting the required data, engaging broadly with relevant stakeholders and the provision of a report detailing their analysis based upon their discovery work and associated analysis.

Current Status

The attached document provides a summary of the current state and baseline projections for the project. The analysis of the collected data is underway with additional engagement sessions planned to assist in the interpretation of the data and to test the initial findings. Further analysis is being undertaken testing assumptions regarding (for example) facilities and resources in Central Otago, the role of primary care, the use of telehealth and any potential after-hours facility,

Next Steps & Actions

Final paper to be presented to the Board for the June meeting.

Southland clinical needs analysis

Summary of current state and baseline projections

David Moore, Rebecca Rippon, Tom Love, Kelvin Woock
April 2022

Contents

Appendices

Tables

Figures

1. Introduction

Southern District Health Board has commissioned a clinical needs analysis for the Southland region, with a view that this work will help inform a master site planning process to be undertaken at a later stage.

1.1 Purpose

The purpose of the analysis is to examine the Southland region's population demographics, changes and trends over time with a view to understanding the role of Southland Hospital as a secondary catchment, its link to the Dunedin campus and the wider region.

The analysis will identify:

1. The current Southland population identifiers, ethnicity markers, growth and demand projections.
2. The changes and/or improvements that need to be made in order to better meet the needs of the population now and in the future.
3. A future view of how our region's structure and mix/configuration of resources and services might look like.

Southern DHB recognises that the Māori experience of health services in the Southern region is inequitable. An overarching principle for needs analysis and services planning is the commitment to New Zealand's Māori Health Strategy He Korowai Oranga and its overall aim of Pae Ora, 'healthy futures for Māori'. This means that an equity lens is applied to the analysis and engagement undertaken in the course of the project.

The clinical needs analysis reflects the wider context of Southern DHB, considering communities in Central Otago and Queenstown, and the range of services provided in Dunedin. Equally, recognising the role of the unique Southern model of community hospitals is important.

1.2 This paper, and additional steps

This paper provides a summary of the analysis undertaken to date under points 1 & 2 above. It sets out the current Southland population and future population growth scenarios, as well as the implications of this on clinical service volumes if we continue to deliver services in the way we currently do. We also summarise feedback from clinical services and providers about the current state and changes that need to be made in order to better meet the needs of the population now and into the future.

The final report will need to go a step further by:

- modifying the baseline service projection to reflect an assumption about the potential for acute demand mitigation (recognising that there are critical dependencies including workforce and resourcing)
- modifying the baseline service volume projection to reflect a level of planned interventions to meet population need
- exploring the impact of potential different service configurations (long term options) across the network.

The Southern Health Strategic Briefing outlines five key areas of focus to create a connected system that is more equitable, provides care closer to home, is accessible and cohesive:

1. Thriving localities
2. Effective integration
3. Networked specialist services
4. Activated enablers
5. Empowered workforce

Method for demographic driven service projections

The baseline projection is essentially the 'status quo' projection—hospital volume pressure from growth and changes in the composition of the population if we continue to deliver services in the way we do currently.

The base period is the 2020/21 year, acknowledging there will be some ongoing COVID-19 impacts but avoiding the lockdown period from March to May 2020. Hospital volumes are projected out according to a detailed breakdown by age, sex, ethnicity and domicile (territorial authority); and following the Statistics NZ population projections (2018 base) for the corresponding demographic groups.

It is the starting point and further work is required to modify these projected volumes to adjust for unmet need, efficiency gains that may be achieved through new or enhanced service models, and service configuration options.

1.3 The Southland geographic region

We have taken a broad view of the population for this analysis, including the following territorial authority areas:

- Invercargill City
- Southland District
- Gore District
- Queenstown-Lakes District
- Central Otago

The combined area has an estimated population (2021) of 151,000 people. This is larger than the old Southland DHB catchment—134,270 people, excluding Wanaka and Central Otago—that some secondary service flow arrangements may still be based on.

1.4 About Southland Hospital and services

The clinical needs analysis will support future decision making and subsequent site master planning for the Southland Hospital campus. Built in 2004, Southland Hospital is a secondary hospital located in Invercargill City.

Southland Hospital provides acute medical and surgical, outpatient clinics, day procedures, 24-hour emergency department, comprehensive ancillary facilities including laboratory, medical imaging, medical diagnostics, specialist paediatric, maternity, rehabilitation and therapy services.

The hospital is a teaching facility, affiliated to the University of Otago and its Dunedin School of Medicine. There are also close ties with the School of Nursing at Invercargill's Southern Institute of Technology and with other tertiary educators including Otago Polytechnic.

Table 1 Southland Hospital current facilities

Facilities	Notes
168 ward beds (156 resourced)	38 Medical, 42 Surgical, 30 Rehab (18 resourced), 13 Children's, 9 Neonatal, 18 Maternity (+4 delivery rooms), 18 Mental health
6 critical care beds	
4 theatres	1 acute and 3 elective
1 endoscopy room	Dental and Bronchoscopy have some sessions
3 procedure rooms	
22 outpatient rooms	2 are Gynaecology
ED with 20 treatment bays	

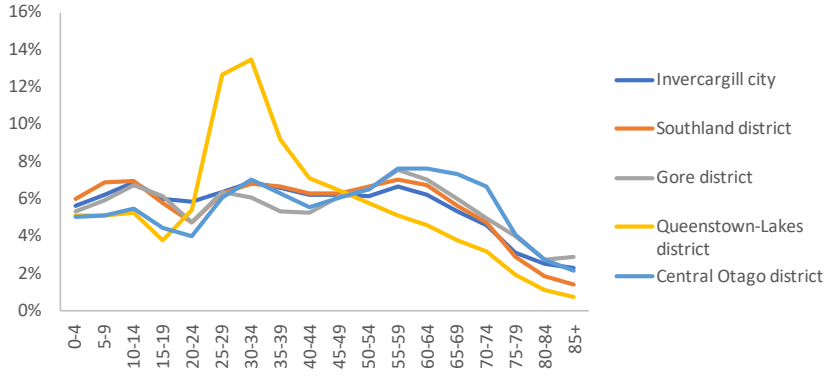
2. Current population

Table 2 Estimated resident population by territorial authority

TLA	2006	2021	15-year growth
Invercargill	51,590	56,930	10%
Southland	29,170	32,740	12%
Gore	12,360	13,030	5%
Queenstown-Lakes	24,090	48,300	100%
Sub-total	**117,210**	**151,000**	**29%**
Central Otago	17,060	24,820	45%
Total	**134,270**	**175,820**	**31%**

Source: Statistics New Zealand

Figure 1 Age distribution by territorial authority, 2021

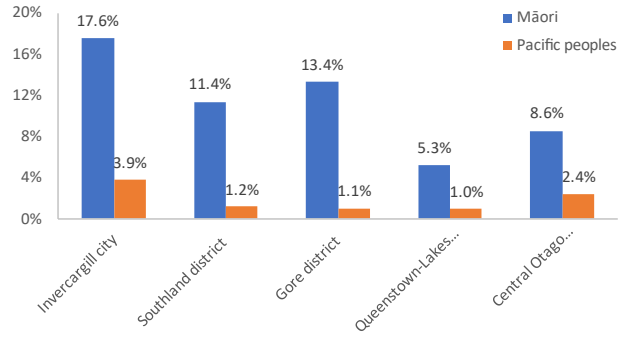


Source: Statistics New Zealand

Key points about the population

- There are 151,000 people living within the four council areas of Invercargill, Southland, Gore and Queenstown-Lakes.
- 38% in Invercargill, 32% in Queenstown-Lakes, 22% in Southland, 9% in Gore.
- 16,335 live in Wanaka which has traditionally flowed to Dunedin Hospital.
- Another 24,820 people live in the Central Otago council area.
- There has been extraordinary population growth in Queenstown-Lakes and Central Otago over the last 15 years. Growth in Invercargill and Southland has been more moderate. Growth in Gore has been minimal.
- Invercargill has the highest proportion of Māori (18%)and the highest absolute number of Māori (9,850). The proportion is slightly higher than the national average.
- The age distribution differs between each area—Queenstown-Lakes has a very high proportion of younger adults aged 25–44 years; Invercargill, Southland and Gore have a higher proportion of children and adolescents; Central Otago has a higher proportion of older adults aged 60–74 years.

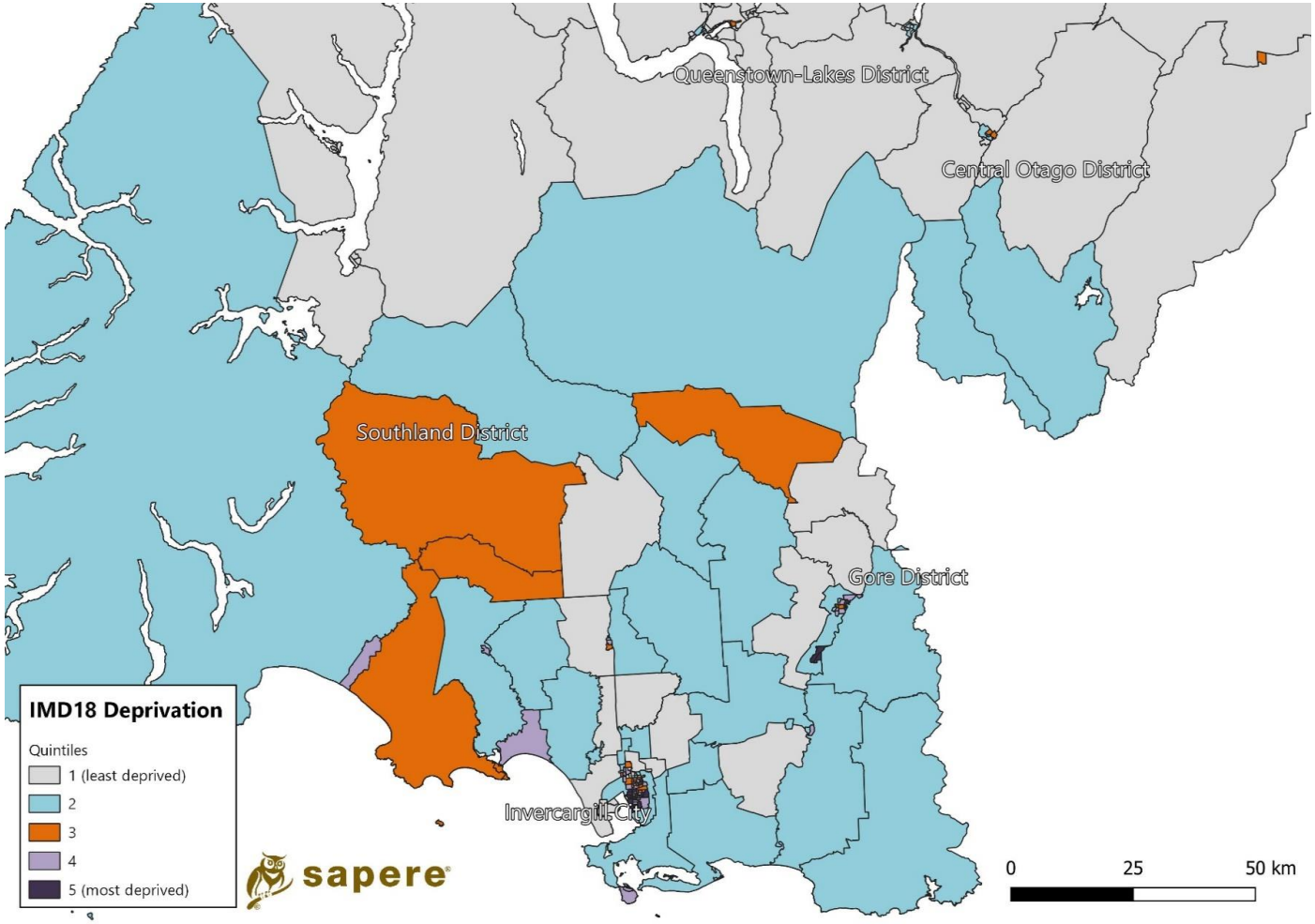
Figure 2 Proportion Māori and Pacific peoples by territorial authority, 2018



Source: Statistics New Zealand

2.1 Index of multiple deprivation

Figure 3 Index of Multiple Deprivation 2018 (University of Auckland)



The University of Auckland Index of Multiple Deprivation (IMD) 2018 comprises 29 indicators grouped into seven domains:

1. Employment
2. Income
3. Crime
4. Housing
5. Health
6. Education
7. Access to services

The IMD measures deprivation at the neighbourhood level in custom-designed data zones (average pop of 761).

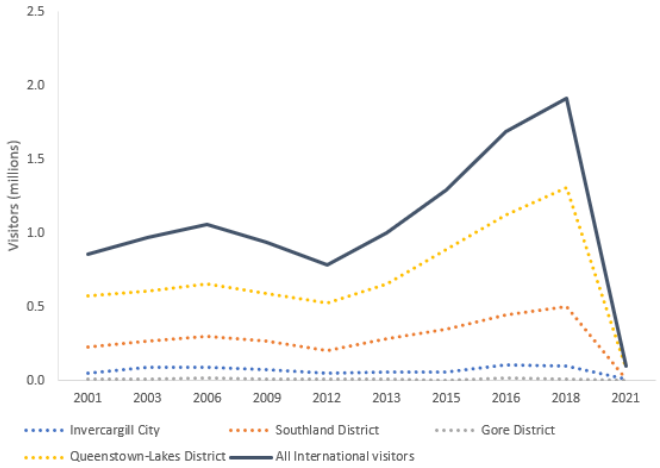
Invercargill has a higher proportion of population living in IMD quintile 4 (27%) and quintile 5 areas (23%)

There are pockets of multiple deprivation in the Gore District (47% of the total Gore population lives in a quintile 4 or 5 area).

13.1

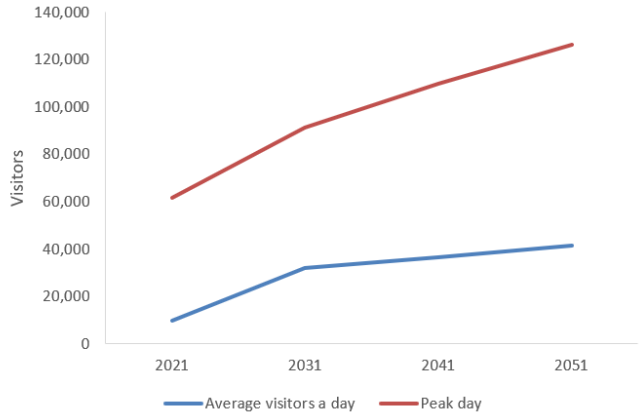
2.2 Visitor population

Figure 4: International visitor populations in the four TLAs of interest over time



Source: Statistics New Zealand, Accommodation Data Programme

Figure 5: Visitor projections for Queenstown-Lakes District



Source: Queenstown-Lakes District Council (Utility Ltd)

Key points about the population

- Figure 4 shows the number of international visitors from 2001 to 2018. Visitors are denoted in millions on the y axis. We observe international visitor numbers from 2001 onwards.
- There is a relatively steady increase in international visitor numbers across all TLAs, although the negative impacts of COVID-19 can be seen in 2021. There is a steep and significant drop off as border closures take effect.
- Also of note are the relative sizes of the TLAs' visitor numbers. The majority of visitors are to Queenstown-Lakes and Southland, with these two TLAs driving the trends in all visitor numbers.
- Queenstown-Lakes District Council prepares population projections that incorporates estimates and projections of visitor numbers—average and peak daily.
- All visitor population projections are observed for Queenstown-Lakes. Figure 5 shows the daily projections of all visitors, both domestic and international, for Queenstown-Lakes from 2021 to 2051.
- The average daily visitors increases sharply from 2021 to 2030 before returning to a steady increase in the years afterwards. This effect is due to the eroding of COVID-19's effects, with visitors numbers slowly returning to a steady state. The peak visitors a day follow a similar trend, though the steady state increase is greater, suggesting heavy seasonality of visitors.
- Total visitor numbers is expected to rebound and increase sharply post-COVID-19.

3. Population projections

Table 3 Projected population

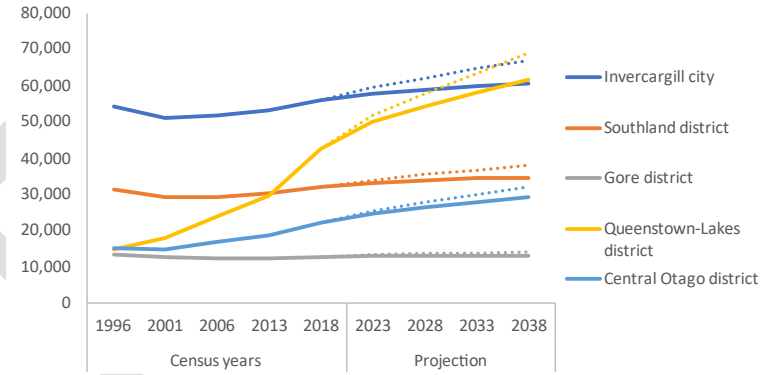
TLA	2023	2038	15-year growth
Invercargill	57,740	60,540	5%
Southland	33,160	34,600	4%
Gore	12,860	12,850	0%
Queenstown-Lakes	50,070	61,480	23%
Q-L high		68,840	37%
Sub-total	**153,830**	**169,470**	**10%**
With Q-L high series		**176,830**	**15%**
Central Otago	24,760	29,210	18%
CO high		31,900	29%
Total	**178,590**	**198,680**	**11%**
With Q-L & CO high		**208,730**	**17%**

Source: Statistics New Zealand

Key points about the population projections over 15 years

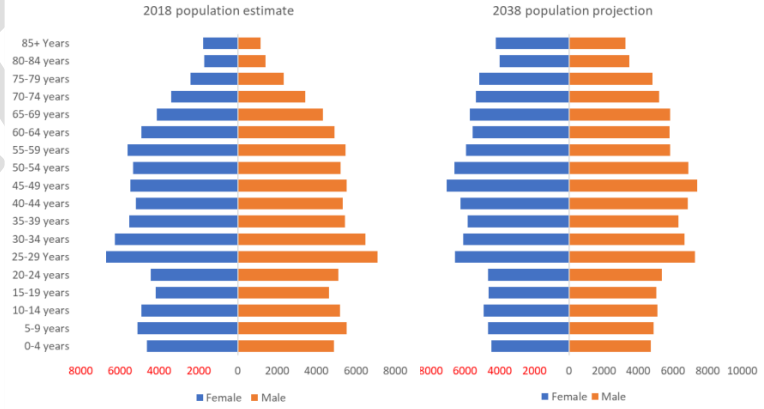
- The population in the total area is projected to grow to at least 169,470 (excluding Central Otago) and 198,680 (including)—a 10–11% increase.
- The high series may be a better planning assumption for Queenstown-Lakes and Central Otago. This would take the 2038 population to 176,830 (excluding Central Otago) and 208,730 (including)—a 15–17% increase.
- Growth is projected in Invercargill and Southland but comparatively modest.
- There will be a continued ageing of the population—by 2038 around one-in-four people will be aged 65+ years.

Figure 6 Population estimates and projections (dotted line is high series)



Source: Statistics New Zealand

Figure 7 Population pyramids in 2038 versus 2018



Source: Statistics New Zealand

3.1 Uncertainty

Figure 8 Population source of Queenstown-Lakes District 1997–2021

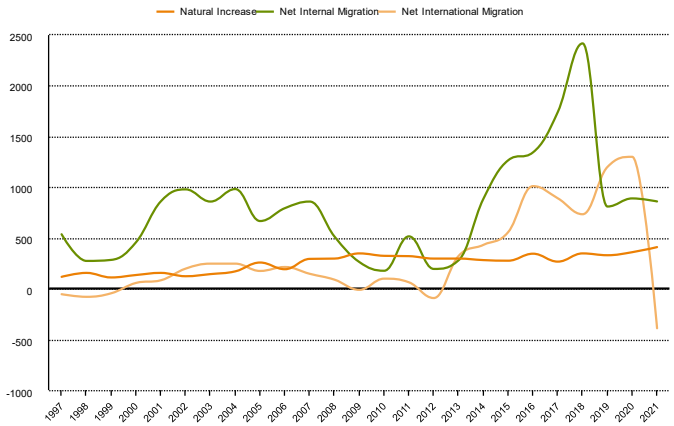
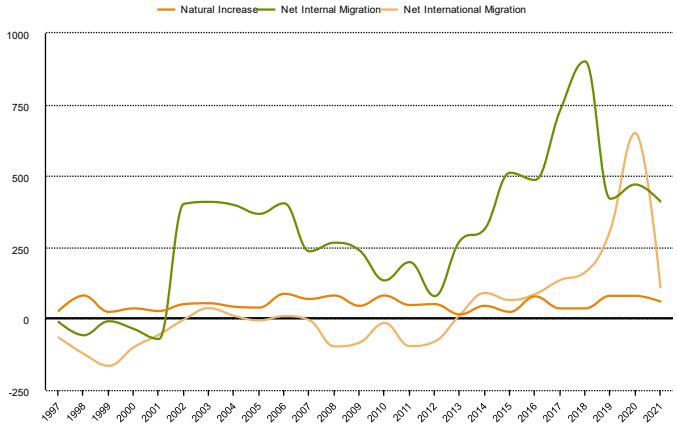


Figure 9 Population source of Central Otago District 1997–2021

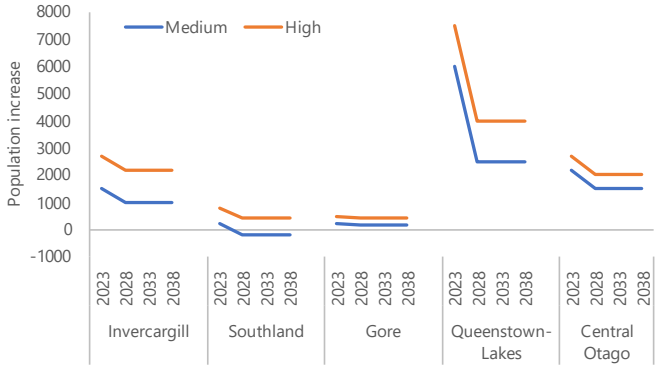


Source: Infometrics Regional Economic Profiles

Historic growth driven by net migration

- Queenstown-Lakes has a gradual natural increase in its population over time due to the relatively high population of reproductive age.
- There was a sharp increase in both net internal migration and net international migration to Queenstown-Lakes between 2013 and 2018 (Figure 8).
- Similarly, Central Otago experienced a steep increase in net internal migration between 2013 and 2018 and a peak in net international migration (Figure 9).
- The Statistics NZ alternative projections—high, medium and low growth—incorporate different fertility, mortality and migration assumptions for each geographic area and are produced to illustrate possible scenarios. Statistics NZ generally considers the medium projection suitable for assessing possible population changes, but advises that customer can judge which are most suitable for their purposes.
- Internal migration can be difficult to predict and this is the area where the Statistics NZ projections are typically least robust.

Figure 10 Statistics NZ net migration assumptions for population projections

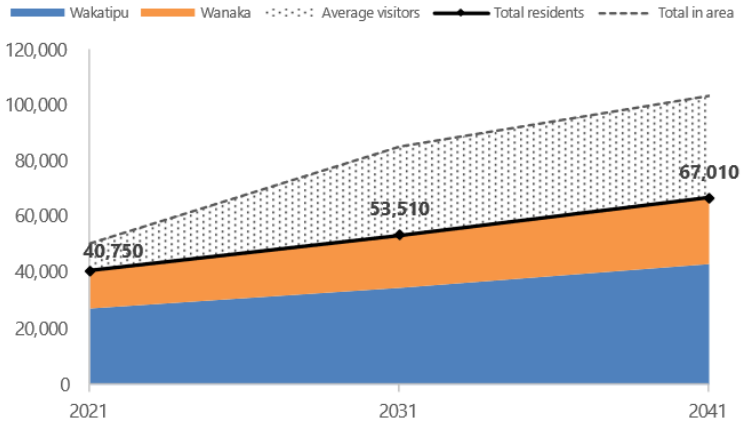


Alternate projections prepared by councils

Queenstown-Lakes District Council prepares population projections that incorporate additional information and provides a more localised model. The latest Council projections (June 2020) were prepared in a time of unprecedented uncertainty as the COVID-19 situation was unfolding.

- The impact of COVID-19 has had a profound impact on Queenstown-Lakes however the Council believes that it will continue to grow strongly.
- The Council projections show an increase in population to 67,010 by 2041. This compares to the Statistics NZ 'high' projection that shows a population of 68,840 by 2038.
- The Statistics NZ numbers are slightly higher, but we note that they were produced more recently and work off a higher 2021 base compared to the Council projections.

Figure 11 QLDC population projections 2021–2041



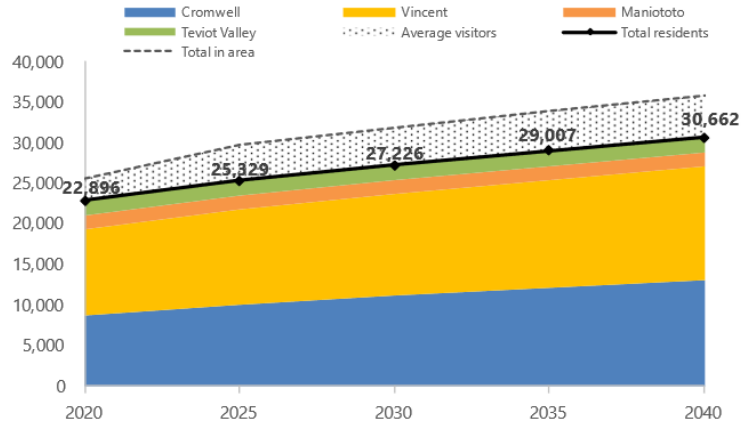
Source: Queenstown-Lakes District Council (Utility Ltd)

Central Otago District Council also prepares population projections using employment and job growth as the basis of the modelling. The latest Council projections were prepared in the first half of 2020 and there was considerable uncertainty about short and long term COVID-19 impacts.

The projections assumed a sharp decrease in jobs in 2020 before recovering to pre-COVID-19 levels by 2025. A review in December 2020 suggested that there has been strong growth in the resident population, while visitor numbers have remained steady. This is contrary to what was assumed in the projections. The Council recommended adopting a 'business as usual' scenario for its Long Term Plan—an unconstrained scenario that effectively ignores zoning constraints.

- The Council projections show an increase in population to 30,662 by 2040. This compares to the Statistics NZ 'high' projection that shows a population of 31,900 by 2038.
- Again, the Statistics NZ numbers are slightly higher, but broadly similar to the Council projections.

Figure 12 Central Otago District Council population projections 2020–2040



Source: Central Otago District Council (Rationale)

4. Māori in Murihiku

Regional Papatipu Rūnanga of Ngāi Tahu exist to uphold the mana of their people over the land, the sea and the natural resources. There are four Papatipu Rūnaka in Murihiku (Southland): Hokonui, Waihōpai, Awarua and Ōraka-Aparima. Not all Māori living in Murihiku affiliate to Ngāi Tahu.

Table 4 Estimated Māori population by territorial authority

TLA	2021	%
Invercargill	9,773	54%
Southland	3,612	20%
Gore	1,815	10%
Queenstown-Lakes	2,780	15%
Sub-total	17,980	100%
Central Otago	2,170	
Total	20,150	

Source: Statistics New Zealand

Figure 13 Māori age distribution by territorial authority, 2021

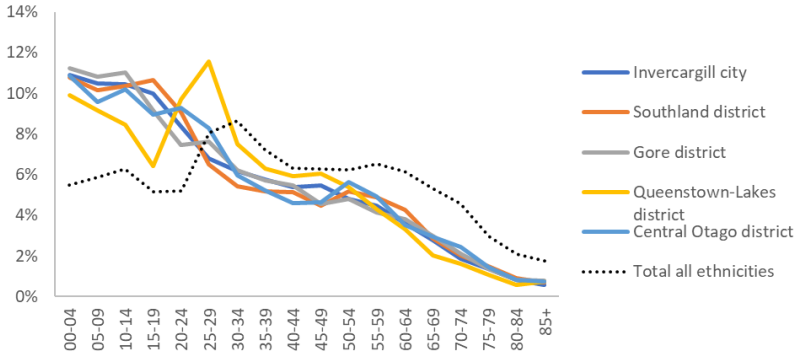


Table 5 Projected Māori population – **TO BE REPLACED WITH NEW ETHNIC PROJECTIONS JUST RELEASED BY STATS NZ**

TLA	2023	2038	15-year growth
Invercargill	~~10,119~~	~~13,056~~	~~29%~~
Southland	~~3,738~~	~~4,702~~	~~26%~~
Gore	~~1,925~~	~~3,045~~	~~58%~~
Queenstown-Lakes	~~3,065~~	~~5,275~~	~~72%~~
Sub-total	~~18,847~~	~~26,078~~	~~38%~~
Central Otago	~~2,377~~	~~3,566~~	~~81%~~
Total	~~21,224~~	~~26,997~~	~~43%~~

Key points about the population

- The largest number of Māori live in Invercargill City, which also has the highest proportion of Māori among its total population (18%).
- With the exception of Queenstown, which, like the total population has a high number of Māori in the younger adult age groups; the age-distribution of Māori in each territorial authority is broadly similar.
- The Māori population is younger than the total population—shown by the high proportion of children and young people in Figure 13.
- The proportion of older Māori is smaller compared to the total population, however the older Māori population is projected to increase strongly over the next decades.
- The Māori population is projected to experience strong growth over the next 15 years.

5. Summary of baseline (status quo) hospital service projections

Most inpatient activity for Invercargill and Southland district will be at Southland Hospital. Around half for Gore residents will flow to Southland Hospital. There is a substantial flow from Queenstown-Lakes to Dunedin and almost no flow from Central Otago to Southland Hospital based on current activity. Growth in older age groups drives service demand for medicine, rehabilitation, orthopaedics, general surgery and urology. Māori will represent a greater proportion of patients across all services in future.

Figure 14 Proportion of hospital discharges by facility, 2038 projected

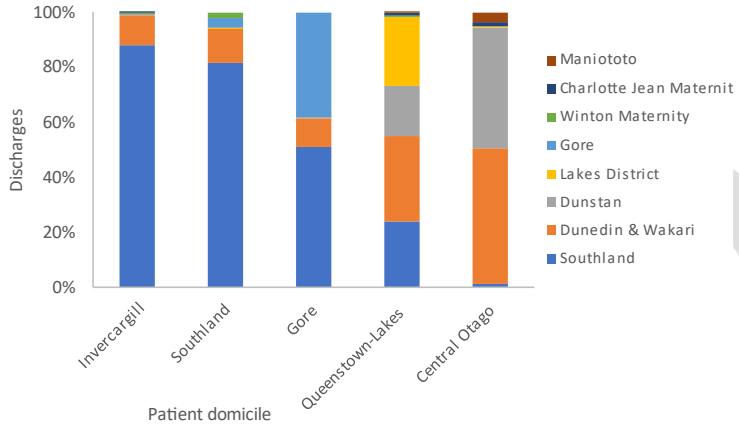


Figure 15 Southland Hospital projected discharge growth by patient domicile

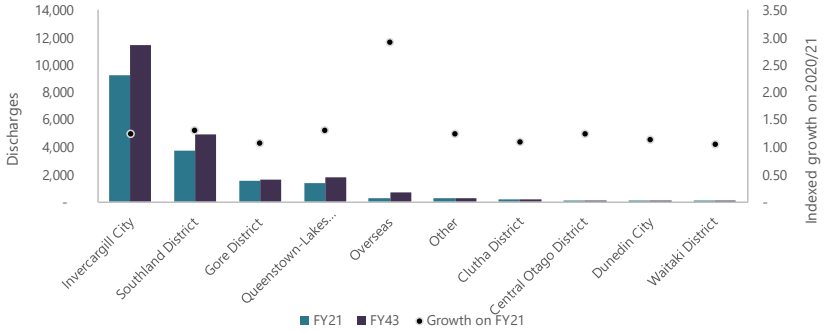


Figure 16 Southland hospital projected discharge growth by service

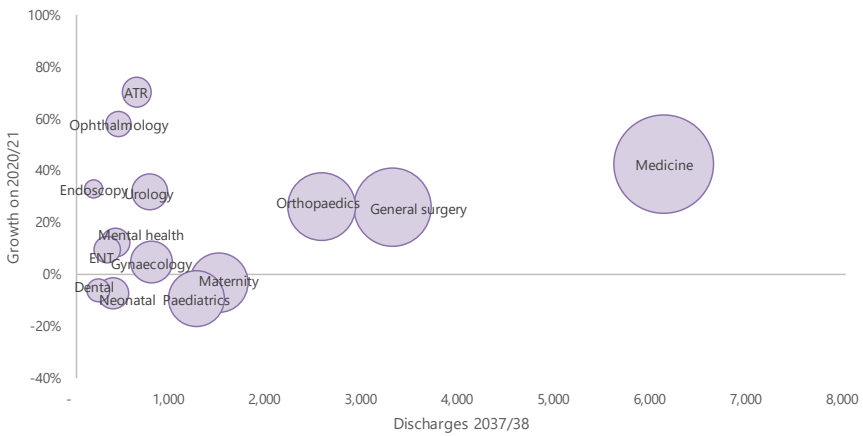
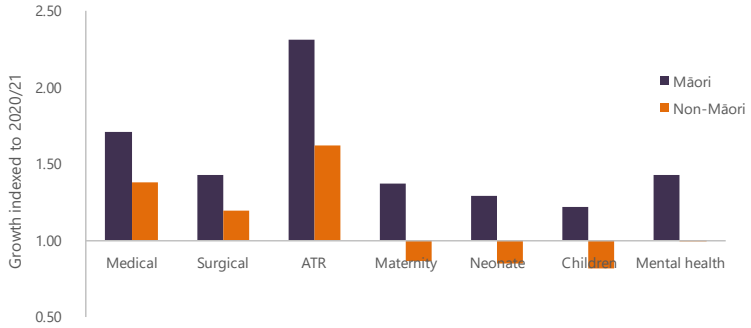


Figure 17 Southland Hospital 2038 discharge growth on 2020/21 by ethnicity



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6. Primary and community context

General practice is under substantial pressure

- There are two major issues with regard to general practice—the difficulty recruiting GPs and the increasing volume and complexity that general practice is managing with the same level of resource.
- GPs we have heard from to date talked about the intrinsic rewards of general practice, but that it is still very difficult to attract people to Southland. The combination of GPs approaching retirement and changing lifestyle choices will exacerbate the workforce challenges.
- Increasing complexity, to a large extent associated with ageing, means that consultations take longer (fewer patients seen in a session) and follow-up time takes longer. Changing technology means that over time more can be offered.
- These challenges result in an unenrolled population that some report is the highest level they've experienced in many years. Practices recognise the inequitable health outcomes that persist in the Southern Health system.
- More team-based approaches require a change in practice and traditionally GPs have not been trained in how to oversee a team. The current funding model does not support this approach.
- GPs have observed that nurse practitioners tend to be focused on particular areas and often don't stay in general practice. Some practices highlighted the benefit and potential of new workforces, such as health improvement practitioners and health coaches, but felt they could be maximised if they were operating under a different structure.
- One training practice noted they had a vibrant cohort of young GPs and that more exposure to provincial/rural practice would help attract workforce.
- Some clinicians reflect that they could keep more patients out of hospital if they had more time and resources, and that having access to consultants is helpful on an advice basis. GPs can be limited to the diagnostics available to them and distance from the hospital is a consideration.
- Lack of access to specialist services is problematic—GPs see the human impact of this in their offices. Health pathways need work—being able to access imaging when appropriate would save specialist time.
- There are digital opportunities, both in terms of streamlining disparate systems and smarter use of analytics and intelligence.

Figure 18 Proportion of population enrolled in a WellSouth practice, April 2021

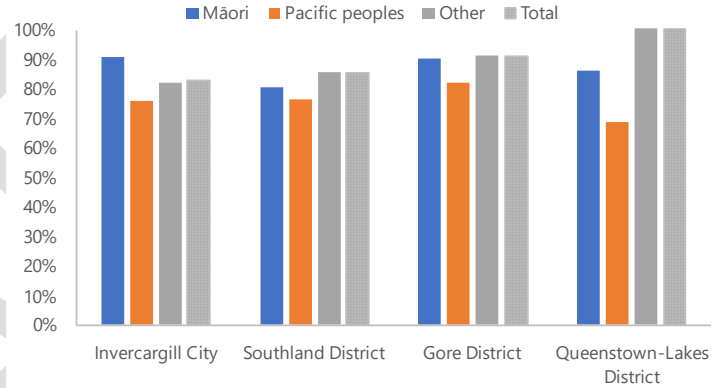
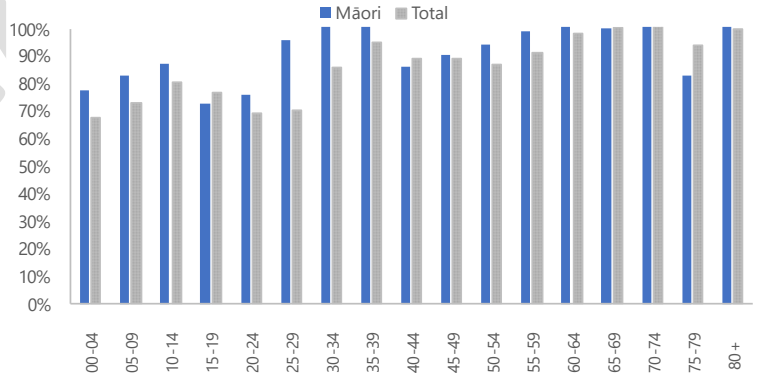


Figure 19 Proportion of Southland population enrolled, by age, April 2021



Source: WellSouth PHO

Māori providers

- The Southern Strategic Briefing highlighted the need to reorient to Iwi Māori leadership; across the system, but especially in localities. Strategies and resources within localities should be deployed to address Māori health improvement and equity as a matter of priority.
- Māori providers described, in various ways, a network or 'ecosystem' of connected providers including primary providers, rural hospitals and the secondary hospital. The locality opportunity is to cast the net widely, uncover the unique strengths of different providers and commit to meaningful access and communication so they can create ways of working together. Central to this would be a shared vision and mechanisms for connectivity.

  'Providing person and whānau-centred services, on the basis of good clinical services, on the basis of good relationships'
- Māori providers are at the flax roots and punching above their weight, delivering a large number of face-to-face consultations with limited resources. Māori models of hauora represent an opportunity to provide a more responsive and integrated service to people and whānau.
- After hours services are not easy to access and the fee is unaffordable for many of the Māori provider client cohort. One Māori provider described the need for a new, fit-for-purpose model, with the expectation of telehealth and provision of things like suturing, etc.
- The Māori provider nurse practitioner walk-in service is overwhelmed with demand. The big areas of need identified for whānau are dental, basic medications for things such as hypertension and gout when general practice is not accessible, sexual health (there is a wait and need to travel for this service for communities like Gore and Mataura) and mental health. This service sees mostly younger adults, some of whom are enrolled with a practice.
- Māori providers are managing increasing acuity of mental health need that is not able to be met by the DHB secondary service.
- Māori providers share the concerns of their communities around access to specialist services (early prevention, detection and treatment) and the long waits that whānau face when there isn't the money to access private providers.
- An Iwi-PHO partnership is looking to develop a new model and capacity to service unmet need.

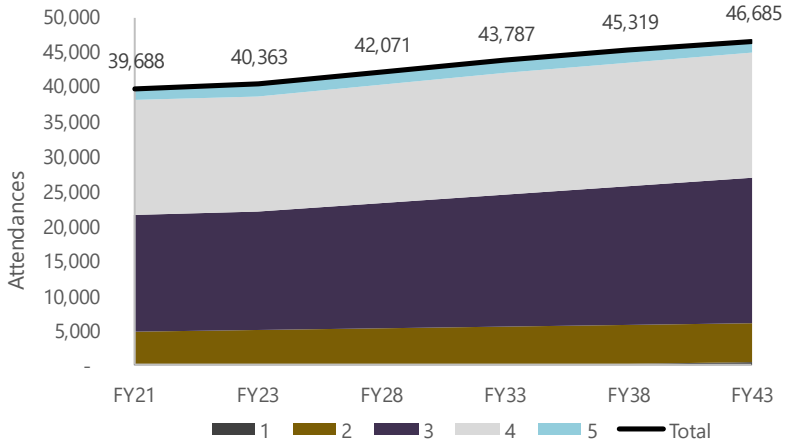
7. Emergency Department

- The Emergency Department (ED) at Southland Hospital is seeing the impacts of population ageing. Increasing complexity shows up, for example, in the number of medications that need to be dealt with in an older patient that presents with chest pain.
- Obesity is another complexity that increases time and resource in the ED. For example, taking much longer to insert an IV line or needing image guidance.
- The ED notes the importance of responding to the relatively higher proportion of Māori (and Pasifika) compared to other parts of the South Island. Also, the impact of poverty that is both dispersed across Southland and in some pockets.
- Access to primary care impacts on presentations to ED. Anecdotally, some people come to the ED because they can't afford primary care consultation fees. Others are unable to get a timely appointment or may be unenrolled. These people add work to see but tend not to be the patients that fill up the department.
- After-hours services in primary care are limited. One view from a senior clinician is that if there were good after-hours with access to imaging that a decent number of patients would not need to be seen in the ED (possibly around 5000 over a year).
- The ability to see and treat people in the rural hospitals varies (often between daytime and after-hours) and St John Ambulance will anticipate a pathway and transfer direct to Southland.
- The ED recognises that the resourcing in primary care is not sufficient to be able to shift services to the community. Preventative medicine will take a long time to make a significant difference to service demand.
- Bed block on the wards means that patients wait in the ED for a bed to become available (reportedly often 7–8 overnight). Opening additional beds will go some way to addressing this but they will quickly fill when additional theatre capacity is opened.
- Like most service areas, there are workforce challenges for the ED. It is difficult to recruit emergency medicine consultants and the on-call roster is unattractive compared to other, larger hospitals. It is difficult to recruit nurses.

Table 6 ED attendances by domicile, % at each hospital, 2020/21

	Patient domicile				
Emergency Department	Invercargill	Southland	Gore	Q-L	Central Otago
Southland Hospital	98%	92%	33%	5%	2%
Lakes District Hospital	1%	2%	0%	81%	7%
Gore Hospital	0%	3%	63%	0%	0%
Dunstan Hospital	0%	0%	0%	8%	67%
Dunedin Hospital	1%	2%	3%	6%	23%
All attendances	100%	100%	100%	100%	100%

Figure 20 Demographic projection of Southland Hospital ED attendances



8. Medicine

- The medical department feels the increasing impact of ageing and reports commonly seeing patients in their 90s. Delays in the pathway through and out of hospital lead to rapid deterioration in bed.
- A hospital admission can be the transition point to aged residential care (ARC) and the medical department reports that there can be a protracted process for assessment and placement in an ARC facility. It might be that there is a wait for a needs assessor to be able to undertake the assessment and/or availability of an appropriate ARC bed (the medical department's experience is that there has been a shortage of hospital level bed recently). Shortages of allied health staff also impact, for example if a physiotherapist needs to see a patient before discharge. The sense from the medical department is that, of 38 patients on the medical ward at any one time, around 6–8 might be waiting for placement.
- Clinicians observe the changing and increasing expectations of patients and families, with an expectation of more tests, investigations and plans.
- Another reflection is that ageing of the medical patient cohort is having an impact on the perception and job satisfaction of physicians.
- Primary care is also feeling the impact of ageing, complexity and expectation. Capacity constraints and workforce challenges in primary care impact on the hospital service. The medical department notes the inability for some people to enrol in a practice, which can lead to presentation at the ED, but also a loss of continuity of general practitioner in some cases. Changes in doctors means that it is not always recognised what is a change from baseline and they may be more likely to refer to the hospital.
- There is only one medical registrar on duty in the evenings. The time it takes for them to see and assess people who present to the hospital after 4pm can lead to potentially unnecessary overnight stays. The service has identified an opportunity to roster a second registrar in the evenings, to get through patient assessments more quickly, and discharge those that do not require admission at an appropriate hour of the night. This would also reduce the time spent waiting in ED to be seen by a medical registrar.
- There is significant bed occupancy pressure on the medical ward with outliers being placed on the surgical and rehabilitation wards.

Figure 21 Southland Hospital medicine inpatient volume growth on 2020/21

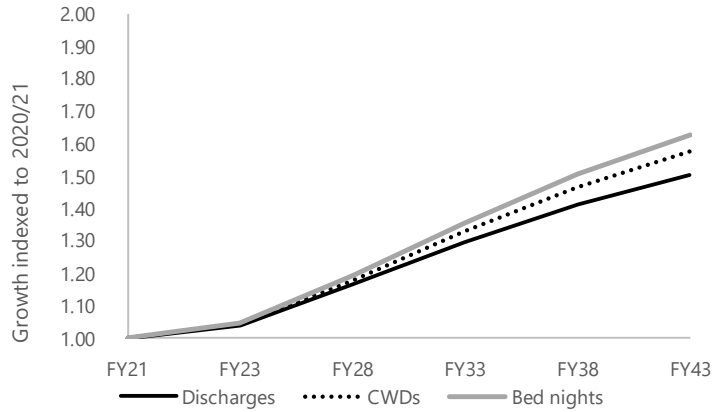
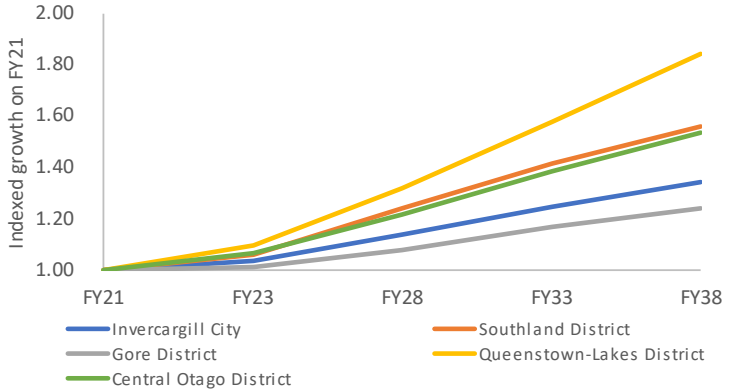


Figure 22 Medical discharge growth on 2020/21 by patient domicile (any hospital)



9. Assessment Treatment & Rehabilitation (AT&R)

- The last 18 months or so it has been very difficult to manage discharges for complex patients. Constraints within community services has seen them restrict their geographical coverage area and it is difficult to support people living at a distance from the hospital. Lakes District Hospital has limited allied health cover and consequently rehabilitating patients from that area is a significant issue.
- AT&R is impacted by staffing difficulties and increasing complexity (e.g. bariatric patients, cognitive impairment) in aged residential care (ARC). ARC providers have trouble finding registered nursing staff and might close beds because of staffing constraints.
- Home and community support services also experience a shortage of carers, particularly in rural areas and this can delay hospital discharge for some patients.
- The service raised the challenges of managing older patients, in inpatient and ARC, with psychological and behavioural issues. There is no neuropsychology support in Southland and limited psychogeriatric support (2 days a fortnight). In Invercargill, there is only one dementia care unit meaning some people might have to be sent to Dunedin (or Christchurch).
- The service has observed a decrease in community resilience post-COVID-19 lockdowns and feels that people are less able to cope with minor conditions within their usual support network. This manifests in referrals for ARC that may not meet criteria.
- Recruitment is an issue for the AT&R service—nursing and allied health.
- The physiotherapy service does a lot of contracting out, particularly in rural areas, and sometimes uses private physiotherapists for inpatient cover.
- The service receives requests from Central Otago because there is no support locally. Because of the growing population of older people in Central Otago, the AT&R service identifies the need for a consolidation of older persons' services in that locality, with close links to Dunstan Hospital. There is an increasing retirement village presence in Queenstown-Lakes and Central Otago.
- AT&R recognises the opportunity to work more closely with general practice. The service would like to work more proactively in the community however its limited resource is focused on the inpatient service.

Figure 23 Southland Hospital AT&R inpatient volume growth over 2020/21

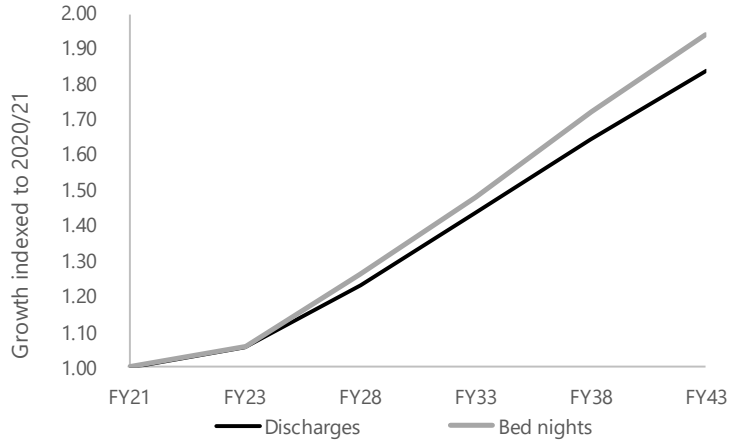
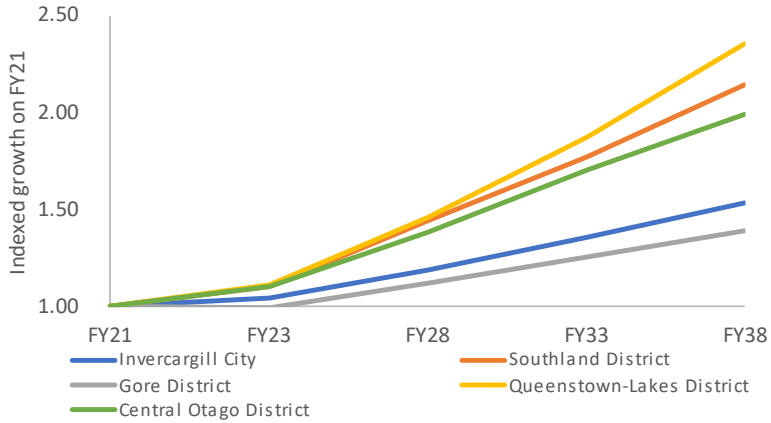


Figure 24 AT&R discharge growth on 2020/21, by patient domicile (any hospital)



10. Surgical services

- Hospital surgical services are seeing the impact of ageing and that impact has become significant over the decade – seeing medical patients in their 90s. General surgery services including urology are particularly impacted. With ageing comes complexity and longer theatre times. There is a lot of colorectal surgery that may not have previously been done, many with malignant colorectal sections.
- Now, elective surgical levels are lower than appropriate storing up trouble for the future. Workforce shortages in nurses, anaesthetic technicians, and allied health, mean operations are being cancelled. The consequence is, now, there is almost no non-malignant cancer work.
- Urology has access to only half a day of theatre time a week and believes it to be under-resourced for the level of demand. Wait lists are over 12 months. The workload has increased very substantially.
- No ERCPs are being done in Southland meaning a two to three week wait for the procedure in Dunedin.
- A restriction of one high dependency bed per session restricts the number of, for instance cancer operations.
- There is a question mark over the mix of surgery that should now be done as some can take up an afternoon, such as complex pelvic surgery. There is a fragile critical care unit.
- Decision-making on surgery is by surgeons and there is opportunity to develop a preoperative service run by geriatricians and physios to make sure the patient journey is appropriate.
- Complex trauma is dealt with at the hospital unlike most other district hospitals.
- However, the team identifies it is not doing well with emergency surgery either. The hospital is not doing gall bladders, patients with pancreatitis, abscesses due to lack of resources. There is only one acute theatre, and it stops at 7-8pm.
- Shortages on the ward mean patients can't be released into a rest home from midday Friday to Monday afternoon.

Figure 25 Southland Hospital general surgery inpatient growth on 2020/21

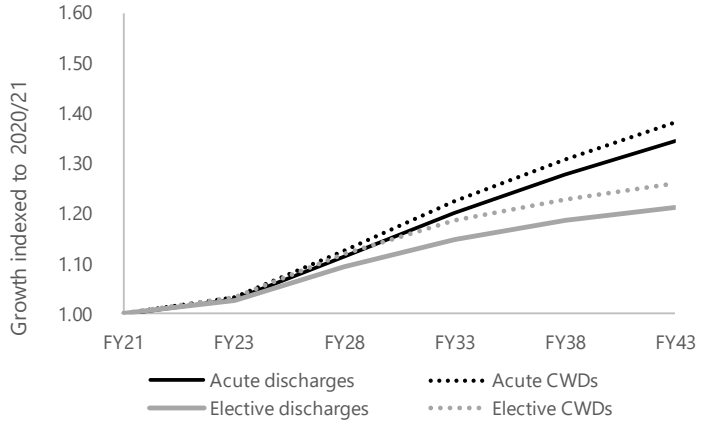
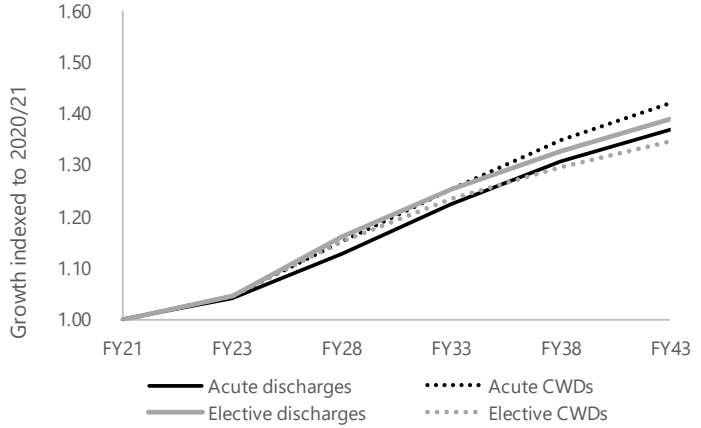


Figure 26 Southland Hospital urology inpatient growth on 2020/21



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11. Orthopaedics

- Orthopaedic services are seeing the impact of ageing and that impact has become significant over the decade – seeing medical patients in their 90s. As noted, with ageing comes complexity and longer theatre times. For instance, there are now hip operations on patients in their 80s.
- Again, elective surgical levels are lower than appropriate storing up trouble for the future. Patients are so severe they, we were told, could not walk even 50 meters. For orthopaedic services, in addition to nurses, anaesthetic technicians, a lack of physiotherapists mean operations are being cancelled.
- The consequence is, now, currently, a lot of shoulder surgery does not happen, and patients are invalids with arthritic hips and knees. Thresholds to surgery compare poorly to others; the threshold in Southland is 71 but 50 in Christchurch.
- Because of bed shortages, techniques have been developed to move patients to home care, for instance with external fixators. But access to beds is still limiting theatre capacity in this surgical service like others.
- A reduced range of surgery could release time to orthopaedics, e.g., one session could be used for three hip operations. There is no critical care unit and there is a fragile critical care unit.
- Decision-making on surgery is by surgeons and there is opportunity to develop a preoperative service run by geriatricians and physios to make sure the patient journey is appropriate.
- Complex trauma is dealt with at the hospital unlike most other district hospitals. There are issues of unpaid patient debt and, also, a question of appropriate ACC funding.

Figure 27 Southland Hospital orthopaedic inpatient growth on 2020/21

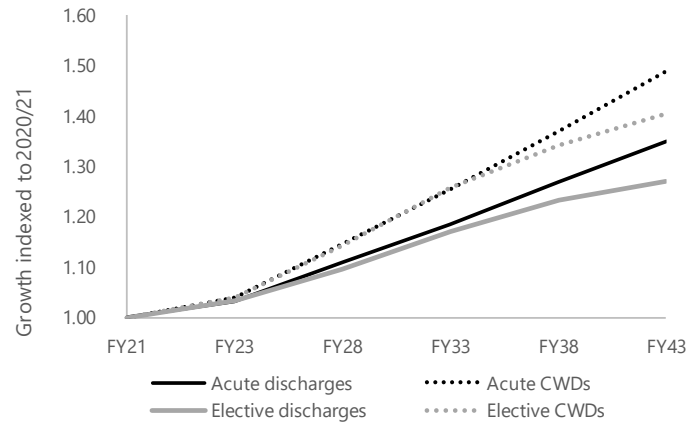
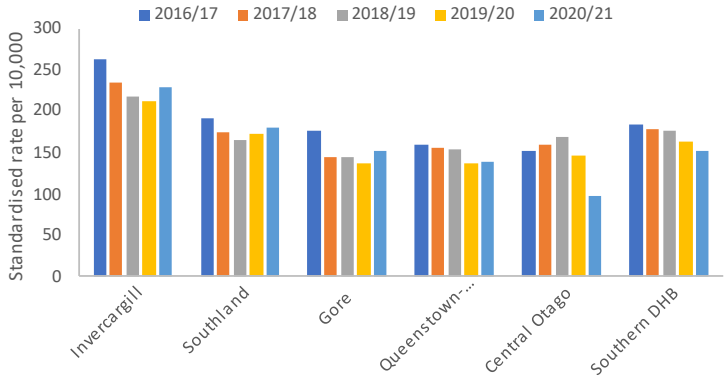


Figure 28 Orthopaedic standardised intervention rates



Source: Southern DHB Planning & Funding

12. Women's health

- New primary birthing units are planned for Wanaka and Dunstan Hospital in Clyde. The Clyde unit will replace the existing Central Otago primary maternity unit currently located in Alexandra.
- Staffing is a major issue for maternity. There is a shortage of midwives which can result in diversion to Dunedin and recently some unplanned staffing situations has led to a shortage of obstetricians. Consultant shortages impacts call rosters and non-clinical time.
- There is an increase in referrals of women with comorbidities and the service reports an increase in referrals from Wanaka. Increasing age and comorbidities drives up caesarean section rates.
- Obstetrics has one half-day a week for caesarean sections and uses some gynaecology theatre time to do caesareans. If there is an emergency and the acute theatre is occupied then an elective theatre case will be displaced.
- After-hours, the time to deliver a baby out by emergency caesarean section is longer than in business hours.
- The biggest issue with transfers from rural facilities in transport—timeliness and availability of helicopter. Gore is closer and women may arrive by private transport.
- There is a flow-on effect with clinics and the service finds it difficult to provide a sufficient number of clinics. Waitlists increase if the department is unable to catch up.
- Gynaecology clinics can be hard to staff and access to clinic rooms in the main outpatient facility is limited. Room bookings are unavailable to provide additional 'catch-up' clinics. Some clinics require a nurse and the staff may not be available.

Figure 29 Maternity discharge growth by patient domicile

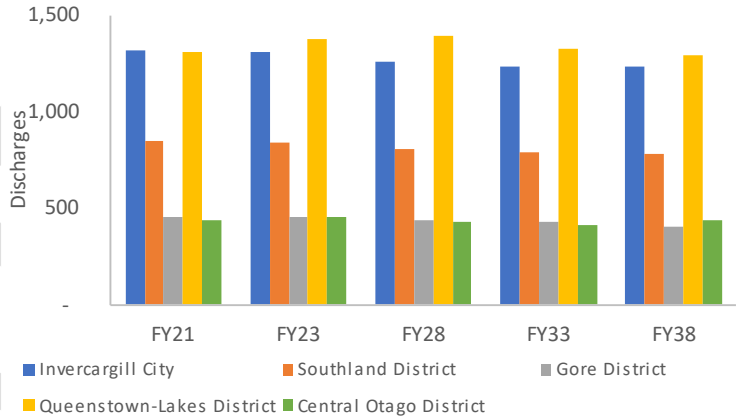
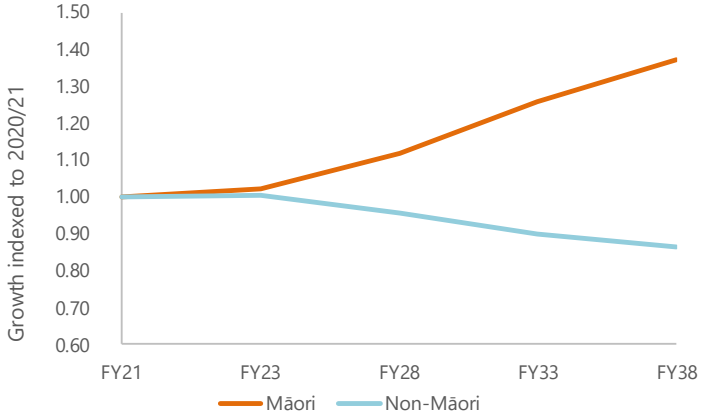


Figure 30 Southland Hospital maternity inpatient growth on 2020/21, ethnicity



13. Children's health

- The catchment for paediatrics is sizeable with Queenstown patients being covered from Invercargill.
- There is a large number of children attending the service who previously might not have survived cancer, a cardiac lesion, etc. This increased survival rate does, however, create a bow wave for the service.
- The call roster for paediatricians is a challenging one-in-three. Most SMO recruits are international now. There is a MECA compliant roster for junior doctors and the service at the time of interview was looking for another paediatrician.
- The outreach nurses are highly functional and capable.
- There are just under four paediatricians moving to around five but with a benchmark compared to other DHBs of possibly as many as eight.
- There are limited rooms and space. At Southland hospital, the waiting room needs to be more functional. Clinic space in Queenstown is limited.
- The rooms are in demand by visiting services (monthly surgery, neurology four times a year, gastro two times a year, oncology and endocrine).
- The level of service that can be offered is less than what might be offered in other DHBs because of distance and size of services. Some families have needed to move to other cities to access the full range of services that they need.
- Paediatricians report seeing a lot of children who might otherwise be seen in general practice.
- Ophthalmology and ENT (paediatrics) don't visit Queenstown. For those parents/caregivers and children, it is a two hour drive to Southland or, even worse, to Dunedin, often with toddlers in tow. There are, however, a great number of private providers in Cromwell but this does not work for those on low incomes.
- The Child, Adolescent and Family mental health service is constrained, leaving paediatrics to manage a lot of mental health in its service so CAFs can look after the most acute. Access to psychology is difficult.

Figure 31 Southland Hospital paediatric inpatient growth on 2020/21, ethnicity

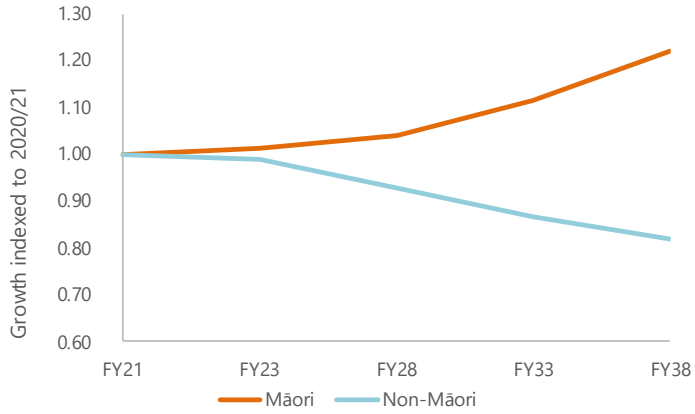
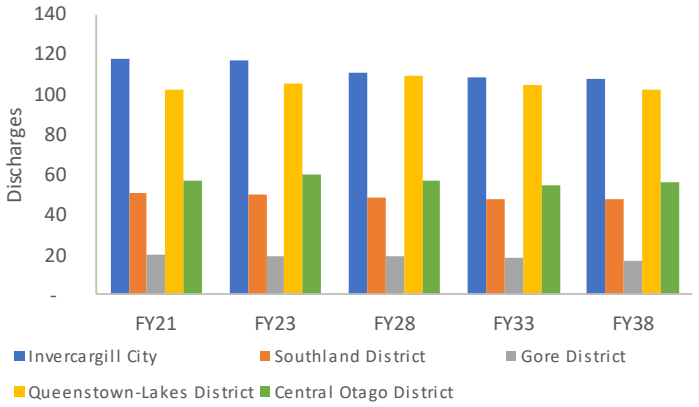


Figure 32 Neonatal discharge growth by patient domicile



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14. Rural hospitals

- There is both opportunity and issues in working with rural hospitals. The opportunity is that more care can be localised and patients can step-down to rural hospital beds. However, the model of care and workforce is developing with each rural hospital offering what it can, with the staff it has, rather than being able to offer a standardised model of care.
- Geographic distance has implications. Travel is a substantial issue for patients and a costly one for those living rurally. St John struggles to support the region and the number of transports.
- The rural outreach nurses are regarded as highly capable and these nurses deal with a wider variety of patient issues.
- Queenstown hospital is classified as rural and is run by rural hospital specialists.
- The hospital is clearly inadequate for growing needs. The outpatient workload is substantial and the supports are very limited. The absence of some services such as ENT and ophthalmology exacerbates inequities. Stakeholders tell us there needs to be a lot more clinic space and availability of nursing.
- The position of Dunstan is interesting and there is an active discussion of whether it should we be tied in with Southland, and whether there could be another hospital in Cromwell.
- Southland based clinicians told us Gore works reasonably well and the new build there has helped with additional rooms (although those rooms have become less available in the short term as activity has increased).
- Rural workforce issues, particularly in aged care, are acute.
- There is a heavy reliance on overseas nursing and medical workforce, which has been difficult with COVID-19 and border issues.
- There are opportunities. Telehealth would lower the travel and other access burdens and could be serviced from Dunedin. A health practitioner assistant workforce could help.
- Locality planning is seen as a real possibility to address issues around access to specialists, an ageing GP workforce and demands of aged care including dementia. Access to geriatricians would be particularly useful.

Figure 33 Inpatient discharges for Gore residents by facility

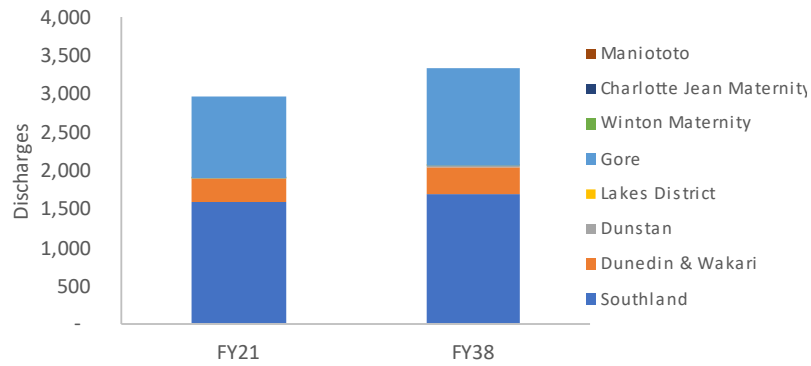
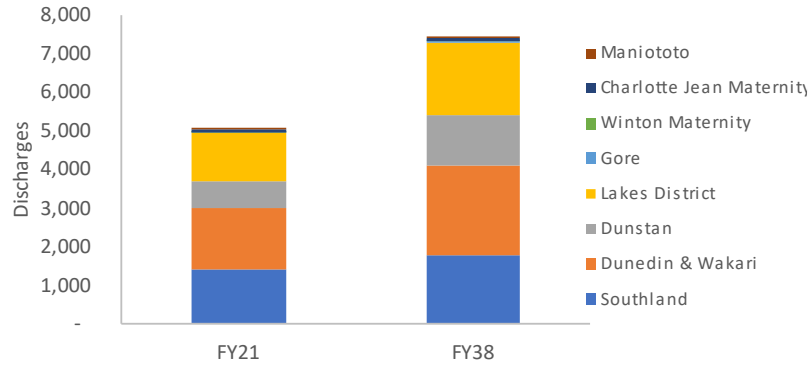


Figure 34 Inpatient discharges for Queenstown-Lakes residents by facility



15. Mental health

- The inpatient unit is reasonably fit-for-purpose, with the exception of the low stimulus area, with the ability to separate cohorts. The bed numbers can flex up if required. There are frequently one or two people on the unit for whom finding appropriate community accommodation options is difficult. Finding a 'bed for life' and for those that age early proves the most difficult.
- The service reports that a lot of emergency presentations are drug-related. If the If Police transport a drug-affected person directly to the inpatient unit they may end up secluded whereas they would potentially be better managed in an appropriate space in ED if that can be done safely.
- A long-term plan for the service is to hold more evening clinics that are accessible for whānau. The specialist mental health emergency team is receiving more referrals, although the on-call response is a psychiatrist and stops unnecessary admissions.
- The DHB mental health service provides outreach from community teams based in Gore, Balclutha and Queenstown (as well as Invercargill). Some permanent FTE has been based in Te Anau and an outreach clinic is held every six weeks with a senior medical officer (SMO). SMO outreach is held weekly in Gore and Balclutha.
- The increasing impact of drugs and alcohol is an issue and the service sees a need for detox and rehabilitation closer to Southland.
- The mental health service reports the increasing prevalence of stress and anxiety among young people, and a drop in the age of onset. Referral are increasing in complexity and the age has decreased from 18, to 16, to 10–12 years. There is an opportunity to do more work in schools.
- There is a plan for the Police to lead some work, based off the Manaaki Tairāwhiti cross-sector model, to develop a wellbeing plan with Iwi and key objectives to focus on. This will be an important locality initiative for the service to partner in.
- Staffing is a challenge. There is competition with ACC for overseas SMO recruits.

Figure 35 Southland Hospital mental health inpatient growth on 2020/21

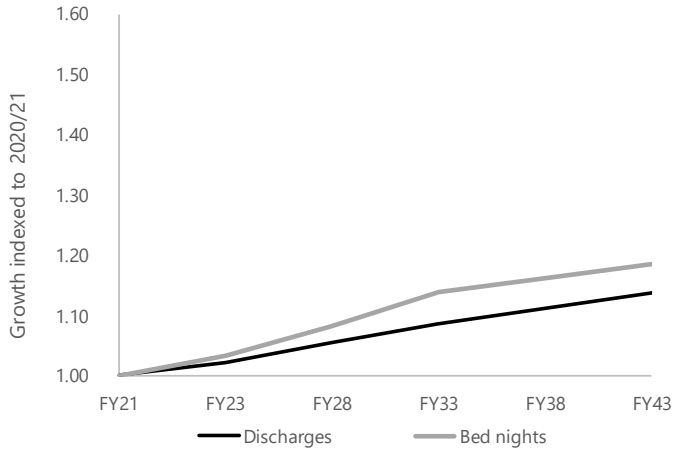
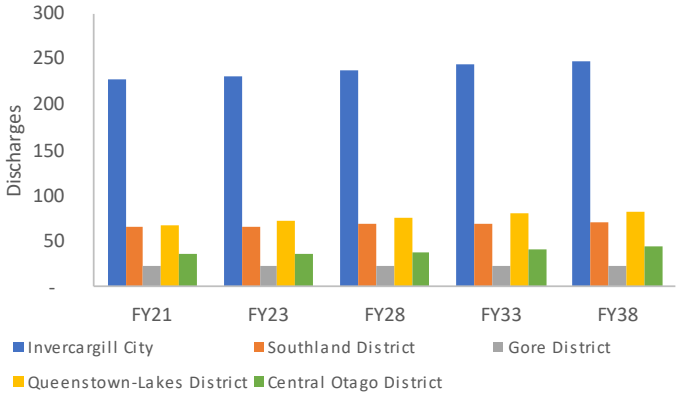
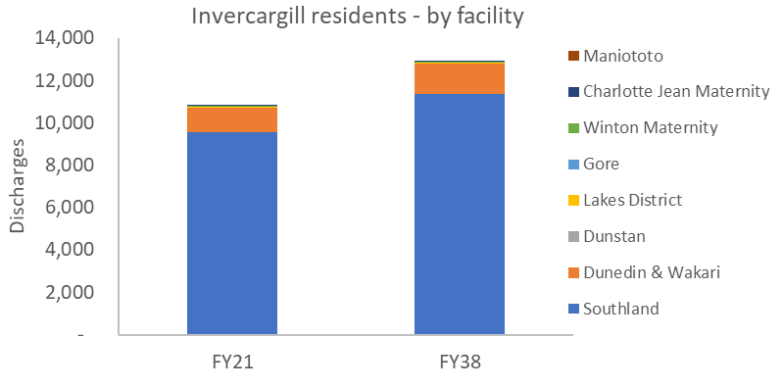


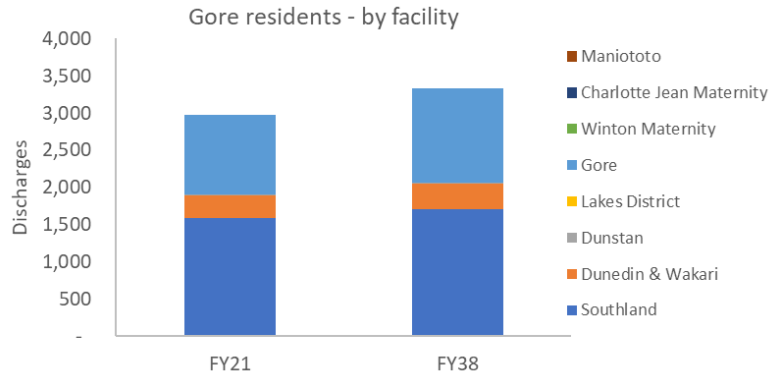
Figure 36 Mental health discharge growth by patient domicile

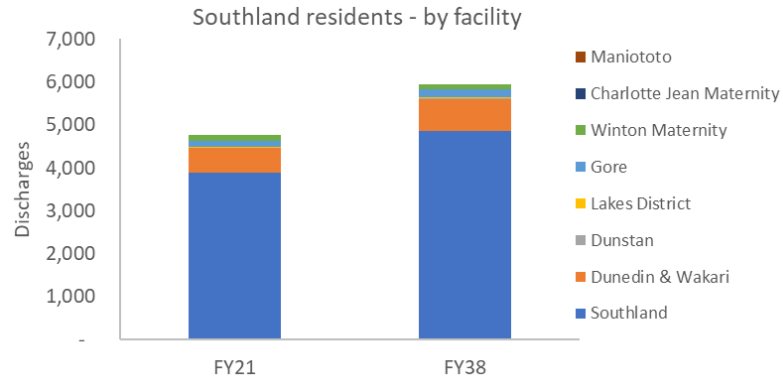


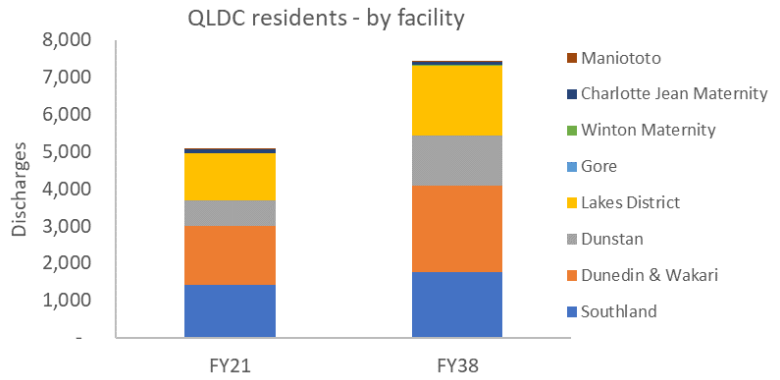
13.1

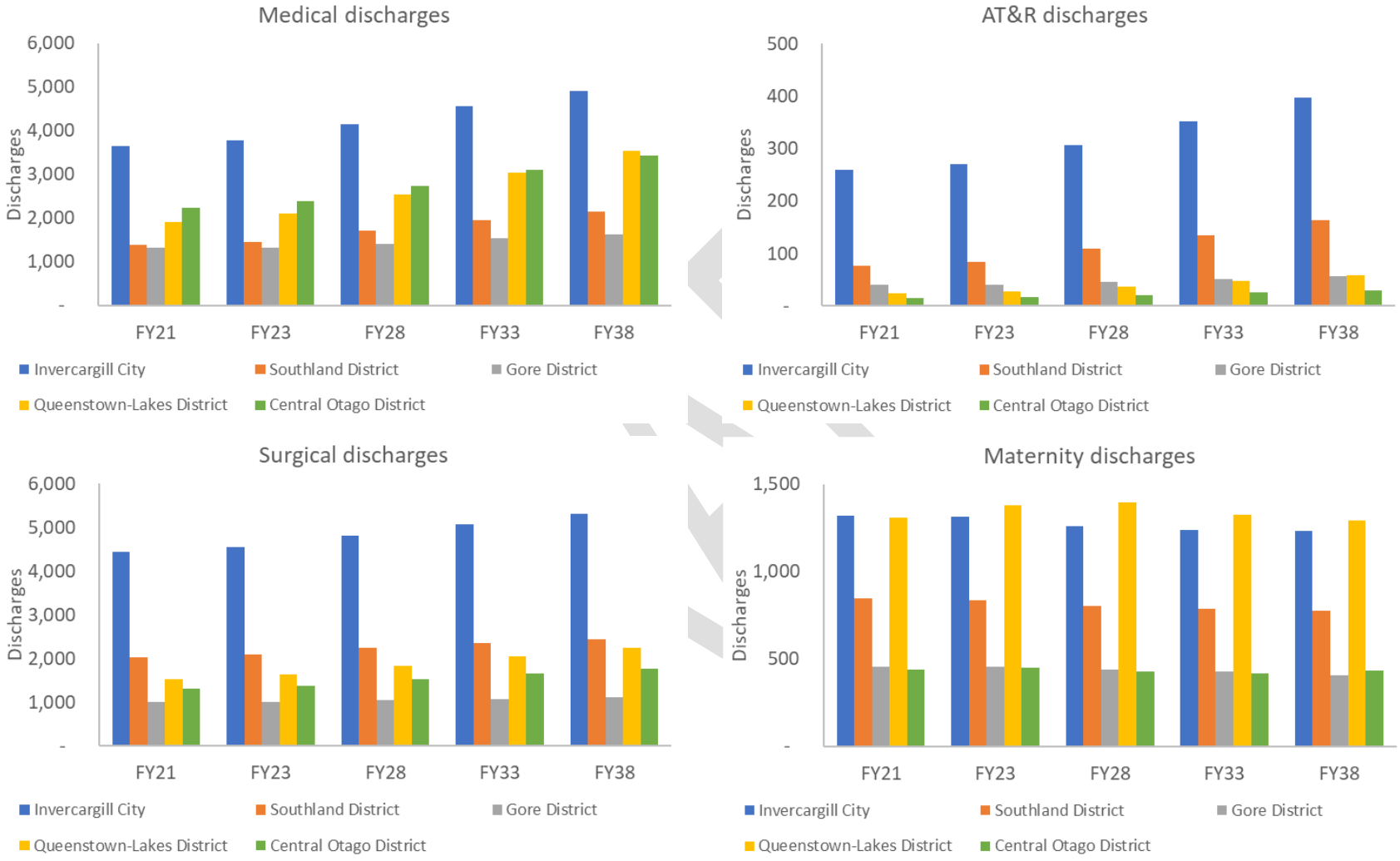
Appendix A Baseline service volume growth by domicile

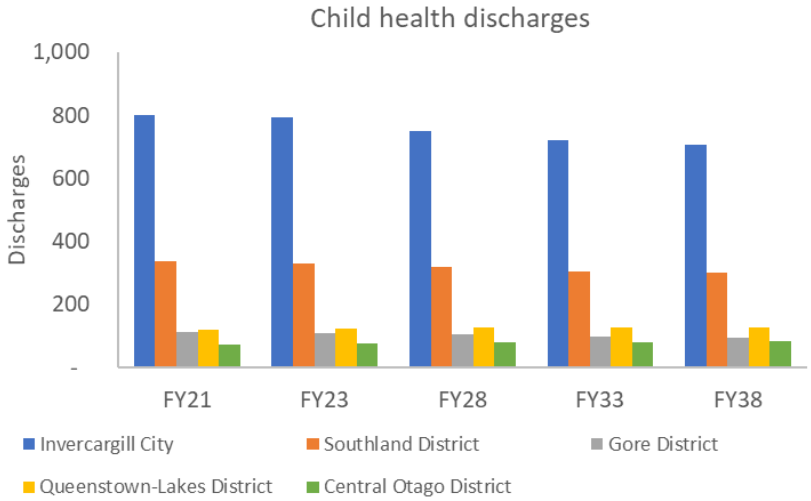


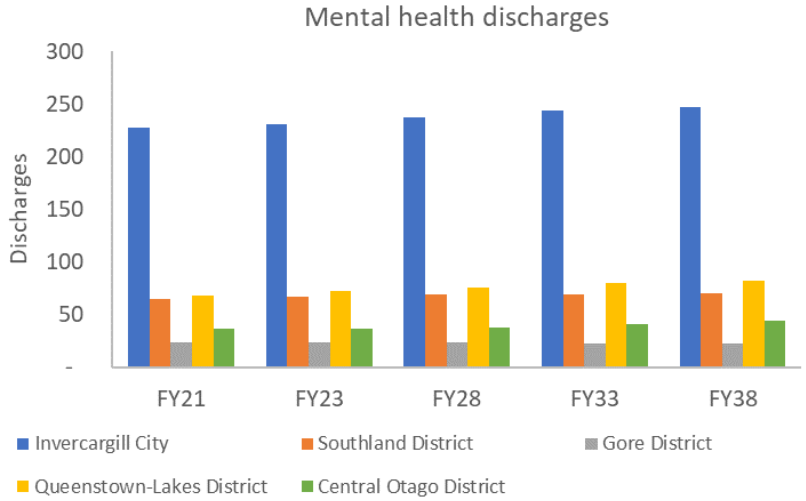


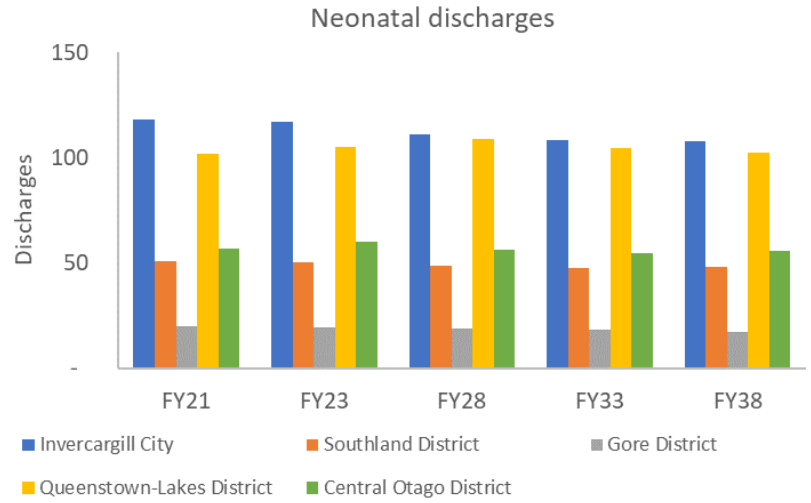





Medical discharges
6,000
5,000
4,000
3,000
2,000
1,000
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District
AT&R discharges
500
400
300
200
100
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District
Surgical discharges
6,000
5,000
4,000
3,000
2,000
1,000
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District
Maternity discharges
1,500
1,000
500
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District


Child health discharges
1,000
800
600
400
200
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District


Mental health discharges
300
250
200
150
100
50
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District


Neonatal discharges
150
100
50
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District

Appendix B Desktop scan of service models

This aims to serve as a horizon scan or summary of contemporary and emerging models of care across a range of topics and areas of Southern DHB's service offerings that could apply to its clinical services planning for the Southland region. This horizon scan should not be considered exhaustive.

As disease burden increases and patients' needs become more complex (compounded by aging), a common theme across most of the models of care change and reflected in the wider national (and international) health strategies, is about moving care as close to the patients' home as possible. This means it is moving into the community and primary settings and out of secondary and tertiary settings. This is for a variety of reasons, including (but not limited to) a lower cost to the health system; more holistic, relevant, timely care for patients and whanau; and greater ownership and involvement in patients' own healthcare journeys.

Development of primary, community, and social hubs to integrate health and social care

With the increasing focus on providing services in community settings and as close to home as possible comes an increased emphasis on health promotion, prevention, early intervention, and better integrated models of care to limit the burden on hospital systems.

Developing primary, community, and social hubs can help to manage some of these activities, take the pressure off the hospitals, and improve patient experiences by placing care within the community, all while integrating health care with social care, enabling interdisciplinary work within the community setting (allied health, social work, psychology, pharmacy, and primary care).

Youth One Stop Shop (YOSS) practices in New Zealand provide an example of integrated hubs that combine health and social services as wrap-around care for youths and may provide lessons for how similar hubs could be constructed for larger populations.

Case study: Youth One Stop Shop services providing wraparound care

Youth One Stop Shop (YOSS) practices provide free holistic health and social services for young people in given areas, as well as for their families/whānau (Healthpoint, n.d.). They are built upon a youth development model, which is about empowerment, trust, and providing a comfortable space in which youth can take ownership of their own pathway. The practices provide wrap-around services to ensure individuals needs are met in a coordinated way. The services that are coordinated and housed within a YOSS practice can include:

- clinical services (doctors, nurses, school-based services such as sexual health clinics)
- social enterprise work, partnering with organisation to develop youth skills
- youth support, including the likes of budgeting, employment support, driver licensing and parenting
- young parent support with 1-on-1 mentoring and help
- counselling and psychologist access.

This model has been shown to be more likely to provide targeted or configured programmes for those facing signfiicant health inequalities (Ministry of Health, 2009). The co-location and integration make it easy for youth to access a range of services they may need (potentially even through "bundling" in consultations).

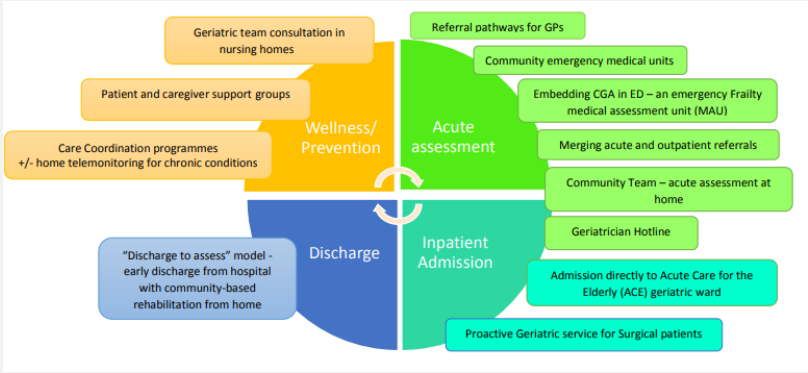
Wraparound approach to provide older-person care in the home

Older person care in New Zealand has come under scrutiny and official Government review in recent years because of piecemeal approaches that in some areas had overlaps and in other areas gaps. Governments' strategy in New Zealand and internationally is now focused on keeping older people living at home for longer and out of hospitals and older person care facilities because it is cheaper and likely improves patient experience.

Case study: Proposed wrap-around approach of Waitemata DHB to older-person care

Waitemata DHB canvassed the emerging models of care in older persons care, evaluated across four domains:

- wellness/prevention in primary and community settings
- acute assessment
- discharge
- inpatient admission (The National Institute for Health Innovation, n.d.).



Source: (The National Institute for Health Innovation, n.d.)

The wellness/prevention domain is focused on increasing the level of active management in the primary and community settings to provide care as close to home as possible and reduce the likelihood of older people needing to advance to secondary care. This includes increasing frequency and consistency of consultation and use of telehealth as an enabler, plus providing resources to support groups and caregivers to allow greater self-management of conditions.

The acute assessment domain is focused on streamlining and increasing the efficiency of the assessment process for older person health needs. This includes the development of locally agreed detailed guidelines to pre-determine the referral process for patients; the development of community emergency frailty units that can provide rapid comprehensive geriatric assessment and treatment as well short-term (< 72hrs) admission, and nurses for patients sent home to recover; providing dedicated frailty assessment units within emergency departments for early, real-time geriatrician review; merging acute and outpatient referrals since they often have little difference in clinical severity and no difference in process of care required; home-based treatment and rehabilitation to avoid hospital admission; and geriatric hotlines like the TALK service at King's College Hospital, London, that provides 24/7 access to specialist geriatrician advice for healthcare professionals that helps to get advice rapidly and avoid patients attending ED.

The inpatient admissions domain is focused on fast-tracking hospital admissions for older people straight to a geriatric ward, as well as providing proactive geriatric services for surgical patients which includes preoperative screening using CHA, identification of any problems pre-treatment, provision of education on exercise, nutrition, and pain management, and post-operative review and follow-up therapy in the home.

The discharge domain looks to discharge older person patients as quickly as possible, providing the post-treatment needs assessed within the patient's own home. This also requires care packages be put in place directly with the patient at home so that they have the right level of care and support at a faster rate than if they were kept in hospital for longer.

Focus on streamlining and consolidating specialist advice

There have always been issues for healthcare professionals in being able to access the right specialist information at the right time. When it is not possible, inefficiencies are created and patients often end up not receiving the care they should at the earliest possible moment, which leads to longer length of stay and subsequent burden on the hospital, and sometimes inappropriate care.

The focus has turned to being able to streamline and consolidate specialist advice resources to make sure the right specialist information can be accessed easily at the right time to provide the appropriate care and reduce the time patients need to spend at hospital.

Case study: HealthPathways website for consolidated best practice guidance for GP teams

Gurung et al. (2019) also looked at HealthPathways in Canterbury as a case study of emerging models of care. The HealthPathways website was established in Canterbury by GPs and hospital clinicians in response to the Ministry of Health's 2006 desire to cut waiting times to six months.

The HealthPathways website provides easily followable and localised best-practice guidance for GP teams for both pre- and post-referral patient management and provides a much-needed interface between GPs and hospital services to streamline information systems and allow for efficient knowledge transfer. GPs can access the website containing the locally relevant clinical pathway and information regarding investigations, differential diagnoses, acute and conservative management, and patient education easily during a patient consultation and then use that to inform the care and next actions the GP should take for the patient. It also provides access guidelines based on need, cost, and availability of services which assists GPs in providing care to patients with poorest health status.

Given each pathway has been established in collaboration by GPs and hospital services, there is consistency in how patients advance through the care process which allows for better continuity and consistency of care as well as more efficient processing. Also, it means that GPs do not have to organise multiple sources of information and can rely upon the system to portray an accurate and agreed pathway for patients. Most of the pathways also include links to HealthInfo, which is a supplementary website that provides health information for patients, consistent with what is described in the clinical pathways.

Since implementation there have been associated improvements in referral quality, more equitable referral triage, and more transparent management of demand for secondary care. Buy-in from GPs and hospital services and the willingness to work together to develop the locally relevant pathways was critical for the programme's success.

Ambulatory/outpatient care moving into the community

There has been a fundamental shift in ambulatory/outpatient care from hospital (secondary) settings to community-based settings to limit the burden and pressure on the hospital system (Gurung et al., 2019). Within New Zealand there are three main shifts identified:

- transfer of services or elements of services from secondary to primary care settings
- relocation of specialist care from outpatient clinics to primary care settings, without changing the people who deliver the service
- liaison/joint working between specialists and primary care practitioners, or within primary community care practitioners to provide care to individual patients.

As well as aligning with the goals of getting care closer to the home of the patients' and easing the burden of care on the hospital system, re-location of ambulatory/outpatient services to community-based settings may have increased equity and cost-effectiveness of delivery in rural areas (Gurung et al., 2019).

Case study: Tararua Health Group Limited for community-based ambulatory care provision

Gurung et al. (2019) looked at Tararua Health Group Limited as a case study amongst their wider review of ambulatory services in community-based settings. It provides a nice example of how ambulatory/outpatient services can be delivered in community-based and primary care settings and away from hospitals.

Tararua Health Group Limited has been around since 2009 and is comprised of 3 GP practices across Dannevirke and Pahiatua as well as a community hospital, using a hub-and-spoke model across the region. The hospital has 8 GP beds that receive care from GPs on a roster system, 3 beds for maternity services, an x-ray service, and provides ultrasound services 2 days per week. There is also an after-hours telephone triage system provided by the hospital.

Across the network there is a single linked patient management system that means patient records from all four sites are integrated and collated to allow sharing of information between the practices, linkages to radiology services, and MidCentral health, which enables participation from specialists.

What makes this work is the GP-based model with multi-disciplinary case management, as well as advice from the Central PHO clinical pharmacist, and appointment of GP with Special Interest, Clinical Nurse Specialist, RN with Special Interest, and Allied Health to work within the network. It also focuses on a stratified approach that targets those with high needs and those at high risk., and ultimately has high potential to be able to prevent emergency department presentations, plus keep people in their homes for longer.

Increasing use of telehealth for timely and preventative consultation

As technology advances and society becomes better interconnected across different systems, telehealth poses a viable cost-saving and efficient way to provide timely and preventative consultation in certain care applications, keeping people in their homes for longer and out of the emergency department. Telehealth can include the use of messaging, emails, telephone calls, video calls / teleconferences, and applications.

Telehealth has proven to be beneficial during the COVID-19 pandemic, allowing consultations to go ahead virtually regardless of social distancing mandates that restricted physical consultation. Looking forward, telehealth is particularly attractive for consulting those in rural or hard to reach places, however, doesn't come without issue as those are the same areas that are likely to still have poor and/or underdeveloped internet infrastructure (Wilson et al., 2021).

Telehealth can be used feasibly in a range of settings to interact with patients across the continuum of care, saving time (particularly travel time) and costs.

Case study: using telehealth for stroke rehabilitation to improve equity of outcomes

Wade and Stocks (2017) summarised the use of telehealth to reduce inequalities of cardiovascular outcomes in Australia and New Zealand. Typically, post-stroke, most patients benefit from rehabilitation services to restore motor function and capabilities they may have lost, such as being able to walk unassisted and talk. The response requires a lot of multidisciplinary action and a team of allied health professionals, including physiotherapists, occupational therapists, and speech therapists who conduct assessment and tailor rehabilitation programmes for the patient. A coordinated response like this is difficult, timely, and expensive, and because of limited public funding and availability of services, patients accessing public health services often receive less than the ideal amount and length of rehabilitation. This is a particular problem for those from low-socioeconomic areas that can only access public health care.

The case study of Crotty et al. (2014) looked at the use of telehealth for post-stroke speech pathology in Adelaide. The telehealth channel of consultation and rehabilitation employed a coaching model, effectively giving the patient fewer home visits but greater feedback and tasks for the patient to complete on their own (i.e.

"homework"). Patients were given a tablet computer that had an off-the-shelf teleconferencing app to connect with therapists and also apps that would be helpful.

On average, participants felt they had achieved 75 per cent of the goals set at the beginning of the programme and had high levels of satisfaction with the process. Speech therapists were able to double the occasions of service and direct patient contact time whilst also halving their required travel time.

Managing unplanned care

Focus is shifting to providing out-of-hospital preventative initiatives and active management systems in the primary and community settings to reduce unplanned admissions, accident and emergency presentations, ambulance service utilisation, emergency mental health attendance, and so on. This is again to minimise the number of people presenting at hospital for unplanned care, minimise the burden of care on the secondary and tertiary sectors of the health system, minimise the costs of illness to society, and improve the patients' treatment experience.

Managing unplanned care successfully in the primary and community settings requires targeting the needs of people and engaging them across the system, using interprofessional arrangements and relationships (i.e. pharmacists, nurses, paramedics, physician assistants, advanced practice nurses, physicians, and others) to provide cohesive and comprehensive care. It also requires that services and providers are integrated and working in unison (plus using a range of different resources, approaches, and management programmes) to ensure out-of-hospital activities are handled well.

The inclusion of unplanned care in models of care may significantly improve patients' healthcare experience while reducing unnecessary admissions and hospital resources (Myers et al., 2016).

Case study: Successfully managed unplanned care in the community

Myers et al. (2016) provide a succinct example of how unplanned care can be successfully managed and minimised by focusing on providing integrated and cohesive interventions in the primary and community settings.

The first patient is an 80-year-old female with a past medical history of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), chronic renal insufficiency, and abdominal aortic aneurysm. The patient was discharged on a Friday afternoon at 4:30 pm. As the patient's oxygen supplier closed at 5 pm, the patient was unable to get a new home oxygen concentrator. Prior to the initially scheduled MIH provider visit, the patient called into the MCC with a complaint of respiratory distress with SPo2 of 80%. The MCC immediately dispatched a specially credentialed local MIH paramedic. The paramedic completed an assessment and identified that the oxygen concentrator was dilapidated, and the nasal cannula tubing was over 20-ft long. The patient was placed on portable oxygen with a new nasal cannula, and albuterol/ipatropium was administered by nebulizer. The paramedic connected with the MCC and the on-duty MIH Physician Assistant (PA) was conferenced, via telemedicine, to perform a real-time comprehensive assessment and collaborate in additional care and disposition. Vitals signs normalized with the new shorter cannula and nebulizer treatment. The oxygen supplier was contacted who promised delivery that evening. The patient was supplied with oxygen tanks to bridge until her new concentrator arrived. The patient was given supportive care instructions with follow-up phone calls and a visit with the MIH PA the following morning.

The MIH PA visited the patient the next morning, and the patient reported that she had not received the new oxygen concentrator the previous night. The MIH PA contacted an Evolution Health Mobile Integrated Care Coordinator (MICC) who arranged for a different oxygen company to complete the Durable Medical Equipment, order since the original company was unable to complete the delivery within 48 hours. The MICC verified the new oxygen concentrator was delivered by early Saturday afternoon. The patient received follow-up calls from the office with a follow-up visit by the MIH PA in 1 week. The MIH Team was an integral part of a care plan that enabled the patient to successfully avoid hospital readmission for over 5 months.

Changes to staff and management structures for urgent care / primary care after-hours

Over time there have been growing trauma presentations associated with risk-taking recreations, an aging population, higher health need, and therefore higher chance of presentation at urgent care / primary care after-hours facilities with acute illness. The focus remains to try and keep care as close to home as possible and reduce emergency department admissions at hospitals to keep resources available for serious and more urgent health problems.

Development of competent primary care practices that can provide urgent care (and therefore ease demand on hospital emergency departments) is the main goal. This change can be brought about through changes to staff and management structures to make them better equipped to manage the patients that present to them. For example, the changes may include:

- Employing more senior decision makers to deal with emergency/urgent situations in GP practices.
- Increasing access to acute short-notice 24/7 MIC/GP care.
- Introduction of acute community-based health care hubs to keep care within the community.
- Using telemedicine for outlying and rural areas to allow for urgent care access.
- Greater integration with mental health services.

Case study: Enhanced out-of-hours GP model in Canterbury

Gurung et al. (2019) identified a 24-hour GP surgery in Canterbury as an example of an innovative model type to strengthen primary care's ability to take secondary care responsibilities and provide extra access for patients seeking emergency after-hours care.

The offerings of the general practice include observation beds and access to diagnostic tests such as blood tests and x-rays, plus there are GPs on-hand to see patients who otherwise would have had to go to the hospital emergency department.

Through their review, Gurung et al. found that the success of the practice in being able to provide out-of-hours care was largely in part due to the introduction of an electronic shared care record view which allowed for GPs to access patients' full medical history outside of regular hours, allowing for timely consultation and treatment. The records of out-of-hours are shared back to other healthcare providers during patient follow-ups.

Changes to the operating models of rural hospitals

It is well documented throughout literature and the New Zealand experience that rural communities face inequities in accessing and benefiting from healthcare, as well as discrepancies in quality, continuity, timeliness, and comprehensiveness (Marek et al., 2020). Many changes have been made somewhat recently to the way care is delivered rurally to provide better, more comprehensive offerings and better outcomes for rural communities.

As some have put it, rural health should be considered much more than merely the practice of health in another location and requires a different approach (i.e. it is not just "small-scale" urban care) – rural health services should be considered as part of the economic and social fabric of the community as well (Blattner et al., 2020; Bourke et al., 2012). The health services should be strong, integrated (across primary, secondary, and social settings), innovative, cooperative, and holistic in terms of its care for the population. Blattner et al. (2020) look at Hokianga Hospital in the far north as a successful case study of an integrated, holistic service that is embedded within the social fabric of the community.

Case study: Ashburton Hospital change from secondary specialist to rural generalist model

Withington et al. (2020) reviewed the Ashburton hospital as a case study for how rural hospitals can successfully change their operating models and perform efficiently and effectively by moving from a secondary specialist model to a rural generalist model.

Previously, Ashburton hospital included an acute and elective surgical roster led by 3 general surgeons, and 3 FTEs worth of anaesthetists. There were 4 physicians running acute medical and rehab admissions as well as outpatient clinics, limited paediatric cover, and subspecialty outpatient clinics were operated with support of visiting specialists from Christchurch. There was a two-tier roster with an experienced and stable MOSS workforce that replaced all RMO positions.

Change was needed because of an aging/retiring SMO workforce; difficulty recruiting replacement surgeons, physicians, anaesthetists, RMOs; vulnerability with retirement/resignation; Canterbury 2011 earthquakes closing operating theatres; and strong community support to maintain hospital services in Ashburton.

Now, the hospital has an SMO workforce made up of 8 full- or part-time Rural Hospital Medicine (RHM) fellows with 6 FTE total, working a 1:5 acute roster, taking all medical, non-operative surgical, and paediatric admissions during that period. The second tier of the roster is made up of 8 RMOs, ranging from PHY2 to PGY5 and RHM trainees. They are organised into three inpatient teams (consistent of 2-3 RHM SMOs, a registrar, and one RMO) that are responsible for the continuity of care from admission to discharge. There has been a complete removal of surgical inpatient beds with only a few day procedures remaining.

The new model serves more acute patients now and a similar number of inpatients with a decrease in average length of stay in acute medical inpatients (increased efficiency). This decrease is likely because of the benefits of the integrated generalist model where no specialist silos or compartments exist, and therefore smaller clinical teams have better autonomy over continuity of care. The success and change were enabled by the increasingly recognised RHM qualification and support from remaining specialist SMOs and hospital management staff.

Increasing use of digital

The aging population of New Zealand as well as the increasing disease burden and complexity of disease contributes to growing demand for surgery which has impacts on the fixed capacity of operating theatres as well as hospital inpatient capacity. The focus is now on reducing the need for operation/surgery through preventative action in primary and community settings, and where operations/surgery are necessary, making them more efficient where possible, and thus freeing up resources and reducing administration burden (decrease length of stay, decrease cost of surgery, etc.).

Ways of increasing efficiency may include:

- increased used of eObservation programmes to limit the administration burden
- increases in allied health support to assist rehabilitation and discharge planning
- using specialty nurses for patient follow-up, and in some cases, use of virtual follow-up to share the likes of test results
- new technologies and integrated laparoscopic theatre suites with 3D equipment to reduce theatre times and increase throughput of patients.

Case study: ED at a Glance (EDaaG) in Nelson Marlborough DHB

Nelson Marlborough DHB introduced a system called ED at a Glance (EDaaG) that provides a virtual, collated whiteboard of updated emergency department information for all patients, allowing for timely decision-making and oversight (Morton, 2015). Having a central, updated source of patient information allows for decision makers to assess the priority of each case and allow for resources to be applied appropriately. The system also allows for capture of why patients stay longer than 6 hours within the emergency department, destination coding so that it is clear where patients are heading, automated list generation for x-ray sessions, and back-end reporting.

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An update for the Board from the Southern Blood Cancer Service – April 2022

1.0 Exec summary

Recognising ongoing demand and capacity challenges, Ernst Young (EY) was commissioned by the Southern District Health Board and Te Aho o Te Kahu | the Cancer Control Agency (CCA) to provide advice on the development of a three-year action plan for the Southern Blood Cancer Service (SBCS). Their work identified the most immediate gaps in SBCS regarding workforce resourcing, facilities and service delivery, with recommendations for action between 2022-2024 to address these gaps.

The EY reports recommendations have been previously endorsed by the Board with a significant investment already approved. The purpose of this paper is to provide an update on progress to date and highlight the next steps in progressing these recommendations to support the improved provision of SBCS for SDHB.

Report highlights 3 key areas.

a) **Current recruitment** - From the new positions approved we have successfully been able to recruit 17/19 (~90%) to date. *(Budgeted and approved)*

b) **Support/Admin recruitment** - We are progressing the current proposal to recruit 4 additional mixed role Administration staff and 2 mixed role Nursing staff positions. *(Pending approval, in circa $405K)*

c) **Facilities upgrade -** We are also keen to rapidly progress the required refurbishment for the SBCS facilities. *(Pending some CAPEX approval. Contractor quote in circa $374K)*

2.0 Recruitment update

To date we have filled 17/19 new positions (~90%) and the impact of this workforce uplift has already positively impacted patient wait lists most notably in radiation and medical oncology. As a result of existing / long standing Vacancy we are still 6.4FTE understaffed with the most vulnerable service being Haematology at -2.4FTE.

	Schedule of New Positions for $2M Investment in Oncology			
Position	**Existing Vacant FTE**	**NEW/FTE**	**Filled**	**Total Vacancy**
Radiation Oncology Registrars	0	3.0	2.0	1.0
Medical Physicists	1.0	3.0	2.0	2.0
Registered Nurses - Dunedin x 1, Invercargill x1	0	2.0	2.0	0
Clinical Nurse Specialists (0.6 Haematology, 1.0 Radiation,1.0 lung)	0	2.6	2.6	0
Clinical Nurse Coordinator	0	0.6	0.6	0
Radiation Therapist	0	1.0	1.0	0
Medical Oncologist	1.0	1.8	1.8	1.0

Oncology Registrar	0	1.0	1.0	0
Haematologist	2.4	1.0	1.0	2.4
Haematology Registrar	0	1.0	1.0	0
Medical Transcriptionist	0	1.0	1.0	0
Faster Cancer Treatment Nurse/Coordinator *(fixed – needs to be permanent)*	0	1.0	1.0	0
TOTAL	**4.4**	**19**	**17**	**6.4**

3.0 Support /Admin staff update

In response to recognising the ongoing demand and capacity challenges with the increased clinical FTE and the corresponding increased workload this creates the other recommendation from the EY report is to increase administration and nursing staffing. This is to support not only the increased workload but to ensure clinical staff are working at the top of scope to maximise service efficiency.

This has been scoped by EY to be 2.0 FTE nursing and 4.0 FTE administration roles and has since been worked through by the clinical teams and is detailed below.

3.1 Clinical Healthcare Assistant/ Non-clinical Healthcare Assistant (HCA)

The Otago Oncology Day Unit (ODU) and Outpatient Department would be more efficient if the nurses working clinically did not need to clean, tidy and stock – this could be done by a HCA, as could clinic support such as chaperoning, recording weights, and assisting nurses with set tasks. This proposes introducing the HCA roles to undertake these tasks. Invercargill who already has the HCA role but at a very small FTE they would benefit from additional hours for the same reasons.

Health Care Assistant (HCA)

- 0.05 FTE increase in Southland (an additional 2 hours per week. They already have 8hrs / 0.2 FTE per week now).
- 0.5 FTE in Dunedin – a new role

3.2 Nursing Leadership

Nursing leadership has been highlighted as a critical gap that is needed to support the current workforce, improve coordination and operational efficiency also, to have the capacity to be able to advance new innovative ways to improve service planning and delivery. Roles such as clinical nurse coordinators for managing chemotherapy treatments, associate charge nurse managers for clinical staff and service oversight are examples.

Clinical Nurse Coordinator (CNC) Senior Nurse Grade 3

- 0.2 FTE increase in Dunedin
- Translate a specialty nurse 0.2 FTE to 0.2 FTE CNC (both Grade 3 so cost neutral)
- Translate 0.2 FTE of CNC to ACNM in Southland to make 0.3 FTE CNC and 0.7 FTE ACNM. Currently 0.5 FTE ACNM / 0.5 FTE CNC.

3.3 Administration

Is has been well established that there is a lack of both clinical and non-clinical administrative support staff for SBCS which is impacting service efficiency and translating to an increased workload for our clinical and technical staff.

Administration staff are critical to support the delivery of care and to ensure clinics are fully booked and operate as efficiently as possible. Through progressing these recommendations, we will be able to better support the medical and technical staff, increase our clinic efficiency and to ensure we maintain the highest quality of patient care.

Administration roles

- 2.0 FTE Booking Coordinator Dunedin
- 1.5 FTE Medical Transcriptionist (1.0 FTE Dunedin, 0.5 FTE Invercargill)
- 0.5 FTE MOSAIQ specialist administrator

3.4 Registered Nurses (RN)

The initial EY recommendation was to consider 2.0FTE up lift in RN to support SBCS, but through working through the above mixed role model we have reduced this to 1.25FTE in substitution for the proposed resourcing plan. The Costing of the proposed RN/HCA model is also cheaper than the initially proposed 2 RNs has been calculated and is attached noting that.

- 0.7 FTE RN Dunedin Oncology Day Unit
- 0.55 FTE Southland Oncology Day Unit

4.0 Facilities work update

The EY report also highlighted critical facilities issues, in particular relating to the lack of private areas for consultation with patients, which would be exacerbated by increased throughput and workforce expansion.

This is placing a significant risk to patient safety and impeding our ability to operate clinics in a fuller capacity. Without sufficient bed bay spaces, clinic rooms or having to use clinics that are inadequately equipped, patient outcomes are at risk and our ability to fully utilise our workforce to further reduce waitlists is compromised.

To create some immediate room the Senior Medical Officers (SMOs) have now vacated their ground floor offices to enable additional space to be refitted/refurbished as clinic rooms (this is part of the planned refurbishment work). Offices have been allocated in the Children's pavilion; some issues have been identified that will need to be worked through.

Building & Property (B&P) have worked with key clinical and management staff to determine space requirements and a rethink of the current building footprint. The Oncology New Office Layout 103 demolition and proposed new spaces include creating an additional 5 clinic rooms, 1 patient bed bay and some staff spaces on the ground floor of Oncology. Minor works are required on the first floor's Chemotherapy / Oncology Day Unit to create a clinical nurse coordinator office, a purpose-built

medication room and reception area. The second floor of Oncology redesigns a space fit for the medical transcriptionists and refurbishes the Oncology Research Unit.

Following a tender process, the works have been secured, with project management by an external provider. Work is expected to commence quickly given the urgency of addressing this space issue with some but not all capital has been set aside for this. A planning start date indicated by the project management group has been set for late May. This is pending on the CAPEX applications being approved. (approved capital investment to be split between the service and nurse managers' budgets with some contingencies to be required.

5.0 Immediate Next steps

a) Continue recruitment into vacant roles

b) Seek approval to action Support / Admin recruitment

c) Seek CAPEX approval to progress facilities work.

Craig Ashton, General Manager Medicine Women's and Children's

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) Finance, Audit & Risk Committee ▪ Unconfirmed minutes 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.
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.
Equity Investment Strategy	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.
Quality and Clinical Governance	To allow activities and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.
Lease Approval ▪ Te Kāika Wellbeing Hub	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Capex ▪ Capital Expenditure Update ▪ Scanning Business Case ▪ Dunedin Mobile X-Ray Machines ▪ Surgical Sterilising Unit (SSU), Dunedin ▪ Wanaka Birthing Unit	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 ▪ Nursing Workforce Development ▪ Strategy Primary and Community ▪ Southern Oral Health and Otago University Faculty of Dentistry 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.
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.

*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.