Southern DHB Board Meeting

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

08/06/2022 09:30 AM - 12:30 PM

9.	Strategic Change Programme	CEO	101
10.	Māori Health Actions to Address Amenable Mortality and Conditions	CMHS&IO	126
11.	Time for Change Te Hurihanga Programme	ED MHAID	128
12.	Presentations:		137
	12.1 Southland Clinical Needs Analysis	11.00 am David Moore & Rebecca Rippon	137
	12.2 Clinical Council	11.30 am CC Chair	185
	12.3 Patient Flow Taskforce	12.00 pm COO	207
13.	Resolution to Exclude the Public		220

APOLOGIES

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

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Board, 8 June 2022

Recommendation

That the Board receive and note the Interests Registers.

Purpose

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

Changes to Interests Registers since the last Board meeting:

- Mata Cherrington – Hiringa Oranga o Awarua Limited removed

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
	18.03.2022	Associate, Centre for Social Impact	Nil
	18.03.2022	~~Director, Hiringa Oranga o Awarua Ltd~~	~~Possible conflict when contracts with Southern DHB come up for renewal.~~ Removed 10.05.2022
	18.03.2022	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	

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, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017 (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

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	Executive Member of the International Society of Social Paediatrics and Child Health (ISSOP)	Nil
	19.01.2022	Consultant to the World Health Organization, Geneva	Nil
	19.01.2022	Fellow of the New Zealand College of Public Health Medicine	Nil
	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

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	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
	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, 3 May 2022, 9.30 am
Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Pete Hodgson	Chair
	Prof Peter Crampton	Deputy Chair
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	*(by Zoom)*
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	
	Miss Lesley Soper	
	A/Prof Moana Theodore	
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Dr Ben Pearson	Crown Monitor
	Ms Amy Adams	Member, Interim Health NZ Board *(from 1.20 pm)*
	Mr Chris Fleming	Chief Executive Officer
	Mr Hamish Brown	Acting Chief Operating Officer
	Ms Mata Cherrington	Chief Māori Health Strategy and Improvement Officer *(until 12.45 pm)*
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer *(by Zoom)*
	Prof John Eastwood	Chief Medical Officer
	Dr David Gow	Chair, Clinical Council *(by Zoom)*
	Ms Toni Gutschlag	Executive Director Mental Health, Addictions and Intellectual Disability
	Mr Andrew Lesperance	Executive Director Planning, Funding and Population/Public Health
	Dr Hywel Lloyd	Director Quality and Clinical Governance Solutions
	Mr Nigel Trainor	Executive Director Corporate Services
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer *(by Zoom)*
	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 was received from Ms Tanya Basel, Executive Director People and Capability, and Ms Fiona Pimm and Prof Sue Crengle, members of the interim Māori Health Authority.

An apology for an early departure was received from the Chief Māori Health Strategy and Improvement Officer.

An apology for the first part of the meeting was received from Ms Amy Adams, member of Interim Health NZ.

3.0 DECLARATION OF INTERESTS

The Interests Registers (tab 2) were noted. The Chair asked that any changes 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 5 April 2022 be approved and adopted as a true and correct record."

J O'Callaghan/P Crampton

5.0 ACTION SHEET

The Board Action Sheet and status updates (tab 5) were taken as read.

Strategic Change Programme

It was noted that a technical workshop on how to interpret the Strategic Change Portfolio Plan Report had been scheduled for 18 May 2022.

6.0 ADVISORY COMMITTEE REPORTS

Community and Public Health Advisory Committee

The Board received a verbal report from Mr Tuari Potiki, Chair, Community and Public Health Advisory Committee (CPHAC), on the final CPHAC meeting held on 2 May 2022. Mr Potiki reported that the Committee received:

- A comprehensive update from the Executive Director Planning, Funding and Population/Public Health;
- An appropriately challenging presentation and recommendations from the Pasifika community and providers;
- Verbal reports from the PHO and Māori Health leads on their future direction and plans.

Disability Support Advisory Committee

The Board received a verbal report from A/Prof Moana Theodore, Chair of the Disability Support Advisory Committee (DSAC), on the final DSAC meeting held on 2 May 2022, during which she advised the Committee:

- Discussed patient stories and agreed to endorse the approach to refreshing the patient stories programme;
- Received an update from John Marrable, Disability Working Group Chair, on the Disability Action Plan implementation and noted the priority areas of disability awareness training for all staff, electronic health records linked to a digital health passport, and accessibility;
- Noted that there would be quarterly communication with consumers and community groups on the Disability Strategy implementation;
- Thanked Committee and Board members and staff who had supported DSAC over the years, and the Disability Working Group, who would be continuing to implement the Disability Strategy.

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee (HAC) meeting held on 4 April 2022 (tab 6.3) were taken as read and Mrs Jean O'Callaghan, HAC Chair, took questions.

7.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 7) was taken as read.

CEO Departure

The CEO reported that an interim CEO would be appointed in the coming days by the CEO of Health NZ.

Omicron Update

Dr Hywel Lloyd, Director of Quality and Clinical Governance Solutions and Southern DHB's Emergency Co-ordination Centre (ECC) Controller, presented a COVID update (tab 15.2). This included an overview of how case numbers and hospitalisations were tracking nationally and locally against modelling, and the impact on aged residential care facilities.

In summary, Dr Lloyd advised that:

- Oral antiviral pathways were being worked through, with 27 pharmacies identified for distribution;
- There were good links with Māori and Pasifika NGOs, and former refugee communities;
- Community connectors remained well utilised but demand was reducing;
- Primary Care was under pressure but managing, their cases numbers were easing;
- Public Health had flexed into exposure event teams supporting aged residential care (ARC);
- 65/65 ARC facilities have had COVID positive staff
    - 48% have had COVID positive residents, 23% have active cases
    - ARC have experienced a considerable increase in positive cases in the last two weeks
- Secondary care admissions – there had been an increase in the level of morbidity, with three COVID cases in ICU that day;
- Cases were being transferred from Southland to Dunedin Hospital when required to ease pressure;
- There were ongoing workforce constraints across the Health sector, particularly in
    - Aged Residential Care
    - Home Community Support Services
    - Rural Hospital staffing was precarious, and
    - Maternity services were struggling to find Lead Maternity Carers (LMCs)

Following his briefing, Dr Lloyd responded to questions on Māori and Pacifika infection rates, Aaron Lodge occupancy, immunity against other COVID variants,

and the number of hospitalisations due to COVID versus patients who incidentally had COVID.

The CEO advised that:

- The pandemic response still dominated Southern DHB activity and the organisation had to be prepared for another spike.
- Funding for supporting the COVID response was expected to be extended to the end of December 2022, with the expectation that it would cover the entire vaccination workforce, ie for MMR, influenza, etc. This would provide an opportunity to promote the COVID programme workforce, particularly Māori and Pasifika, into Health careers.
- 62% of people affected by the cold-chain breach had received replacement COVID vaccination doses. This number had been impacted by the requirement to wait three months after contracting COVID before having a replacement vaccination. The number of people who could not be reached was about 9%.

  A draft report on the incident had been received from the independent reviewers.

Industrial Action

The Chief Allied Health, Scientific and Technical Officer (CAHS&TO) reported that three strike notices had been received from the Public Service Association (PSA) covering allied, public health, scientific and technical professionals. These were for:

- 9-15 May 2022, work to rule
- 15-16 May 2022, complete withdrawal of labour for 24 hours
- 17-20 May 2022, work to rule

In addition, notice had been received from the APEX union that physicists would be working to rule on particular machines, commencing 16 May 2022.

The CEO advised that the strike action would impact productivity.

The CAHS&TO reported that negotiations were continuing with the unions, then responded to questions on contingency planning for the strikes.

Acknowledgement – COVID Response

The Board congratulated SDHB staff and primary care for managing the totality of the COVID pandemic well and recorded its gratitude for the tenacity and quality of planning that went into that.

Management responded to questions on midwifery, obstetrics and gynaecology services, and the impact of nursing recruitment on bed closures.

8.0 FINANCE AND PERFORMANCE

Financial Report

The Executive Director Corporate Services (EDCS) presented the financial results for the period ended 31 March 2022 (tab 8.1).

It was noted that the reduction for planned care volumes not achieved and unbudgeted improvement action plan funding for the year to date had been recognised during the month, so the month and year-to-date figures were the same.

The EDCS advised that:

- The year-end forecast deficit had been held at $32m, given the result for April 2022;
- Cashflow was a concern, as it was uncertain whether the current overdraft facility would be available after the transition to Health NZ.

Volumes Report

The Acting COO presented the volumes report for the year to 31 March 2022 (tab 8.2), noting the significant disruption to planned care due to COVID and staff shortages. The focus had therefore been on maintaining acute non-deferrable care, including cancer care.

It was noted that planned surgery performance was slightly better than the previous month, due to increased bed availability and some outsourcing. The Acting COO reported that the team had been strongly focused on trying to get patients through and minimising disruption to them.

In response to a concern about long term surgical discharge and resourced bed trends, the EDCS advised that discharges were sitting at about 88-90% but caseweights were about 94-95%, which indicated more complex surgeries and less minor cases were being undertaken. It was noted that a further report on productivity would be considered at the June 2022 Hospital Advisory Committee meeting.

Quality Dashboard

The Director of Quality and Clinical Governance Solutions (EDQ&CGS) presented the quality metrics (tab 8.3), during which he noted the following key points.

- The staff events data was not available due to a technical glitch. The figures for February and March were similar to previous months.
- The Invercargill Hospital average length of stay graph did not appear to be correct and would be reviewed.
- Hospital acquired complications had been gradually trending down over the last four years but were still red according to the Health Roundtable.
- Hospital acquired infections had gone from red to amber during the month.

Dr Gow, Chair of the Clinical Council, advised that because the metrics were either externally benchmarked or a three year average, there was a risk of Southern DHB comparing itself against its own practice, which may or may not benchmark well against external comparators.

Management responded to questions on the availability of data by service, hospital acquired infections, short notice postponements, and complaint resolution.

Performance

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

9.0 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 advised that the previous month's performance was not included in the report due to a technical issue.

10.0 MĀORI HEALTH ACTIONS TO ADDRESS AMENABLE MORTALITY AND CONDITIONS

An update on actions to support Māori amenable mortality improvement (tab 10) was taken as read, noting that an update had been provided to the Community and Public Health Advisory Committee the previous day.

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) reported that she was working with the Data Analyst Equity to acquire the data required to form a baseline for performance reporting.

The Board requested that in addition to the Māori Strategy Group, the CMHS&IO consider forming a Māori Clinical Group, as included in the 2020/21 Annual Plan.

11.0 TIME FOR CHANGE - TE HURIHANGA PROGRAMME

A progress report on the *Time for Change - Te Hurihanga* priority projects (tab 11) was taken as read and the Executive Director, Mental Health, Addictions and Intellectual Disability Services (EDMHAID) provided the following updates.

- The Queenstown Lakes crises services model workshops were under way and a model would be submitted to the governance group for endorsement later in the week.
- The Alcohol and Other Drugs (AOD) process had been amended based on feedback received and a request for proposal (RfP) would be going out that week.
- The CMHS&IO was taking the lead on the first phase of the kaupapa Māori model development.
- The Ward 11 RfP had closed and two proposals had been put forward.

The EDMHAID responded to questions on overall progress and how staff were feeling.

The Board noted the work under way and thanked the EDMHAID and all those involved in the change programme, and requested a further update on progress at its next meeting.

It was agreed that consideration of the Mental Health investment in the public excluded agenda papers (tab 4) be brought forward to the public part of the meeting.

It was resolved:

> **"That the Board note the report and approve $7.005 million in 2022/23 for the initial phase of priorities in *Time for Change – Te Hurihanga*."**

P Hodgson/L Soper

The EDMHAID acknowledged the hard work of Mental Health and Addictions staff and advised that she was impressed with their dedication and service to the community.

12.0 PRESENTATIONS

Southland Clinical Needs Analysis

David Moore and Rebecca Rippon from Sapere and Simon Donlevy, General Manager Southland/Deputy Chief Operating Officer, joined the meeting for this item.

A summary of the current state of the Southland Clinical Needs Analysis, which included baseline projections (tab 12), was taken as read and Mr Moore summarised the key issues identified for the future delivery of services.

The GM Southland asked the Board to note that the report was a draft and further work was still to be completed, including a second round of engagement with the clinical teams.

Board members provided feedback on the draft report, following which demographic trends and future configuration of secondary services in the Queenstown/Central Otago area were discussed.

Patient Flow Taskforce

Ms Megan Boivin, Patient Flow Operations Manager, Dunedin, joined the meeting by Zoom for this item.

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

- The tireless work and outstanding dedication of the workforce over the past few months during the constraints posed by the Omicron outbreak.
- COVID had presented the opportunity to integrate services across the system.
- There had been a reprieve during the early part of April when pressure on beds had eased and people were flowing into the wards and out of hospital in a reasonable amount of time.
- COVID had increased pressure on the system, particularly in primary care and the Emergency Departments. Support was being provided to rural hospitals and aged residential care (ARC), who had workforce issues, and the Dunedin campus had been supporting Southland by taking COVID patients.
- There were numerous initiatives under way to improve patient flow and it was hoped to have the high throughput joint (orthopaedic) unit operating by the end of May 2022.
- More people were being admitted under the Generalism model and access to diagnostics was being improved.
- The discharge summary project and power of attorney matters were being advanced.

- A working group on integrated care in the community was being formed, with priority being given to decongesting ED and supporting the aged care cohort of patients.
- An excellent response had been received from nursing and occupational therapy students who had been working alongside Registered Nurses (RNs) in ARC facilities to care for residents in place. The contribution made by the Assessment, Treatment and Rehabilitation (AT&R) team to the ARC COVID outbreak response was also acknowledged.
- Four AT&R beds had been opened in Southland, however SIT also had challenges with staff absenteeism.
- The efforts put in by the Patient Flow Operations Manager, the Clinical Council, and the clinical teams, under the leadership of the COO, to improve patient flow was noted. The whole Southern health system was working as one team to ensure resources were utilised and the best care delivered to patients as close to their home as possible.
- A Patient Flow Operations Manager was starting in Southland at the end of the month.

The CEO advised that a quantitative report would be provided for the next meeting and suggested that the integrated operations centre concept be presented to the Hospital Advisory Committee in June.

13.0 QUALITY AND CLINICAL GOVERNANCE

Reaffirming Clinical Governance and Hospital Acquired Complications

The Director of Quality and Clinical Governance Solutions (DQ&CGS) presented plans for implementing clinical governance capability throughout the district (tab 12.1) and reducing hospital acquired complications (tab 12.2).

The Clinical Council Chair advised that providing individual and departmental data, together with a structure to facilitate discussion on good clinical governance, was key to enabling staff to know whether they were providing safe and effective care. The Clinical Council was trying to set an expectation of accountability through this process.

During discussion, it was suggested that:

- SDHB's values, in particular manaakitanga, be used to inform the discussion on the vision for clinical governance;
- The definition of equity on page 6 of the clinical governance report be reviewed, along with how Māori clinical governance could be included.

Management responded to questions on how the clinical governance work fitted with the performance and accountability framework.

The DQ&CGS was thanked for the reports.

14.0 COLONOSCOPY

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

The Board received a verbal update from Mr Connolly on colonoscopy services, during which he advised that:

- An initial meeting had been held on the formation of a regional South Island colonoscopy group under Health NZ, with the objective of co-operating to provide more efficient and better services;
- There would be challenges, however, with the growth in the number of people requiring colonoscopies, particularly in Canterbury.

The Chief Operating Officer reported that discussions were occurring with a candidate for the Gastroenterologist position in Southland.

The Board thanked Mr Connolly for his work.

15.0 ONCOLOGY UPDATE

An update from the Southern Blood and Cancer Service on the implementation of the EY report recommendations (tab 14) was taken as read and the Chief Operating Officer took questions.

16.0 PASIFIKA HEALTH

The Chair reported that Pasifika health leaders presented to the Community and Public Health Advisory Committee (CPHAC) the previous day and tabled the following requests:

1. Genuine partnership and meaningful commitment from the DHB/new entity with Pasifika people as a pre-requisite for improved health outcomes;
2. Pasifika representation at the decision-making table and relevant advisory committees in the new Health system;
3. Genuine commitment to design Pasifika specific equity, including an annual and long term operational budget to deliver on desired health outcomes;
4. DHB directs management to meet with the Southern Pasifika Collective in May 2022 to support the development of a business plan for its aspirations, including the establishment of a Pasifika Southern Health Hub.

The Chair advised that he and the Deputy Chair would be attending a meeting the following day to discuss the possibility of setting up a Pasifika oriented primary care facility.

The CEO noted Health NZ's intent to have Pasifika leadership at national, regional and local levels.

The CPHAC Chair reported that the presentation the previous day had been a powerful one that challenged CPHAC and the Board for not properly addressing Pasifika health issues and he had apologised for that.

The Deputy Chair noted that the Strategic Briefing for the new Health system would be going out for consultation in two to three weeks' time and suggested that the Pasifika messaging be woven into that process, so the new entity picked it up as a strategic issue.

It was resolved:

"That the Board support the recommendations as written from the Pasifika leaders."

T Potiki/L Soper

PUBLIC EXCLUDED SESSION

***At 12.45 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 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.
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 M9(2)(i) and 9(2)(j) of the Official Information Act.

P Crampton/J O'Callaghan

The meeting closed with a karakia at 4.25 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 30 May 2022

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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. Further meetings held with IT to establish a group to prioritise Power BI work for the District. Commentary provided in the front sheet when trends change.	Partially complete
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
Sept 2021	**Māori Health – Actions to Address Amenable Mortality and Conditions** (Minute 24.0)	Monthly reports to be submitted to Board.	CMHS&IO		Ongoing
Dec 2021	(Minute 16.0)	Suggested that the Māori Health Strategy Group's role include providing support and advice on equity across the organisation (incl. to Quality Directorate, Clinical and Community Health Councils).	CMHS&IO		
May 2022	(Minute 10.0)	Consideration to be given to forming a Māori Clinical Group, in addition to the Māori Strategy Group.	CMHS&IO	The CMHSIO sought advice from the IGC on the undertaking in the 2021/22 Annual Plan to set up a Māori Clinical	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				Governance Group. The concept was not supported in principle, noting that there is a Clinical Council already in place with Iwi representation to be confirmed.	
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. Data sources include TAS, Midwifery Council, PBUs, LMCs and DHB. Update attached.	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	Scheduled for 18 May 2022.	Completed
May 2022	**Reaffirming Clinical Governance** (Minute 13.0)	▪ SDHB's values, in particular manaakitanga, to be used to inform discussion on the vision for clinical governance. ▪ The definition of equity on page 6 of the clinical governance report to be reviewed, along with how Māori clinical governance can be included.	DQ&CGS	The team will emphasise the DHB values manaakitanga, pono, whaiwhakaaro and whanaungatanga, during conversations on clinical governance. The description of equity within the six dimensions of quality has been updated to define equity in the context of Māori. Meeting arranged with Māori Health Strategy & Improvement Executive Director and Māori Clinical leaders to progress Māori clinical governance.	Ongoing

Overview of the Midwifery Workforce FTE in SDHB
May 2022

In March 2022 the Board requested comparable data on the total number of midwives (DHB+LMCs) per birth, and the number of women of reproductive age, to provide the full picture for the Southern district.

While the FTE calculation for hospital midwives is relatively straightforward because it is based on CCDM and TrendCare data, the identification of LMCs coverage within the SDHB district and the analysis of the population in need of midwives presents some challenges. The nature of the complexity in identifying the appropriate midwifery coverage for SDHB can be summarised as per below:

1. There are issues with data collection and accuracy of our pregnancy and birth data. The systems for collating this data, and coding relevant information are different, or even missing, among localities (Otago, Central Otago, Lakes, Southland)
2. LMCs are self-employed health professionals, and they are entitled not to share their caseload (number of clients per year).
3. The definition of full-time equivalent caseload for LMCs cannot be generalised, and it is affected by clinical complexity and geographical matters

Hospital midwives - To calculate the midwifery FTE needed to staff our SDHB maternity units is becoming very accurate thanks to CCDM implementation and TrendCare utilisation. In May 2022 the midwifery FTE picture is represented as per below:

Dunedin- Queen Mary Maternity: budgeted FTE 32.88, Current midwifery FTE 13, Back fill RNs FTE 7.3, **Total vacancies 12.58**

Invercargill- Southland Maternity: budgeted FTE 16.78, current midwifery FTE 3.8, back fill RNs FTE 4.6, **Total vacancies FTE 8.38**

The data is self-explanatory, and currently the total FTE needed to fully staff Southland and Otago Maternity Units is 20.96 (total midwifery vacancy FTE 32.86). The DHB Central-Lakes Primary Maternity Units do not have access to TrendCare, therefore there is no midwifery calculation provided for that locality, and midwifery staff needs are identified based on the capacity to fill the roster, and the model of care adopted in the unit.

On the other hand, to determine the LMCs FTE needed to support our community is very challenging due to the nature of the self-employed role and data collection matters. To calculate how many LMCs are needed to look after all the pregnant people in SDHB we need access to the SDHB pregnancy numbers, the caseload capacity based on numbers of clients taken by SDHB LMCs per year and to agree on the definition of full time equivalent applicable to LMCs' caseload to make the two groups of midwives comparable.

1. Data collection

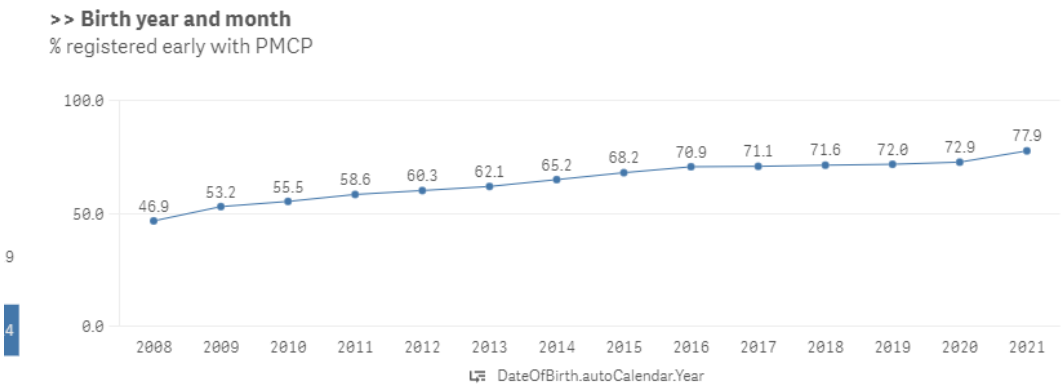
Booking with an LMC

In 1999 in New Zealand LMC midwives provided care to 40% of the birthing population, increasing to 77% of all women in 2010, and 88% of all women giving birth in 2016 registered with an LMC

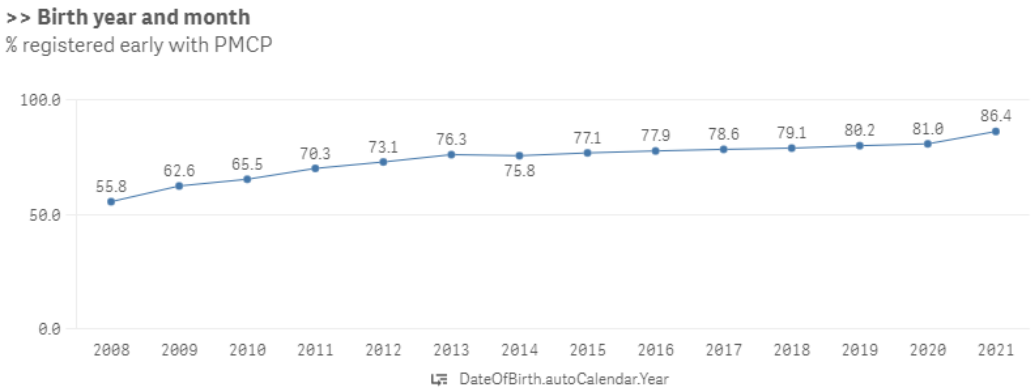
midwife. However, in 2019 while the national average rate was 73.1%, SDHB was recording 80.2% registration with LMCs. **The current NZ data collection shows a national average of 77.9 % with Southern DHB sitting at 86.4%, meaning that only 13.6% of the pregnant population is not booked with an LMC at the end of the first trimester** (MOH, Maternity Clinical Indicators trends)**.** The rationale behind women/pregnant people not been booked with an LMC can vary from lack of engagement with the health system, booking with the GP, and no availability of LMCs at the time of booking.

See below the registration trend which highlights the positive increase of SDHB registrations.

Early Registration with LMC – NZ



Early Registration with LMC - Southern



Outreach antenatal clinic data

In Queen Mary Maternity, the Outreach team looks after women/pregnant people who are not booked with an LMC because either they couldn't find an LMC available to look after them or for personal choice. A range of 30 to 100 women/pregnant people a month (increasing trend over Christmas) have been seen antenatally in the Outreach clinic, equivalent to 1 to 2.5FTE LMCs caseload. Data collection in progress.

Births under hospital midwives

According to our Business Analyst, data on births grouped by LMCs/Core midwives and primary/secondary from MaternityPlus can be provided, but only for those birthing in Queen Mary Maternity. The eligible population numbers are not available and therefore this data is incomplete. The stats would only be valid if we had a complete dataset which included Southland (which use IPM/CLICK) and all the Lakes-Central Otago-Otago Primary Maternity Units like Oamaru (using Maternity Expect or MaternityPlus), Balclutha (use Maternity Expect), COMU, Queenstown, Gore and Winton.

Queen Mary Maternity - In 2021 core midwifery staff looked after 318 primary care births and Obstetricians delivered 13 primary care babies, which is the equivalent of 8.27FTE LMCs' births.

As stated above, relevant data about primary v secondary births from the other areas within the district are not available.

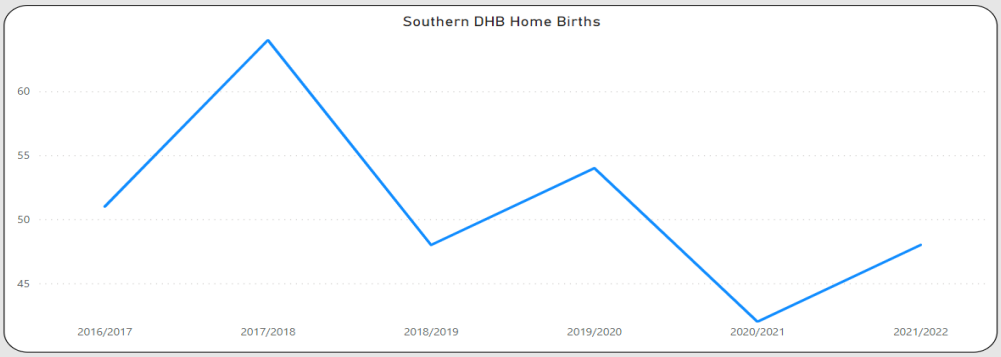
Births in SDHB 20/21

TLA	Dunstan Hospital	Clutha Health First	Dunedin Hospital	Gore Hospital	Southland Hospital	Lakes District Hospital	Oamaru Hospital	Auckland City Hospital	Christchurch Hospital	River Ridge East Birth Centre	St Georges Hospital	Timaru Hospital	Waikato Hospital	Whangarei Hospital	Total
Central Otago	1		160		11										172
Clutha		27	139	15	15										196
Dunedin			1,136		1			5	3	1				1	1,147
Gore		1	1	47	92										141
Invercargill			7		572	1		1	1				1		583
Queenstown-Lakes			116		244	76		3	7		1	1			448
Southland			6	13	289	1			1						310
Waitaki			146		1	1	41		1			1			191
Total	**1**	**28**	**1,711**	**75**	**1,225**	**79**	**41**	**9**	**13**	**1**	**1**	**2**	**1**	**1**	**3,188**

Note: undercount of approximately 50-100 births due to incomplete data from Winton Maternity Unit and Central Otago Maternity Unit (formerly Charlotte Jean).

Home Births

Ethnicity	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	Total
Asian	2	1		5	3	5	**16**
Maori	1	9	15	8	8	8	**49**
Other	46	52	32	40	30	34	**234**
Pacific	2	2	1	1	1	1	**8**
Total	**51**	**64**	**48**	**54**	**42**	**48**	**307**



Population data

To determine the midwifery workforce requirements in Southern, it is necessary to determine the population in need of midwifery care. Pregnancy data would be ideal because the birth data does not include pregnancies which ended in the first trimester where midwifery care was provided by LMCs from the beginning of their pregnancy. Therefore birth data does not fully reflect the midwifery care needed to inform the number of people in need of an LMC.

Pregnancy data: according to Stats NZ- MOH in 2022 the female population (15y-49y) in SDHB includes 81,220 people with an estimation of 81,950 in 2025 (increase by 8.9%, equal to 730 people). The data collection available doesn't allow us to depict the pregnancy rate in SDHB because SDHB does not have good access to pregnancy volumes as pregnancies aren't registered with us. Our best proxy for pregnancy volumes is using Antenatal First Blood Screen (AN1 test, which is processed by our lab provider SCL). In the 2021 calendar year 5,048 individuals had an AN1. There was a total of 5,681 tests as some women had multiple tests (some of these will be for multiple pregnancies, some for the same pregnancy). Based on this data SDHB pregnancy rate is approximately 6.99%. Pregnancies were distributed as per the chart below.

AN1 test by localities

Dunedin	1627
Invercargill	948
(blank)	748
Queenstown-Lakes	710
Southland	449
Central Otago	357
Waitaki	306
Clutha	286
Gore	172
Other	78
Total	**5681**

2. SDHB LMCs caseload definition and numbers

An attempt was made to collect SDHB LMCS caseload numbers sending a request via email and e-txt, with a few reminders. However, only 50% of LMC's replied to us and shared their numbers. These numbers identify an average of 47 women/pregnant people per head count, and ranged between 1 and 111

3. Full-time equivalent LMC definition

In New Zealand the average reported LMC caseload was 37.18 women per year, ranged between 1 and 90 (NZMC, 2020). T**he average caseload** reported by midwives whose **main work** was self-employed LMC midwife **is 41.62 women per year.**

Historically, NZCOM has recommended a full-time community midwife Lead Maternity Carer (LMC) case load as being between 40 and 50 women. However, this recommendation was made as early as 1993 when the average complexity was significantly lower due to community midwives taking a smaller (and healthier) proportion of the birthing population.

Community midwifery has historically worked on an 'overs and unders' principle, where an individual midwife's caseload will be a mix of lower and higher need clients, who require less than and more than an 'average' amount of time, respectively. Since the inception of the models, as a greater proportion of the population, and in particular, women/pregnant people with complexity that would have previously been under the care of a GP as an LMC, shared care team or DHB midwifery team, have started to receive LMC midwife care, and an unequal geographic distribution of need has become more pronounced. (This has meant that 'overs and unders' no longer functions well at the individual clinician level. This is reflected in population data where we now see that women/pregnant people in high deprivation, Māori & Pacific women, teenagers and women 40 and over are less likely to have a community LMC midwife (NZCOM, 2017).

According to the NZCOM *Report and recommendations of the Community Midwifery Funding Co-Design Project* (November,2017) **1 FTE is set at an average of 54 hours per course of care and an average of 40 births per year.** If that can be manageable for an urban LMC located in Dunedin, it can be very challenging for semi-rural, rural and remote LMCs in Lakes and Central Otago who would spend up to double of that time to look after the same number of women. So, if 1 FTE for an urban LMC can be translated to 40 women/pregnant people per year, it would be possibly 20 women/pregnant people for a rural midwife, and even less for remote LMCs, depending on distance and clinical and social complexity.

4. Conclusion

Currently to identify the need of LMC coverage we can only rely on estimated Outreach numbers, Core attendance at birth which highlights the inability of the LMC to attend the birth, and LMC communications regarding their caseload numbers and their availability to provide care. Better data collection and an integrated data system across the SDHB is necessary if we are to have the ability to reliably inform future recruitment actions.

Karen Ferraccioli
Director of Midwifery

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Monday, 2 May 2022, commencing at 1.00 pm, in the Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Tuari Potiki	Chair
	Dr Moana Theodore	Deputy Chair
	Prof Peter Crampton	
	Mrs Kaye Crowther	
	Dr Doug Hill	*(by Zoom)*
	Dr Lyndell Kelly	*(by Zoom)*
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr John Chambers	Board Member
	Mrs Jean O'Callaghan	Board Member
	Ms Lesley Soper	Board Member
	Mr Roger Jarrold	Crown Monitor *(until 2.27 pm)*
	Dr Ben Pearson	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Mr Andrew Lesperance	Executive Director Planning, Funding and Population/Public Health
	Ms Mata Cherrington	Chief Māori Health Strategy and Improvement Officer *(until 1.57 pm)*
	Prof John Eastwood	Chief Medical Officer
	Mr Andrew Swanson-Dobbs	Chief Executive, WellSouth Primary Health Network *(by Zoom)*
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer *(by Zoom)*
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

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

2.0 APOLOGIES

Apologies were received from Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer, and Ms Toni Gutschlag, Executive Director, Mental Health and Intellectual Disability.

An apology for an early departure was received from Ms Mata Cherrington, Chief Māori Health Strategy and Improvement Officer.

3.0 DECLARATION OF INTERESTS

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

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

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the Community and Public Health Advisory Committee meeting held on 1 March 2022 be approved and adopted as a correct record."

T Potiki/M Theodore

5.0 CHAIR'S UPDATE

The Deputy Chair advised that, in addition to the Planning, Funding and Population/Public Health reports on the agenda, the Executive Director Mental Health and Intellectual Disability (EDMHAID), the Chief Executive of WellSouth and the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) had been asked to provide an overview of the future direction and plans for their services over the next two years.

6.0 MATTERS ARISING

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

7.0 REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 6).

Dental General Anaesthetic Waiting List

The Executive Director, Planning, Funding and Population/Public Health (EDPF&P/PH) informed the Committee that a paper on oral health was included in the agenda papers for the following day's Board meeting.

Autism Spectrum Disorder

A paper summarising assessment for Autism Spectrum Disorder (ASD) was circulated with the agenda for members' information (tab 6)

8.0 PLANNING, FUNDING AND POPULATION/PUBLIC HEALTH REPORT

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

COVID Vaccination Cold Chain Breach

91% of individuals affected by the cold chain breach had been contacted and had either been vaccinated, were booked into be vaccinated, or had declined an additional vaccine. Some people were pending, as they had caught COVID so had to wait three months before getting another vaccination, 4% could not be reached after multiple attempts but efforts would continue to contact them.

A review into the incident was being undertaken by an independent auditor and a final report was expected in the next couple of weeks.

Emergency Q

There was good co-operation between the parties to implement Emergency Q (emergency department patient triage/transfer digital platform) at Southland Hospital.

Frailty Pathway

Sally O'Connor, Director of Nursing, Planning, Funding and Population/Public Health, was leading the development of a best practice pathway for the frail older population, with the aim of maintaining them in their own home as long as possible.

Aged Residential Care (ARC)

A number of ARC facilities had been negatively impacted by Omicron and to date SDHB had provided support to about a dozen of them. This included support from the Infection Prevention and Control Team and provision of SDHB Registered Nurses and Healthcare Assistants.

Ten residents who had tested positive of COVID had died.

Health Needs Assessment

The Health Needs Assessment (HNA) project was progressing well.

Refugee Health

The Ministry of Health had renewed the refugee contract for another 12 months but gave notification there would be changes to align it with other national contracts following that.

Smokefree Campaign

Consideration was being given to reducing vaping as well as smoking.

The Chief Medical Officer advised that in New Zealand vaping had been accepted as a transition to a less toxic substance, however there had been some deaths attributed to vaping in the USA.

Dr Pearson advised that microplastics in the lungs from vaping could cause COPD in the longer term.

The CEO asked that a check be made to ensure SDHB was not funding vaping for people wanting to quit smoking.

The Board Chair informed the Committee of a nicotine replacement therapy development he was involved with, which was expected to be submitted to MedSafe in November/December 2022.

Immunisation Campaign

Campaigns for MMR and other immunisations would be launched during May 2022.

Those not registered with a GP practice could receive their immunisations from pharmacies or outreach teams.

Hearing and Vision Screening

The Vision Hearing Service had been impacted by COVID and catch-up plans put in place.

Sexual Health

A strategy was being developed for the future model of care for sexual health, as this service would not be part of the new Dunedin Hospital.

Well Child Tamariki Ora (WCTO)

Additional WCTO clinics were being held in Mataura.

Sudden Unexplained Death in Infants (SUDI) – Safe Sleep Programme

The Safe Sleep Programme was being devolved back to each DHB and funding had been secured for 500 whakakura.

Oral Health

The Oral Health Service was about 24% behind target as at the end of March 2022. A number of initiatives were being undertaken to address the backlog, including additional surgical bus sessions and additional clinics at the Dental School.

Management responded to questions on anti-vaccination protesting in schools, utilisation of the COVID and MIQ workforce, B4 School Checks, and the effectiveness of whakakura and pepipods.

9.0 LOOKING FORWARD

Māori Health

The Committee received a verbal update from the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) on equity funding, during which she highlighted the following initiatives.

- *Clinical Nurse Specialist Roles*

  The CMHS&IO acknowledged the contribution of Jane Wilson, Chief Nursing and Midwifery Officer, to the Māori Clinical Nurse Specialist positions. A request for interest had gone out for two Clinical Nurse Specialists and two Registered Nurses (RNs) to be based in the community.

- *Māori Health Data*

  Work was occurring with Glenda Oben, Data Analyst Equity, on the equity reporting required for management and the Iwi Governance Committee.

- *Māori Workforce Development Specialist*

  Ross Heath had commenced in the Māori Workforce Development Specialist position.

The CMHS&IO then responded to questions on the Māori Health priorities for the next 12-18 months.

The Chief Māori Health Strategy and Improvement Officer left the meeting at 1.57 pm.

10.0 PASIFIKA HEALTH

Faumuina Professor Fa'afetai Sopoaga, Chair, Pacific Trust Otago, Dr George Ngaei, Chair, Pacific Island Advisory Charitable Trust, Cr Hana Halalele, General Manager, Oamaru Pacific Island Community Group, Maiele Paia, President of the Oamaru Community Group, Dr Letava Tafuna'i, Clinical Director, Pacific Trust Otago, Lloyd Maole, General Manager, Pacific Trust Otago, Lealiifanovalevale Erolia Rooney, Community Trustee, WellSouth, and Stuart Barson, Southern Health Care Home

Lead, WellSouth PHO, joined the meeting by Zoom and were welcomed with a mihi, which was followed by a round of introductions.

The Committee received a presentation from Pasifika leaders on *the opportunity to make a difference for Pasifika health and wellbeing* (tab 9). Faumuina Prof Fa'afetai Sopoaga provided the context for the presentation, during which she advised that Pasifika were disproportionately represented in poor health outcomes and had been poorly served by the Southern DHB.

Dr Ngaei then outlined the historical context and the work of Pasifika providers in the area, including their COVID pandemic response.

Hana Halalele acknowledged the strong relationship with the WellSouth PHO and requested that the Community and Public Health Advisory Committee formally adopt the following recommendations in principle and take them to the Board:

1. Genuine partnership and meaningful commitment from the DHB/new entity with Pasifika people as a pre-requisite for improved health outcomes;
2. Pasifika representation at the decision-making table and relevant advisory committees in the new Health system;
3. Genuine commitment to design Pasifika specific equity, including an annual and long term operational budget to deliver on desired health outcomes;
4. DHB directs management to meet with the Southern Pasifika Collective in May 2022 to support the development of a business plan for its aspirations, including the establishment of a Pasifika Southern Health Hub.

The Chair thanked the Pasifika leaders for their presentation and acknowledged their challenge, which would be elevated to the Board the following day.

The Board Chair advised that he and the Deputy Chair were also scheduled to meet with Dr Losa Moata'ane of the Pacific Trust Otago.

The CEO reported that the operating model and high level structure issued by Health NZ and the Māori Health Authority included national, regional and local Pacific leadership.

On behalf of the Board and Committee, the Chair apologised for SDHB's poor engagement with the Pasifika community and undertook to ensure that their message was taken forward to the new Health system.

Mr Roger Jarrold, Crown Monitor, left the meeting at 2.27 pm.

11.0 PLANNING, FUNDING AND POPULATION/PUBLIC HEALTH REPORT (Continued)

The EDPF&P/PH commented on the Planning, Funding and Population/Public Health Report (tab 7) as follows.

Primary Maternity

Maternity services continued to be constrained from a workforce perspective.

Rural Hospitals

The collective contract proposal for the rural hospitals was progressing well and would be submitted to the Board next month.

Primary Care

Primary Care had been instrumental in the COVID pandemic response and deserved a huge vote of thanks for their work.

Pharmacy

Over 50 pharmacies in the district were taking part in the influenza and COVID vaccination programmes, and a small number of pharmacies were stocking Paxlovid, an antiviral medicine.

Older Persons' Health

Rest Home bed numbers were reducing, in line with the strategy to assist people to age in their home; dementia bed numbers were close to budget but hospital and psychogeriatric bed numbers continued to be above projections.

Home and community support services had been stretched due to COVID and had been avoiding taking new clients.

Management responded to questions on maternity workforce data and psychogeriatric bed availability.

12.0 LOOKING FORWARD

WellSouth Primary Health Network

The CEO, WellSouth, presented a paper on the vaccination strategy for the next nine months (tab 7) and raised the question of where clinical governance for the immunisation programme should sit in future.

During discussion:

- The CEO advised that under the new model for the Health sector, the Public Health Agency would have oversight of immunisation but primary care and secondary care would need to be connected to that.
- It was noted that a good response to the COVID pandemic had been achieved by Southern health providers and MSD working well together over an extended period, and it was important not to lose that. It was therefore agreed clinical governance oversight should be a shared responsibility and lie as broadly as possible at a local level.

The CEO, WellSouth, acknowledged the effort and work that CPHAC members had put in during their term.

Members expressed concern about the national immunisation rate, particularly for Māori.

Management were asked to follow-up discussions with the Office of the Privacy Commissioner regarding the use of information collected during COVID vaccination for primary care enrolment.

13.0 FINANCE REPORT

A report on Planning, Funding and Population/Public Health financial performance to 31 March 2022 (tab 10) was taken as read. The EDPF&P/PH commented on the variances, then responded to questions.

Pharmaceuticals

The EDPF&P/PH advised that:

- The additional dispensing fees incurred for COVID related pharmaceuticals would be followed up with the Ministry of Health;
- A paper on plans to manage the overall pharmaceutical spend would be submitted to next month's Board meeting.

14.0 MINUTES OF PREVIOUS MEETING – PUBLIC EXCLUDED BUSINESS

It was resolved:

"That the minutes of the public excluded section of the Community and Public Health Advisory Committee meeting held on 6 December 2021 be approved and adopted as a true and correct record."

T Potiki/K Crowther

15.0 CLOSING COMMENTS

The Chair thanked Dr Doug Hill, Chair, and Mr Andrew Swanson-Dobbs, CEO, WellSouth, for their leadership and collaboration with Southern DHB, particularly during the COVID response.

In closing the last Southern DHB CPHAC meeting, the Chair thanked everyone for their contribution, participation, commitment, and engagement during the term of the Board.

The meeting closed at 3.30 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board

Minutes of the Disability Support Advisory Committee meeting held on Monday, 2 May 2022, commencing at 3.30 pm, in the Board Room, Southland Hospital Campus, Invercargill

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

1.0 WELCOME

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

2.0 APOLOGIES

No apologies were received.

3.0 DECLARATION OF INTERESTS

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

It was noted that Mr Potiki's updated interests were included in the following day's Board meeting papers.

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

4.0 PREVIOUS MINUTES

It was resolved:

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

M Theodore/K Crowther

5.0 MATTERS ARISING

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

6.0 REVIEW OF ACTION SHEET

The Committee received the action sheet (tab 6).

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

- Patient stories were an ongoing action.
- Unfortunately, the query regarding reassessment of Home and Community Support Services clients had not been able to be progressed as the aged care team had been under significant pressure responding to the COVID outbreak. Management were aware of the issues and would ensure they were reviewed.
- Links to the on-line Disability Awareness training modules had been sent to Board members.
- The Disability Working Group (DWG) had picked up the action to progress a directory of community groups.
- Southland Hospital's disability access was being looked into by the Consumer Experience Manager.

7.0 CHAIR'S UPDATE

As it was the last Disability Support Advisory Committee (DSAC) meeting, the Chair advised she had asked the DWG Chair and DQ&CGS to reflect on the priorities for the next couple of years in their reporting.

8.0 PATIENT STORY

The Committee viewed a video recording of Cyril's story and experience with the Health system, and what he thought could be improved.

It was noted that:

- 25% of the population were living with disabilities and that increased as people aged;
- Misdiagnosis and treatment failures had significant morbidity, both physically, emotionally and socially.

9.0 PATIENT STORY REFRESH

A paper setting out a revised approach to consumer stories, their collection and use by Southern DHB was taken as read (tab 9).

The Consumer Experience Manager (CEM) advised that the main changes proposed were:

- Shortening the stories to 2-3 minute videos that could be embedded in staff meetings across the board to improve understanding of the impact of treatment and practices on patients, and linking them to the four "C's" of patient centre care (culture, care, communication, collaboration);
- Broadening the stories from patients to consumers, their whanau and staff.

The DQ&CGS advised that consumer stories were one of the building blocks for patient safety and harm reduction. Clinical governance was about an organisation "wrapping processes and security around individual clinical decision-making" and consumer stories made the emotional connection to caring.

Committee members expressed their support for patient stories and noted that they could have a powerful impact.

It was resolved:

"That the Committee approve the revised approach to consumer stories, their collection and use by Southern DHB and its successors."

M Theodore/J Chambers

10.0 DISABILITY STRATEGY AND ACTION PLAN IMPLEMENTATION

Mr John Marrable, Chair of the Disability Working Group (DWG), presented an update on DWG activity and reflections on the year ahead (tab 10), during which he advised that the following priorities had been identified.

- *Staff Training*

  Positive feedback had been received on "The Accessibility Game" workshop run by Julie Woods but it was disappointing that only 49% of staff had completed the on-line disability awareness training.

  The Committee discussed ways of increasing the uptake of training.

- *Electronic health records linked to a digital health passport*

- *Accessibility*

  Mr Marrable had conducted audits of:

  - Dunedin Hospital's COVID green stream entrance and identified over 30 items to be addressed, some of which had been started;
  - Southland Hospital's main entrance and recommended that someone with disability awareness training be stationed in the lobby.

  Mr Marrable would be conducting a full accessibility audit of Southland Hospital on 17 June 2022. Once that was completed, he would start looking at Dunedin facilities.

Mr Marrable also reported that a directory of community groups for consumers was being progressed in association with Livingwell Disability Resource Centre.

Mrs Crowther informed the Committee that she had joined the on-line Disability Working Group's update to 42 community groups and it had provided some useful information.

The Community Liaison Officer reported that it was intended to hold DWG forums quarterly and post Zoom recordings on the SDHB website.

The Chair reported that she had been invited to the March DWG meeting and conveyed her thanks to the DWG for their work. She also spoke about the history of DSAC, noting that DWG would be progressing the Disability Strategy implementation, with DHB management and staff, after DSAC finished.

Mr Marrable noted that the Disability Strategy was a working document and was gaining momentum. He thanked the DSAC for its support.

The DQ&CGS expressed his appreciation for the work Mr Marrable had put into the Disability Working Group and the support provided by the Consumer Liaison Manager and Consumer Liaison Officer.

11.0 ACKNOWLEDGEMENTS

The Chair thanked the Committee, Board members, Crown Monitors, and staff, past and present, who had supported DSAC over the years.

The Chair also acknowledged:

- The leadership provided by Mrs Kaye Crowther, DSAC Deputy Chair, and her commitment to the community;
- The late Dave Cull, former Board Chair, who gave her the opportunity to Chair DSAC;
- The contribution of each DWG member;
- Gail Thomson and Dr Hywel Lloyd, former and current Directors of Quality and Clinical Governance Solutions, and their teams, and
- The strong support and mentorship provided to her by Mr Tuari Potiki, Board Member and CPHAC Chair.

The Chair advised that her hope was that people with lived disability would provide leadership for the new Health system and the new Ministry for Disabled People to tackle inequities and increase participation in the workforce.

In concluding, the Chair thanked everyone for their support and reminded them of the Disability Strategy vision: *Within the southern district all disabled people, tāngata whaikaha, and Deaf people will have an equal opportunity to achieve their best possible health outcomes, enabling their participation within their community. Health and disability support services will recognise the agency of disabled people, tāngata whaikaha, and Deaf people and their family or whānau through responding to their diverse requirements and removing disabling barriers.*

The CEO and members acknowledged the leadership provided by A/Prof Moana Theodore, DSAC Chair, and noted that the Disability Strategy vision should be included in the Southern Transition Strategic Briefing.

The meeting closed with a karakia at 4.30 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

HOSPITAL ADVISORY COMMITTEE MEETING

7 June 2022

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

FOR INFORMATION

Item: CEO Report to Board

Proposed by: Chris Fleming, Chief Executive

Meeting of: 8 June 2022

Recommendation

That the Board:

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

Purpose

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

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

1. Organisational Performance

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

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

The impact of COVID has remained high on the operating environment particularly 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 April was adverse to plan as expected. The result was an operating deficit of $1.003 million compared to a planned deficit of $2.286 million, so $1.283 million favourable to plan. The year to date deficit is now $21.863 million compared to a budgeted deficit of $13.190 million, a variance of $8.673 million.

The BAU budget (which excludes COVID related revenue and expenditure) is a year to date deficit of $20.866 million against a plan of $13.190 million, so $7.676 million adverse to plan.

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

- Planned care below expectations $1.164 million
- Continued need to outsource activity above that planned, which is $283k for the month
- Pharmaceuticals which relates to phasing, the underlying budget issues, and increased Pharmac forecasts of $807k
- Air Ambulance Services $195k
- ICT and Software exceeding budget $122k.
- Inter District Flows $498k
- Offset by favourable other revenue streams.

From a volumes perspective:

- Total case weighted discharges were adverse to plan at -322 or -7.4% for the month compared to the plan, and down 751 or 15.7% on the same month last year. Year to date case weighted discharges are adverse 844 or 1.79% year to date against plan and down 2,031 or 4.2% against last year
- Medical case weights are up 707 or 4.14% year to date on plan, and down 449 or 2.46% compared to last year
- Surgical case weights are down on plan 1,809 or 7.07% with acutes down 520 or 4.30% and electives down 1,289 or 9.56%. Compared to last year, surgical acute case weights are down 634 or 5.19% and electives are down 755 or 5.83%
- Raw discharges (actual number of patients) are up 14 or 0.3% for the month against plan, which is down 434 or 8.8% compared to the same month last year. Year to date raw discharges are down 1,624 or 3.19% compared to last year
- Mental Health bed days are 1,032 or 32.5% below planned levels for the month (indicating a 67.5% bed occupancy) and 202 or 8.6% 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 417 or 5.6% compared to April 2021, with Dunedin down 2.4%, Southland down 11.7%, and Lakes up 2.6%. On a year to date basis ED presentations are down 2.5% 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

At the time of the Board meeting there will only be 15 more working days before Health New Zealand is formally established on 1 July 2022. The establishment of the organisation is progressing, however there is still much to be done. On 26 May 2022 the Interim Chief Executive of Health New Zealand, Margie Apa, made an announcement of appointments to interim roles at a national, regional and district level. The text of the announcement is included in Appendix 1 at the end of this report.

At that point in time there have been no permanent appointments made to the national executive team however many of these roles have now been advertised. It has been made clear that interim roles are just that, interim, and that the permanent appointments are all contestable.

Two significant changes that have occurred however are firstly that there has been the appointment of four Interim Regional Directors, with Peter Bramley (presently the Chief Executive of Canterbury and West Coast District Health Boards) being appointed the Southern Region's Interim Regional Director. It is noted that unlike the other regions, Peter

will also be the Interim District Director for both Canterbury and the West Coast. In other regions these roles have been separated.

It has also been clarified that the Interim Regional and District Directors are responsible for oversight of existing structures and accountabilities. Delegations for the Interim District Directors will be the same as the existing Chief Executive delegations for the relevant district. The Interim Regional Director will have a higher level of delegations, yet to be determined, which will see some of the issues which would have previously needed to be considered by the Board being able to be approved at Regional Director level with only the highest level of items needing to go to the Chief Executive of Health New Zealand.

The Tier 2 appointments made to Health New Zealand will be responsible for the transformation of the system and will work with the Regional and District Directors to ensure a smooth transition over time. The Interim Regional and District Director appointments at this stage are to 30 September 2022 with the possibility that these will be extended to 31 December 2022.

We have also now received very clear expectations over the focus that the Regional and District Directors need to have over the coming 3 to 6 months. The areas of focus required are:

- Supporting the transition to the long term Health New Zealand structures
- Winter planning for 2022
- Planned care performance
- Financial performance
- Capital planning.

None of these come as a surprise however there are many other factors not noted that will remain critical to ensure the success of the Southern Health System moving forward.

3. Interim District Director

Hamish Brown will be Interim District Director effective 1 July 2022. This will initially be for a period of three months. The current Chief Operating Officer role will not be back-filled at this time, with the General Manager team providing further overall operational guidance for Dunedin and Southland Hospitals.

4. COVID – Omicron Outbreak

Public Health Response

While it would appear that COVID-19 cases in the Southern district have peaked, case numbers are reducing slowly.

Public Health South (PHS) continues to have a seven day roster in place. These teams mostly comprise of staff employed specifically for COVID-19 response work as most permanent Public Health staff have transitioned back to their business-as-usual work. Our response teams are now predominantly focusing on outbreak management of the following high-risk settings: Aged Residential Care facilities, Marae and Tangihanga and 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 residential housing settings including residential disability premises. We are no longer working with faith-based places of worship as this is no longer a priority group, primarily due to the cases coming from the community rather than the setting itself causing an outbreak. It will be a priority for the COVID-19 response staff to pivot from reactive case management to proactively working with management of

these priority settings to support good contingency planning as well as facilitating the prompt notification of clusters.

Our PHS cultural liaison staff 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.

Work is continuing on looking at what beyond Phase 3 means and looks like for the teams. A priority is to review our current COVID response team workforce, ensure the position descriptions are fit for purpose for expectations moving forward. We have now been advised that we will be receiving additional funding for the 2022/23 year. A plan is being developed around staffing needs and we will then undertake the appropriate Human Resources steps to extend contracts as required.

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.

The borders opened further on 12 April. At this stage we will only receive non-scheduled (private flights) into Queenstown International Airport. We are still waiting for scheduled flights to resume with the airlines on 23 May. This is now unlikely to involve a health response from the Queenstown Airport Health team but with potential for a greater involvement with the airport agencies moving forward.

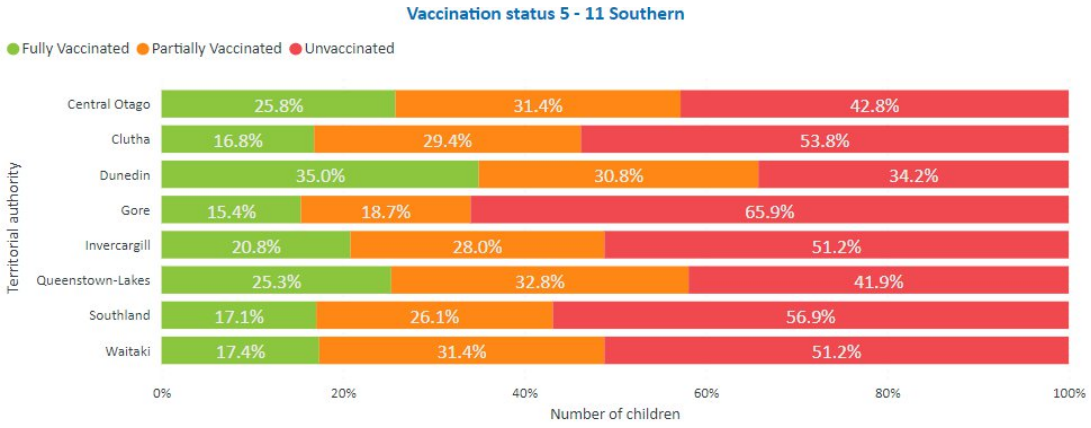
COVID-19 Resiliency

The focus of the COVID-19 resiliency work involved getting in contact and conducting surveys on churches, private training establishments, activity centres, age concern, boarding houses and temporary or supported accommodation within the Otago and Southland district. This has involved helping these institutions and services to prevent COVID-19 cases from emerging or if there are any cases to keep it contained by following the appropriate guidelines and protocols. This has also included asking about COVID-19 response plans (particularly if there was a case), understanding of the traffic light system, Rapid Antigen Tests (RATs), if relevant what type of residents they have, and a description of their accommodation and any other issues or concerns people may have in relation to COVID-19. Challenges have involved just keeping up to date with COVID-19 information and any changes that occur especially when following up. Work has also been concentrated on Pacific Island churches and the Pasifika community. This has involved contact and support for both Māori and Pasifika cases i.e., identifying if there are any support needs such as food, medical supplies, mental health support, or help needed in relation to physical symptoms of COVID-19. In general, it has been found that people are very appreciative of any assistance that is offered.

5. COVID-19 Vaccination Programme

Southern DHB remains above the national average for the proportion of booster doses and paediatric doses administered. As of 30 April 2022, 92.5% of Māori are double-dosed, 74.7% of the eligible population have been boosted, and 55.3% of the paediatric population have received at least one vaccination, figure 1 below represents a breakdown of paediatric COVID-19 immunisations by region. The COVID-19 programme continues to see the number of General Practices participating decline from 80 providers at our peak, to 66 at the end of April. General Practices delivered only 26% of COVID-19 Immunisations, our Southern DHB sites have delivered 22% across the two sites and our Māori providers have delivered 11% across the three providers. Pharmacies are now our largest COVID-19 immunisation provider, delivering 41% across 40 pharmacies. Our programme pivoted into a call campaign by Territorial Authority, enabling us to understand each locality's needs better and create bespoke solutions to increase immunisation rates.

Figure 1 below, shows Paediatric COVID-19 immunisation percentages broken down by single dose, fully vaccinated and unvaccinated by Territorial Authority.



Cold Chain Breach

The bulk of Cold Chain Failure activities have been completed. We have had an active response (phone conversation) from 92.3% of affected people, and 64.2% of people have had a replacement dose. The final actions to gain an active response from the remaining 123 people include:

- Further attempts to source new phone numbers continue for 60 people (including sending list of National Health Index numbers (NHIs) with no phone number to the Ministry of Health via Household Contacts)
- Final short message service (SMS) and emails with reply enabled will be sent to 123 people where these contact details exist
- Advertisements placed in local publications/targeted Facebook advertisement
- Pharmacies.

We began a two week text campaign (from 25 April through to 8 May) to promote walk-ins with four rural pharmacies across the district: Waihemo Pharmacy (Palmerston), North Otago Dispensary (Oamaru), Riverton Pharmacy (Riverton), and Life Pharmacy La Hoods (Gore). We will review the data and see if there was any impact.

Māori and Pacific Providers

We continue to work closely with our Māori and Pacific providers who are also experiencing low levels of demand. Each of the Māori providers are also offering influenza immunisations and exploring measles, mumps, rubella (MMR) immunisations alongside the Population Health Project Manager. Our Pacific providers are also exploring ways to pivot into an all-in immunisation approach for their populations.

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 6,325 vaccinations to hard-to-reach individuals and health care workers. This service is also now offering influenza and MMR vaccinations. Following Whakarongorau call centre, General Practice is the next biggest referrer into the service as they cannot provide these vaccinations. 50% of patients referred into outreach are housebound or have very poor mobility.

Novavax

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

Pop-up Clinic Activity

Over the month of April pop-up clinics were delivered in Limehills, Tapanui, Wanaka, Te Anau, Otautau and Balclutha. These pop-up clinics are planned alongside key community stakeholders to address demand and equity of access.

Aged Residential Care

Onsite booster clinics at Aged Residential Care facilities were completed in February 2022. As required, processes and relationships are in place to support vaccinations for new arrivals. There is no longer a General Practice able to administer onsite COVID-19 vaccinations in Invercargill. The Southern DHB Vaccination Outreach team from the Invercargill Mass Clinic is now delivering these vaccinations as required.

Disability Residential Facilities

Onsite booster clinics at Disability residential facilities were completed in February 2022. Processes and relationships are in place to support vaccinations for new arrivals as required. The possibility of additional booster clinics that include influenza vaccination and MMR vaccinations for these groups is being explored. Initial feedback suggests that there would be low uptake as these clients already have established vaccination relationships with their primary care providers. The Ministry of Health is expected to release a new dashboard next month to help District Health Boards track their vaccination rates of Disability Support Service and Accident Compensation Corporation (ACC) clients.

Mental Health and Addictions Residential Facilities

Onsite booster clinics at Mental Health and Addictions residential facilities were completed in February 2022. Processes and relationships are in place to support vaccinations for new arrivals as required. The Ministry of Health have 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 their application for this funding from the Ministry of Health. We are yet to be advised on the outcome of this funding round.

5 to 11 year olds

Demand continued to decrease this month in line with a national trend and the vaccination programme is ensuring capacity is maintained across the Southern District. There are 52 clinics across the district offering Paediatric vaccinations.

Specialist Paediatric COVID-19 Vaccination Clinics continued to be held 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.

Our Programme team will have a renewed focus on reaching this cohort throughout May and June, with support from other DHBs and the Ministry of Health.

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.	To be determined. Continual focus essential.

Risk	Management of Risk Avenue	Effectiveness
	Resource plan being developed with unbudgeted capital expenditure and operational expenditure requirements.	
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

Public Service Association (PSA) Union industrial action went ahead as below:

- 08:00hrs on Monday 9 May to 23:58hrs on Sunday 15 May – ban on working before and after agreed finish times and stopping work to take all entitled breaks.
- 00:01hrs Tuesday 17 May to 18:00hrs Friday 20 May 2022 – ban on working before and after agreed finish times and stopping work to take all entitled breaks.
- 11:59hrs on Sunday 15 May to 11:59hrs on Monday 16 May 2022 – complete withdrawal of labour.

Medical Physicists (Association of Professionals and Executive Employees Inc (APEX) Union) industrial action went ahead as below:

- 00:01hrs on 16 May to 23:59hrs on 20 May 2022 – ban on work on specific equipment outside of 08:00hrs and 16:30hrs.

The APEX Union issued the following notices of intended strike action for Medical Physicists:

- 00:01hrs on 23 May to 23:59hrs on 27 May 2022 – ban on work on specific equipment outside of 08:00hrs and 16:30hrs.
- 00:01hrs on 30 May to 23:59hrs on 3 June 2022 – ban on work on specific equipment outside of 08:00hrs and 16:30hrs.
- 00:01hrs on 6 June to 23:59hrs on 10 June 2022 – ban on work on specific equipment outside of 08:00hrs and 16:30hrs.
- 00:01hrs on 13 June to 23:59hrs on 17 June 2022 – ban on work on specific equipment outside of 08:00hrs and 16:30hrs.

8. Hospital Operations Update

April has continued the theme established in March with the COVID-19 outbreak and the ongoing response. COVID activity appeared to peak in mid to late April with high occupancy within the COVID wards in both Southland and Dunedin Hospitals.

Continued pressure on occupancy in Southland has meant that numerous patients have had to be transferred to Dunedin Ward 7a. Patients have been selected for transfer that would require either a higher level of intervention or to access a service not provided in Southland. ICU has also experienced several days of high occupancy forcing the opening of the red pod in the second stage. This has worked very well clinically and operationally and been worked around remediation work which has commenced in non-clinical areas therefore not resulting in delays to programme.

Despite the increase in COVID admissions, processes commenced in February and March seem to be functioning well, including screening and exposure event tracking, and the response has felt less frenetic as a result.

Workforce challenges remain with ongoing absenteeism across all work groups. The impact of the absenteeism has been daily operational challenges to shift resources. The operations team, and especially the duty nurse manager teams on both sites have done an exemplary job across this period. Bed numbers open have remained high however the number of shifts in significant care deficit has increased.

ED volumes across both sites have been variable with days of record highs. The Dunedin 6ATR ward has had ten beds closed because of COVID surge preparation and staff supporting the aged residential care sector through the omicron peak. This has caused an increase in the medical footprint with a resulting impact on the surgical bed numbers and planned care. Whilst not the result of Assessment, Treatment and Rehabilitation (AT&R), a similar trend is apparent in Southland. The impact of the absenteeism in the theatre suites and tight surgical beds has seen a poor month in terms of planned care discharges and case weight however our daily case weight output has been six case weight higher per day than in March. April's high numbers of stat days have also impacted planned care.

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

April saw the highest numbers of both staff and resident COVID positives cases. Both the ARC Sector, and the DHB's ability to support the sector was incredibly stretched. Despite multiple strategies to 'keep it out', by the end of April, about one-third of ARC staff and residents had tested COVID positive.

The ARC COVID Support Team evolved and grew rapidly and continuously over the past two months, moving from one or two facilities with resident outbreaks to, at one point, 20 facilities with resident outbreaks and over 180 residents with COVID. The ARC COVID Support team essentially is made up of staff who have, for the most part, taken on this role on top of their already busy responsibilities, working extra hours seven days per week.

While the Community Services Directorate shoulders the responsibility, significant leadership and support from the Planning, Funding and Population/Public Health Director of Nursing, PHS, Infection Prevention and Control (IPC) and Assessment, AT&R staff, have made it possible for us to support facilities to safely care for their residents in place. Support has included:

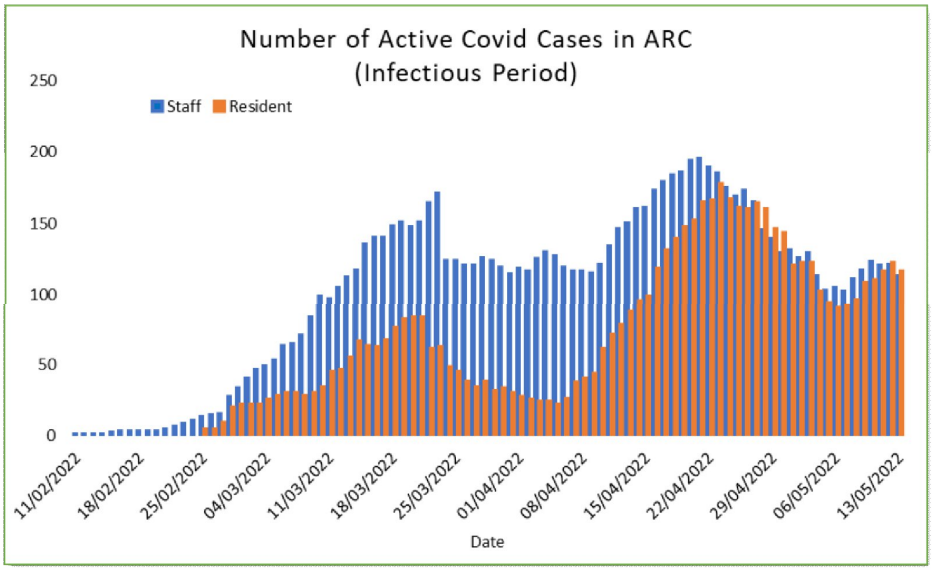
- virtual outbreak meetings with facilities, IPC, PHS, and Community Services to understand and support the outbreak
- onsite IPC visits to review the situation, provide donning and doffing training, advice on isolation
- sourcing personal protective equipment (PPE) and Rapid Antigen Tests (RATs), and other necessities like biohazard bags
- support with communications
- providing DHB staff to work in the facilities (and all the logistics around that)
- specific guidance and advice on testing, isolation, staff return to work, etc.

Good communications with the ARC Sector and use of data have allowed us to be proactive in support in a number of cases, as we often see resident outbreaks follow higher numbers of staff infections. Resident outbreaks have occurred in 38 facilities (58%), with eight facilities having multiple outbreaks, i.e. facility is clear of COVID before another resident tests positive. The impact on facilities with outbreaks is significant and is negatively impacting residents, staff, and families. In critical situations the DHB has supported ten ARC facilities across the district with DHB staff. Logistically this has been challenging, but most importantly has only been possible with the goodwill of the staff who volunteered and the teams where they have come from. Special mention is required for staff from Ward 6 AT&R and the nursing leadership in supporting this.

One concerning observation is the large number of ARC staff burnt out and some leaving their roles, especially where there have been long outbreaks and multiple outbreaks. Workforce and vacancies in the ARC sector has been an issue for a while, however ARC facilities are reporting no applicants for most roles.

We have yet to see resident COVID outbreaks in 27 (42%) our facilities. It is anticipated that many of these facilities will experience a COVID outbreak amongst residents over the next months. Complicating this is the threat of influenza over the winter months, further straining an already burdened sector.

Discussions are occurring to maintain the active support to the ARC facilities over the next months. The ARC sector is only becoming more fragile, as they continue to lose staff, and COVID is not disappearing. One facility that providers both hospital level and rest home level care, has voluntarily transferred their hospital level residents to other facilities, and will be providing only rest home level care until their registered nurse staffing can recover. We repeat from last month that the ARC workforce is in crisis, and options such as pay parity for registered nurses and pathways for internationally qualified nurses and their families to enter NZ must be addressed urgently.



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

HCSS Services continue to be fragile with high staff absenteeism due to COVID and COVID isolation, inability to fill vacancies and remaining staff fatigued. Fatigue is a common theme: COVID fatigue, mask fatigue, rosters changing fatigue, etc. Components of the Restorative Model have been paused at this time, including regular client reviews and reassessments, peer review and some quality initiatives. The focus remains on providing essential services to existing clients and assuring new referrals for essential services from hospital and the community are supported.

11. Time for Change – Te Hurihanga Programme

Progress continues with the implementation of Time for Change. A project manager has commenced work with the client group for the community/residential service to replace Ward 11. The Request for Proposal (RFP) for intensive community services have closed and the evaluation panel is working through the selection process. The crisis response service model for the Central Lakes Queenstown District is being finalised and commissioning for this service will commence in May. The RFP for Alcohol and Drug Services in Otago closes in May an evaluation panel has been confirmed.

12. Co-Response Team (CRT)

The Police-led 12-month pilot has been in place for six months and a meeting with the Police to look at the evaluation process is planned for next week. The third party in the pilot, St John, did indicate they were withdrawing due to funding but it has now been confirmed they will continue for a further six weeks while a sustainable solution is worked through. Budget 2022 included funding for new initiatives such as the co-response model and we look forward to hearing more about this from Health New Zealand.

13. Tourism Recovery Fund – Psychosocial Mental Wellbeing Recovery.

A range of wellbeing initiatives continue to be supported. A new community co-ordinator is in place in Fiordland and work is continuing on role development. An evaluation framework has been drafted and is being considered by Te Hau Toka. A Memorandum of Understanding is being developed with Queenstown Lakes District Council to support the combined role of an activities co-ordinator. Investigations are underway to support a dedicated online

resource to support community wellbeing in the district. Te Hau Toka are holding a workshop this month to further develop the action plan for the next quarter.

14. Equity Investment Strategy

Francis Health has been contracted to assist with the design of an Equity Investment Strategy to ensure there is an effective allocation of the new investment into addressing inequities within the Southern DHB. The outcomes sought include investment into projects that address inequities across the health system and improve the health of Māori across the southern district, by ensuring that Māori are able to access timely, appropriate, responsive and effective health care. The strategy will assist in the decision making on the distribution of and investment in models of care that address inequities.

15. Disability Working Group Quarterly Forum

In April, the Disability Working Group held the first quarterly forum to update consumers and consumer groups of progress of operationalising the Southern Disability Strategy. April marked one year since the launch of the strategy.

There were 46 attendees at the forum, which was well received, and planning is underway for the next forum in July. One of the biggest benefits of the forum was that it is helping to develop the community networks that will help spread the work about the strategy and the work of the group and, hopefully, improve engagement with the disability sector across the district.

16. Organisational Development

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

- Change
  - Gender and Sexual Diversity Workshops for staff confirmed and commencing 2 and 3 May
  - 12 month programme for Accessibility Game (in support of Disability Strategy) was agreed and sessions commenced in April
  - Internal Accreditation for Change Cycle Workshop facilitation commencing late May 2022
  - The OD team have supported Southern DHB's engagement and participation with Education Perfect's 'Te Ao Māori for Professionals' last few months and this has been recognised along with other colleagues in an award presentation to be held in early May
  - The OD team has begun collaborating with the Māori Health Directorate on a proposed Māori Workforce Development Strategy. The team have also been collaborating with CDHB colleagues and have sourced some current operationalised action plans which will help move things forward in this space.
- Performance
  - Further Essential Corporate Training Workshops continue, with Appraisals, Performance Management and Having Courageous Conversations workshops being held this month. This programme continues with good levels of engagement via virtual delivery
  - Revised SMO Performance Review templates and SMO mandatory training framework completed for Deputy Medical Director. Further support available including training support

- LearningWorks funded NZ Qualifications Level 4 & 3 leadership and management development courses commenced this month (First Line Manager, Introduction to Team Leadership and Adult and Tertiary Education/facilitation skills)
- The team facilitated various team building and team performance workshops this month including the Community Alcohol and Drug Service, Practice Development Unit, Medicine, Women's and Children's Health, Public Health, Paediatrics and on-boarding workshops for Health Care Assistants.

- Leaders
  - The Emerging Nursing Leaders Programme was further supported this month using newly acquired accredited leadership tools and framework in support of teams (Belbin). This has a focus on Leading Self and Leading Others, using a strengths-based approach
  - A leadership development programme for Clinical Directors has been developed and supported by OD team. First session was this month and focussed on service planning. Further work is progressing regarding developing a clinical leadership competency framework
  - LEADS cohort for 2021/22 confirmed for 19, 23 and 31 May. This programme places more emphasis on the leadership and management development gaps including leading through change and performance management.

- Wellbeing
  - Wellbeing pilots for ED and ICU staff using the chnnl App have now been completed. Work is currently underway to evaluate the pilots with a view to further implementation of this app in priority areas (funding dependant)
  - Speak Up app is currently in development with external developer (Firebrand)
  - Speak Up e-learning module with Healthlearn Content Review group for further instructional design support. The module has attracted the attention of other DHBs
  - OD team provided significant support to Aukaha Kia Kaha Committee this month including the planning, coordination and delivery of staff wellbeing gifts to staff throughout the southern system. This work is labour intensive given the logistical challenges but the feedback from staff has been very positive to date.

17. Recruitment Challenges Update

The Market

We have been provided with market intelligence confirming the patterns we have been seeing to our vacancies across the district to our DHB vacancies, there is a large disparity to the supply and demand of roles to candidates within the job market across Otago and Southland, making our roles increasingly difficult to recruit to. For example, administration roles throughout the Southland district have increased yet there is a very low supply of candidates, where this was previously not a hard to fill area to fill for the DHB it has now become a significant challenge to attract appropriate candidates.

Immigration

Restrictions on Immigration / Border closure challenges include:

- Paperwork required to support immigration is still a significant job with changes to the new visas to be on offer; the new residency process will also add to this with current employees requiring supporting paperwork, the number of which is unknown. Upcoming visa changes are of concern due to the uncertainty as to who will lead the accreditation of Southern because this will come in to place at the same time as Health NZ.

Corporate vacancies

- IT vacancies have been identified as an area of low supply nationwide
- We are seeing candidates pull out, being offered higher salaries elsewhere, and significant decreases in candidate applications
- Administration vacancies across both clinical and non-clinical are facing many challenges, salaries are being declined and candidates being offered other roles at various steps throughout the process. Some vacancies, especially where fixed term are not receiving any applications and needing to be readvertised
- Corporate vacancy salaries are less enticing due to the government pay freeze and the impending Health NZ changes.

Nursing recruitment

- Observing a decline in numbers of applications across all vacancies and reduced quality of talent
- Vacancies are rising across all areas and becoming much harder to fill, hiring applicants we may not have considered in the past
- Advised not able to support Aged Residential Care nurses on Skilled Shortage visas – this will decrease our candidate pool for the rising number of vacancies.

General

- New Initiatives: to support the attraction of talent to Southern DHB:
  - Rejig of current Recruitment Advisor portfolios to assist in more effective recruitment
  - Further develop and implement employee referral programme
  - Review relocation policy to include all disciplines (not just SMO and Executive)
- Current campaigns:
  - Southland 'Fit in-Stand Out' attraction campaign is now domestically and internationally last week April
  - Midwifery campaign – currently working with the Executive Director of Midwifery to explore and work alongside Karen to see what additional angles can be used for Midwifery recruitment. Currently advertising on Spotify, TikTok, Googleadwords, Programmatic.
  - Generic Nursing – this is an 'always on' campaign, where we follow online activity of our target audience and serve up advertising to across multiple platforms – kind of like stalking!

Chris Fleming
Chief Executive Officer

31 May 2022

APPENDIX 1 – Email from Margie Apa, Interim Chief Executive Health New Zealand

Tēnā koutou

It was great to be able to come together as a healthcare leadership team recently as Riana and I outlined the new structure and operating model for Health New Zealand and the Māori Health Authority.

I am pleased to advise that I have made a number of appointments to key interim leadership roles to help us to continue with our momentum as we move closer to the introduction of our new organisations on 1 July.

These roles will provide continuity and leadership across the sector while we recruit leaders, transition into the new organisations, and develop new operating models that will enable us to deliver services that are nationally planned, regionally delivered, and locally tailored.

The interim appointments include Health New Zealand interim executive leadership roles, interim regional directors and interim district directors.

Getting the right people around us and building a strong leadership team as we embark on this change is critical. Riana and I remain fully committed to the very thorough recruitment process that is underway for permanent appointments.

I appreciate there is a lot of information to digest and many of you will need to consider how these changes affect your local workplace or team. I want to make sure you have the chance to discuss any changes with your team, so we'll hold off cascading the communications to the workforce in our People Pānui until later today.

Over the next few months, the functional and operating structures that sit under these Tier two national leadership roles will be evolved and developed and we'll shortly have a process and timeframes around the operating model and co-design sprints.

We are working closely with your local communications team, and, as well as the People Pānui update to the workforce, we're also developing new channels to share further updates and support communications around what people need to know for Day 1. In the meantime, you may like to direct people to the FAQs that are on are on our website here.

Interim appointments to the executive leadership team

The interim appointments to the Health New Zealand executive leadership team in each of the three sub-teams, and the Office of the Chief Executive and Governance and Change team are below:

	Interim Leadership Team	Interim Leads
Clinical	Clinical Leadership	Peter Watson (Medical)
		Dale Oliff (Nursing)
Delivery	Commissioning	Keriana Brooking
	Hospital & Specialist	Dale Bramley
	Pacific	Gerardine Clifford-Lidstone
	Improvement / Innovation	TBD
	National Public Health Service	Jo Gibbs
Enabling	Chief Finance Officer	Rosalie Percival
	People & Culture	Rosemary Clements
	Data & Digital	Shayne Hunter (EOI out to sector)
	Infrastructure Investment	Wayne McNee (EOI out to sector)
	Corporate Services (Interim establishment of national/regional head office)	Sue Gordon
CE Office	Governance, Partnership & Risk	Deborah Roche
	Change Management Office	Alan Cassidy (appointed)
	Communications & Engagement	Helen Mexted
	Maori Health Authority Executive	Riana to advise

I am delighted to welcome these people and I am grateful to them all for their time and wisdom as we come together to guide our people and system through this important change.

There are two further interim roles which will sit within the CE governance and change team:

- **Ailsa Claire** will lead the **Workforce Taskforce**; this is the second of the three taskforces to be announced so far, aimed at making rapid progress in critical areas across the sector.
- **Andrew Slater** has been seconded from Whakarongorau to scope the future **transformation agenda**.

I am also seeking Expressions of Interest for interim leads for Data and Digital and for Infrastructure and Investment – you can signal your interest by emailing dinah.nicholas@health.govt.nz.

New interim regional and district director roles

I am also announcing the following interim regional roles, effective 1 July. These roles are needed for now to guide and unify our local healthcare teams to work together for the benefit of our patients, whānau and communities while a regional management board is established, and the national structures are recruited to and embedded.

The temporary changes have also created opportunities for senior leaders to step into interim district director roles, and I welcome the following people to their roles:

Interim Regional Directors	Districts	Interim District Directors
Northern **Fionnagh Dougan**	Northland	Nick Chamberlain
	Waitematā	Andrew Brant
	Auckland	Mike Shepherd
	Counties Manukau	Peter Watson
Te Manawa Taki **Kevin Snee**	Waikato	Chris Lowry/Riki Nia Nia
	Lakes	Nick Saville-Wood
	Bay of Plenty	Peter Chandler
	Tairāwhiti	Jim Green
	Taranaki	Gillian Campbell
Central **Russ Simpson**	Hawke's Bay	Andrew Boyd
	MidCentral	Jeff Brown
	Whanganui	Andrew McKinnon
	Capital & Coast / Hutt Valley	John Tait
	Wairarapa	Dale Oliff
Te Wai Pounamu **Peter Bramley**	Canterbury / West Coast	Peter Bramley
	South Canterbury	Jason Power
	Nelson Marlborough	Lexie O'Shea
	Southern	Hamish Brown

I deeply appreciate your ongoing commitment and leadership during this time of change.

Together we have a real opportunity to unify how we work across the healthcare system to deliver the changes our patients, communities and whānau expect and deserve. For more information, please visit the Health New Zealand website.

Ngā mihi

Margie

Margie Apa
Chief Executive Officer
Interim Health New Zealand

FOR APPROVAL

Item: Financial Report for the period ended 30 April 2022.

Proposed by: Nigel Trainor, Executive Director Corporate Services

Meeting of: Board Meeting, 8 June 2022

Recommendation

That the Board approves the Financial Report for the period ended 30 April 2022.

Purpose

1. To provide the Board with the financial performance of the DHB for the month and year to date ended 30 April 2022.

Specific Implications for Consideration

2. **Financial**

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

Next Steps & Action

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

Appendices

Appendix 1 Financial Report for the Board

Southern DHB Financial Report

Financial Report for:	30 April 2022
Report Prepared by:	Finance
Date:	12 May 2022

Report to Board

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the period ending 30 April 2022.

The April 2022 result was a deficit of $1.0m, being $1.3m favourable to budget.
The year to date result is a deficit of $21.9m which is $8.7m 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 expected to be covered by additional MoH funding.

SOUTHERN DISTRICT HEALTH BOARD
Summary of Monthly Results - By Key Drivers
For the month of April 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	115,802	2,412	1,281	4,938	668	12	2	105,062	102,283	2,779	F	1,427	500	927	F
Non-Government & Crown Agency	636	-	-	-	-	-	-	636	847	(211)	U	-	-	-	
Total Revenue	116,438	2,412	1,281	4,938	668	12	2	105,698	103,130	2,568	F	1,427	500	927	
EXPENSES															
Workforce Costs	45,113	493	1,204	-	505	12	2	42,897	42,481	(416)	U	-	-	-	
Outsourced Services	4,140	(6)	46	-	-	-	-	4,100	3,890	(210)	U	-	-	-	
Clinical Supplies	8,911	1	-	-	90	3	-	8,817	8,876	59	F	-	-	-	
Infrastructure & Non-Clinical Supplies	6,220	147	31	-	73	(3)	-	5,972	5,347	(625)	U	-	-	-	
Provider Payments	49,697	1,777	-	4,938	-	-	-	41,555	41,286	(269)	U	1,427	500	(927)	U
Non-Operating Expenses	3,360	-	-	-	-	-	-	3,360	3,536	176	F	-	-	-	
Total Expenses	117,441	2,412	1,281	4,938	668	12	2	106,701	105,416	(1,285)	U	1,427	500	(927)	
NET SURPLUS / (DEFICIT)	(1,003)	-	-	-	-	-	-	(1,003)	(2,286)	1,283	F	-	-	-	

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 30 April 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	1,115,727	15,103	35,610	6,660	9,156	1,380	458	97	1,036,389	1,023,552	12,837	F	10,874	4,500	6,374	F
Non-Government & Crown Agency	7,770	-	-	-	-	-	-	-	7,770	8,473	(703)	U	-	-	-	
Total Revenue	1,123,497	15,103	35,610	6,660	9,156	1,380	458	97	1,044,159	1,032,025	12,134	F	10,874	4,500	6,374	
EXPENSES																
Workforce Costs	443,731	16,096	7,351	4,864	-	1,075	84	77	414,184	413,998	(186)	U	-	-	-	
Outsourced Services	44,054	-	512	46	-	-	-	-	43,496	38,668	(4,828)	U	-	-	-	
Clinical Supplies	95,670	-	103	132	-	119	18	-	95,298	89,162	(6,136)	U	-	-	-	
Infrastructure & Non-Clinical Supplies	60,397	-	1,679	691	-	186	356	20	57,465	53,516	(3,949)	U	-	-	-	
Provider Payments	469,329	-	25,965	931	9,156	-	-	-	422,403	416,747	(5,656)	U	10,874	4,500	(6,374)	U
Non-Operating Expenses	32,179	-	-	-	-	-	-	-	32,179	33,124	945	F	-	-	-	
Total Expenses	1,145,360	16,096	35,610	6,664	9,156	1,380	458	97	1,065,025	1,045,215	(19,810)	U	10,874	4,500	(6,374)	
NET SURPLUS / (DEFICIT)	(21,863)	(993)	-	(4)	-	-	-	-	(20,866)	(13,190)	(7,676)	U	-	-	-	

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.

Drivers of the result:

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

Driver variance	**Month Variance 000's**	**YTD Variance 000's**
Planned Care reduction for volumes not achieved (Oct-Apr)	(1,164)	(3,813)
Pharmaceuticals – Budget lower than Pharmac forecast, incr dispensing	(807)	(8,475)
Outsourced clinical services – related to Surgical services	(283)	(5,177)
Air Ambulance mix usage and 10% price increase	(195)	(2,242)
ITC & Software	(133)	(2,432)
IDFs (net) (YTD includes one Starship patient $1m)	(498)	(2,954)
Sub Total	**(3,080)**	**(25,093)**
Offset by		
Unbudgeted Improvement Action Plan Funding	203	4,629
Additional Public Health, Mental Health, Primary Care Funding	498	4,752
Allied Health workforce costs	83	2,748
Other Government Revenue – ACC back pay & price increase	142	2,385
Clinical Supplies - Implants & Prostheses	236	1,035
Capital Charge – Budget set before final June 21 adjustments	121	687
Total Variance	**(1,797)**	**(8,857)**

Pharmaceuticals:

The YTD cost of the Pharms is $96.9m ($68.4m Community and $28.5m Provider), a crude extrapolation would give a full year spend of $116m. 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 to be over $1m. Further work is being undertaken to understand if this will be funded by MoH, our current assumption is that it will not be funded.

Month detail:

Consolidated Revenue was $12.8m favourable to budget.

Variance area	**Variance**
Covid related	
Unbudgeted COVID-19 Community Care Funding	$4.94m
Unbudgeted COVID-19 Vaccination Funding	$2.41m
Unbudgeted COVID-19 Incremental Costs Funding	$1.28m
Unbudgeted COVID-19 Endemic Funding	$0.67m
COVID-19 Surveillance & Testing Funding	$0.93m
Non-Covid related	
Unbudgeted Improvement Action Plan Funding	$0.20m
Unbudgeted Nursing Pay Equity Funding	$0.82m
Unbudgeted Support Workers IBT Funding	$0.86m
Unbudgeted Support Workers Pay Equity Funding	$2.14m
Planned Care reduction for volumes not achieved (Oct-Mar)	$(1.16)m
IDF Funding	$(0.35)m
Reduction PBF – Pharms COVID-19 Funding	$(0.15)m
Total	**$12.59m**

Expenses were $11.5m unfavourable to budget.

Workforce costs were $2.6m unfavourable including $1.7m for unbudgeted Vaccination and Resurgence costs.

Variance area	**Variance**
SMOs – 11.41 FTE unfavourable with vacancies more than offset by additional overtime and outsourced in a number of areas for cover plus Professional Fees/Memberships	$(0.43)m
RMOs – remain unfavourable with low rates of leave being taken plus overtime, over budget by 23.0 FTE	$(0.07)m
Nursing – 175.93 FTE unfavourable of which 156.0 are unbudgeted relating to Covid response, reflecting $1.24m unbudgeted Covid activity,	$(1.75)m

covered by revenue. The MECA settlement monthly cost $0.8m is funded by the MoH.	
Allied Health – 18.68 FTE favourable in a number of areas including Dental Therapists, Occupational Therapists, Physiotherapists, Psychologists & Technicians, largely driven by continued unfilled vacancies.	$0.06m
Management/Admin – 89.41 FTE unfavourable of which 93 are unbudgeted relating to Covid response, reflecting $0.53m unbudgeted Covid activity Covered by revenue.	$(0.54)m

Outsourced Services is $0.3m unfavourable with additional surgical activity including ENT, Ophthalmology, Urology, Orthopaedics and General Surgery.

Clinical Supplies are $0.03m unfavourable. This includes underspends in Treatment Disposables, Instruments & Equipment and Implants & Prostheses (Hips, Knees, Orthopaedic, Shunts/Stents), mostly offset by higher than budgeted Air Ambulance and Pharmaceuticals costs.

Provider Payments were $7.9m unfavourable, reflecting COVID-19 $1.8m Vaccination and $4.9m Community Care expenses (both offset by additional revenue). Other costs unfavourable to budget include Community Pharmaceuticals $0.6m and Primary Health Care $0.2m.

Year To Date

Revenue is $87.0m favourable to budget. This is made up as follows:

Variance area	**Variance**
Nursing Pay Equity Funding, settlement and ongoing	$18.40m
Unbudgeted COVID-19 Vaccination Funding (incl Māori)	$35.61m
Unbudgeted COVID-19 Incremental Costs Funding	$6.66m
Unbudgeted COVID-19 Community Care Funding	$9.16m
Unbudgeted COVID-19 Endemic & MIQ Funding	$1.84m
COVID-19 Surveillance & Testing Funding	$6.37m
Unbudgeted Improvement Action Plan Funding	$4.63m
Unbudgeted Public Health core contract uplift	$1.95m
Unbudgeted Support Workers IBT Funding	$0.96m
Unbudgeted Support Workers Pay Equity Funding	$2.14m
ACC Contract backpay and increase	$2.38m
Mental Health Funding	$1.16m
Primary Care Funding	$1.64m
Planned Care reduction for volumes not achieved (Oct-Apr)	$(3.81)m
Reduction PBF – Pharms COVID-19 (net)	$(1.54)m
IDF Funding	$(1.66)m
Ineligible Patients	$(1.08)m
Total	**$84.81m**

Expenses are $95.6m unfavourable to budget.

Workforce costs are $29.7m unfavourable including $13.8m unbudgeted Vaccination, Resurgence and Endemic costs.

Variance area	**Variance**
SMO – indirect costs $1.9m unfavourable, being mostly CME, outsourced remains $0.7m higher than budget in a number of areas due to vacancies. FTE are 6.98 under budget but is offset by increased overtime payments of $3.8m against a budget of $0.3m comprising 5.0 FTE	$(2.42)m
RMOs – remain unfavourable with low rates of leave being taken, increased overtime, relocation costs and FTE's 10.6 over budget.	$(1.58)m
Nursing – remains complex as there are three main areas that need separating, these are: • Nursing MECA settlement – pay equity settlement cost to date $19.4m and offset by revenue of $18.4m • Unbudgeted Nursing FTE of 80.1 YTD at a cost of $6.8m for COVID response covered by unbudgeted revenue • BAU Nursing FTE for the YTD is just under budget at 1,956 (Budget 1,961), the BAU Nursing costs are also under budget	$(23.03)m
Allied Health – remains favourable in a number of areas including Occupational Therapists, Physiotherapists, Psychologists & Technicians, 46.3 FTE overall, largely driven by continued vacancies.	$2.06m
Management/Admin – continues to be unfavourable, driven by unbudgeted Covid FTE of 77.1 and costs $4.6m	$(4.29)m

Outsourced Services is $5.4m 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 $1.4m 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, partially offset by underspends in Implants & Prostheses.

Infrastructure and Non-Clinical Supplies are $6.9m unfavourable in a range of areas, including COVID-19 expenses $3.0m, Patient Meals, Cleaning, Facilities, Transport & Travel, IT Services and Microsoft Licenses.

Provider Payments are $48.1m unfavourable, reflecting $0.4m ARRC back-payments relating to the FY22 contract uplift, $4.7m Community Pharmaceuticals, $1.6m Primary Care, $26.0m COVID-19 Vaccination expenses, $9.2m Community Care expenses and $0.9m COVID-19 Resurgence expenses (offset by additional COVID-19 revenue).

Staffing Covid-19 impact

The table below has been included to highlight the movement in FTE over the last 13 months. COVID-19 FTE has increased from 32 FTE in April 2021 to 314 FTE in April 2022. This is a combination of staffing for vaccination clinics, endemic and public health resourcing, in addition to special leave for COVID-19 sickness.

Operational FTE has increased slightly from 4,327 FTE to 4,368 FTE. RMO, Allied Health, Support and Management FTE are all below normal operational resourcing. This is due to all COVID-19 related staff and dependant sickness being transferred from BAU to COVID-19 cost centres as special leave. Nursing FTE has increased, despite the transfer of special leave to COVID-19, this is due to additional resourcing employed for CCDM (Care Capacity Demand Management) and Patient Watches.

Type	Staff Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	2021/22 YTD Average	Variance Apr to Apr	Variance April to YTD Average	Comment
COVID	SMO		0.13	0.11		0.15	0.07	0.15	0.03	0.85	1.48	14.46	5.06	10.11	3.24	(10.11)	(6.87)	April includes special leave due to COVID sickness - 6.8FTE
	RMO					0.30	2.30	0.20	0.00	0.10	2.00	0.88	10.16	14.22	3.02	(14.22)	(11.20)	April incls high levels of special leave due to COVID sickness -9.5FTE and 4.3FTE additional overtime
	Nursing	14.38	42.11	59.27	55.91	77.78	93.61	64.95	58.67	57.76	47.49	69.30	125.78	156.21	80.75	(141.83)	(75.46)	April incls high levels of special leave due to COVID sickness - 66FTE. Ordinary time 74.5FTE broken down into vacination clinics 22FTE, Endemic 24FTE, Public Health 6FTE
	Allied Health	0.11	0.15	0.46	0.47	6.98	47.97	3.15	5.92	4.24	6.50	48.88	39.86	37.93	20.19	(37.82)	(17.74)	April incls high levels of special leave due to COVID sickness (26FTE). Ordinary time 11FTE, driven by Public Health
	Support						0.05						1.19	3.00	0.42	(3.00)	(2.58)	April incls high levels of special leave due to COVID sickness
	Mgmt / Admin	17.88	40.56	63.11	62.97	87.21	97.67	73.32	65.02	62.83	58.49	86.46	83.73	92.95	77.07	(75.07)	(15.89)	April incls high levels of special leave due to COVID sickness - 19FTE and 60FTE Ordinary time due to Vacination clinics / vaccination implementation 36FTE, Public Health 8FTE and Endemic FTE 6FTE
COVID Total		**32.37**	**82.95**	**122.95**	**119.35**	**172.42**	**241.67**	**141.77**	**129.64**	**125.78**	**115.96**	**219.98**	**265.78**	**314.42**	**184.68**	**(282.05)**	**(129.74)**	
Operational	SMO	330.91	305.10	325.48	308.43	319.98	312.75	309.72	325.80	322.08	296.67	303.07	331.53	335.83	316.59	(4.92)	(19.24)	
	RMO	373.35	365.72	357.45	346.06	347.38	337.59	341.20	346.55	336.39	366.39	368.69	350.58	365.37	350.62	7.98	(14.75)	
	Nursing	2,000.09	1,947.95	1,937.20	1,896.83	1,891.69	1,892.00	1,897.51	2,004.58	1,964.56	1,996.57	1,970.47	1,942.50	2,091.23	1,954.79	(91.14)	(136.44)	Despite a large amount of FTE allocated to COVID, Nursing FTE has increased mainly due to an increase April to April in Health Care Assistants. (due to CCDM and an increase in patient watches)
	Allied Health	758.58	737.55	742.20	716.01	733.06	694.07	707.19	716.10	711.17	633.26	674.53	692.78	720.60	699.88	37.98	(20.72)	Ordinary time reduced due to Allied staff working on COVID as above plus higher levels of special leave due to COVID
	Support	105.44	105.50	104.31	101.00	102.05	100.67	99.74	101.64	101.57	94.41	102.76	98.63	101.18	100.37	4.26	(0.81)	
	Mgmt / Admin	758.92	753.05	752.02	756.94	765.62	746.30	737.79	750.04	738.45	637.00	734.76	750.79	754.55	737.22	4.37	(17.33)	
Operational Total		**4,327.29**	**4,214.87**	**4,218.66**	**4,125.27**	**4,159.78**	**4,083.38**	**4,093.15**	**4,244.71**	**4,174.22**	**4,024.30**	**4,154.28**	**4,166.81**	**4,368.76**	**4,159.47**	**(41.47)**	**(209.29)**	
Grand Total		**4,359.66**	**4,297.82**	**4,341.61**	**4,244.62**	**4,332.20**	**4,325.05**	**4,234.92**	**4,374.35**	**4,300.00**	**4,140.26**	**4,374.26**	**4,432.59**	**4,683.18**	**4,344.14**	**(323.52)**	**(339.04)**	

Financial Summary Reports

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 30 April 2022

Month Actual $000	Month Budget $000	Variance $000			YTD Actual $000	YTD Budget $000	Variance $000		LY Full Year Actual $000	Full Year Budget $000
				REVENUE						
115,802	102,783	13,019	F	Government & Crown Agency	1,115,727	1,028,052	87,675	F	1,187,928	1,233,735
636	847	(211)	U	Non-Government & Crown Agency	7,770	8,473	(703)	U	12,489	10,168
116,438	103,630	12,808	F	*Total Revenue*	1,123,497	1,036,525	86,972	F	1,200,417	1,243,903
				EXPENSES						
45,113	42,481	(2,632)	U	Workforce Costs	443,731	413,998	(29,733)	U	481,291	502,352
4,140	3,890	(250)	U	Outsourced Services	44,054	38,668	(5,386)	U	47,821	46,095
8,911	8,876	(35)	U	Clinical Supplies	95,670	89,162	(6,508)	U	111,249	107,947
6,220	5,347	(873)	U	Infrastructure & Non-Clinical Supplies	60,397	53,516	(6,881)	U	62,476	64,693
49,697	41,786	(7,911)	U	Provider Payments	469,329	421,247	(48,082)	U	489,958	506,799
3,360	3,536	176	F	Non-Operating Expenses	32,179	33,124	945	F	37,059	40,324
117,441	105,916	(11,525)	U	*Total Expenses*	1,145,360	1,049,715	(95,645)	U	1,229,854	1,268,210
(1,003)	(2,286)	1,283	F	**NET SURPLUS / (DEFICIT)**	(21,863)	(13,190)	(8,673)	U	(29,437)	(24,307)

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 30 April 2022

Actual 30 June 2021 $000		Actual 30 April 2022 $000	Budget 30 April 2022 $000	Actual 31 March 2022 $000	Budget 30 June 2022 $000
	CURRENT ASSETS				
7,582	Cash & Cash Equivalents	-	7	5,805	7
61,438	Trade & Other Receivables	89,187	50,200	74,197	48,474
6,159	Inventories	6,379	5,150	6,670	5,235
75,179	*Total Current Assets*	95,566	55,357	86,672	53,716
	NON-CURRENT ASSETS				
325,558	Property, Plant & Equipment	327,640	355,481	328,101	358,043
6,258	Intangible Assets	9,847	20,800	10,033	25,118
331,816	*Total Non-Current Assets*	337,487	376,281	338,134	383,161
406,995	**TOTAL ASSETS**	433,053	431,638	424,806	436,877
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	4,203	18,336	-	33,663
72,840	Payables & Deferred Revenue	97,505	69,303	96,344	69,492
235	Short Term Borrowings	111	1,916	110	1,979
82,596	Holidays Act 2003	87,946	88,846	87,361	90,146
95,374	Employee Entitlements	106,686	90,459	103,376	88,211
251,045	*Total Current Liabilities*	296,451	268,860	287,191	283,491
	NON-CURRENT LIABILITIES				
856	Term Borrowings	763	10,370	773	10,754
19,411	Employee Entitlements	18,706	20,186	18,706	20,144
20,267	*Total Non-Current Liabilities*	19,469	30,556	19,479	30,898
271,312	**TOTAL LIABILITIES**	315,920	299,416	306,670	314,389
135,683	**NET ASSETS**	117,133	132,222	118,136	122,488
	EQUITY				
486,579	Contributed Capital	489,891	493,782	489,894	495,164
108,500	Property Revaluation Reserves	108,500	108,500	108,500	108,500
(459,395)	Accumulated Surplus/(Deficit)	(481,258)	(470,060)	(480,258)	(481,176)
135,683	*Total Equity*	117,133	132,222	118,136	122,488
	Statement of Changes in Equity				
165,991	Opening Balance	135,683	138,188	135,683	138,189
(30,933)	Operating Surplus/(Deficit)	(21,863)	(13,190)	(20,860)	(24,307)
1,333	Crown Capital Contributions	3,313	7,224	3,313	9,313
(707)	Return of Capital	-	-	-	(707)
135,683	Closing Balance	117,133	132,222	118,136	122,488

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 30 April 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	1,087,585	1,036,586	50,999	1,240,738	987,739
Non-Government & Crown Agency Revenue	7,245	8,193	(948)	9,832	8,498
Interest Received	429	280	149	336	285
Cash was applied to:					
Payments to Suppliers	(650,214)	(605,490)	(44,724)	(719,719)	(597,887)
Payments to Employees	(423,649)	(411,861)	(11,788)	(498,453)	(377,001)
Capital Charge	(3,368)	(3,507)	139	(7,142)	(4,124)
Goods & Services Tax (net)	(439)	3,076	(3,515)	(2,604)	1,677
Net Cash Inflow / (Outflow) from Operations	17,589	27,277	(9,688)	22,988	19,187
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	93	-	93	-	4
Cash was applied to:					
Capital Expenditure	(32,563)	(59,672)	27,109	(71,902)	(24,626)
Net Cash Inflow / (Outflow) from Investing Activity	(32,470)	(59,672)	27,202	(71,902)	(24,622)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	3,313	7,224	(3,911)	8,556	1,308
Cash was applied to:					
Repayment of Borrowings	(217)	(739)	522	(879)	(792)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	3,096	6,485	(3,389)	7,677	516
Total Increase / (Decrease) in Cash	(11,785)	(25,910)	14,125	(41,237)	(4,919)
Net Opening Cash & Cash Equivalents	7,582	7,582	0	7,582	31,011
Net Closing Cash & Cash Equivalents	(4,203)	(18,328)	14,125	(33,655)	26,092

Cash flow from Operating Activities is unfavourable to budget by $9.7m. Government revenue received includes the Nursing Pay Equity funding and ongoing unbudgeted COVID-19 funding. Payments to Suppliers is unfavourable in line with the Statement of Financial Performance, driven to a large extent by unbudgeted Provider payments for COVID-19. Payments to Employees is unfavourable by $11.8m with the unbudgeted Nursing Settlement payments of $18.6m being largely offset by the budgeted expected pay out for Employee Entitlements $14.3m.

Cash flow from Investing Activities is favourable to budget by $27.2m. The Capital Expenditure cash spend reflects project delays in several larger projects.
Cashflow from Financing Activities is $3.4m unfavourable with delays in Capital project drawdowns.
Overall, Cash flow is favourable to budget by $14.1m.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure - Cash Flow
For the period ending 30 April 2022

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	9,740	25,408	15,668	U	6,570
Clinical Equipment	18,422	16,190	(2,232)	O	12,083
Other Equipment	628	1,124	496	U	635
Information Technology	2,570	2,795	225	U	2,643
Motor Vehicles	-	30	30	U	14
Software	1,203	14,125	12,922	U	2,680
Total Expenditure	32,563	59,672	27,109	U	24,625

At 30 April 2022, our Financial Position on page 9 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $337.5m, which is $38.8m less than the budget of $376.3m.

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: 6/05/2022 5:38:31 ...

1/07/2021 30/04/2022

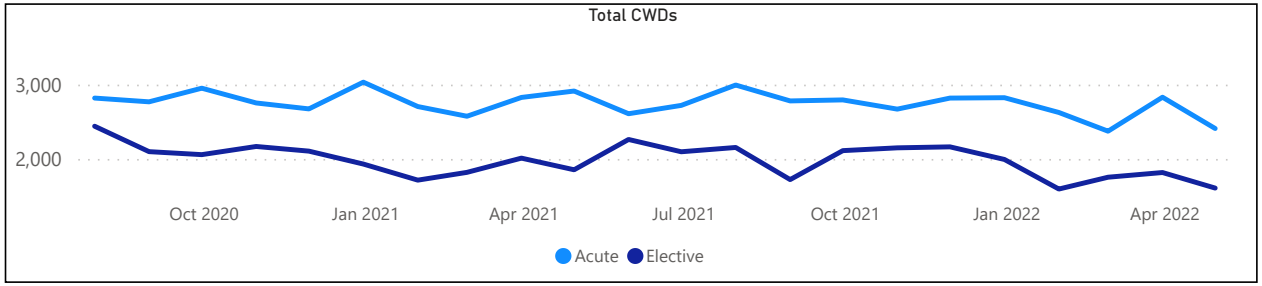
Caseweights	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Medical Caseweights												
Medical Acute	1,344	1,315	29	2%	1,423	-79	14,613	14,219	394	3%	14,796	-183
Medical Elective	222	255	-32	-13%	342	-120	3,178	2,865	313	11%	3,444	-266
Total	**1,567**	**1,570**	**-3**	**-0%**	**1,765**	**-198**	**17,791**	**17,084**	**707**	**4%**	**18,240**	**-449**
Surgical Caseweights												
Surgical Acute	999	1,169	-170	-15%	1,343	-344	11,585	12,105	-520	-4%	12,219	-634
Surgical Elective	1,051	1,199	-148	-12%	1,102	-50	12,191	13,479	-1,289	-10%	12,946	-755
Total	**2,050**	**2,368**	**-318**	**-13%**	**2,445**	**-394**	**23,776**	**25,584**	**-1,809**	**-7%**	**25,164**	**-1,389**
Maternity Caseweights												
Maternity Acute	66	80	-14	-17%	148	-82	927	883	44	5%	1,008	-81
Maternity Elective	335	322	13	4%	411	-76	3,702	3,489	214	6%	3,813	-111
Total	**401**	**402**	**-1**	**-0%**	**559**	**-158**	**4,629**	**4,371**	**258**	**6%**	**4,821**	**-192**
Total	**4,018**	**4,340**	**-322**	**-7%**	**4,769**	**-751**	**46,196**	**47,039**	**-844**	**-2%**	**48,226**	**-2,031**

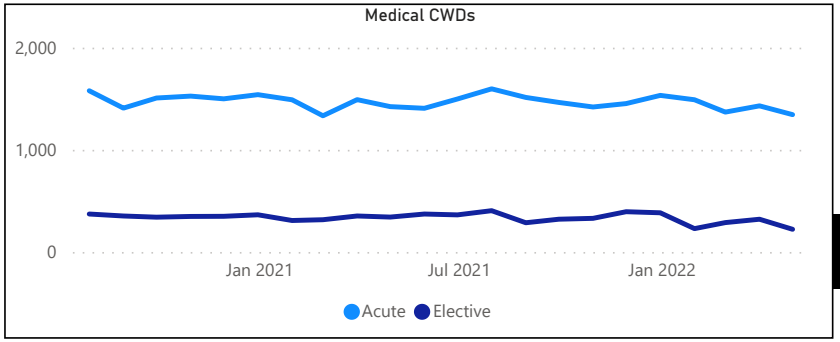
TOTALS

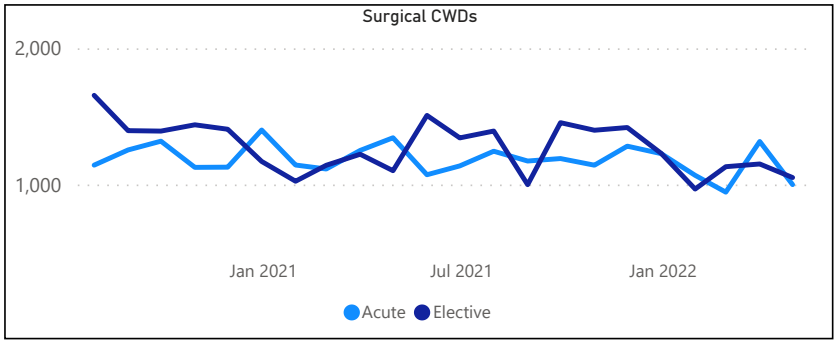
Acute	2,410	2,564	-154	-6%	2,914	-504	27,125	27,206	-82	-0%	28,023	-899
Elective	1,608	1,776	-168	-9%	1,855	-246	19,071	19,833	-762	-4%	20,203	-1,132
Total	**4,018**	**4,340**	**-322**	**-7%**	**4,769**	**-751**	**46,196**	**47,039**	**-844**	**-2%**	**48,226**	**-2,031**

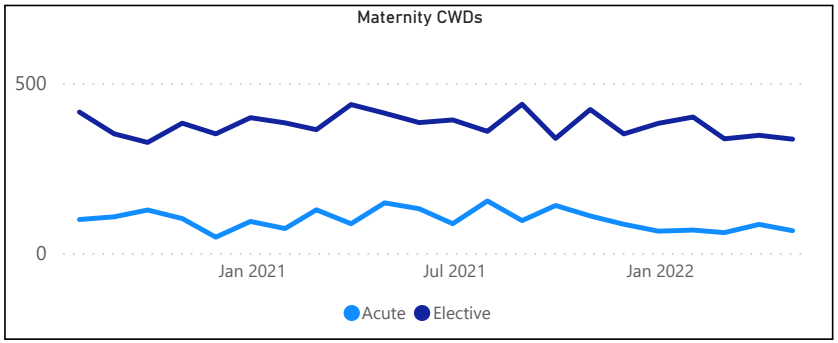
TOTALS excluding Maternity

Acute	2,344	2,484	-140	-6%	2,766	-423	26,198	26,324	-126	-0%	27,015	-817
Elective	1,273	1,454	-181	-12%	1,443	-170	15,369	16,344	-976	-6%	16,390	-1,021
Total	**3,617**	**3,938**	**-321**	**-8%**	**4,210**	**-593**	**41,567**	**42,668**	**-1,101**	**-3%**	**43,405**	**-1,838**









8.2

SERVICE PROVIDER RAW DISCHARGES

As at: 6/05/2022 5:38:31 ...

1/07/2021 30/04/2022

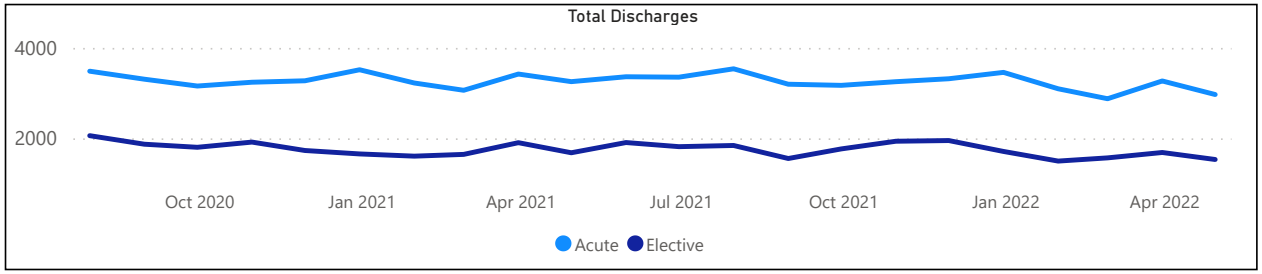
Discharges	MTD Actual	MTD Target	MTD Variance	% Variance (MTD)	MTD LY Actual	Year on Year Monthly Variance	YTD Actual	YTD Target	YTD Variance	% Variance (YTD)	YTD LY Actual	Year on Year YTD Variance
Medical Discharges												
Medical Acute	2,245	2,104	141	7%	2,305	-60	24,065	22,732	1,333	6%	23,906	159
Medical Elective	316	297	19	6%	387	-71	3,802	3,315	487	15%	3,926	-124
Total	**2,561**	**2,401**	**160**	**7%**	**2,692**	**-131**	**27,867**	**26,047**	**1,820**	**7%**	**27,832**	**35**
Surgical Discharges												
Surgical Acute	665	756	-91	-12%	838	-173	7,311	7,840	-529	-7%	8,147	-836
Surgical Elective	701	827	-126	-15%	763	-62	8,094	9,401	-1,307	-14%	8,961	-867
Total	**1,366**	**1,582**	**-216**	**-14%**	**1,601**	**-235**	**15,405**	**17,241**	**-1,836**	**-11%**	**17,108**	**-1,703**
Maternity Discharges												
Maternity Acute	59	72	-13	-18%	111	-52	771	787	-16	-2%	891	-120
Maternity Elective	515	433	82	19%	531	-16	5,147	4,668	479	10%	4,983	164
Total	**574**	**504**	**70**	**14%**	**642**	**-68**	**5,918**	**5,455**	**463**	**8%**	**5,874**	**44**
Total	**4,501**	**4,487**	**14**	**0%**	**4,935**	**-434**	**49,190**	**48,742**	**448**	**1%**	**50,814**	**-1,624**

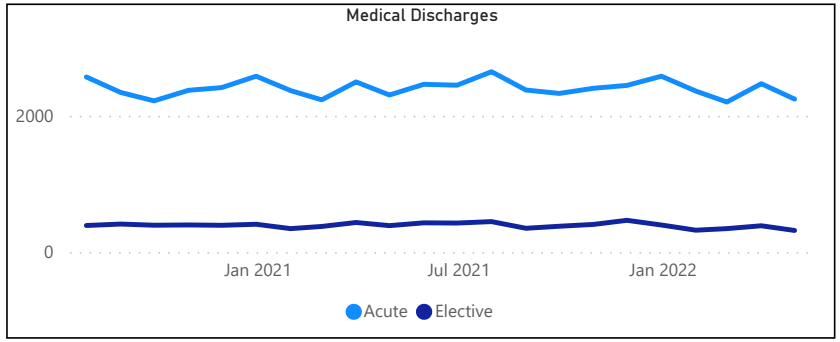
TOTALS

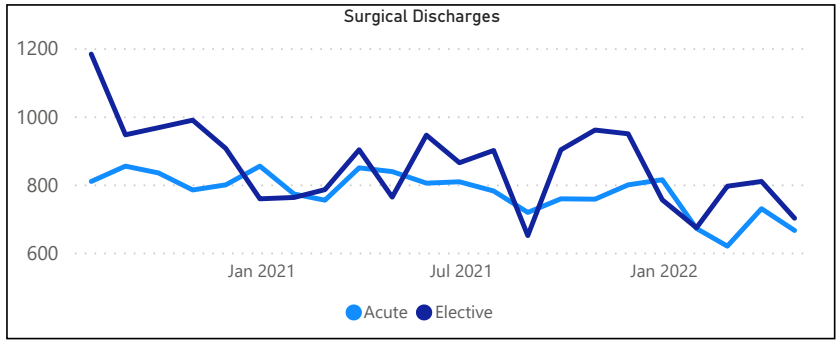
Elective	1,532	1,556	-24	-2%	1,681	-149	17,043	17,383	-340	-2%	17,870	-827
Acute	2,969	2,931	38	1%	3,254	-285	32,147	31,359	788	3%	32,944	-797
Total	**4,501**	**4,487**	**14**	**0%**	**4,935**	**-434**	**49,190**	**48,742**	**448**	**1%**	**50,814**	**-1,624**

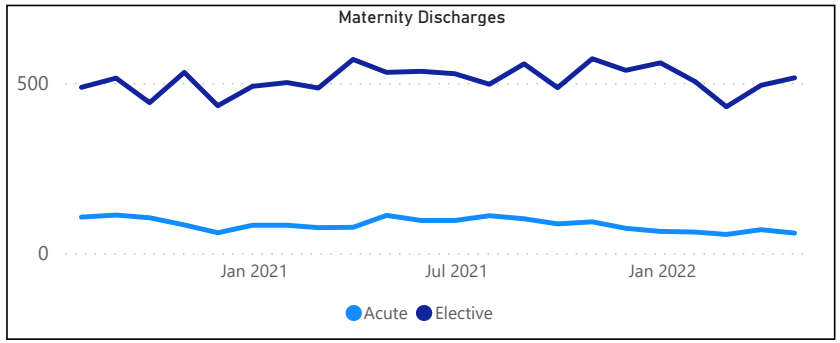
TOTALS excluding Maternity

Elective	1,017	1,124	-107	-10%	1,150	-133	11,896	12,716	-820	-6%	12,887	-991
Acute	2,910	2,859	51	2%	3,143	-233	31,376	30,572	804	3%	32,053	-677
Total	**3,927**	**3,983**	**-56**	**-1%**	**4,293**	**-366**	**43,272**	**43,287**	**-15**	**-0%**	**44,940**	**-1,668**



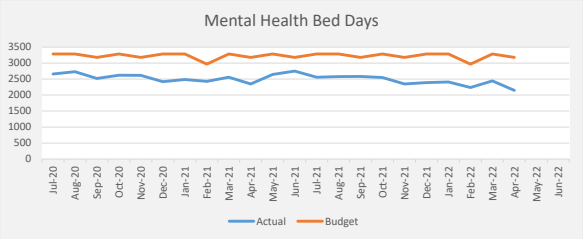




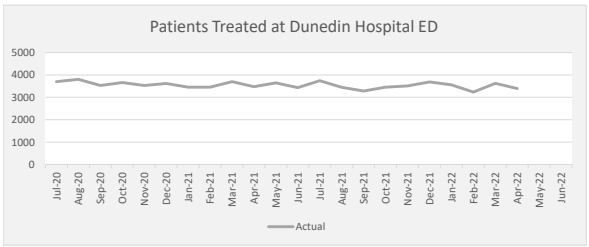


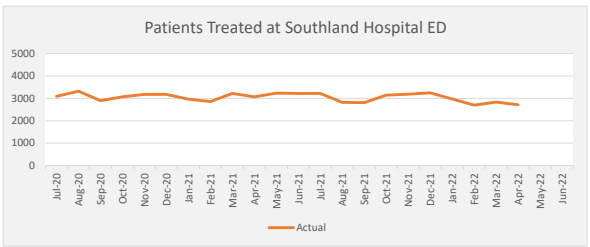
OTHER ACTIVITY

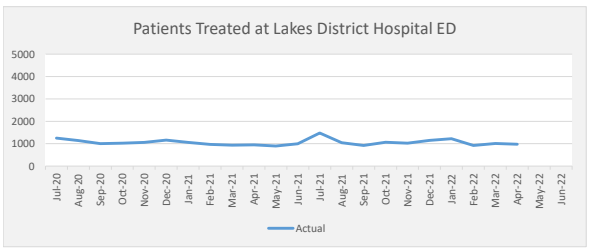
Apr-22				Apr-21	YEAR ON YEAR		YTD 2021/2022				YTD Apr-21	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,148	3,180	(1,032)	-32%	2,350	(202)	**Mental Health bed days**	24,252	32,224	(7,972)	-25%	25,396	(1,144)

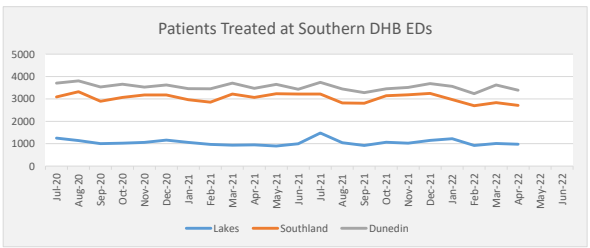


Apr-22	Apr-21	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2021/2022	YTD Apr-21	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,392	3,474	(82)	Dunedin	34,932	35,947	(1,015)
975	950	25	Lakes	10,805	10,543	262
2,708	3,068	(360)	Southland	29,628	30,829	(1,201)
7,075	7,492	(417)	**Total ED presentations**	75,365	77,319	(1,954)









8.2

FOR INFORMATION

Item: Quality Dashboard – April 2022

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

Patrick O'Connor, Quality Improvement Manager

Meeting of: Board – June 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

Discussion

10. Please note that the graphs for Staff Events for the last three months have been blue. IT are due to complete work within Power BI to update the reporting. The severity scale has been changed from a RAM rating to a SAC event. The graph colour coding has yet to be updated.

    The table below describes the Events severity by month

Month/Year	Sac1	Sac2	Sac3	SAC4	<NS>	Total
February 22	0	0	57	6	15	**78**
March 22	0	0	70	10	35	**105**
April 22	0	0	2	59	6	**67**

11. There has been a rather large drop in Invercargill Hospital average length of stay as indicated on the 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 and the significant drop in length of stay reported.

Next Steps & Actions

12. 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	36	32							
6 Mental Health Restraints no	165	125		46	48		13	13	
7 Deaths no	49	58		25	28		14	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	19	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	83	82		40	42		30	30	
15 Complaint response target met %	61	100		69	100		31	100	
16 Short Notice Postponments no				50	44		35	28	
17 Short Notice Postponments %				7	5		13	7	
Operations									
18 Referrals Declined %				15	15		11	14	
19 Length of stay days				3.6	4.5		3.1	3.3	
20 Patients with stay > 7 days no				315	384		153	169	
21 Patients with stay > 21 days no				77	87		43	42	

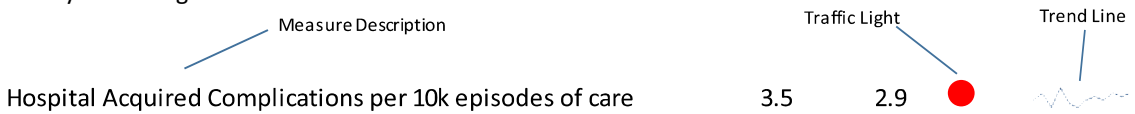
Executive Quality Dashboard – Māori

		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	3	3							
8	ED Wait Time - % patients discharged within 6 hours				83	95		91	95	
9	Vulnerable Patients (Aged 70 and over; Triage Category 1 2 3) in ED > 6 hours	14	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	12	7							
17	Short Notice Postponments %	15	7							
	Operations									
18	Referrals Declined %	12	19							
19	Length of stay days									
20	Patients with stay > 7 days no	28	38							
21	Patients with stay > 21 days no	10	10							

Appendix 2 **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 3 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 3.6% of patients for peer hospitals across Australasia. This is to the end of December 21 Invercargill is slightly ahead of peers (3.2%) with 3% of admitted patients suffering a major hospital acquired complication. The rate of HACs for Maori patients in Dunedin Hospital is slightly higher than the long term trend and shows a rising trend. We will check this again next quarter to see if further investigation is required	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 Benchmark: HRT
2	Healthcare Associated Infections per 10k episodes of care	Based on the HRT data the rate of infections in Dunedin Hospital continues 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

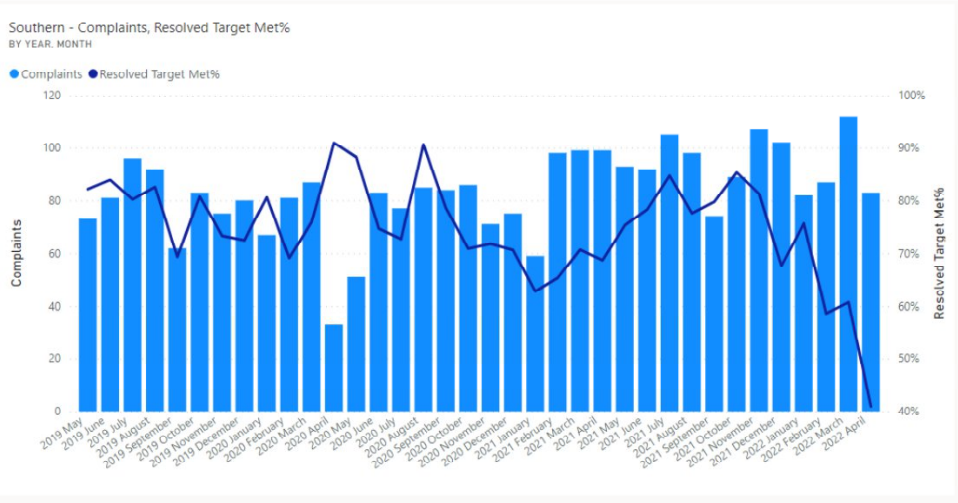
		been benchmarked red against peers. Further investigation is required but is delayed by resource constraints at this time	Benchmark: HRT
4	Readmissions within 7 days %	Readmissions continue to be stable across both hospitals however Invercargill was slightly higher than the long term average this month 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 continue at lower levels this month	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 Maori ED Wait Time figures are in line with the rest of the population	Monthly 6 Hour % Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This excludes the time spent in ED observation Benchmark: MOH Target
9	Vulnerable Patients > 6 hours in ED	Dunedin remains at high levels compared to the long term average while Invercargill has moved into line with the long term average. 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. We will review in the next round of HRT data which is due soon	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 has been showing a rising trend but has shown a major correction in April.	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

Appendix 4 Executive Dashboard – Patient Experience (Southern)



Safety 1st data.

Complaints

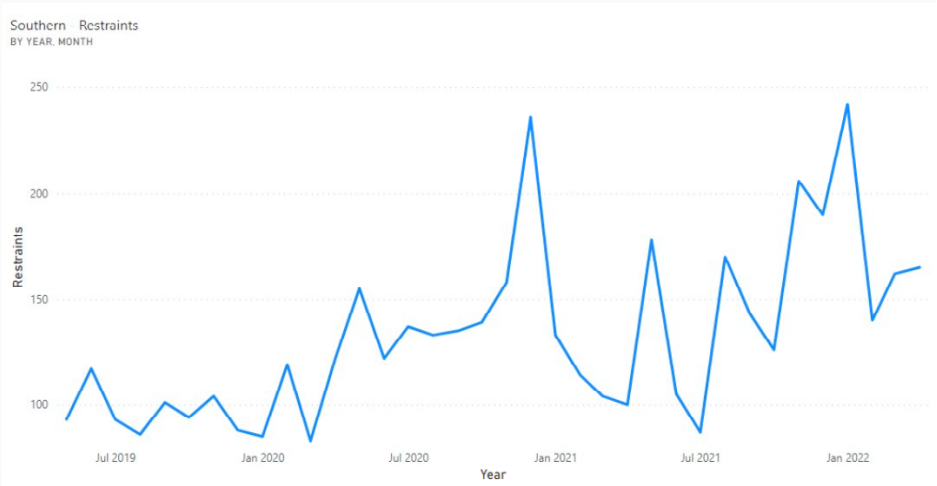
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

Resolutions

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

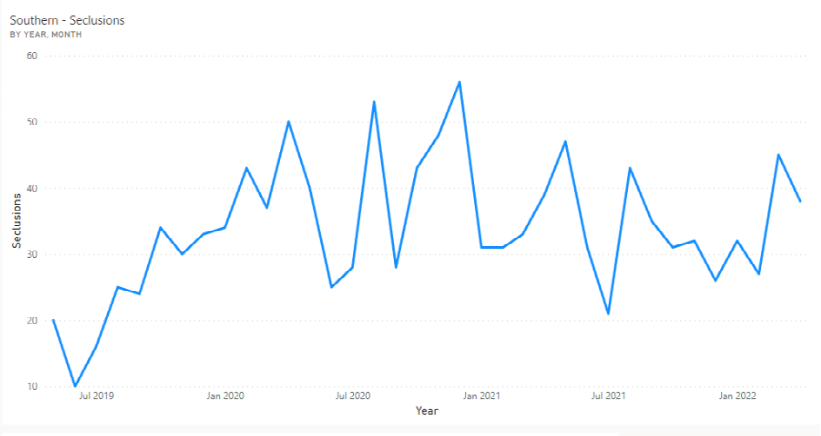
Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.

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



Restraints

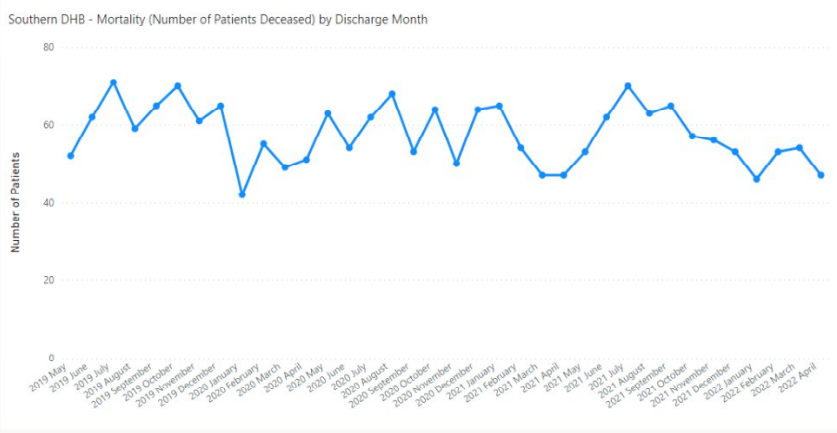
Safety 1st data. The number of restraint events per month. Restraints data includes Dunedin, Invercargill, Wakari and Lakes



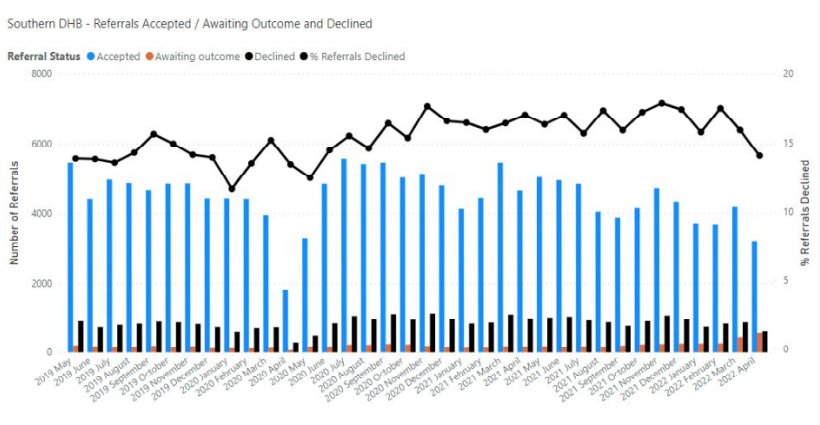
Seclusions

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

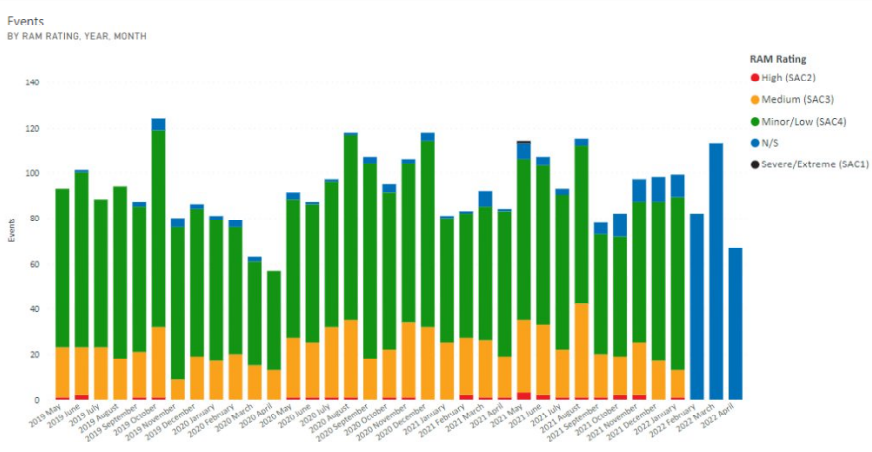
Executive Dashboard – Experience (Southern)



Deaths
Number of patients deceased by discharge month



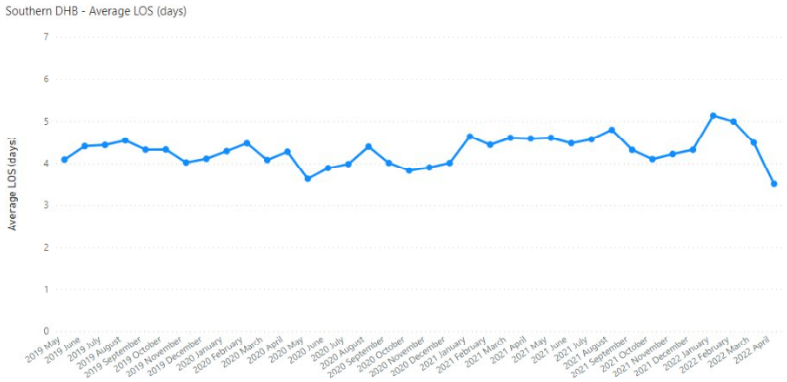
Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



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

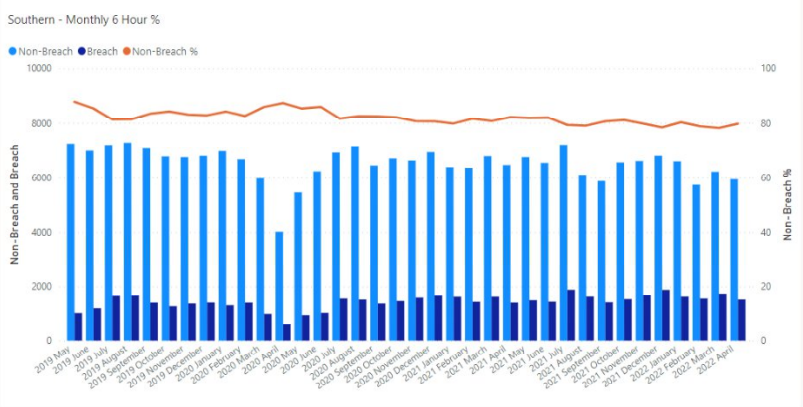
Staff events have historically included a small number of Employee events which appear as not scored. These relate to Privacy/Confidentiality, Building and Property, Security, Falls form (visitor falls) which were not associated with clinical practice. These events are not assessed in the same way as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

Executive Dashboard – Efficiency (Southern)



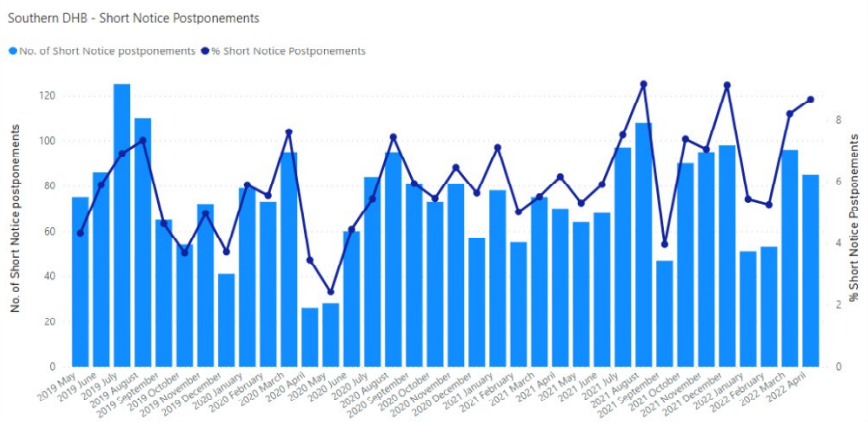
Average Length of Stay

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



Monthly 6 Hour %

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

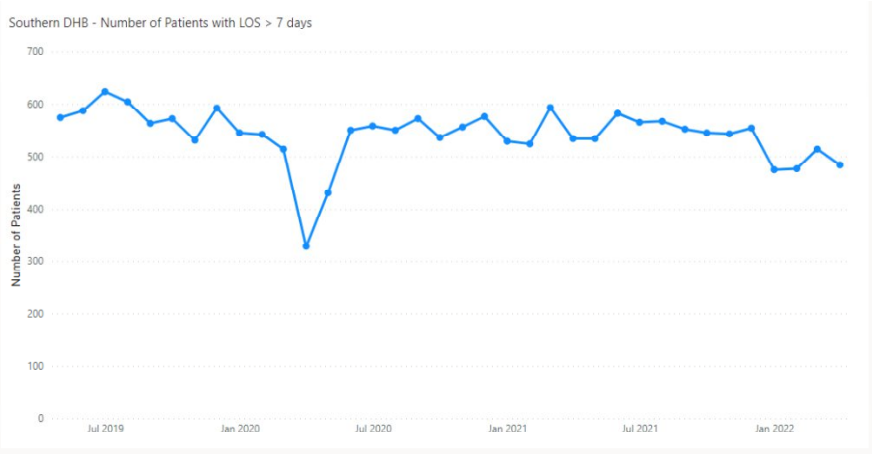


Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure.

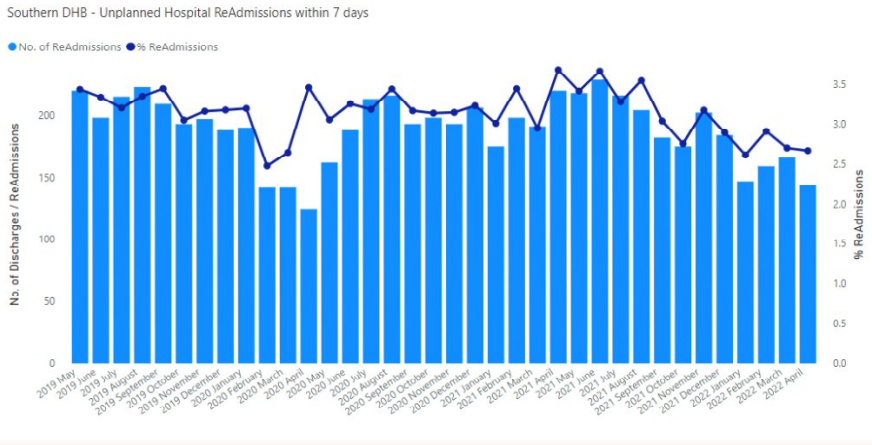
Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

Executive Dashboard – Timely (Southern)



Number of Patients with LOS > 7 days

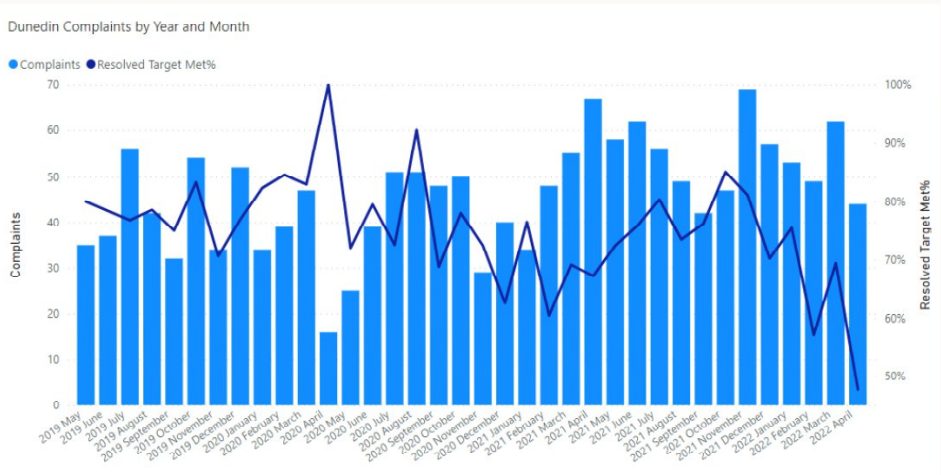
Number of patients in hospital at any point of time when they have exceeded 7 days since admission.



Unplanned Hospital Readmissions within 7 Days

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

Executive Dashboard – Patient Experience (Dunedin)



Safety 1st data.

Complaints

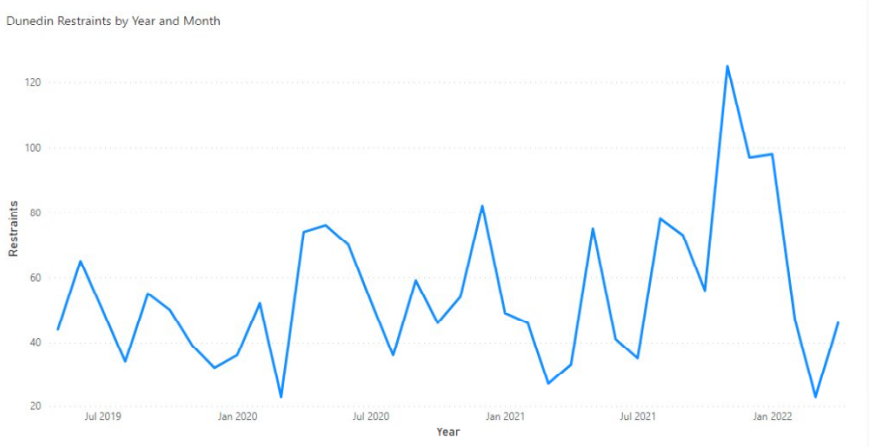
The number of internal complaints (from website, phone, email, letter, health and disability advocacy, comment form, etc) per month.

Resolutions

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

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

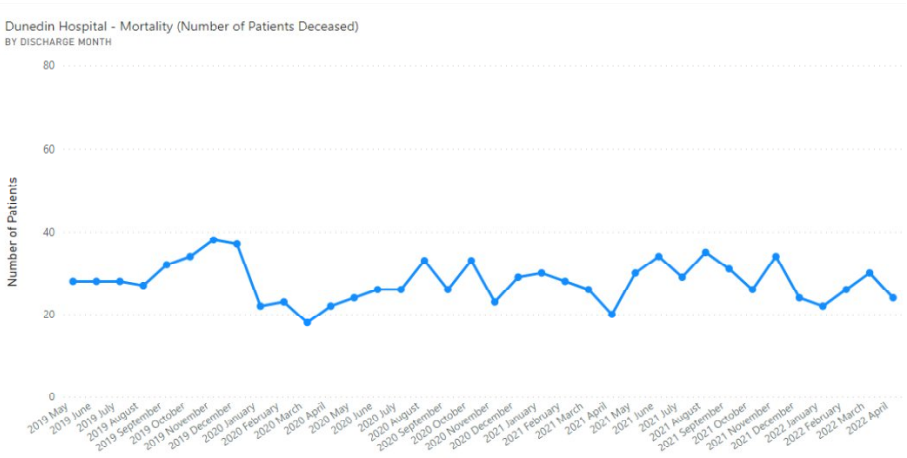
We have increased the number of complaints where we are responding to the consumer within target (20 days). It has increased from 60% in January to the high 70s in recent months.



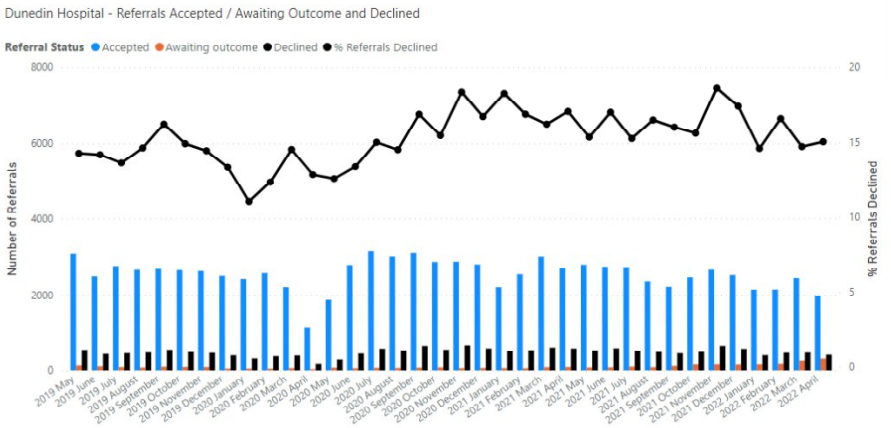
Restraints

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

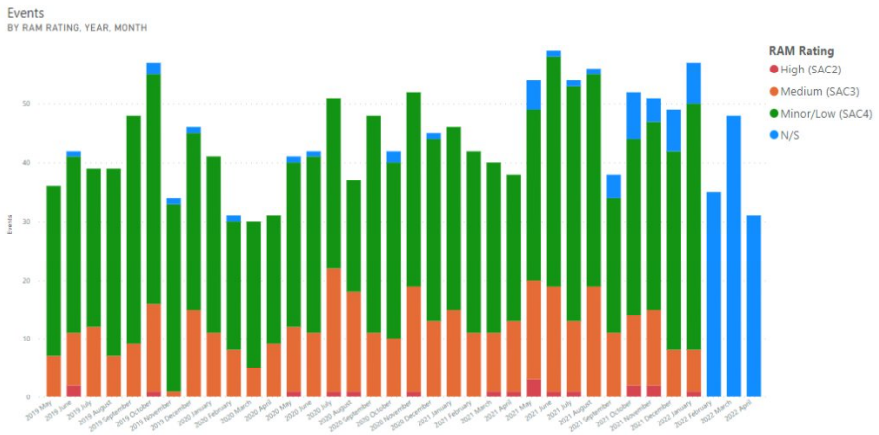
Executive Dashboard – Effectiveness (Dunedin)



Deaths
Number of patients deceased by discharge month.

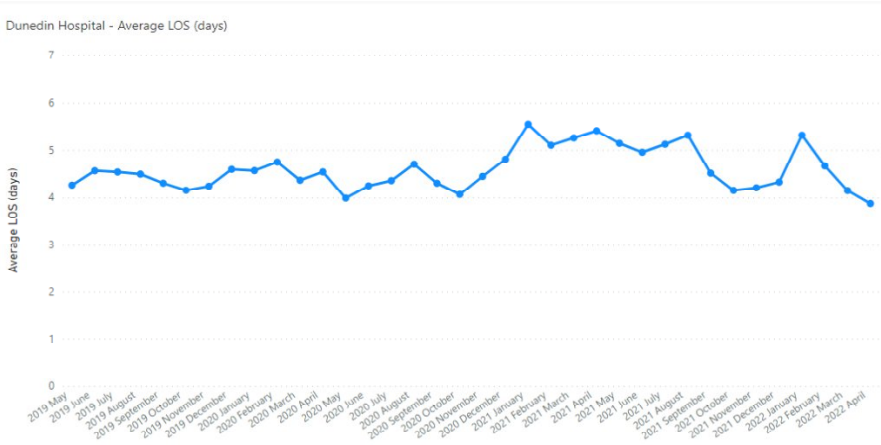


Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



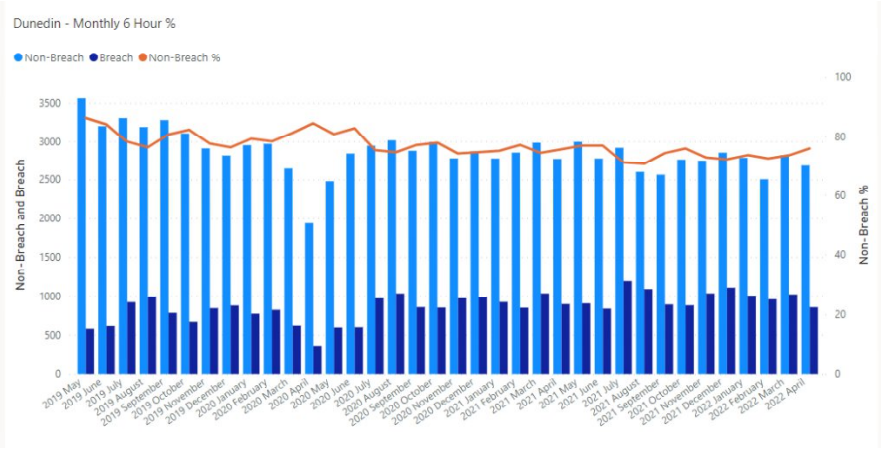
Safety 1st data.
The monthly number of reported staff adverse events Categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

Executive Dashboard – Efficiency (Dunedin)



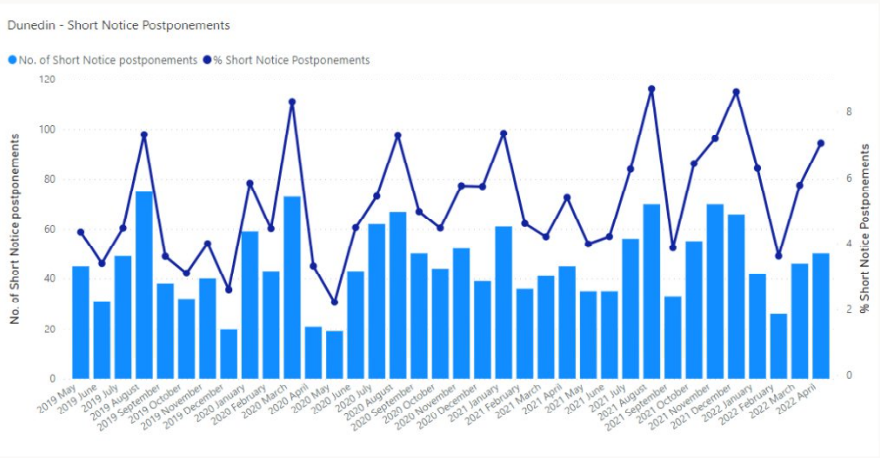
Average Length of Stay

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



Monthly 6 Hour %

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

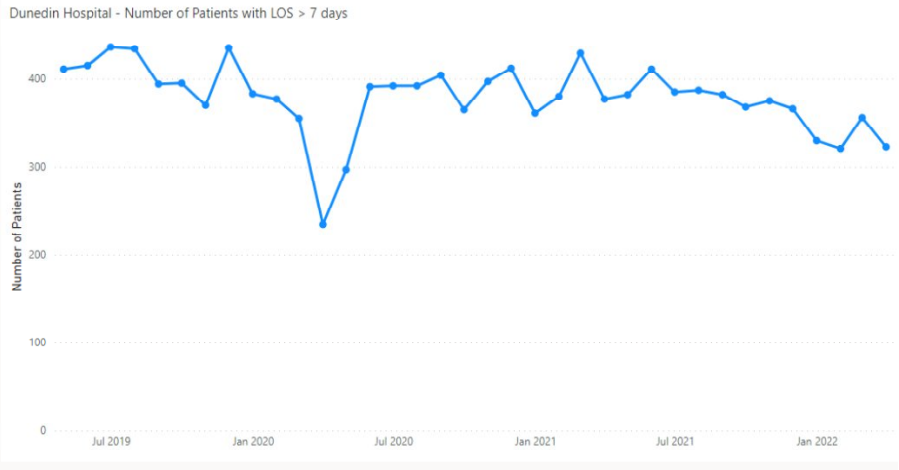


Short Notice Postponements

Theatre postponements within 24 hours of the scheduled procedure.

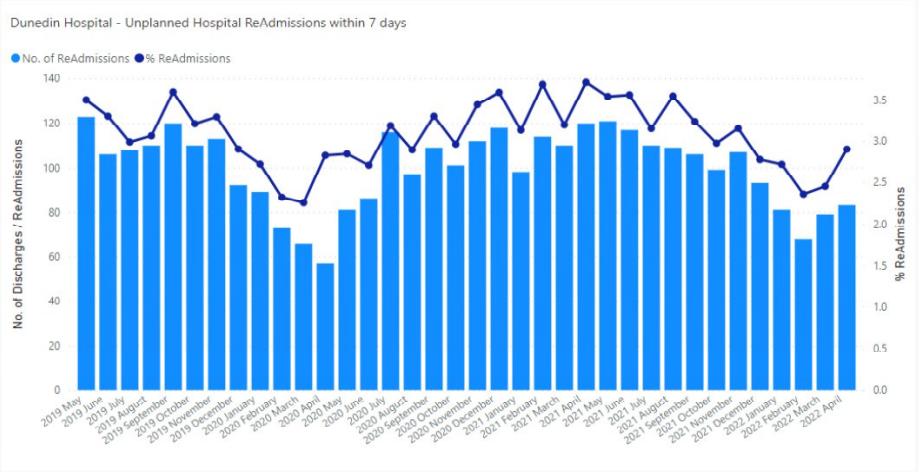
Short notice postponements have returned to more normal levels after a high in August due to the Covid lockdown.

Executive Dashboard – Timely (Dunedin)



Number of Patients with LOS > 7 days

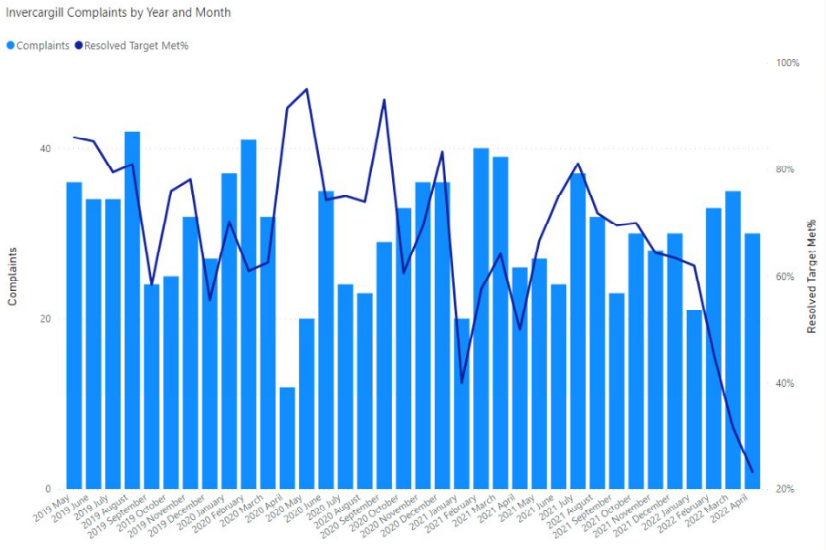
Number of patients per month who have a LOS > 7 days



Unplanned Hospital Readmissions within 7 Days

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

Executive Dashboard – Patient Experience (Invercargill)



Safety 1st data.

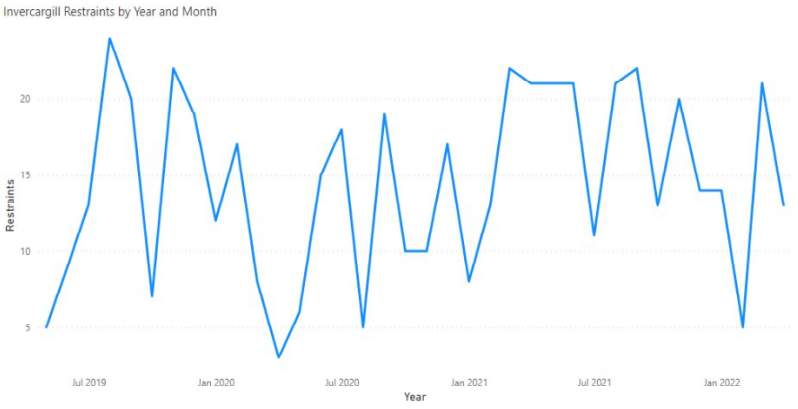
Complaints

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

Resolutions

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

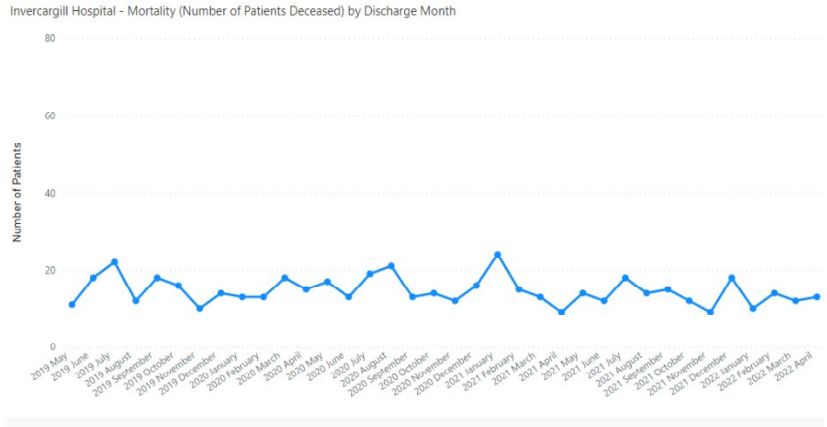
Complaints remain at high levels with little change in the last few months. Systemic issues driving complaint volumes will need to be addressed to drive a reduction in complaints.



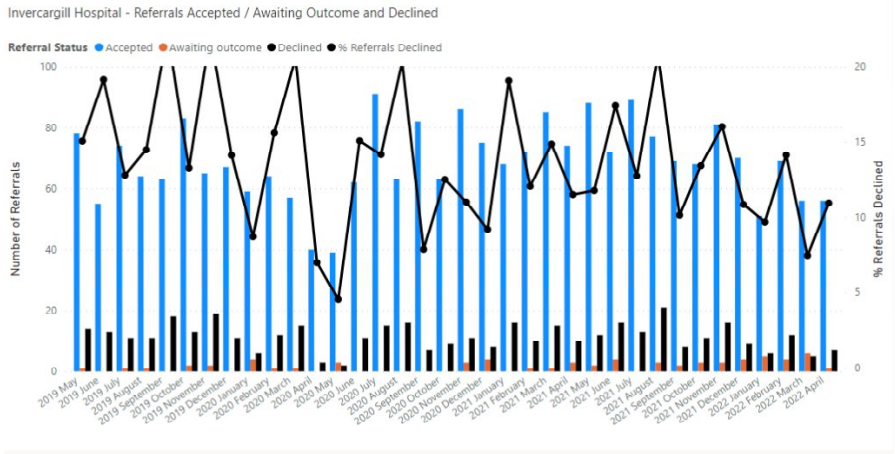
Restraints

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

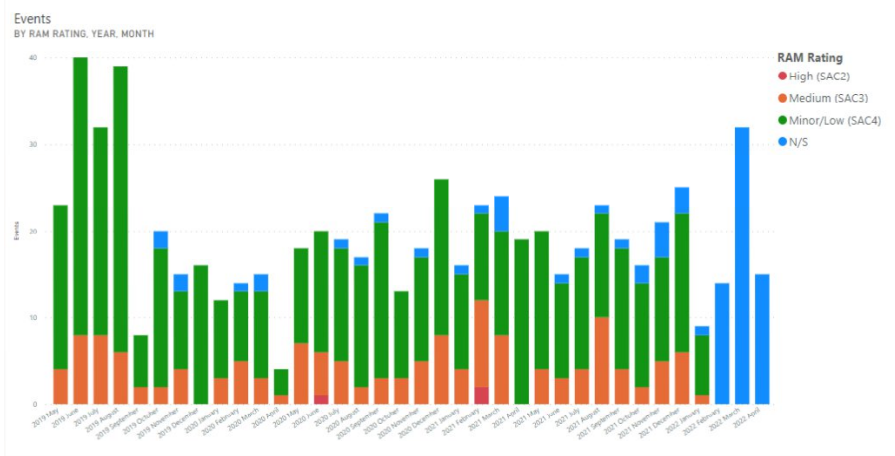
Executive Dashboard – Effectiveness (Invercargill)



Deaths
Number of patients deceased by discharge month.

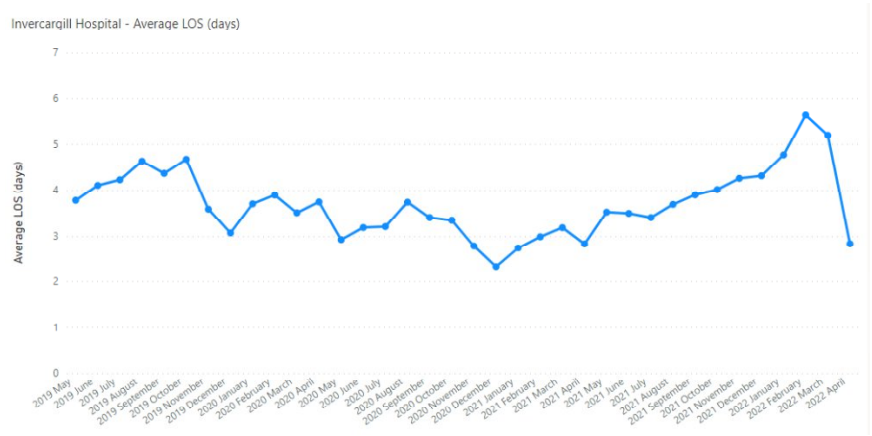


Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined.



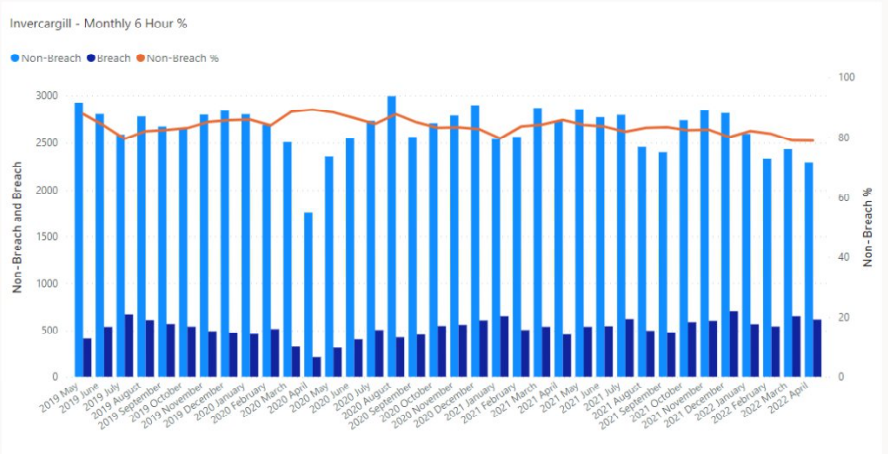
Safety 1st data.
The monthly number of reported
Staff adverse events.
Categorised by severity assessment Codes 1-4 and by 'N/S' (Not specified).

Executive Dashboard – Efficiency (Invercargill)



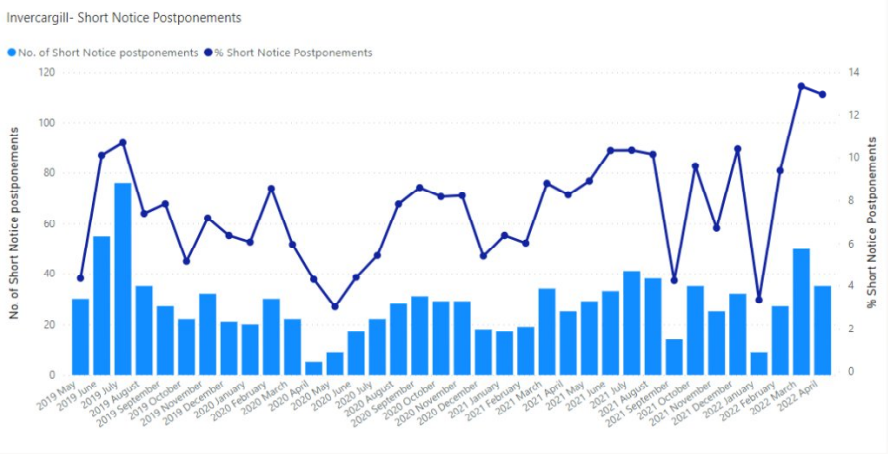
Average Length of Stay

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



Monthly 6 Hour %

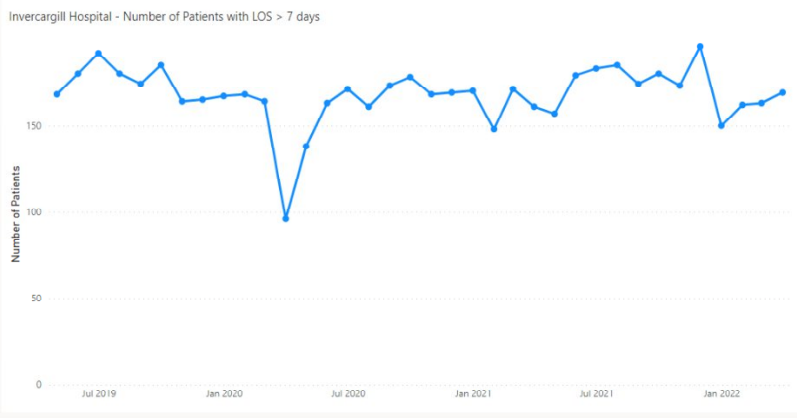
Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This includes the time spent in ED observation.



Short Notice Postponements

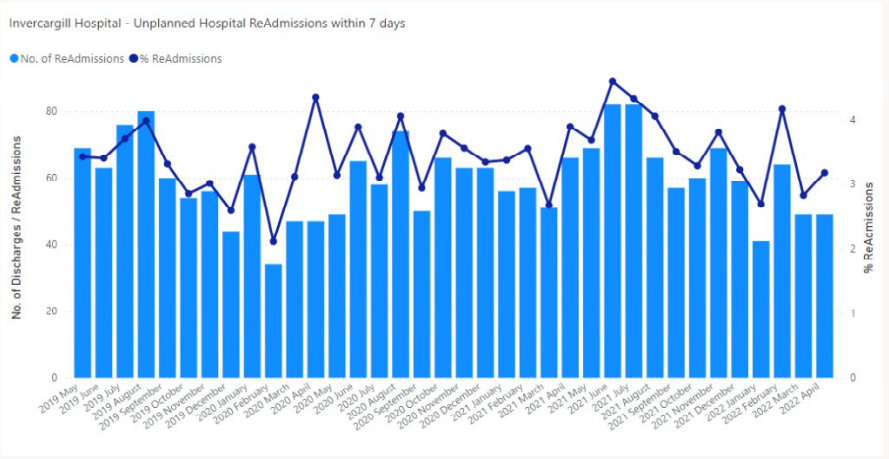
Theatre postponements Within 24 hours of the scheduled procedure.

Executive Dashboard – Timely (Invercargill)



Number of Patients with LOS > 7 days

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



Unplanned Hospital Readmissions within 7 Days

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

Please note that the graphs for SAC events require updating. This is in the work programme for IT but has been delayed due to resource constraints in IT

FOR INFORMATION

Item: Performance Dashboard Update March 2022

Proposed by: Planning & Accountability Mgr

Meeting of: 8 June 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.

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. Development of an improved dashboard is in its last stages – improving usability, stability and interprebility.

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 April 2022**

PERFORMANCE DASHBOARD INITIATIVE

Monthly Snapshot of current metrics as of 23/05/22:

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 April data because they have been extracted late May.

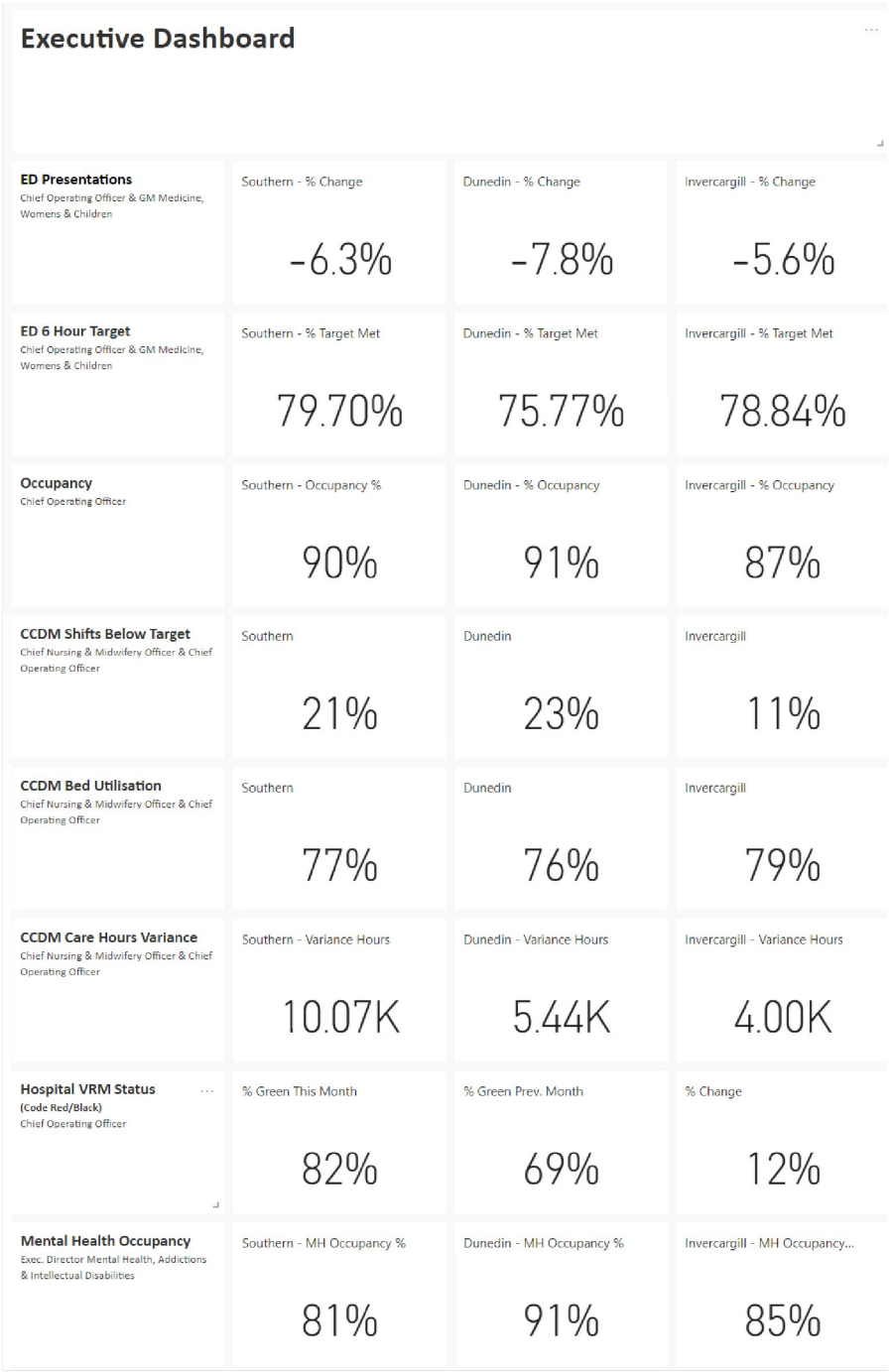


Figure 2

ED Presentations KPI Apr 2022

Southern	Apr	Mar	
ED Presentations This Month	7449	ED Presentations Prev. Month 7954	% Change -6.3% ▼
Cat 1&2 This Month	1216	Cat 1&2 Prev. Month 1447	% Change -16.0% ▼
Dunedin Hospital			
ED Presentations This Month	3537	ED Presentations Prev. Month 3835	% Change -7.8% ▼
Cat 1&2 This Month	764	Cat 1&2 Prev. Month 913	% Change -16.3% ▼
Southland (Kew) Hospital			
ED Presentations This Month	2911	ED Presentations Prev. Month 3084	% Change -5.6% ▼
Cat 1&2 This Month	360	Cat 1&2 Prev. Month 450	% Change -20.0% ▼

Figure 3.

Figure 4.

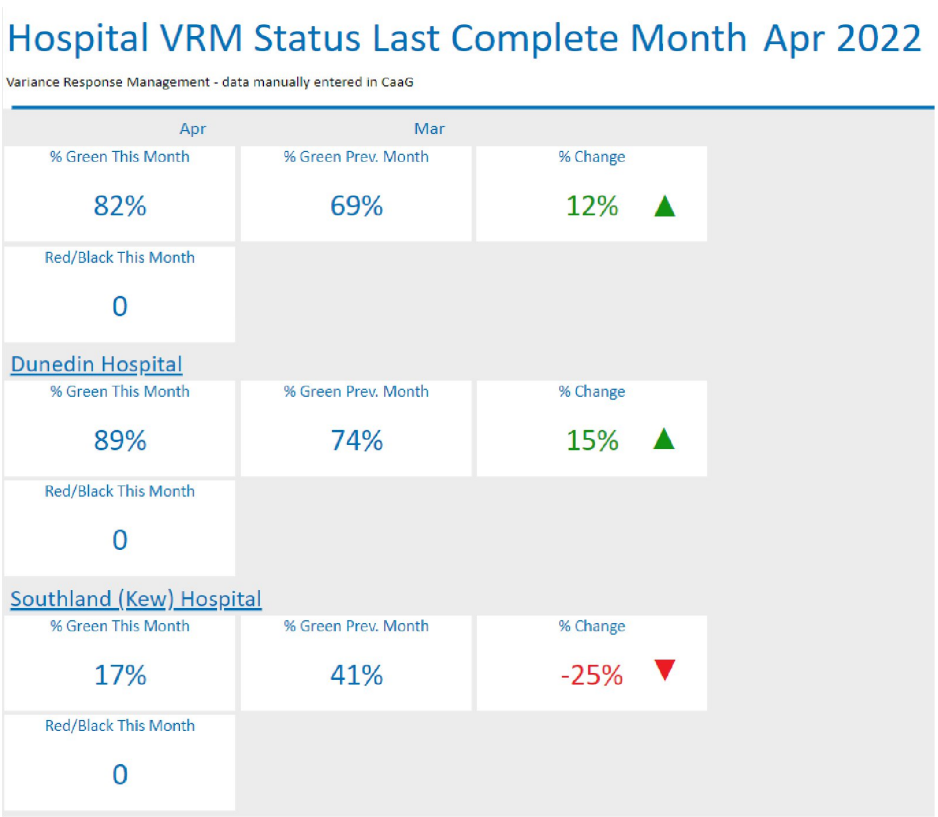


Figure 5.


Average Length of Stay Apr 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 Prev
3.65
LOS Last Complete Month
3.61
Total Change
-0.04
Highest Avg
Mental Health Sub-Acute
72.85
Longest Stay
Mental Health Acute Care
287.76
7 Day Stays
General Medicine
177
Dunedin Hospital
LOS Previous Month
3.46
LOS Last Complete Month
3.57
Total Change
0.11
Highest Avg
Geriatric
33.72
Longest Stay
Psychogeriatric
118.10
7 Day Stays
General Medicine
76
Southland (Kew) Hospital
LOS Previous Month
3.57
LOS Last Complete Month
3.09
Total Change
-0.48
Highest Avg
Rehab Geriatric Active
31.71
Longest Stay
Rehab Geriatric Active
93.97
7 Day Stays
General Medicine
55
Average Length of Stay Analysis and Narration
Average LOS (days) by month
4.04
3.80
4.46
4.05
3.70
3.34
3.71
3.72
3.51
3.65
3.61
3.98
2021 June
2021 July
2021 August
2021 Septe...
2021 October
2021 Nove...
2021 Dece...
2022 January
2022 Febru...
2022 March
2022 April
2022 May

8.4

FOR INFORMATION

Item: SDHB Change Programme Report June 2022

Proposed by: Chris Fleming, Chief Executive

Meeting of: Board, 8 June 2022

Recommendation

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

Purpose

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

Specific Implications For Consideration

Background

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.

It is hoped the additional hui on 18 May helped provide extra context to the reporting and content.

Discussion

This month's change programme update is the seventh 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.

Next Steps & Actions

- Continue uploading and refining content within Cascade and upskilling users.
- With the launch of the Southern transitional briefing, look at options for aligning goals to the new framework that this briefing/strategy provides.

Appendices

1. SDHB Change Programme Total May 2022

54
GOALS

60%
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** **Mata Cherrington:** **Key Accomplishments:** Stocktake of different data sources and options for reporting **Challenges:** • Accessing baseline data to assist in progress measurement • Sense-making of the quantity of information available **Next Steps:** • Working with the Equity Data Analyst around presenting information • Developing meaningful dashboard to assist decision-makers *13/05/2022*		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: Workforce advisor has been appointed to Challenges: Challenges with COVID and staff absence has delayed some progress in this area. 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. *17/05/2022*	**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: Sign-off with CNMO and procurement to reallocate/reinvest the CNS resources in to an established Maori Health provider providing nurse-led clinics. Contract has been drafted between DHB and provider for funding. Big uptake in response to EOI for candidates. Challenges: *No value* Next Steps: Signing of contract Recruitment of staff Associate Maori Health Strategy & Improvement Officer to work with provider Development of supports around the nurses to ensure regional coverage. *17/05/2022*	**Appointment of successful candidates** ☐ **Undertake procurement/commissioning of the role** ☐ **Develop ROI** ☑	**33%** 33% ahead
Pro-equity Recruitment	Tanya Basel	**NEW** **Jayne Jepson:** Key Accomplishments: Training with recruitment team scheduled for next week, and meeting organised to define an ongoing training programme Challenges: *No value* Next Steps: *No value* *17/05/2022*	**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:** Communications team are on-board and working to develop videography scripts and launch collateral **Challenges:** *No value* **Next Steps:** Filming in late May/Early June with launch following *10/05/2022*	**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:** The team are building momentum on finalising outstanding indicators and narratives, with a deadline of the end of June. +3 indicators from last month on the portal (62 now; 59 last month). +15 narratives from last month on the website (42 now; 27 last month). Note that not all portal indicators will have narratives – portal will always be a larger quantity. Website improvements are underway Communications plan actively in progress **Challenges:** *No value* **Next Steps:** Continued deployment of indicators Website usability fixes Comms plan *10/05/2022*	**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%** 6% behind

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:** Iwi Governance Committee have taken leadership to drive the articulation of the aspirations of the Rūnanga. IGC are scheduled to meet on 27 May. DHB-WellSouth-Māori Health Directorate working group set up to develop shared thinking and progress for development. Hokonui Rūnanga and wider stakeholders are meeting mid May to reset the rural Southland locality proposal. Terms of reference being drafted to ensure shared understanding and frame direction of group External stakeholders being liaised with about inclusion. **Challenges:** *No value* **Next Steps:** *No value* *12/05/2022*		**1%** 1% ahead
Implementation of the Primary & Community Strategy	Andrew Lesperance			**18%** 40% behind

9

Goal	Owner	Monthly Update	Task	Current Completion
Health hubs Implementation: Te Kaika Community Wellness Hub	Andrew Lesperance	**NEW** **Wesley Bachur:** **Key Accomplishments:** • Naylor Love develop design of Te Kaika presented to stakeholders. • SDHB and OHL (Otakou Health Limited - developer) have agreed to a market-based lease approach. • Co-design contract with OHL has been submitted for approval. • SDHB & MSD will collaborate in lease negotiations with OHL. • MSD security requirements clarified and service impact mitigation worked through at this point. **Challenges:** • Covid infections have had a significant impact on OHL staff. This has cut across all major workstreams, especially tenancy negotiations and progress with co-design. • 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:** • Progress with co-design of services ASAP. • Negotiate lease. • Finalise Development Agreement, License Agreement (lease), and MOU. • Send letter of approval seeking long-term lease to Min of Health. *10/05/2022*	**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**	Hannah Gentile	**NEW** **Hannah Gentile:** Key Accomplishments: • Conditional purchase of property in Wanaka. Are awaiting LIM, due diligence, and MoH approval. In process of working on resource consent application. Sale becomes unconditional June 16th 2022. • Contract for Architectural component of Clyde build signed off. • Design workshops for Clyde build completed in Alex and Cromwell for various stakeholder groups. • Tender document for construction partner written Challenges: Resource consent is currently a 1 - 5 month wait. Next Steps: Concept Design for Clyde Tender for Construction provider released Conditional items for purchase of Wanaka property satisfied *16/05/2022*	**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%** -
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%** 3% behind

CLINICAL SERVICE REDESIGN

Goal	Owner	Monthly Update	Task	Current Completion
Oncology Sustainability Planning	Hamish Brown	**NEW Hamish Brown:** **Key Accomplishments:** Update provided to the SDHB Board as attached. Working through the recommendations for admin and nursing resource. **Challenges:** *No value* **Next Steps:** *No value* *16/05/2022*	**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%** 30% ahead
→ **Address recruitment challenges within the service**	Hamish Brown	**NEW Hamish Brown:** **Key Accomplishments:** Haines recruit campaign live Kiwi Health Jobs critical care nursing campaign underway - several candidates have been offered for review however no offers have been made SBCS - 17/19 vacancies filled. Hematology recruitment - now working with two potential candidates. Ongoing vacancies across nursing and allied health SMO vacancies - 12 advertising across COO directorate. Multiple in the recruitment pipeline. **Challenges:** *No value* **Next Steps:** *No value* *18/05/2022*	**Staff recruited to and in place** ☐ **Meet with CDHB to collaborate on opportunities** ☑ **Initiate Haines Attract recruitment campaign** ☑	**70%** 30% behind
→ **Establish outsourcing arrangement to reduce waitlist immediately**	Hamish Brown			**100%** -
→ **Development of long term Oncology strategic plan**	Hamish Brown			**100%** -

Goal	Owner	Monthly Update	Task	Current Completion
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:** Below are the main headlines and #s Please let know if you would like further detail – or comments. Commentary: March saw a record number of Telehealth appointments across the DHB with 798 TH appointments in total. This included appointments from 19 Specialties which was also a new best. However, April has seen a drop back to 420 Telehealth appointments – (there were also 1129 Follow-ups performed by Telephone only), but pleasingly we have maintained representation across 19 Specialties - pre- March this was regularly sitting at 12 -14 specialities per month. Please note there was also a 28% decrease in total number of appointments across the DHB for this period – I believe this will be primarily because of Covid in the community and the large number of public holidays during April. **Challenges:** *No value* **Next Steps:** *No value* *19/05/2022*	**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%** 6% behind
Enhanced Generalism Model	Hamish Brown	**NEW** **Hamish Brown:** **Key Accomplishments:** Frazer Building decant and build 1. Programme Work completed in the last two weeks: • Demolition works in Stage 1 mostly completed. • Building consent ABA-2022-522 has been approved. • Electrical, plumbing, and floor covering contractors have been engaged. • Electrical and plumbing physical works have commenced. • Painting contractor revising their quotation.	**MAU Decant & Build** ☐ **MAU Design** ☐ **Recruitment: PM, SMO & Allied Health** ☐ **GAMA Implementation** ☑ **Communications Plan** ☑ **SLA/Referral Guidelines** ☑	**50%** 6% ahead

Owner	Monthly Update	Task	Current Completion

- Liaised with the Physio, Rheumatology and Pain Departments to review fitout.
- Request for quotation issued for the carpentry/joinery package.

Work planned for the next two weeks:

- Electrical and plumbing physical works in progress.
- Stage 2 demolition work to commence as soon as the Care Coordination Centre has relocated to 197 Hanover Street.
- Liaison with the Physio, Rheumatology and Pain Departments to coordinate FF&E.
- Fire safety review for the whole building to be completed in the next two weeks.

Date for completion: Although we are still targeting 27 June for Physio/Rheum relocation, the revised date for completion is 11th July 2022, due to the Chorus fibre project at 197 Hanover Street delaying the relocation of the Care Coordination Centre out of Fraser Building to end of May.

1. Financials – (Fraser Building $$ only, does not included costs incurred from decanting teams)

- Project Budget: $700,000 (including contingency)
- Actuals to Date: $151,060
- Estimated Cost to Complete: $593,435
- Contingency allowance (10%): $74,450
- Forecast final cost: $818,945 (including contingency)
- Variance from budget: -$118,945 (MAU budget will cover this)

1. Risks and mitigation strategies

Owner	Monthly Update	Task	Current Completion
	• Contractor resources – Tendering work to multiple contractors with a key selection criterium being availability • Material supply – Identifying any issues at an early stage • Unforeseen services – Available as-built information has been reviewed by designers • Hanover Street decant may potentially impact on Fraser building works – a strategy is being determined to overcome the late Gib board supply • Health and safety – All contractors comply with SDHB health and safety requirements • Project cost – Ongoing value engineering and reuse/recycle materials as much as possible • Asbestos – this has been checked and it has been confirmed that known asbestos has been removed in the work area. 1. Project Issues • Stakeholder communications / management – not all stakeholders have been identified – regular meetings and communication will be required • Hanover Street decant – Chorus fibre project delays and Gib board supply issues – a strategy is being developed • Stakeholders' resistance – the Physio and Rheumatology Service Managers have stressed that staff will be very resistant to the relocation if we do not at least match current working condition standards. The main push-backs are regarding quiet spaces, ventilation and heating/air-conditioning and the reception layout • The Care Coordination Centre Team Leader also warned that her team will not move to 197 Hanover Street if roller blinds and a fridge are not supplied and installed. • Carpentry/joinery package – larger contractors (Naylor Love and Cook Brothers) have turned down this job. Stewart Construction has also turned down this job. This leaves ABL, Stevenson & Williams and Jeff King, all of which do not have access to readily available Gib.		

	Owner	Monthly Update	Task	Current Completion
		This is expected to cause further delays which will impact on the final relocation date. **Challenges:** *No value* **Next Steps:** *No value* *18/05/2022*		
→ **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%** -
→ **Increase general medical admissions.**	Hamish Brown	**NEW** **Hamish Brown:** **Key Accomplishments:** *Updated metrics for April 2022* *· Gen Med admission rate for April – 74.6% (our target is 75%)* *· Overall outliers for the hospital – 7% decrease* *· Number of patients with a LOS < 3 days – 15 % increase* *· The largest group of patients had a length of stay less than 4 days – 56.7% with 78% of the total patients with a LOS < 7 days.* *· The percentage of patients with a LOS between 7 days – 21 days is 18.9% with an additional 3% being >21 days.* *· The main demographic of patients with a length of stay > 7 days are between the ages of 70 – 100 years old or 75% of the patient demographic. This is a 6% increase from March 2022 numbers.* *· Since August 2021, this age group has been the top demographic for this metric with an average of 68% of the patients being in this category* **Challenges:** *No value* **Next Steps:** *No value* *18/05/2022*		**65%** 65% ahead

ENABLING OUR PEOPLE - OUR PEOPLE STRATEGY

Goal	Owner	Monthly Update	Task	Current Completion
Human Resources Information System (HRIS)	Tanya Basel	NEW **Jayne Jepson:** Key Accomplishments: Digital business case for transformation work is currently with Ministry of Health for approval Challenges: *No value* Next Steps: *No value* *17/05/2022*	**Digital Transformation Business Case** ☐ **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%** 32% behind
CCDM Implementation	Jane Wilson	**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%** 12% 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** **Jayne Jepson:** **Key Accomplishments:** Training with recruitment team scheduled for next week, and meeting organised to define an ongoing training programme **Challenges:** *No value* **Next Steps:** *No value* *17/05/2022*	**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%** -
→ **Wellbeing: Aukaha kia kaha programme**	Tanya Basel	**NEW** **Jeff Melville:** **Key Accomplishments:** Work continues with the wellbeing packages as this has proved to be a significant logistical challenge. It is expected that this work will be fully completed by the end of May 2022. Chnnl wellbeing app pilots in ED and ICU have now come to an end. Collated feedback will be presented to the Health and Safety Governance Group. **Challenges:** *No value* **Next Steps:** *No value* *17/05/2022*	**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

Goal	Owner	Monthly Update	Task	Current Completion
↳ **Speak Up Programme**	Tanya Basel	NEW **Jeff Melville:** **Key Accomplishments:** Speak Up Guides recruited now at 24 - this is the new revised role superseding Speak Up Champions. Speak Up app being developed by Firebrand - design phase coming to an end mid May - now commencing prototype phase Restorative Practice Workshops to accredit internal facilitators have been agreed with HR/OD practitioners the initial tranche. (June 2022) Speak Up E-Learning model still with healthlearn content group for further development -initial scoping was completed by OD team **Challenges:** *No value* **Next Steps:** *No value* *17/05/2022*	**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 has made good progress this month on several tasks: a. A supplier has been confirmed through a rapid procurement process and a contract has been signed to engage them. the ePMO will now work with the chosen supplier to develop our overall programme management / project management approach. b. The ePMO has been provided with an agenda slot for the ELT meeting on the 19th of May to outline our programme and project governance approach and to seek executive endorsement of this. She has prepared a proposed approach for discussion and has worked closely with her counterpart at Canterbury District Health Board to ensure that our approach is aligned where practicable. **Challenges:** *No value* **Next Steps:** *No value* *09/05/2022*	**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** ☑	**77%** 15% 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** **Jen Pettitt:** **Key Accomplishments:** - We have met with our counterpart CDO/CIO from CDHB and NMDHB, and with the Deputy Director General for Digital at the Ministry. We have confirmed with these parties that we will design the digital solutions in this programme to meet the functional requirements of the whole of the South Island from inception. This will require us to develop our programme design differently to if we had just focused on SDHB, but meets the broader expectations of HNZ. - We have confirmed with the Ministry / HNZ that they support our stage 1 funding request ($131m) which would enable delivery of the preferred option 3. However, we will need to work with HNZ to get the next stage of our programme agreed to in the future. - We met with key individuals from the Ministry and the Treasuring in Wellington on the 5th of May, and stepped them through our B.C. and responded to their questions and feedback. We have also provided written feedback in response to earlier questions from the Ministry. **Challenges:** **Next Steps:** *No value* *09/05/2022*	**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%** 27% ahead

Goal	Owner	Monthly Update	Task	Current Completion
Scanning Project: The digitisation of clinical records	Patrick Ng	**NEW** **Jen Pettitt:** **Key Accomplishments:** The earlier version of the scanning business case was found not to be of the right standard and it was re-developed in the month of April, 2022. The revised B.C. has subsequently been endorsed by the Executive Leadership Team and was then formally approved by the SDHB Board on the 4th of May, 2022. The next step is to officially 'on-board' the project manager / expert whom we have identified from the successful NMDHB and Mid Central implementations. She will be available in a limited capacity in May and then in a dedicated capacity from June. She will initially be tasked with re-baselining the project plan and then getting underway with implementation, in partnership with the medical records team. **Challenges:** *No value* **Next Steps:** *No value* *09/05/2022*	**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%** 22% behind
Establishment of an Integrated Operations Centre	Hamish Brown	**NEW** **Hamish Brown:** **Key Accomplishments:** Update to ELT as attached. Operations Manager Southland commences 23 May. **Challenges:** *No value* **Next Steps:** *No value* *18/05/2022*	**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

Goal	Owner	Monthly Update	Task	Current Completion
EPMO Strategy and Roadmap	Sara Kidd	**NEW** **Sara Kidd:** **Key Accomplishments:** The tender process for the EPMO Advisory work is finalised and the contract has been awarded to Wellington-based consultancy, Tregasksis Brown (TB). Meetings with TB and executive staff have been scheduled over the next 2 weeks. **Challenges:** Availability of key stakeholders and other competing priorities, especially leading up to the end of financial year. **Next Steps:** Next 2 weeks: TB and Key stakeholder meetings and desktop review (discovery) Following 2 weeks: Formal workshops and consultation Following 2 weeks: Feedback and discussion Final week: Presentation and acceptance of deliverables. *10/05/2022*		**0%** 52% 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%** 25% behind
Clinical Costing System Implementation plan	Nigel Trainor	**NEW** **Jen Pettitt:** **Key Accomplishments:** This clinical costing system has been presented to board. We are currently awaiting approval from CE for CAPEX. We now move to Phase-2 of the project. Meeting has been scheduled with the Service Provider (PowerHealth) to discuss the project timelines and contract requirements later this week. **Challenges:** *No value* **Next Steps:** *No value* *10/05/2022*	**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** ☑	**77%** 77% 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	**NEW** **Hamish Brown:** **Key Accomplishments:** See IOC update above **Challenges:** *No value* **Next Steps:** *No value* *18/05/2022*		**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:** The PICS programme continues to track to plan, with an overall completion date of May, 2023. Key activities including data migration and future state business process development remain on track. The overall approach to the theatre management requirements needs confirmation in June (as it is anticipated that these will be met with the vendor's newly developed theatre module functionality). This will be confirmed in June. A workaround has been identified as a back-up should the module not meet requirements. The project is on track at this stage in terms of deliverables and budget. **Challenges:** *No value* **Next Steps:** *No value* *09/05/2022*	**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** ☑	**43%** -
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%** 3% behind

Goal	Owner	Monthly Update	Task	Current Completion
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:** For Southland ED, we have had some recent updates on the project where the MOT has been separated from the ED project and hence we need confirmation from Hamish and Nigel on scope for ED project only. Preliminary Design is 100% complete. Detailed design is 50% complete but the current change in scope to remove MOT may well affect the detailed design. The current programme was for both ED and MOT projects. Btu the programme need to be revised since the scope is now ED plus 2nd storey only. **Challenges:** *No value* **Next Steps:** *No value* *09/05/2022*		**25%** 25% ahead
Security Review	Nigel Trainor			**100%** -
Dunedin Master Site Planning	Bridget Dickson	**NEW Simon Crack:** **Key Accomplishments:** Public report released on 29 April 2022, alongside media pack and FAQs. Further meetings with key "out of scope of NDH" services will follow in May to discuss service-specific elements of the plan. **Challenges:** *No value* **Next Steps:** *No value* *02/05/2022*	**Deliver & Document** ☐ **Refine Preferred Scenario** ☑ **Explore Spatial Options** ☑ **Define Vision & Principles** ☑ **Mobilisation/Lead-In** ☑	**100%** -
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 – 8 June 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 build 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:

Southern DHB has agreed to use Māori health equity investment for community nursing services focused on prevention, early intervention and addressing amendable 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 Update:

The procurement process has been completed and the Te Kākano Nurse Led Clinics contract has been signed by Awarua Whānau Services.

Southern DHB and WellSouth have committed to support Awarua Whānau Services with facilitating discussions about Te Kakano Model of care with other interested parties across the Southern District. The intention is that the positions will be located across the District with other Māori Providers.

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.

30 June 2022 – Embed Te Kākano Nurse Led Clinics across the District.

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, 8 June 2022

Recommendation

That the Southern DHB Board note this report.

Purpose

1. The Southern DHB Board note this update
2. Note the traffic light 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 was endorsed by the Board and money set aside. We are working with the transition unit and Ministry of Health to confirm 22/23 and 23/24 investment. The investment is essential for the success of this programme.
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 has recruited a Project Manager (0.8FTE). The focus of this project manager will be initially on support for the Network collaborative design initiatives, and project managing the Alcohol and Drug area.
    - An Administrator (0.5 FTE) has been recruited.
    - The recruitment process for a project manager with lived experience (0.5FTE) is underway.
    - The clinical leadership and change management experience of the MHAID Senior Leadership Team is a critical component for the success of the Programme to ensure the change benefits are realised. Each project will have a specified Oversight group made up of senior leaders.
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
    - Communications and stakeholder engagement will increase from mid June 2022. A dedicated Time for Change – Te Hurihanga page will shortly be available on the Southern Health website. It will include a summary of the programme, project updates, frequently asked questions, who's involved and opportunities to engage as well as links to the full Time for Change – Te Hurihanga review.

Discussion

1. Kia Manawanui Aotearoa (2021), the draft Mental Health and Addiction System and Service Framework, and alignment of Time for Change Te Hurihanga
    - Following on from the release of Kia Manawanui Aotearoa (the long term pathway to mental wellbeing), the Ministry of Health has developed a draft Framework, with the sector to help guide it on mental wellbeing support and equitable access to core mental health and addiction services across NZ.
    - The Time for Change Te Hurihanga fits well within this national Framework, notably the:
        - Principles for decisions and approach.
        - The critical shifts needed to prioritise the most pressing changes
        - The approach for locality services as a cohesive, seamless network of support for all people
    - The Framework, once released, will be an essential document to guide and underpin the Time for Change Te Hurihanga programme going forward.
2. Health and Disability System review, locality planning, and networked health services
    - Embedded in the Time for Change Te Hurihanga programme structure are the four Southern Mental Health and Disability Networks. These are independent collaboratives who have interests across their local area (Otago, Southland, Waitaki, and Queenstown Central Lakes).
    - The Networks will (and do) feature in locality planning. Their strong connections with the mental health sector and their pivotal role in Time for Change Te Hurihanga means they will also bring a distinct mental health and addiction focus for each locality plan.
3. Community and provider engagement
    - The Time for Change Te Hurihanga programme has built in structures to assist and promote community and provider engagement, including co-design as part of the process for developing services, the establishment and ongoing commitment of the Cross Sector Group, engagement of those with lived experience through representation and forums, and use of provider and clinical networks. A web-based information resource is soon to be launched.
4. Equity lens
    - The Cross Sector Group is co-chaired with Mata Cherrington and Toni Gutschlag. The joint leadership is essential for ensuring constant attention to improving equity for Maori in our discussions and our decisions.

- Scoping of Kaupapa Maori Mental Health and Addiction Service is in progress, guided by Mata Cherrington
- All Time for Change Te Hurihanga initiatives must be designed and delivered to improve equity.

5. Making Change
    - Time for Change Te Hurihanga programme was launched less than two months ago, and in that time some significant developments have been made, specifically:
        - Collaborative design with the Networks to identify, develop and implement changes to services agreed as a priority by each Network. The programme has invested in project management expertise to assist the Networks and anticipates that service investment will also be needed.
        - Establishment of a crisis respite/support service in Dunedin. This has been possible through constructive discussions with a provider on their service delivery and subsequent changes to their contract. This is an exciting development, and a long-awaited solution to a gap in service delivery in Dunedin.
        - Collaborative design for a crisis respite and support service in Queenstown Lakes area. This is a new service in the area, building on from the feedback and recommendations in the Time for Change Te Hurihanga review which prioritised this as a necessary service. The model of care has been collaboratively developed with the providers and the community, and an RFP is anticipated to be published in late May 2022.
        - The submissions for the RFP for the rapid expansion of Dunedin Alcohol and Drugs services will be assessed over June.
        - Scoping of Peer Led Wellbeing Services and associated Workforce Development will commence once a project manager has been appointed.
6. Providing contemporary models of care
    - Progress is being made to support people to transition out of hospital into their own home, with supports to suit their needs. This is an important project for all involved, and we are working with the patients and their whanau, staff and providers to define and provide the new services that will be required.
    - The review panel for the submissions has met once, and is due to meet again this month to complete the review of all submissions.

Next Steps & Actions

- 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 (15 May 2022)

Appendix 1: Tranche 1 Priority Projects indicative timeline and progress report, 15 May 2022 (red text indicates update from 6 May 2022)

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (15 May 2022)	Reason for investment	Status
-	Network leadership groups co-design				The Chairs of Southern mental health and addiction Network Leadership Groups have recently been invited to participate in a collaborative design process. This will aim to improve and strengthen the existing service delivery systems associated with the networks. We have met with the Chairs and with Otakau Network and Southland Future Directions to discuss the co-design work The collaborative design programme is being funded by the Ministry of Health and rolled out across all DHBs. The intention is to develop the capability for implementing changes needed to the existing service delivery system so that it works better for the local population, delivers a joined up and seamless service across health and social services, and improves health equity. In the Southern area, we are supporting the collaborative design process through the Time for Change – Te Hurihanga programme team	Support of a collaborative design process through the Networks	underway
1	Intensive community support services	short term – 0-3 months	July 2021	June 2023	The request for proposal (RFP) for intensive community support services closed. A selection panel has reviewed the proposals. Discussions underway with proposers Clinical Project Manager engaged. She has provisionally identified the long stay patients on Wards 11 and 9b Wakari and explored what may be required for successful transition to the community. Unit managers advised and involved.	Expanded range of community services to meet the needs of people currently in hospital	Underway

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (15 May 2022)	Reason for investment	Status
					Occupational Therapists involved and are critical for the transition process. Transition planning has commenced – Occupational Therapists will form an essential component of the transition		
2a	Child and youth wellbeing –Central Lakes, Dunedin, all of district (Central Otago and Wanaka)	short term – 0-3 months	Jan 2022	March 2023	The overarching approach has been documented and will guide the planning and delivery of a more integrated model of care. The four priorities identified are: • Referrals • Child/Youth and whanau journey • Primary and Secondary care clinical engagement • Education and professional support Commenced - Central Otago and Wanaka Child and Youth Services, Clinical Network Group: Progressing to a more integrated 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	Support for families, maintain engagement with education	Underway
2b	Crisis intervention and response – Queenstown/Central Lakes and Waitaki, all of district	short term – 0-3 months	Oct 2021	March 2023	Change Leadership Group approved the service model framework for crisis response facility in Queenstown/Central Lakes, acknowledged that more work required and model will be refined over coming weeks. Work is progressing	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 (15 May 2022)	Reason for investment	Status
					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 to 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: Workshops for clinicians scheduled for April to work through the service model of care details. IN PROGRESS 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 Negotiations to increase crisis support services in Dunedin continue		
2ci	Alcohol and drug service – Dunedin (and later Invercargill)	short term – 0-3 months	Jan 2022	June 2023	Open RFP issued, and evaluation scheduled for June 2022 A collaborative design process was embarked on with current AOD providers in Dunedin. We agreed priorities for any new investment, which included ensuring services would provide services for Māori and Pasifika, for people with complex needs including current or historical involvement with Corrections, and a range of other factors.	Increase in capacity, service improvement and changes to models of care	underway

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (15 May 2022)	Reason for investment	Status
					We then held a series of hui for people with lived experience of AOD issues and heard from them about their experiences of services and what they consider as priorities. The outcomes from these meetings have been collated into a summary report which you can read here. The commissioning process is being adapted so that it is an open process, and the RFP will be advertised on GETS this week. 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 completed on 13 and 19 April in Dunedin and Oamaru. Report provided 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)		
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	Contract agreed for additional crisis respite beds Discussions with a local provider for establishment of crisis respite services in Dunedin progressing.	Increase in capacity of specialist services (to better support community services) through service	Underway

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (15 May 2022)	Reason for investment	Status
						improvement and changes to models of care	
3	By Māori for Māori investment				The approach will take into account the number of priority initiatives being led out by the Time for Change Programme, and also the breadth of scope that will be require. Mata Cherrington (Executive Director, Maori Health Strategy and Improvement) will lead the development of the framework for district wide Kaupapa Maori Addiction and Mental Health Services for the Southern district in the first instance.		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. We were visited by a member of the Health NZ mental health infrastructure team this week to scope requirements for short to medium improvements and longer term planning. 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

	Project name	roadmap timeline	Indicative start date	Indicative end date	Update (15 May 2022)	Reason for investment	Status
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. The initial scoping will include supply, competency, development, supervision and training requirements		getting started
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: Southland Clinical Needs Analysis

Proposed by: Hamish Brown, Chief Operating Officer

Meeting of: Board, 8 June 2022

Recommendation

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

That the Board endorses the next steps that, once clinical refinement has been completed, that a Master Site Plan for Southland is commissioned to determine the future facility needs.

Purpose

To provide the Board with the Final Draft of the Southland Clinical Needs Analysis for Southland Hospital for discussion and comment.

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 describe the current state, identify future needs and create a clear pathway for the development of Southland Hospital over the next 10+ years. This has required considering the anticipated growth of the population across the Southern DHB region, including Central Otago and any 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 the final draft of the current state and baseline projections. Analysis of the collected data is complete and further additional remote engagement has occurred with individual services. Additional face-to-face engagement with a broad clinical team, unable to be completed due to COVID, is planned to assist in testing future scenarios regarding (for example) facilities and resources in Central Otago, the role of primary care, the use of telehealth, changes in models of care and any potential after-hours facility. These discussions will determine the likelihood of the demand curves on Southland Hospital being altered and the subsequent impact on future spatial planning.

Discussion

The clinical needs analysis is the foundation document for decision making regarding the future health needs of the Southland population and therefore will guide the spatial requirements of the Southland Hospital.

It is proposed that upon completion of the document that a site master plan is commissioned to determine the requirement for the development of infrastructure to support the needs of the Southland population, specifically at Southland Hospital.

Next Steps & Actions

The report requires further refinement through face-to-face clinical engagement to assess the impact of various scenarios including the impact of primary care, ambulatory care, urgent care centres, telehealth, and other changes in models of care to determine the extent by which demand curves on hospital services can be remodelled.

Following the clinical engagement, the Board is asked to endorse the decision to commission a Site Master Planning process for Southland Hospital, noting final financial decision will rest with Health NZ using the refined Clinical Needs Analysis as the foundation document.

Southland Clinical Needs Analysis

Report to the Board on current issues and future need

David Moore, Rebecca Rippon, Tom Love, Kelvin Woock
26 May 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 Southland clinical needs analysis project was commenced in October 2021 with the aim to create a pathway for the development of Southland Hospital over the next 10+ years—identifying current issues and considering the anticipated needs of the population and changes in models of care over this period.

The analysis will identify:

1. the current Southland population identifiers, ethnicity markers, growth and demand projections
2. current service issues and 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 what the 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 next steps

This paper provides a summary of the analysis undertaken on 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 provide a summary statement of the key issues facing Southland clinical services, along with more detail relating to specific specialties. The issues documented are based on feedback received via numerous meetings and interviews with providers and stakeholders.

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

We set out thoughts on directions for the future to start/continue addressing the problems currently faced, but note that ongoing work and engagement is required to test and explore the options with clinicians and stakeholders. It is worth noting that much of the Southern Primary and Community Care Strategy remains relevant today, as we move into the new health system, but appears to have lost momentum.

Ongoing work will be required to model the potential impact of new models. We pose some initial scenarios to provoke the conversation. There is always a process of iteratively testing modified demand scenarios with clinical groups in the absence of solid data and evidence.

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.

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	

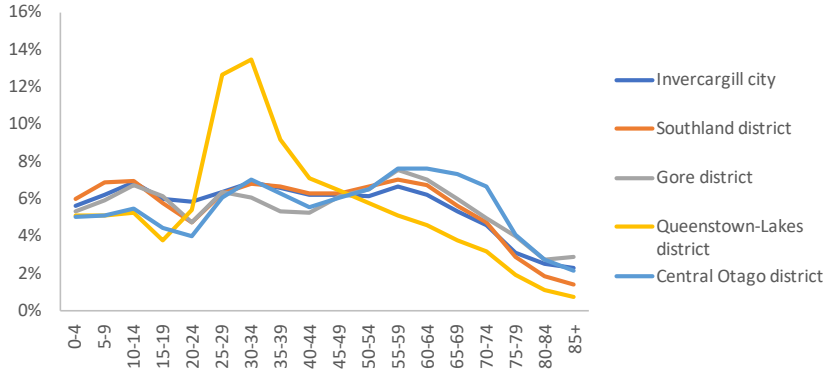
2. The current population of Southland

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

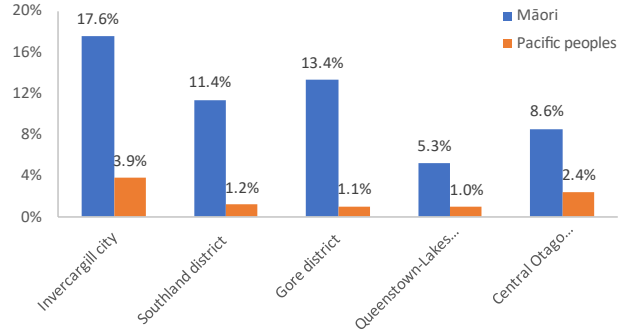


Source: Statistics New Zealand

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.

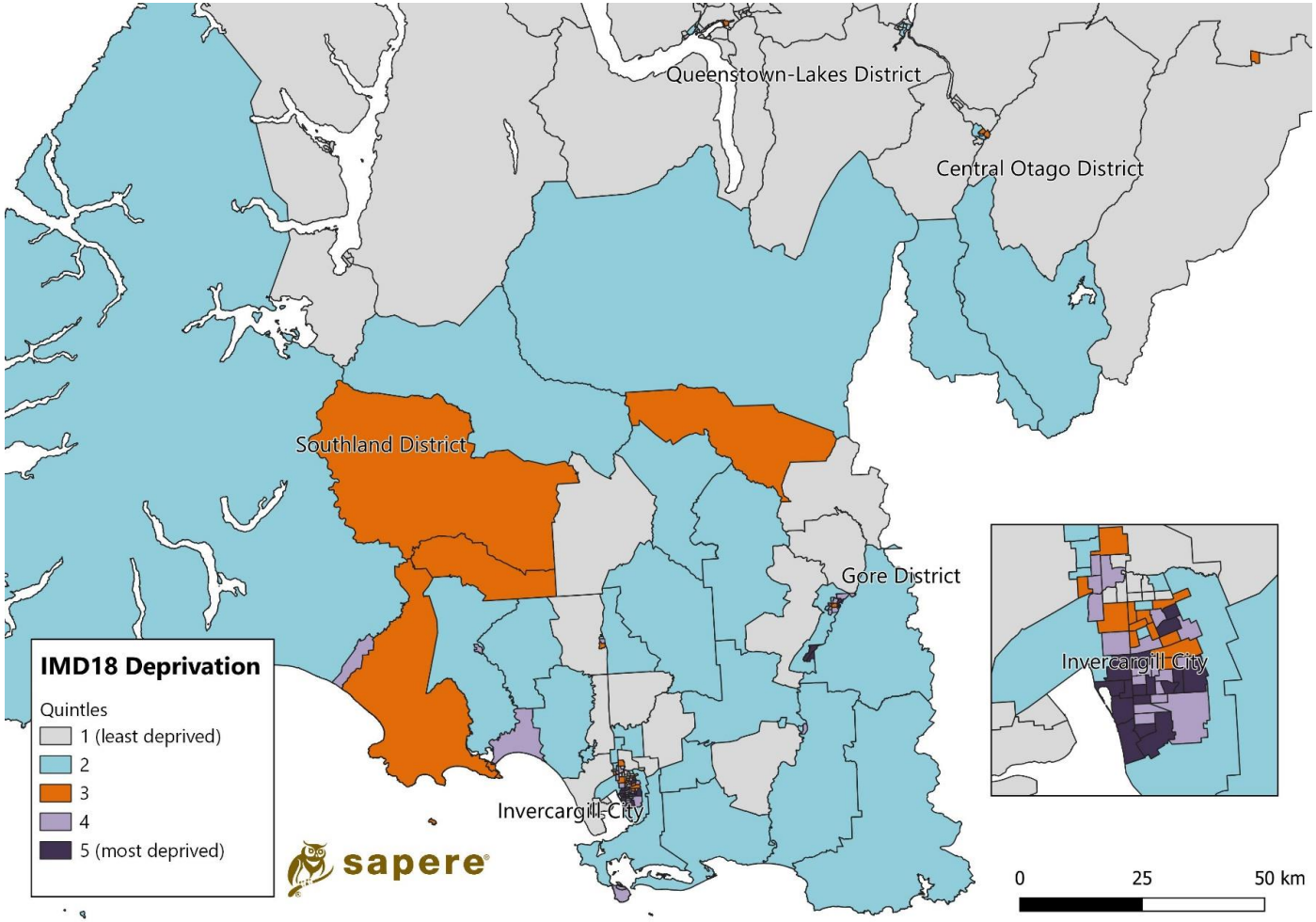
Figure 2 Proportion Māori and Pacific peoples by territorial authority, 2018



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

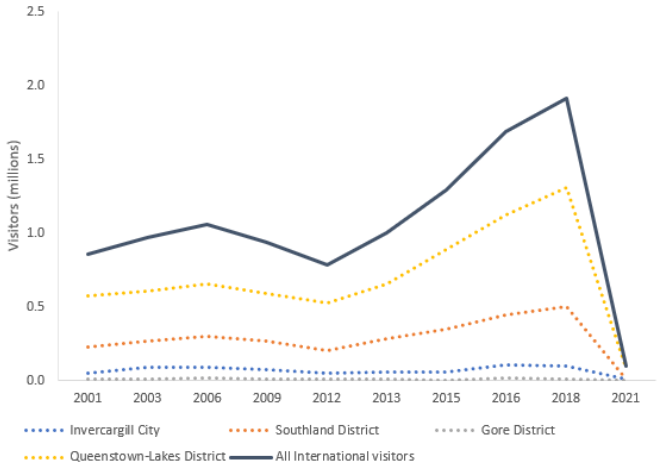
The IMD measures deprivation at the neighbourhood level in custom-designed data zones (average pop of 761).

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).

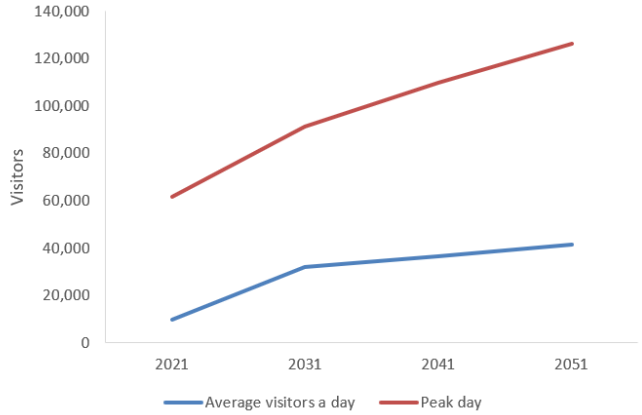
2.2 Visitor population

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. The future population of Southland

Table 3 Projected population

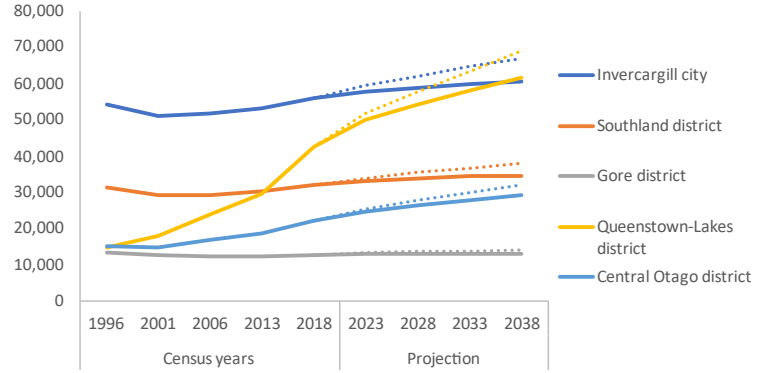
TLA	2023	2038	15-year growth
Invercargill	57,740	60,540	5%
Southland	33,160	34,600	4%
Gore	12,860	12,850	0%
Queenstown-Lakes	50,070	61,480	23%
Q-L high		68,840	37%
Sub-total	**153,830**	**169,470**	**10%**
With Q-L high series		**176,830**	**15%**
Central Otago	24,760	29,210	18%
CO high		31,900	29%
Total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

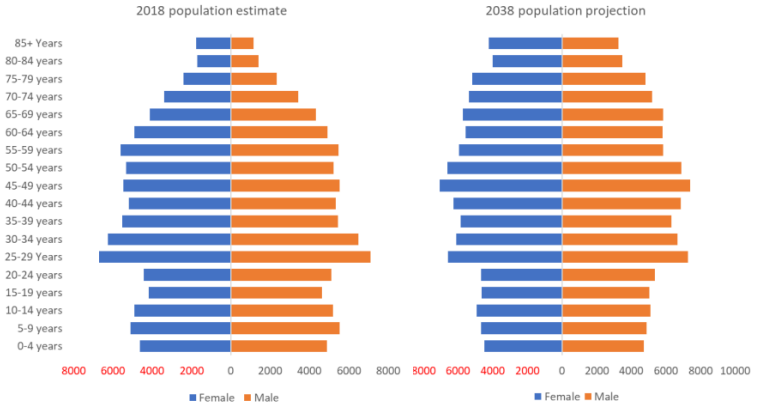
- The population in the total area is projected to grow to at least 169,470 (excluding Central Otago) and 198,680 (including)—a 10–11% increase.
- The high series may be a better planning assumption for Queenstown-Lakes and Central Otago. This would take the 2038 population to 176,830 (excluding Central 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

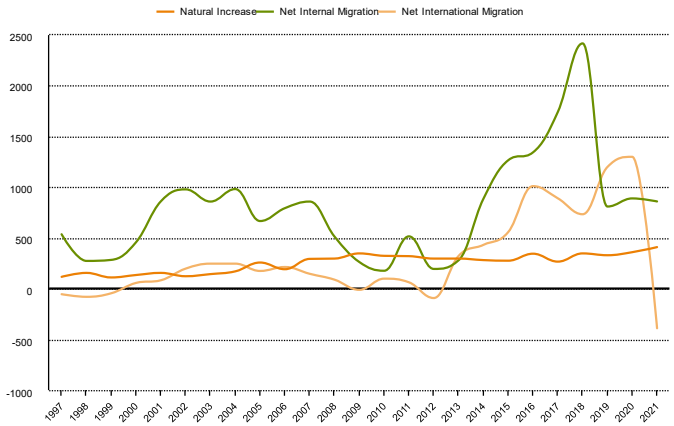
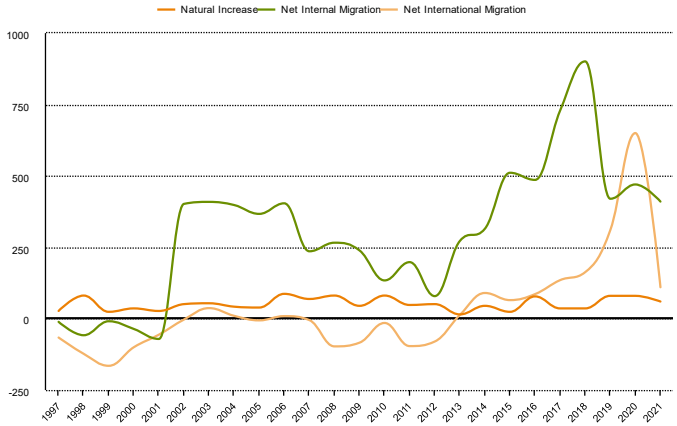


Figure 9 Population source of Central Otago District 1997–2021

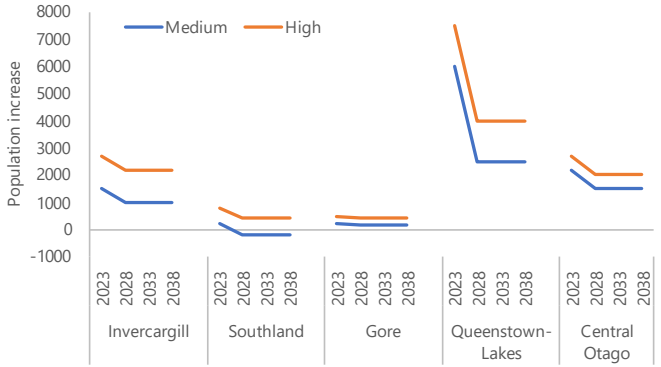


Source: Infometrics Regional Economic Profiles

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



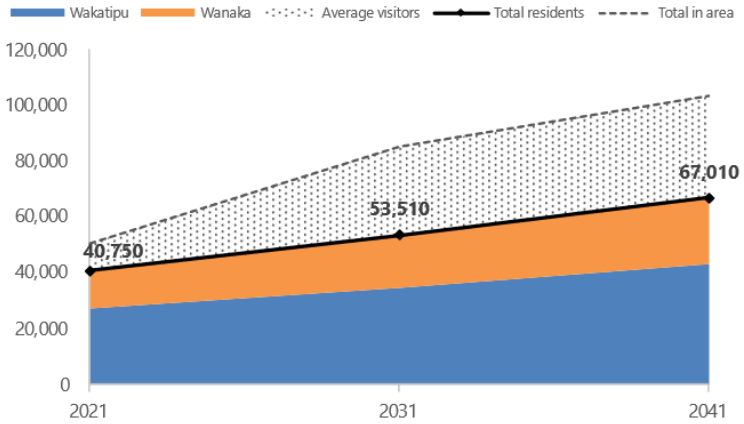
12.1

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



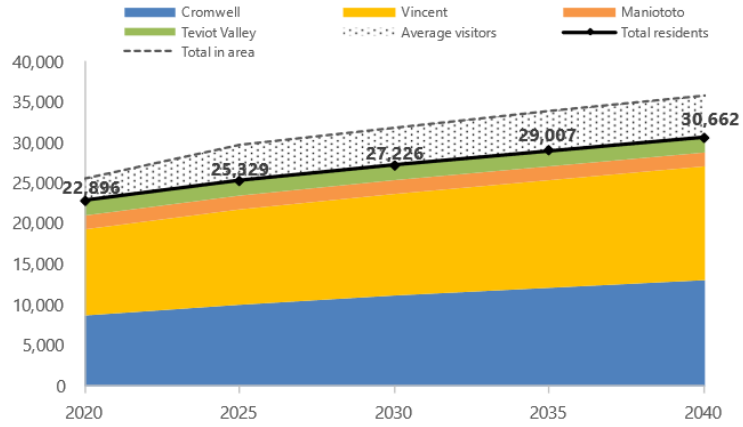
Source: Queenstown-Lakes District Council (Utility Ltd)

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—now and into the future

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 resident Māori population by territorial authority

TLA	2018	%
Invercargill	9,860	54%
Southland	3,620	20%
Gore	1,720	10%
Queenstown-Lakes	2,240	15%
Sub-total	**17,440**	**100%**
Central Otago	1,910	
Total	**19,350**	

Source: Statistics New Zealand

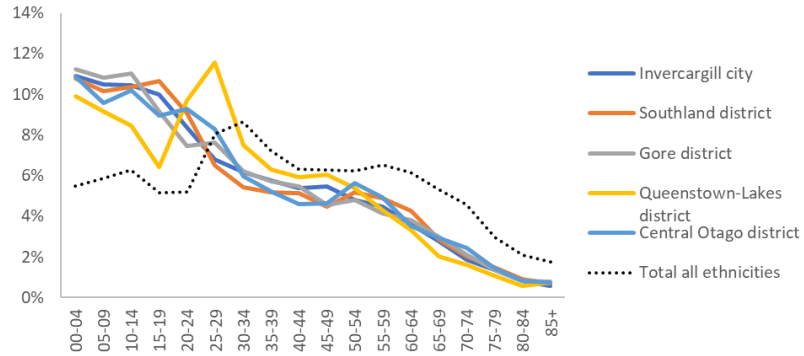
Table 5 Projected Māori population

TLA	2023	2038	15-year growth
Invercargill	11,300	14,050	24%
Southland	4,160	5,010	20%
Gore	2,020	2,500	24%
Queenstown-Lakes	2,550	3,080	21%
Sub-total	**20,030**	**24,640**	**23%**
Central Otago	2,180	2,700	24%
Total	**22,210**	**27,340**	**23%**

Source: Statistics New Zealand

Figure 13 Māori age distribution by territorial authority

add



Key points about the Māori 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 (65+ years) is smaller compared to the total population, however the older Māori population is projected to increase strongly—doubling in Invercargill, Southland and Gore over the next 15 years).
- The Māori population is projected to experience strong growth over the next 15 years (24% growth for Māori living in Invercargill and Gore).

12.1

5. Population growth and ageing will impact demand for clinical services

Method for baseline 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.

Clinical services planning is an ongoing process. Work will continue to model the potential impact of system and service improvements as they become more developed through further engagement.

Under a status quo demographic projection, inpatient discharges would grow over 20 percent by 2038. Discharge growth is outpaced by growth in caseweights (CWDs)—representing increasing complexity and resource consumption—and outpatient contacts, which are in turn outpaced by growth in bed nights—because older people who have longer length of stay in hospital represent a greater proportion of inpatient cases.

Primary care will experience similar demand pressure due to demographic change, with consultation volumes steadily increasing over the next 15 years. Consultations for people aged 65–84 years will increase by over 50 percent and consultations for people aged 85+ will more than double. This increases the time spent both with patients and on follow-up.

Figure 14 Southland Hospital projected volume growth (status quo)

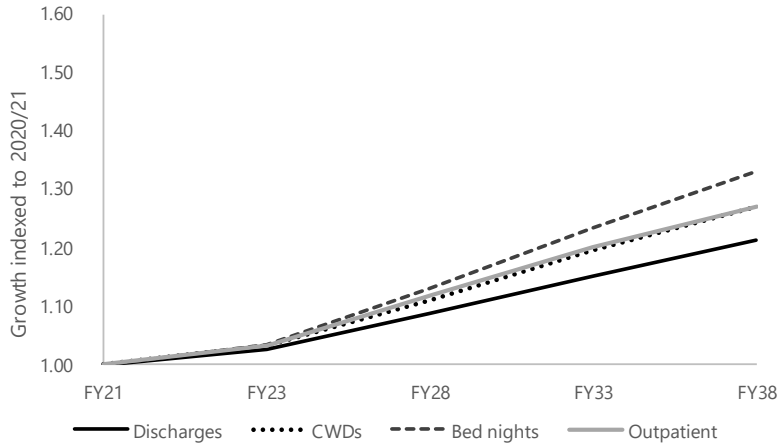
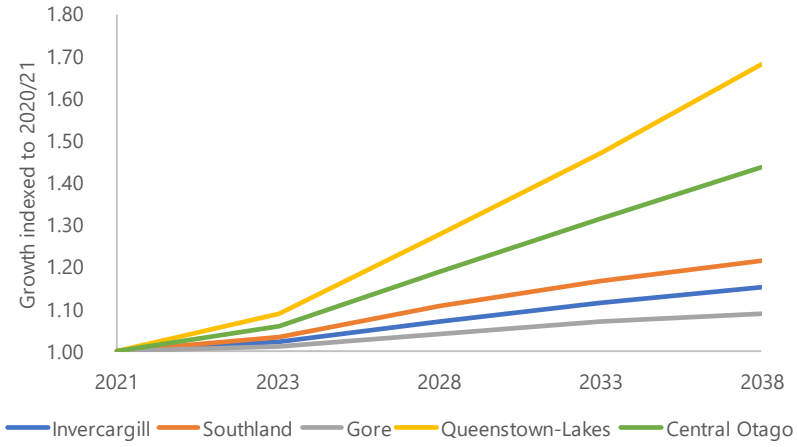


Figure 15 Southland general practice projected consult growth by practice location



Most inpatient activity for Invercargill and Southland district will be at Southland Hospital. Around half of 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 16 Proportion of hospital discharges by facility, 2038 projected

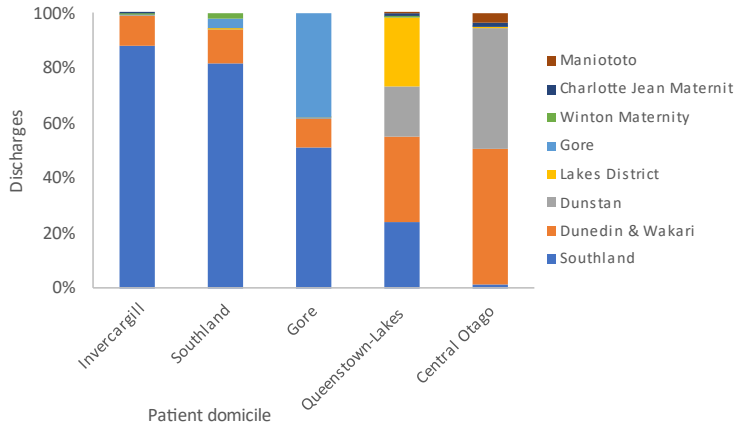


Figure 17 Southland Hospital projected discharge growth by patient domicile

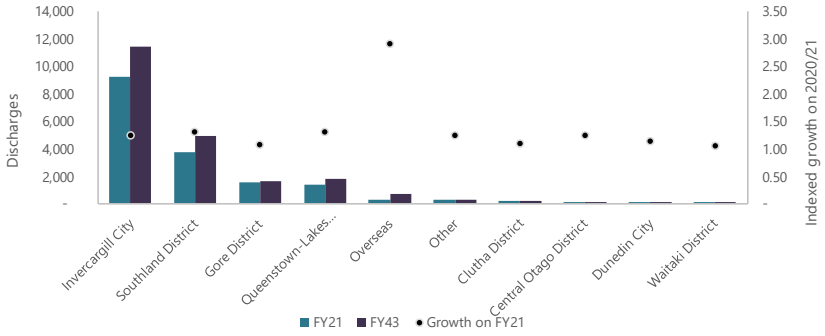


Figure 18 Southland hospital projected discharge growth by service

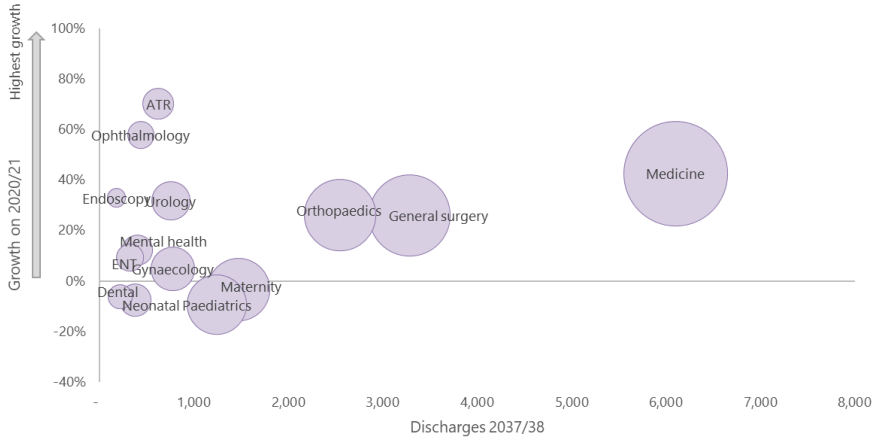
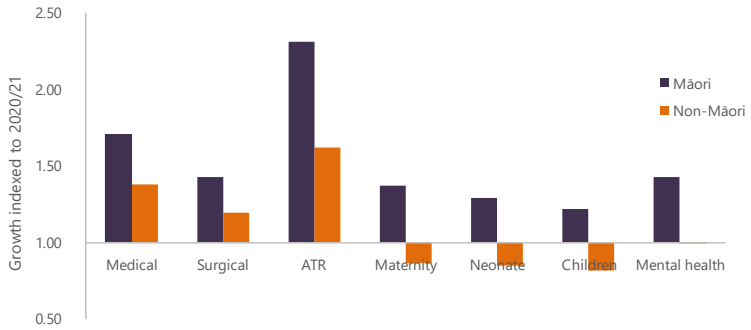


Figure 19 Southland Hospital 2038 discharge growth on 2020/21 by ethnicity



12.1

6. Material challenges facing clinical services

There are numerous issues facing the DHB across several locations, in several ways. These issues compound and materially constrain planned care – there is a higher level of disability before getting orthopaedic surgery, services are not getting to non-malignant general surgeries, gynaecological waitlists blow out, and there is more pressure on primary care as it manages issues that could otherwise be dealt with in hospital services. Inequities persist while the system is stuck in crisis mode.

In the background, these issues are amplified by two aspects of health service demand:

- Growth in complexity across all services. Primary and hospital care services are seeing a growth in complexity and ageing – impacting all services, e.g., complexity of birthing due to obesity, over 90s in medical wards, the Emergency Department (ED) dealing with comorbid patients with multiple medicines and complex social impacts, more complex and time consuming surgeries, paediatricians dealing with increasing mental health problems and conditions that were rarer in the past.
- Visitors and trauma. Visitor populations impact in this region generally through acute trauma. This acute trauma load means a greater number of acute calls making an elective schedule more difficult to sustain than otherwise.

6.1 Workforce issues are critical right now

The first and most prominent is some key aspects of the workforce. Workforce issues have worsened across DHBs with COVID-19, but a number of interviewees observed staff shortages in Southland prior to COVID-19. The workforces presenting as the most under pressure include nursing, midwifery, allied (physiotherapists, sonographers, anaesthetic technicians, psychology).

The absence of some or all of these workforces means the hospital in particular is becoming increasingly inefficient with elective lists cancelled because of a lack of nurses and underpowered services such as rehabilitation.

The Senior Medical Officer (SMO) workforce is under benchmarks in some areas (e.g., obstetrics and gynaecology, radiology) with ongoing recruitment challenges and not enough geriatricians for the ageing population.

6.2 Primary and acute medical care is under stress

A number of elements of primary care come together to bring about a great deal of stress, most clearly seen in Southland Hospital's ED. The first elements start with primary care:

- Primary care is ageing as are its client populations. Enrolled patients can find it difficult to access primary care and, if presenting with a number of issues, may need to set up a series of consultations with one issue being dealt with in each consultation.
- General practice has not been able to enrol new patients for some time, meaning there is now a sizeable unenrolled population.
- Stakeholders report poor access to primary care has become systemic meaning patients tend to put up with their condition worsening more than is optimal.

Urgent care is very limited, expensive and is a very traditional model. Urgent care as it is now, is not seen as much of an option by many Southland stakeholders meaning primary care appropriate work ends up at the ED.

The ED is over-run, meaning, at times, the waiting times could be well beyond what is felt to be clinically acceptable. These ED consultations can be

time consuming as patients are arriving sicker, with less primary care input than is optimal.

Figure 20 Proportion of ED patients seen within clinically recommended time

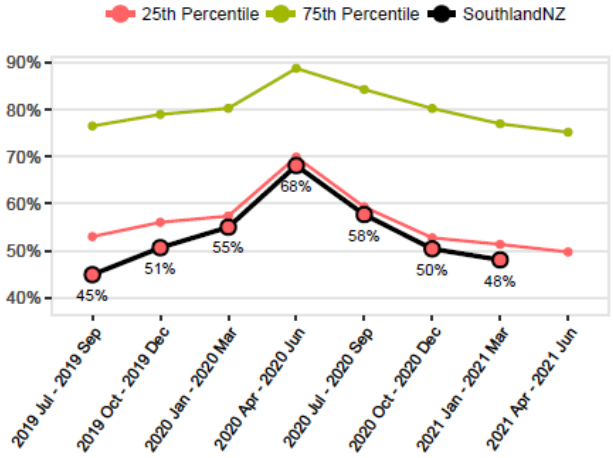
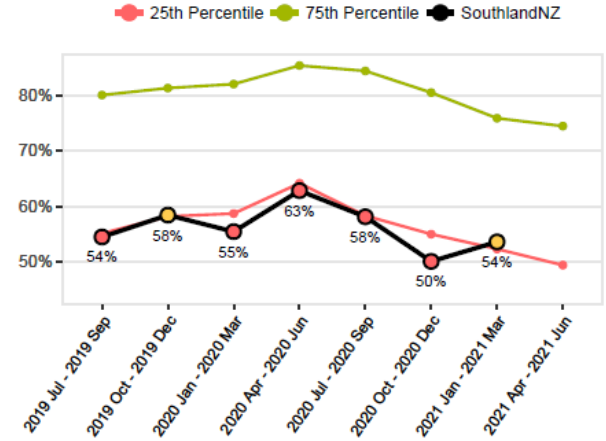


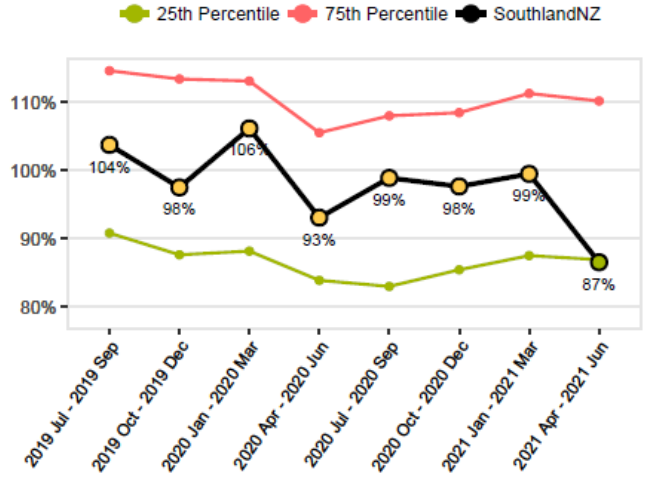
Figure 21 ED waiting times within 6 hours – admitted patients only



Source: Health Roundtable

Patients often can't be admitted on to medical wards because those wards are full, or because there aren't sufficient resourced beds (meaning there are beds but not nurses). Despite challenges, average length of stay in Southland Hospital has compared well with peers— in the quarter ended June 2021, in the top quartile of peer hospitals

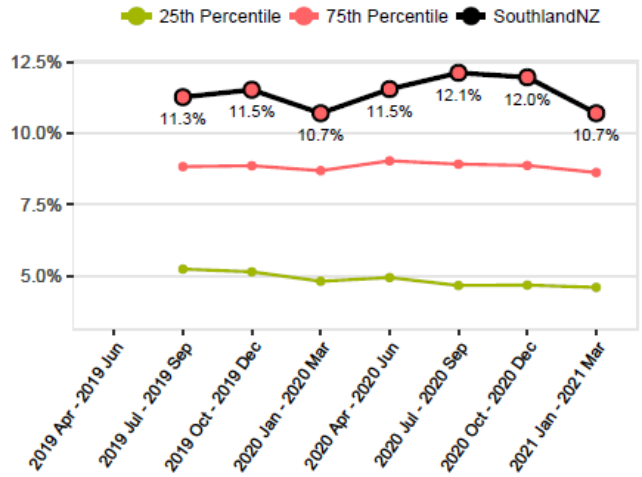
Figure 22 Southland Hospital relative stay index compared to peer group



Source: Health Roundtable

The medical service takes pride in managing it but average length of stay will become more and more challenging. There is difficulty discharging patients to well-resourced community provision. Aged residential care capacity is experiencing a shortage of clinical staff, and home and community support services are limited in rural areas. The challenges community providers face may partly explain an unfavourable readmission rate. Readmissions are higher than expected with one in ten patients being readmitted.

Figure 23 28-day readmission rate



Source: Health Roundtable

6.3 Tier two issues

The first two issues are very material issues and need to be addressed immediately and with some vigour. There are other issues both contributing to the current situation and needing to be addressed in any future service configurations. The second-tier issues we identified are below.

Health of older persons care is fragile and reactive

As noted, aged residential care and home based support providers are limited in what they can provide, often due to workforce issues and in rural areas. The community rehabilitation team has very little resource and is unable to offer support outside of a constrained area. The minimal geriatrician resource is not sufficient to be involved in proactive management of cohorts of older people, and physicians are unable to get out of the hospital and be involved in more multi-disciplinary care in the community.

A lack of physical space

Where there are clinicians, there may not be space. There is a lack of space in Southland Hospital – issues have been identified around ED (which is being made larger), outpatient clinics are lacking, clinic space can be too small, there are too few medical beds, radiology and allied health spaces are inadequate. There are plans to add theatre capacity however the workforce needs to be available to support it.

There is a lack of available clinic rooms in rural hospitals meaning visiting services struggle to find space. Several services indicated they would offer remote services if there were space for them but so far the space that is available is fully utilised.

Inconsistency in rural and local provision

The Southland region is vast and requires patients and families to travel significant distances / time to access clinical services.

Rural provision is seen as very important to support care closer to home, particularly for older people, avoiding the need for travel (even more difficult in winter) and ensuring family and carers can be involved in plans.

Rural hospitals can ease the demand for acute medical services in Invercargill, however they are dependent on a consistent and well-trained workforce, with support from the larger centre. Stakeholders noted there are good rural medicine services in Dunstan and Lakes however Gore appears to have the most difficulty with recruitment. This means that the level of acuity that can be managed locally is variable over different days and times.

7. Possible directions for the future

The issues identified in both the current state and the forecast of demand need to be looked at together. We set out below a set of tentative directions/themes based on stakeholder interviews and other fact finding, including a desktop scan of contemporary and emerging models of care (see Appendix B for detail and case studies).

We note that these directions are still to be tested and further explored with clinical services and other stakeholders.

Improved flow in acute medical demand

Primary care needs increased capacity and to do this it needs to be provided with greater support. There needs to be:

- greater capacity and triaging for urgent appointments in primary care
- additional capacity, to allow those not enrolled to be enrolled in primary care
- a strong focus on acute care, even if that acute care is based alongside Southland Hospital's ED. That model of care may be through extended hours in primary care or there may be a need to establish a new general practice to expand capacity and attend to other unmet needs, as well as addressing extended hours (see Appendix B for consideration of urgent care / after hours).

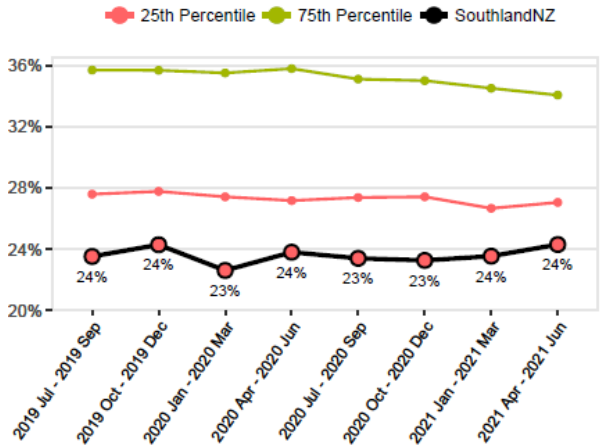
Within the hospital:

- consider introducing a medical assessment and planning unit, that takes some of the strain off ED, and allows patients to be fully assessed and possibly discharged to home.
- focus strongly on social welfare and other interventions that may speed release of patients from the ward to home or to other care
- develop rural hospitals to better support flow—reducing demand for acute services at Southland Hospital, and enabling outflow.

There would be an opportunity to be more proactive in managing known disease, e.g., through use of clinical nurse specialists, and proactive management of complex, older patients. Particularly within a locality network, build on Kaupapa Māori models of care to address health issues in the wider context for the person and whānau.

In addition to that package of managing acute medical demand, there might be some opportunity to ease the pressure on medical beds and consequently on ED, by moving discharges earlier.

Figure 24 Proportion of discharges before noon



Source: Health Roundtable

12.1

Capacity to improve access to planned care

Surgical services would benefit from better management of acute medical care as, currently, medical patients are spilling over into surgical beds. However, beyond this, surgical services need to be reset at a volume of acute and elective capacity which is in balance. Currently, access is set at too high a level meaning patients are sicker and/or more disabled when operated on, and more likely to become troublesome acute cases rather than planned elective cases. Determining the 'right' level of planned intervention is notoriously difficult and national benchmarks often do not meet population need.

The most pressing priority appears to be to address the issues with medical beds, nursing and theatre staff; so that the existing surgeons and theatres can be fully utilised. From there, further addressing unmet need through increased access to planned care will, over time, require increasing clinic space, theatre capacity, beds and surgeon workforce.

Excellence in aged care

We understand there are just two geriatricians. The capacity of SMOs in the aged care service, together with the gaps in allied health, need to be addressed to be able to provide active, partnered care with primary care and patients in community care facilities.

The rural hospitals play a special role in aged care often being a step down from Southland Hospital before being transferred home.

We see across New Zealand an increase in demand for dementia and other memory services as well as a need to higher care beds. Keeping this system in balance and managing increasingly frail patients through their life journeys will be challenging for this dispersed region. Given its population ageing, it is an area to be undertaken well.

There are a number of examples of multidisciplinary health of older persons teams aiming to integrate across ED, hospital and community settings. Appendix B includes an example from Waitematā.

Address facilities and workforce strategically

Southland Hospital needs more ancillary space around it and the clinical service needs both now and in the near future are clear. There needs to be an organised masterplan and a formal, thirty-year rolling capital plan. That capital plan needs to deal with adequate sizing of Southland's clinical facilities including ensuring there is adequate private investment in, for instance, integrated health centres and hubs, rural hospital facilities, etc, even if it is not Health NZ capital.

Within that time horizon, also, there needs to be consideration of a strengthening services in the Central Otago area and possibly implementing a new secondary care facility. This may start with a virtual hub of services and likely will progress into progressively comprehensive services, and possibly a district level secondary care facility. The timeframe for this is likely thirty to forty years but land-banking could be sensible.

In the near term, there needs to be a detailed five-year plan to expand access to clinic spaces in rural hospitals and provide for outpatient activity greater than is possible in existing facilities.

Workforce challenges have been greater in Invercargill than we have seen in most of New Zealand. These longstanding issues require a long-term, strategic focus. The Education Centre is a significant asset for Southland, used to deliver the hospital's training and education schedule for its nursing, medical and allied health staff, as well as students. The joint DHB and University Learning and Research Centre provides an important connection between Health and Education. Southland Hospital is part of the Interprofessional education initiative in collaboration with the Southern Institute of Technology. In light of the difficulty attracting people to Southland, training locals in a range of disciplines and incentivising them to stay will be important for the future of Southland Hospital.

Place based planning and locality management

The new health sector has signalled an intent to work at a very local level to better integrate community and primary care, with social services NGOs, justice agencies and with the education system. This is a long-term strategy but well worth the effort. These place based planning efforts are also instrumental in leveraging consumer and whānau, to empower communities to help strengthen holistic 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 (see Appendix B).

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). Appendix B provides a rural case study.

Using technology

Southland has more motivation than most DHBs to make good use of technology and technologically enhanced models of care due to its travel times and cold winters. Artificial intelligence could be used to assist primary care in managing chronic care and reducing the workload on general practice, shared care platforms reduce co-ordination issues particular in aged care, remote specialist assessments or follow-ups reduce the travel burden on patients. Technology is part of all aspects of Southland's strategic documents. Appendix B includes case studies for telehealth and increasing use of digital.

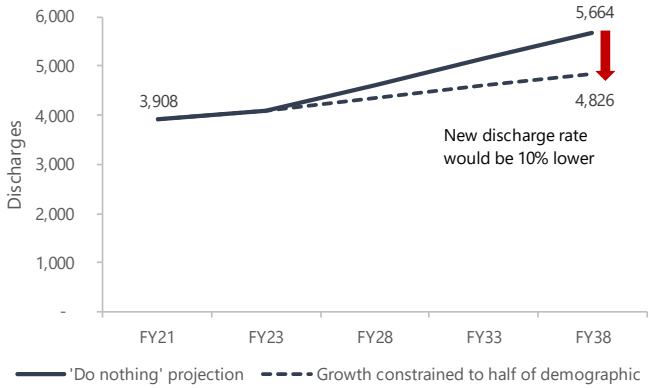
7.1 The potential impact of new models requires ongoing consideration

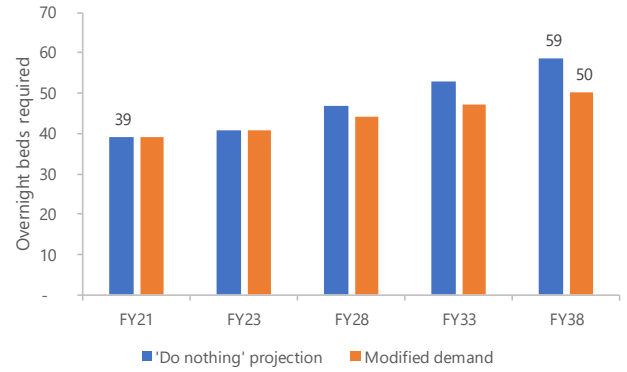
We have highlighted the unsustainable demand pressures on Southland Hospital (and other services) if we don't change the way we do things. The goal is to constrain the growth in acute hospital services, while improving access to planned care and delivering some of that ambulatory care in alternative settings closer to home. In the scenarios below, we set out some possible assumptions for the impact of different strategies. Note that the analysis is demonstrative only and further discussion with clinical groups will generate alternative assumptions/scenarios to test, along with the uplift to be applied to planned surgery (likely at least 10 percent).

Minimising growth in acute medical admissions through primary and community strategies

Scenario: Instead of the full demographic growth, we constrain that to just 50% of demographic growth each year from 2023. Projected ALOS remains the same. Maintaining the projected ALOS (which increase with ageing) will require continued effort as short stay cases are likely to be avoided.

Figure 25 Impact of acute medical admission scenario on discharges and beds

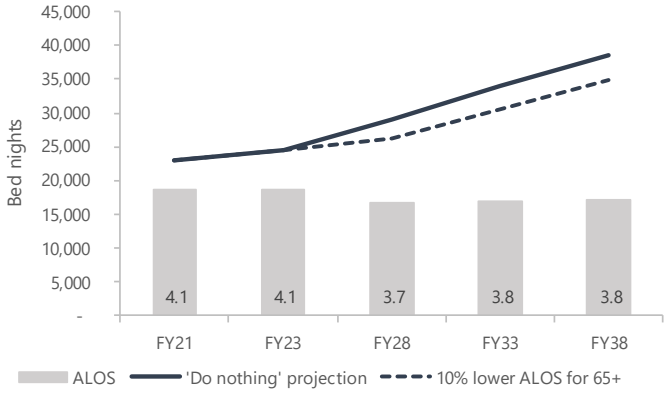


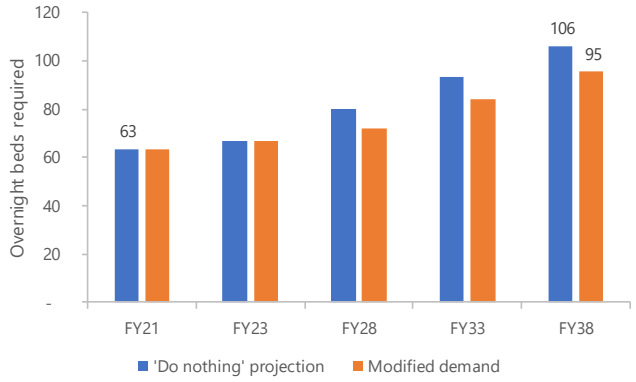


Improving hospital outflow for older patients

Scenario: 10 percent improvement in length of stay for all patients aged 65+ years. Admissions remain the same but ALOS is 10% lower than it otherwise would be.

Figure 26 Impact of older persons length of stay scenario on bed nights and beds





8. Detailed statements of service issues

This final chapter provides more detailed statements of service issues in different specialties or areas. It reflects the feedback shared with us through numerous meetings and interviews with providers and other stakeholders.

8.1 Views from iwi and Māori providers

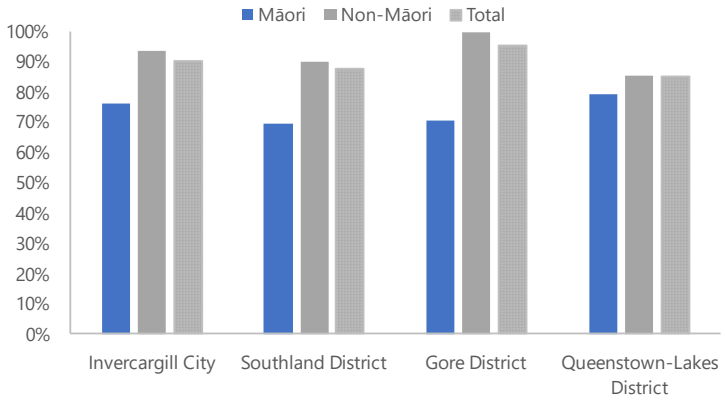
- The Southern Strategic Briefing highlighted the need to reorient to Iwi Māori leadership; across the system, but especially in localities. Strategies and resources within localities should be deployed to address Māori health improvement and equity as a matter of priority.
- An Iwi-PHO partnership is looking to develop a new model and capacity to service unmet need (responding to the unenrolled population).
- There are other opportunities to build on the unique strengths and assets of local Rūnaka to develop hubs for health and social wellbeing, and respond to issues of unmet need, experience and service sustainability.
- Rūnaka representatives and 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.
- Rūnaka representatives spoke about patient and whānau experience: the ability to have whānau present and a key part of the patient journey, lack of cultural responsiveness and the human impact that even small steps can make, the ability to provide contemporary feedback on clinical services, and the importance of ensuring we make health easier to understand (knowing what is going to happen and why).
- 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.

8.2 General practice under major pressure

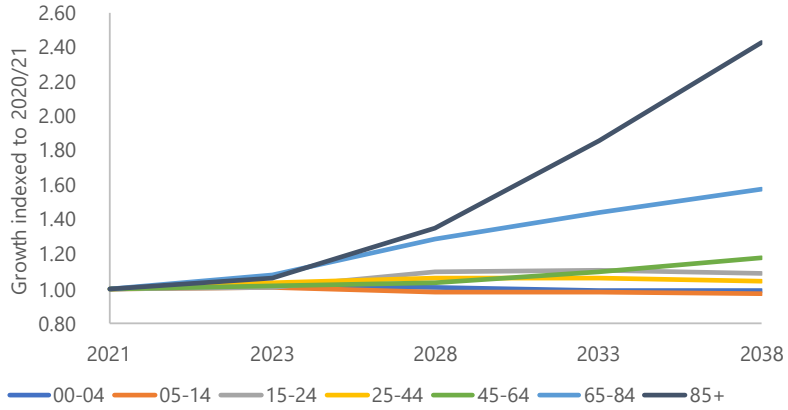
- There are two major issues with regard to general practice—the difficulty recruiting GPs and the increasing volume and complexity that general practice is managing with the same level of resource.
- GPs we have heard from to date talked about the intrinsic rewards of general practice, but that it is 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.

Figure 27 Proportion of population enrolled in a WellSouth practice, April 2022



Source: Enrolled population from WellSouth (April 2022), estimated population from Stats NZ, Sapere calculation

Figure 28 General practice projected consultation growth on 2020/21 by age group



- 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.

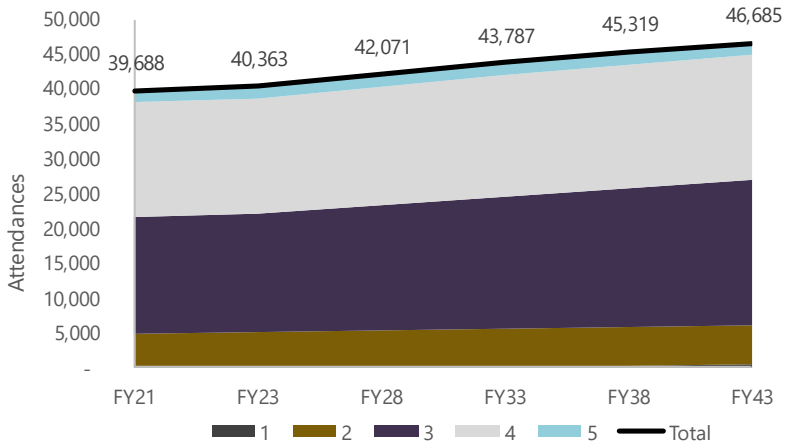
8.3 Emergency Department

- 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 29 Demographic projection of Southland Hospital ED attendances



12.1

8.4 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 30 Southland Hospital medicine inpatient volume growth on 2020/21

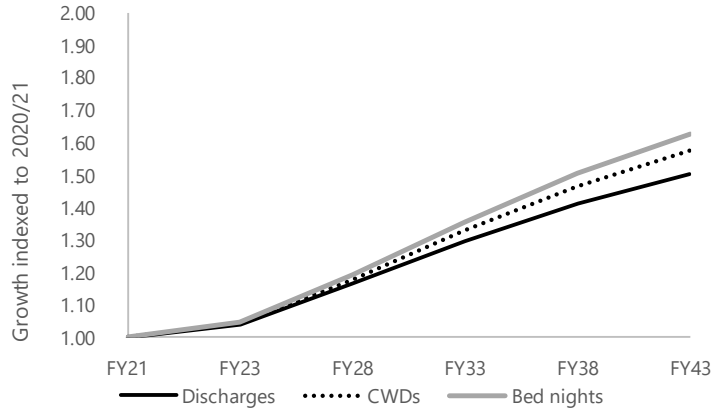
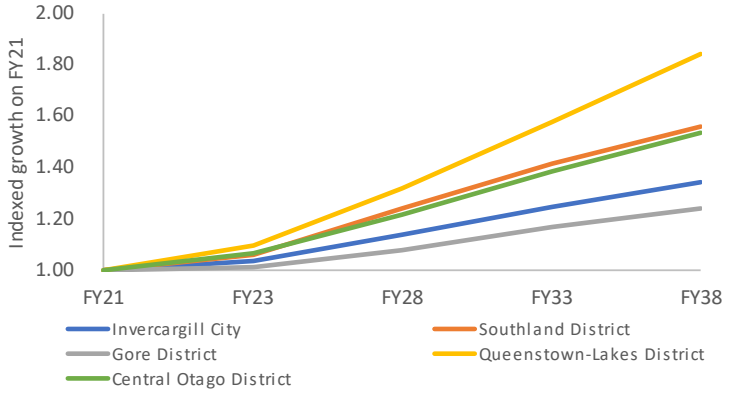


Figure 31 Medical discharge growth on 2020/21 by patient domicile (any hospital)



8.5 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 32 Southland Hospital AT&R inpatient volume growth over 2020/21

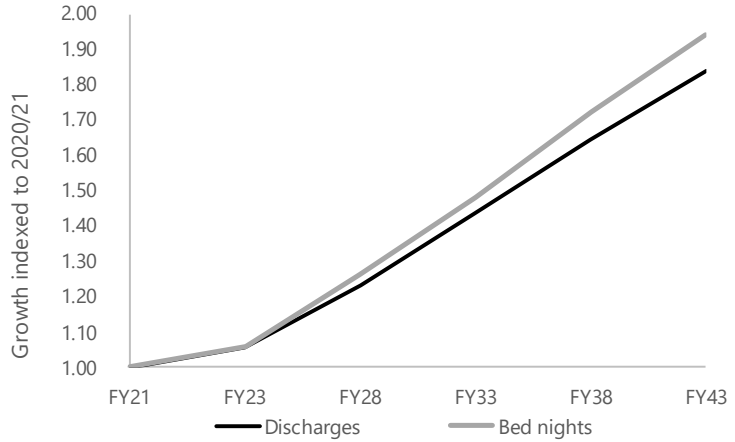
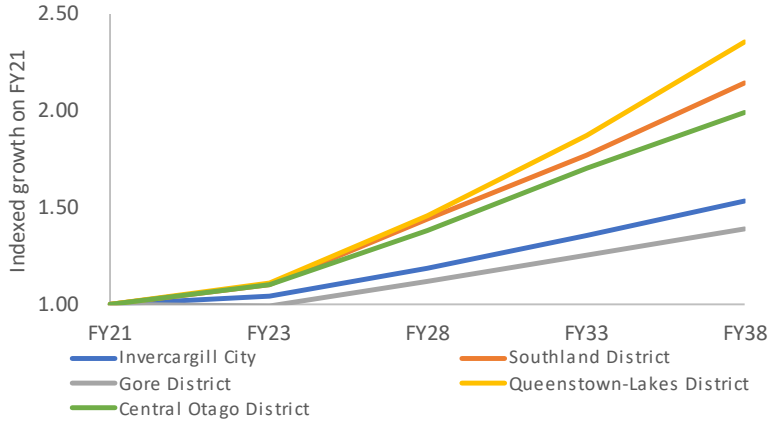


Figure 33 AT&R discharge growth on 2020/21, by patient domicile (any hospital)



12.1

8.6 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. A role delineation model would clarify what work is done where. There is currently a fragile Southland 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.
- Like other services, constraints in aged residential care mean patients can't be released into a rest home from midday Friday to Monday afternoon.

Figure 34 Southland Hospital general surgery inpatient growth on 2020/21

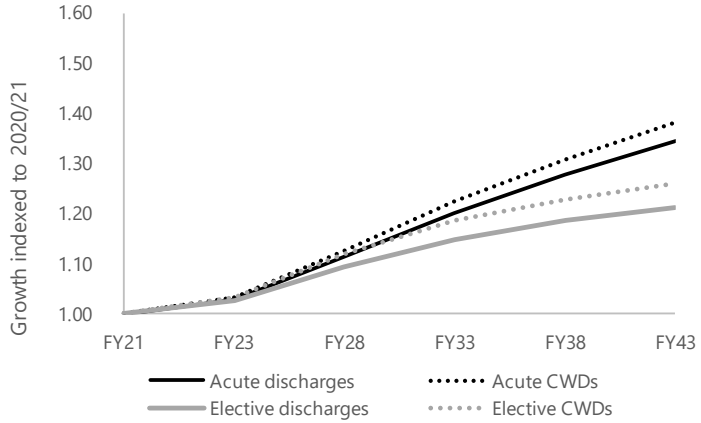
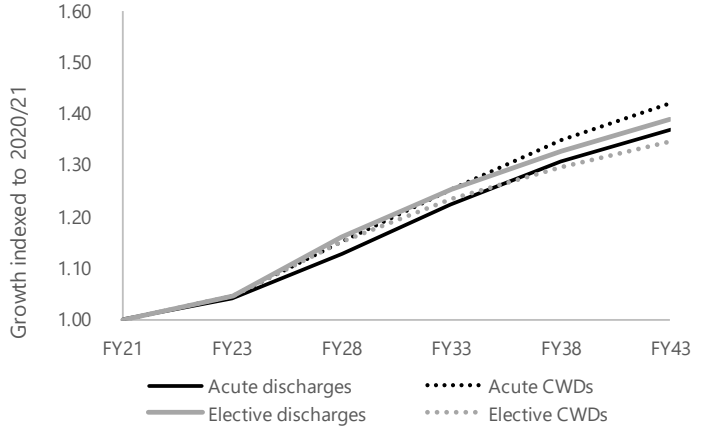


Figure 35 Southland Hospital urology inpatient growth on 2020/21



8.7 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 metres. For orthopaedic services, in addition to nurses and 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.
- 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.
- Comparison of orthopaedic work at Southland Hospital with other peer hospitals shows that Southland has a lower ratio of elective work to acute compared to most others, and the highest proportion of acute accident cases.

Figure 36 Southland Hospital orthopaedic inpatient growth on 2020/21

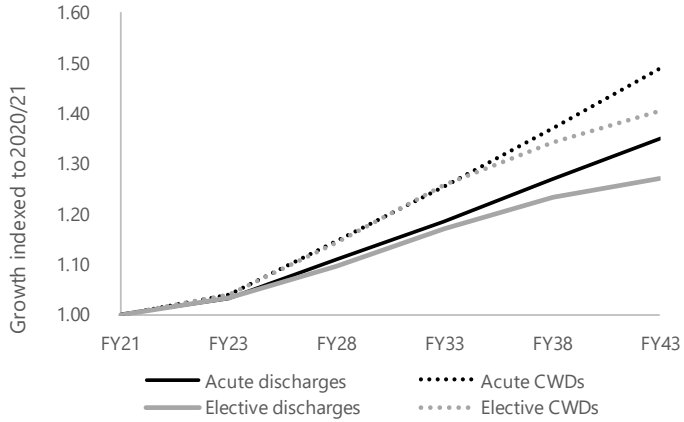
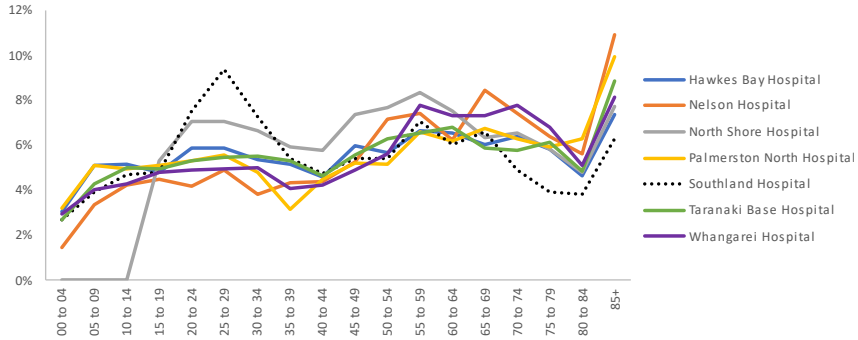


Figure 37 Age profile of acute orthopaedic inpatients 2018/19 to 2020/21



Source: National Minimum Data Set, Ministry of Health

12.1

8.8 Women's health

- Recruitment is an ongoing exercise for obstetrics and gynaecology consultants and the service hires internationally trained specialists. The Association of Salaried Medical Specialists considers the requirement to be higher than established FTE.
- Women's Health has established a new clinical nurse specialist role to help with some of the current issues, undertaking some of the outpatient work that a consultant doesn't necessarily need to do.
- Complexity has increased in both gynaecology and obstetrics and the service is seeing population shifts and the impact of the increasing Central Lakes population.
- Women's Health is using a clinic in town to free up space at Southland Hospital.

Maternity

- 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 obstetrics reports an increase in referrals from Wanaka. Increasing age and comorbidities drives up caesarean section rates.
- The biggest issue with transfers from rural facilities is in transport—timeliness and availability of helicopter. Gore is closer and women may arrive by private transport.
- There has been a change in referral flows, with Central Otago women now choosing to come to Southland (they may have a Queenstown-based midwife or like the ability to have a single room in Southland).

Figure 38 Maternity discharge growth by patient domicile

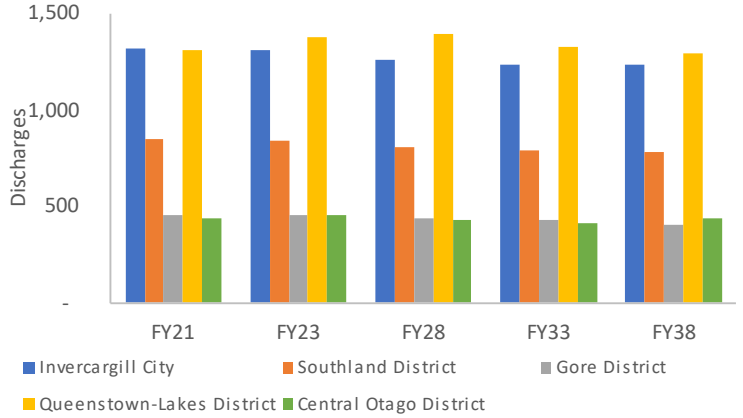
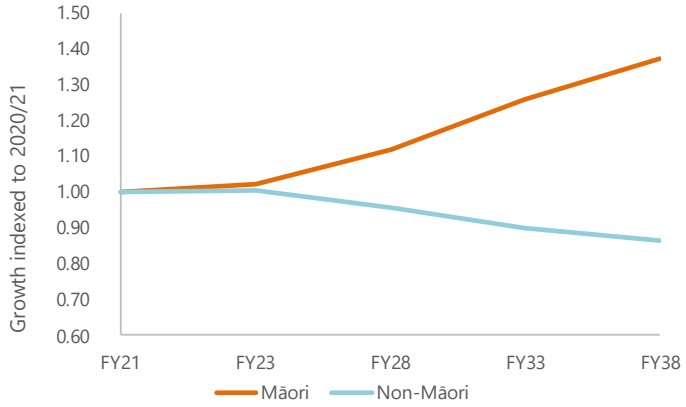


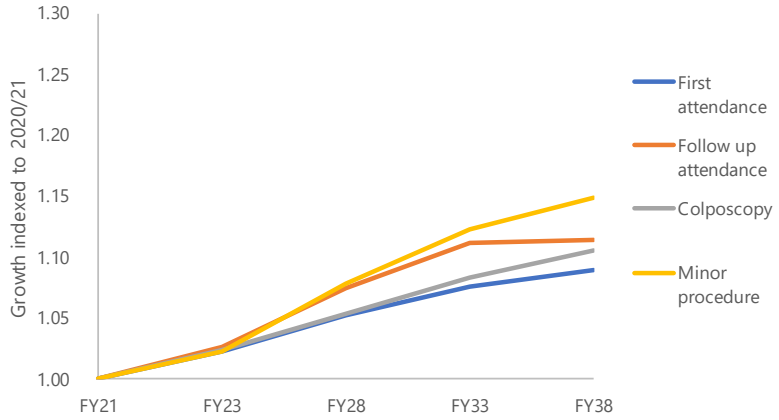
Figure 39 Southland Hospital maternity inpatient growth on 2020/21, ethnicity



Gynaecology

- The service has gotten further behind on first specialist assessments and the waitlist has grown substantially. Some of that increase is related to COVID-19 but the issues existed prior and there are long wait times. There is no clear access criteria.
- 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.
- Health pathways have improved referrals so referrals received have the need for specialist input.
- Additional resourcing in future (some Ministry of Health funded resource is coming) would mean the service would be able to run more clinics if the space were available.
- Issues with access to theatre and ancillary staff impact on the gynaecology service. Obstetrics uses some gynaecology theatre time to do caesareans.

Figure 40 Southland Hospital Gynaecology outpatient growth on 2020/21



12.1

8.9 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.
- 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 41 Southland Hospital paediatric inpatient growth on 2020/21, ethnicity

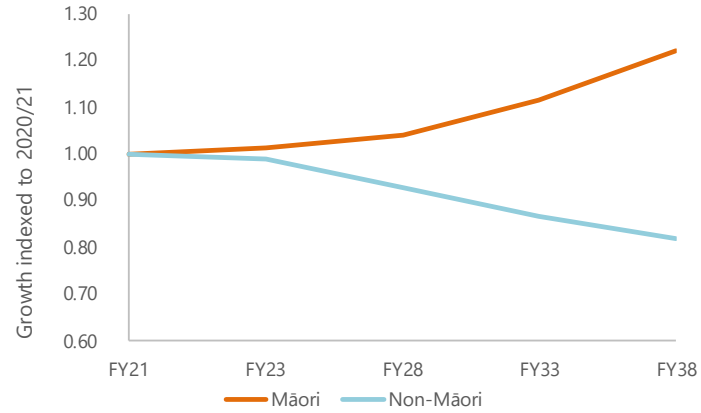
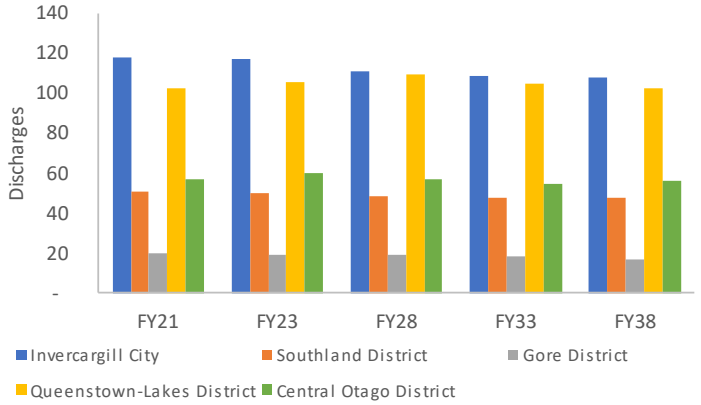


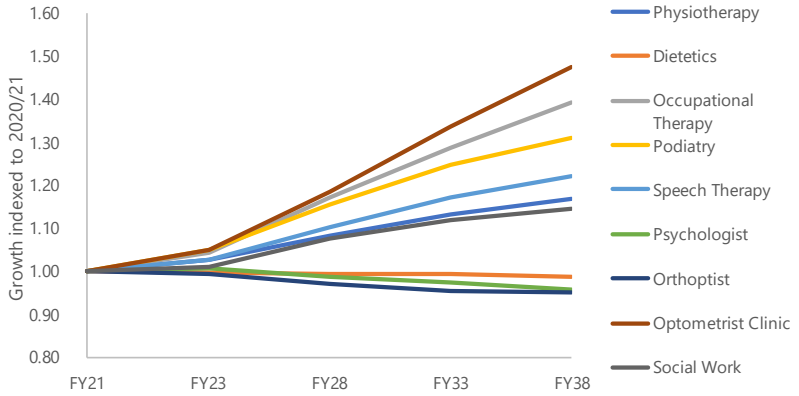
Figure 42 Neonatal discharge growth by patient domicile



8.10 Allied health

- Staff recruitment and retention is currently the biggest issue facing allied health, most specifically felt in Southland physiotherapy, but also turnover in social work, dietetics and to a lesser extent occupational therapy.
- Private providers offering more competitive remuneration packages and attractive hours impact on hospital recruitment.
- New graduates start in Southland, but reportedly often move on to other locations. Allied health professional leadership is thinking about how to incentivise staff to stay in Southland. Support and access to training is available, although it is acknowledged that over the last couple of years it has been more difficult to access.
- Retaining physiotherapy staff is important otherwise problems with senior to junior education arise making it even more difficult to recruit.
- Allied health workforce constraints lead to delays in discharge from hospital and mean patients do not receive the allied health input they need in a timely manner.
- Physiotherapists provide services across inpatient, outpatient and community rehabilitation settings. There is a small team covering inpatient services.
- Historically, allied health has not had a way of measuring acute demand on its service, however there is now a project underway to track this activity.
- More community resource is a priority for the allied health service as community provision is very constrained.
- Outpatient and community services have space problems for the (full complement of) allied health workforce and there are personal workspace issues for therapies staff.
- Allied health professional leadership see a lot of scope for allied health clinicians (if workforce were available) and would like to see initiatives trialled in Southland as well as Dunedin.
- Allied health clinicians working in Lakes Hospital have worked quite independently in the past without too much support, leading to questions around how cover, training and supervision is provided. More recently, Dunstan has been working with Lakes.
- There are shortages of other allied health professionals such as sonographers and anaesthetic technicians that are reported by other services (radiology and surgery) as well as allied health itself. Shortages in theatre ancillary staff can result in delays and list cancellations.

Figure 43 Southland Hospital allied health outpatient growth on 2020/21



12.1

8.11 Radiology

- Like most radiology departments, trends indicate that referrals for complex imaging are increasing steadily, driven not only by hospital volumes but by increasing complexity and technology, new indications and screening/monitoring programmes, etc.
- Diagnostic capability is vital to enable timely access to treatment.
- Community referred work comes to Southland Hospital radiology department (not to private like in some community radiology schemes).
- The radiology service cites its top three issues as: shortage of radiologists, shortage of sonographers (ultrasound), lack of physical space in the department.
- There are three radiologists currently, with budgeted FTE for four. Service volumes have been used to benchmark radiologist FTE (Canterbury tool) and suggest the need for more FTE. Plain film x-ray reporting is outsourced. New indications and scanning mean a need for more radiologists on the floor.
- The on-call roster is unappealing for radiologists compared to other parts of the country (at best it will be one in four).
- The sonography workforce is a big issue, with a drop from four to two sonographers. Consequently there is a long waitlist for ultrasound.
- There are challenges with training of sonography students – with only two ultrasound rooms it is difficult, but only having two sonographers makes it very difficult to take time out to train.
- The medical imaging technologist workforce has doubled over the last decade and the department doesn't have enough space to comfortably accommodate staff.
- The general x-ray area works well however the physical spaces do not work particularly well for CT and MRI.
- A new MRI machine was installed in 2020 with some alterations and additions completed to make the area more useable (although still not ideal).
- The CT scanner is to be replaced and more space will be needed which will impact on office space. The new scanner setup will be functional but again not ideal.
- The radiology department is efficient (e.g. moving to rostered evening and weekend shifts where appropriate and increasing capacity) and performs well on the national CT and MRI wait time performance indicator (scanning most patients within 6 weeks of referral).
- The draft Strategy for Southern Radiology indicates that capacity on the existing CT machine and MRI machine will be exceeded within the next 10 years (CT earlier at around 2024 and MRI sometime after 2028).
- The service is considering options for additional CT provision until utilisation justifies the purchase of a second scanner. Options include using capacity on rural machines (dependent on patients' willingness to travel), arrangements with private, flows back to Dunedin from Clutha. Increased operational hours on the MRI is likely to be required in the near term.
- When new machines are required, the current department does not have the future expansion space to accommodate additional machines and a split in the department would impact on workforce efficiency and cohesion. Scanners should be put side by side to make the best use of staffing and resources.

8.12 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 wide variety of patient issues.
- Queenstown hospital is classified as rural and is run by rural medicine specialists.
- The growing Queenstown population is generating increasing outpatient demand and the supports are limited. The absence of some services such as ENT and ophthalmology exacerbates inequities. Stakeholders tell us there needs to be 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 44 Inpatient discharges for Gore residents by facility

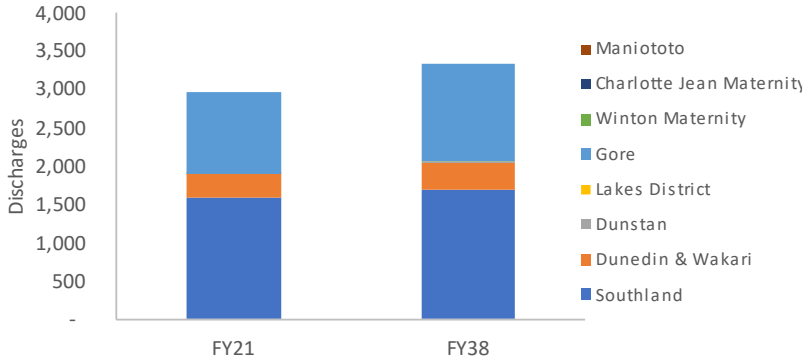
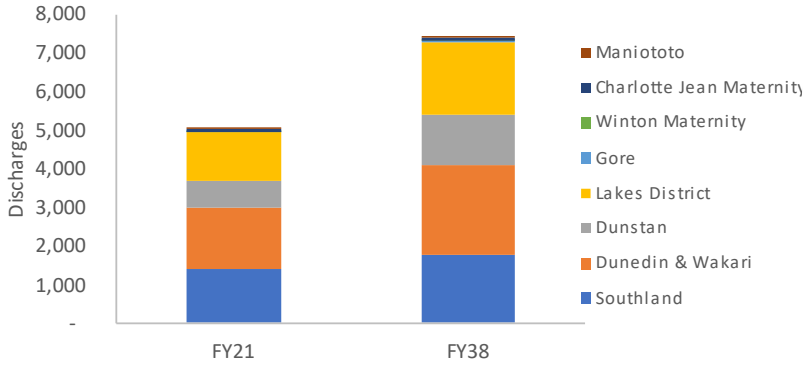


Figure 45 Inpatient discharges for Queenstown-Lakes residents by facility



12.1

8.13 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. Mental health services for young people are not accessible across the region, especially in Southland.
- 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 46 Southland Hospital mental health inpatient growth on 2020/21

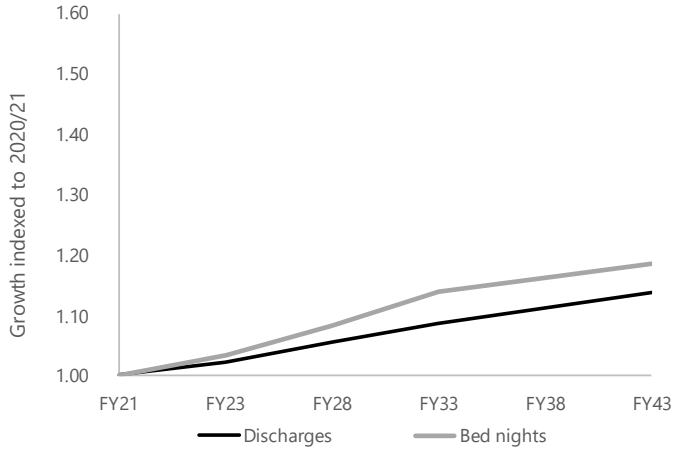
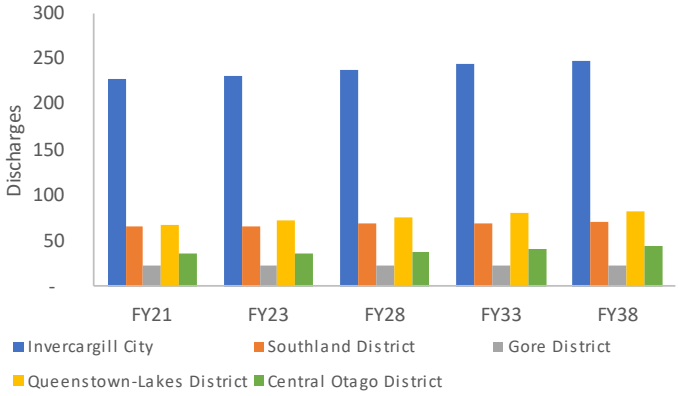
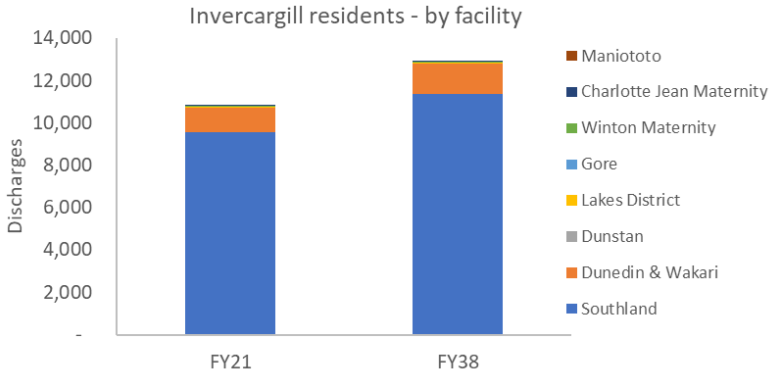
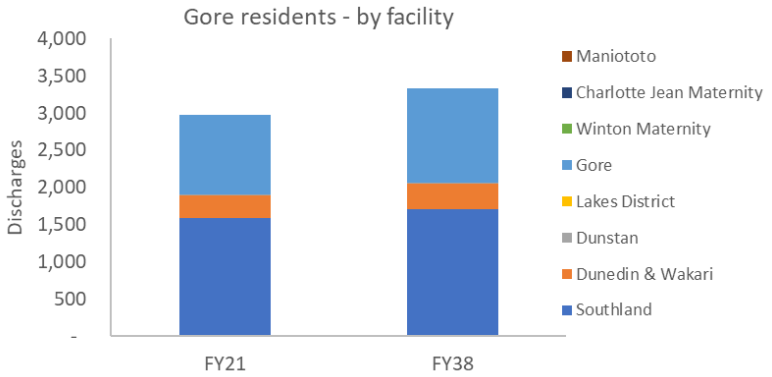


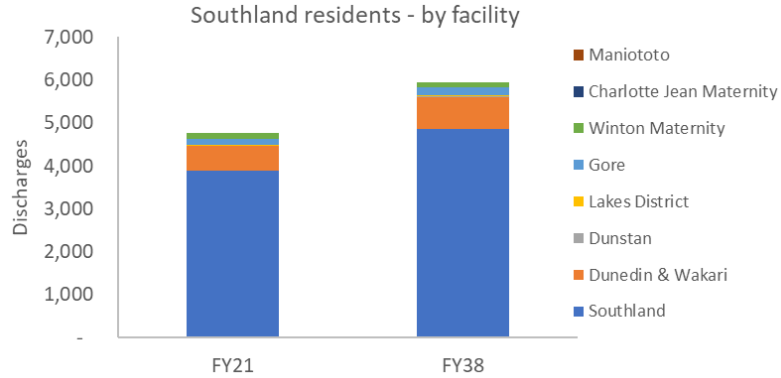
Figure 47 Mental health discharge growth by patient domicile

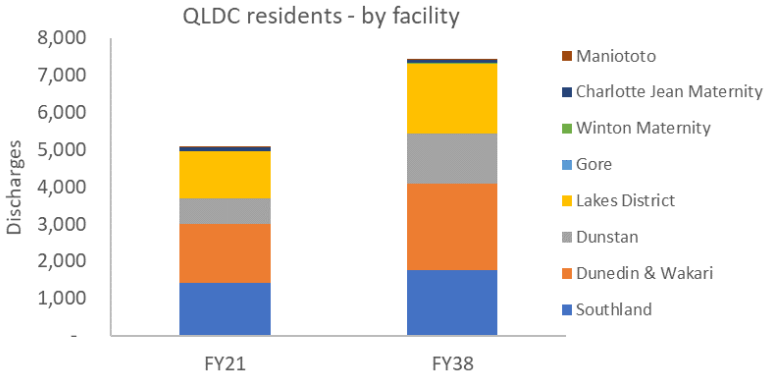


Appendix A Baseline service volume growth by domicile

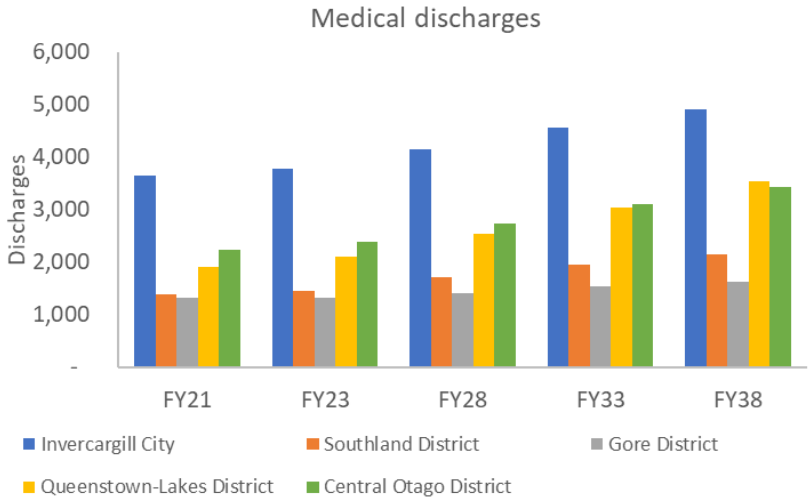


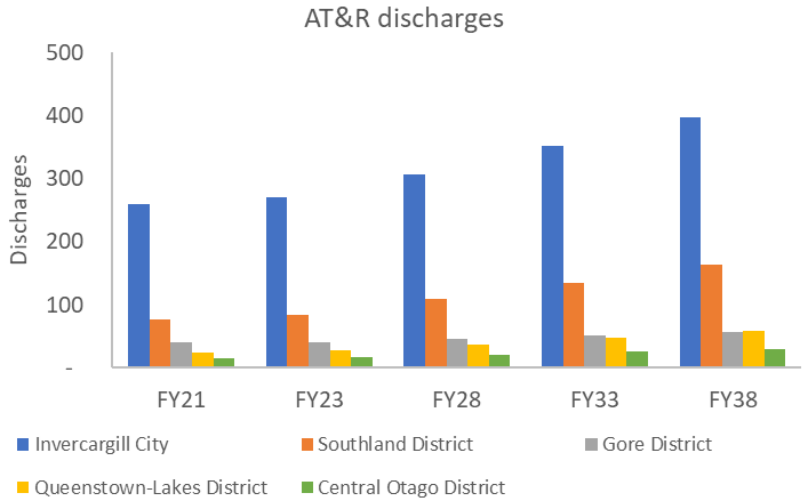


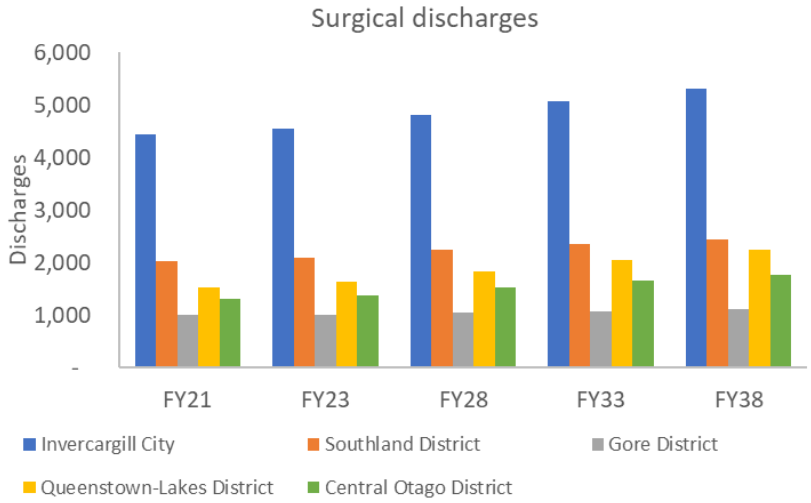


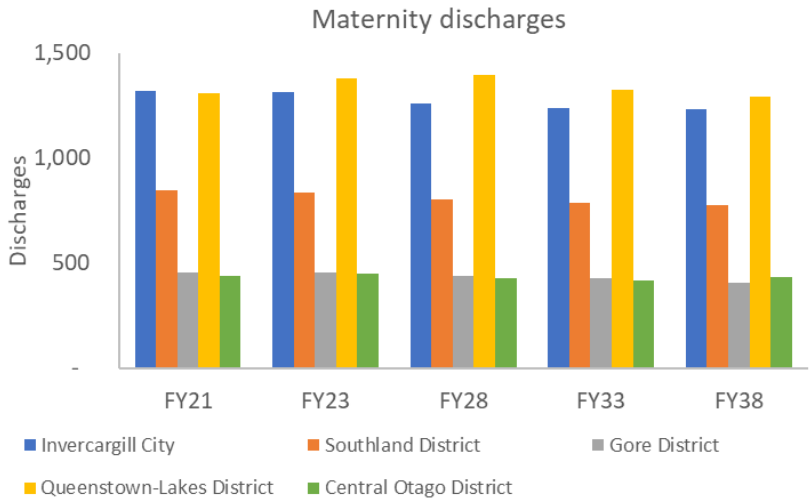


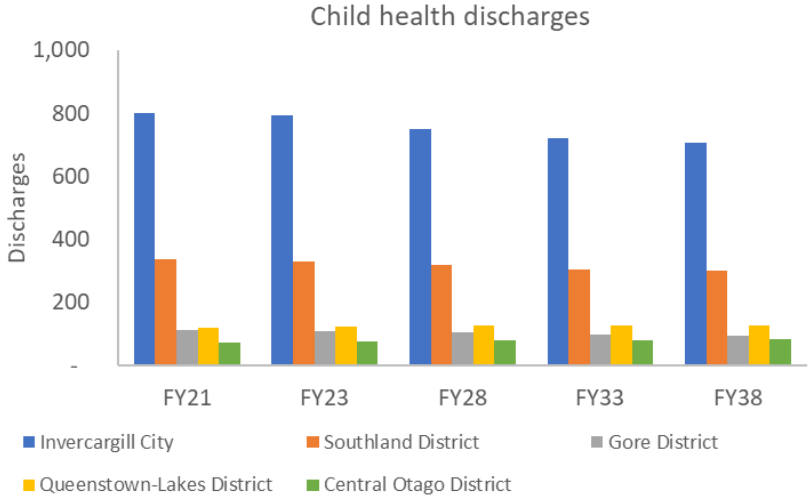
12.1

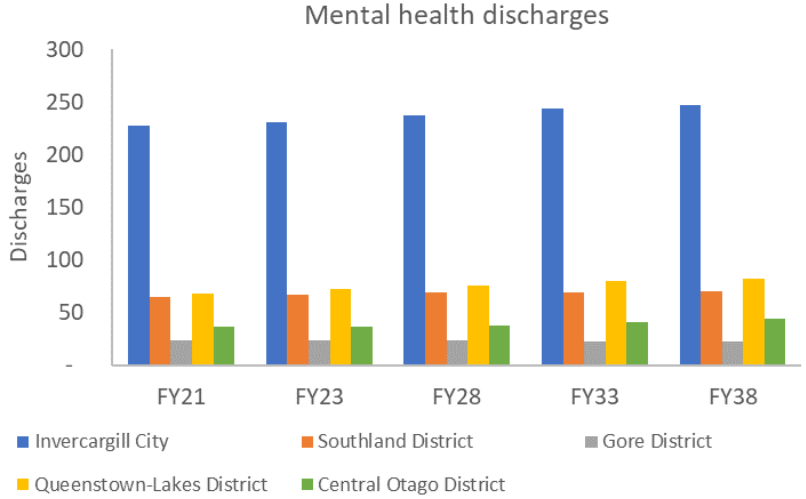

Medical discharges
6,000
5,000
4,000
3,000
2,000
1,000
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District

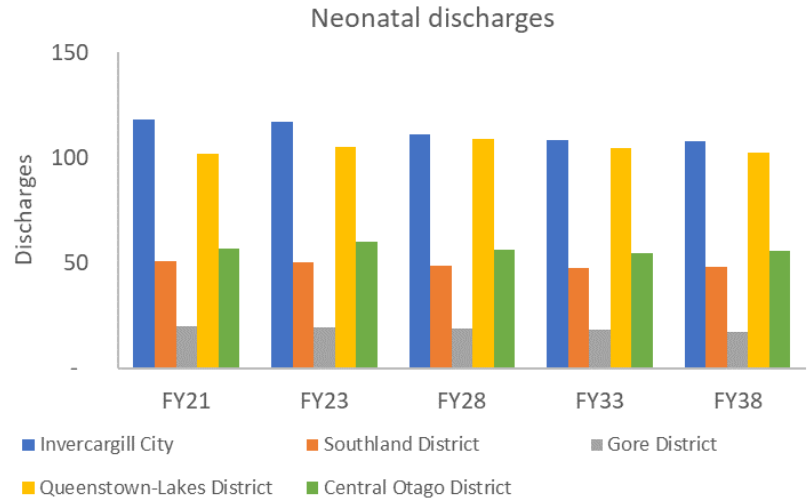

AT&R discharges
500
400
300
200
100
-
Discharges
FY21
FY23
FY28
FY33
FY38
Invercargill City
Southland District
Gore District
Queenstown-Lakes District
Central Otago District


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

12.1

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).

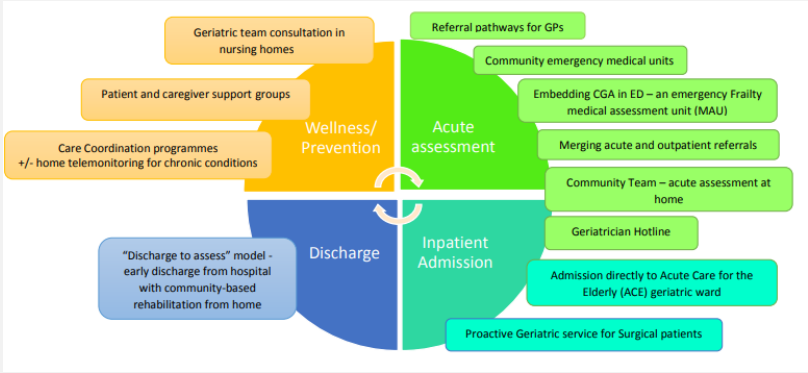
Wraparound approach to provide older-person care in the home

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.

References

Blattner, K., Stokes, T., Rogers-Koroheke, M., Nixon, G., & Dovey, S. (2020). Good care close to home: Local health professional perspectives on how a rural hospital can contribute to the healthcare of its community. New Zealand Medical Journal, 133(1509). https://journal.nzma.org.nz/journal-articles/good-care-close-to-home-local-health-professional-perspectives-on-how-a-rural-hospital-can-contribute-to-the-healthcare-of-its-community

Bourke, L., Humphreys, J. S., Wakerman, J., & Taylor, J. (2012). Understanding rural and remote health: A framework for analysis in Australia. Health & Place, 18(3), 496–503. https://doi.org/10.1016/j.healthplace.2012.02.009

Crotty, M., Killington, M., van den Berg, M., Morris, C., Taylor, A., & Carati, C. (2014). Telerehabilitation for older people using off-the-shelf applications: Acceptability and feasibility. Journal of Telemedicine and Telecare, 20(7), 370–376. https://doi.org/10.1177/1357633X14552382

Gurung, G., Stokes, T., & Gauld, R. (2019). Integrated models of ambulatory care: A scoping literature review to inform Community Health Hub development in the Southern Region. Centre for Health Systems and Technology (CHeST), University of Otago. https://www.otago.ac.nz/healthsystems/otago714754.pdf

Healthpoint. (n.d.). Youth One Stop Shop (YOSS). Healthpoint. Retrieved 21 March 2022, from https://www.healthpoint.co.nz/mental-health-addictions/mental-health-addictions/youth-one-stop-shop-yoss/

Marek, L., Wiki, J., Campbell, M., Kingham, S., Sabel, C., Tomintz, M., & Hobbs, M. (2020). Slipping under the radar: Worsened health outcomes in semi-urban areas of New Zealand. 133(1519). https://journal.nzma.org.nz/journal-articles/slipping-under-the-radar-worsened-health-outcomes-in-semi-urban-areas-of-new-zealand

Ministry of Health. (2009). Evaluation of Youth One Stop Shops. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/youth-one-stop-shop-evaluation-synopsis-v1.1.pdf

Myers, J. B., Cox, J., Teague, S., & Beck, E. (2016). Transitions of Care Model Inclusive of Unplanned Care Improves the Patient Experience. Journal of Patient Experience, 3(1), 20–23. https://doi.org/10.1177/2374373516636742

Wade, V., & Stocks, N. (2017). The Use of Telehealth to Reduce Inequalities in Cardiovascular Outcomes in Australia and New Zealand: A Critical Review. Heart, Lung and Circulation, 26(4), 331–337. https://doi.org/10.1016/j.hlc.2016.10.013

Wilson, G., Currie, O., Bidwell, S., Saeed, B., Dowell, A., Adiguna Halim, A., Toop, L., Richardson, A., Savage, R., & Hudson, B. (2021). Empty waiting rooms: The New Zealand general practice experience with telehealth during the COVID-19 pandemic. New Zealand Medical Journal, 134(1538). https://journal.nzma.org.nz/journal-articles/empty-waiting-rooms-the-new-zealand-general-practice-experience-with-telehealth-during-the-covid-19-pandemic-open-access

Withington, S., Kiuru, S., Wilson, S., Lyons, J., Feberwee, A., & Lander, J. (2020). Transition of the medical model of care at Ashburton hospital over 10 years: The perspective of rural generalists. 133(1512). https://journal.nzma.org.nz/journal-articles/transition-of-the-medical-model-of-care-at-ashburton-hospital-over-10-years-the-perspective-of-rural-generalists

About Sapere

Sapere is one of the largest expert consulting firms in Australasia, and a leader in the provision of independent economic, forensic accounting and public policy services. We provide independent expert testimony, strategic advisory services, data analytics and other advice to Australasia's private sector corporate clients, major law firms, government agencies, and regulatory bodies.

'Sapere' comes from Latin (to be wise) and the phrase 'sapere aude' (dare to be wise). The phrase is associated with German philosopher Immanuel Kant, who promoted the use of reason as a tool of thought; an approach that underpins all Sapere's practice groups.

We build and maintain effective relationships as demonstrated by the volume of repeat work. Many of our experts have held leadership and senior management positions and are experienced in navigating complex relationships in government, industry, and academic settings.

We adopt a collaborative approach to our work and routinely partner with specialist firms in other fields, such as social research, IT design and architecture, and survey design. This enables us to deliver a comprehensive product and to ensure value for money.

For more information, please contact:

David Moore

Phone:	+64 4 915 5355
Mobile:	+64 21 518 002
Email:	dmoore@thinkSapere.com

Wellington	Auckland	Sydney	Melbourne	Canberra
Level 9 1 Willeston Street PO Box 587 Wellington 6140	Level 8 203 Queen Street PO Box 2475 Shortland Street Auckland 1140	Level 18 135 King Street Sydney NSW 2000	Level 5 171 Collins Street Melbourne VIC 3000	PO Box 252 Canberra City ACT 2601
P +64 4 915 7590 F +64 4 915 7596	P +64 9 909 5810 F +64 9 909 5828	P +61 2 9234 0200 F +61 2 9234 0201	P +61 3 9005 1454 F +61 2 9234 0201 (Syd)	P +61 2 6100 6363 F +61 2 9234 0201 (Syd)

www.thinkSapere.com

independence, integrity and objectivity


Clinical Council
SDHB board report
June 22
• Dr David Gow
Southern Health
He hauora, he kuru pounamu
Southern District Health Board
Piki Te Ora

12.2

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

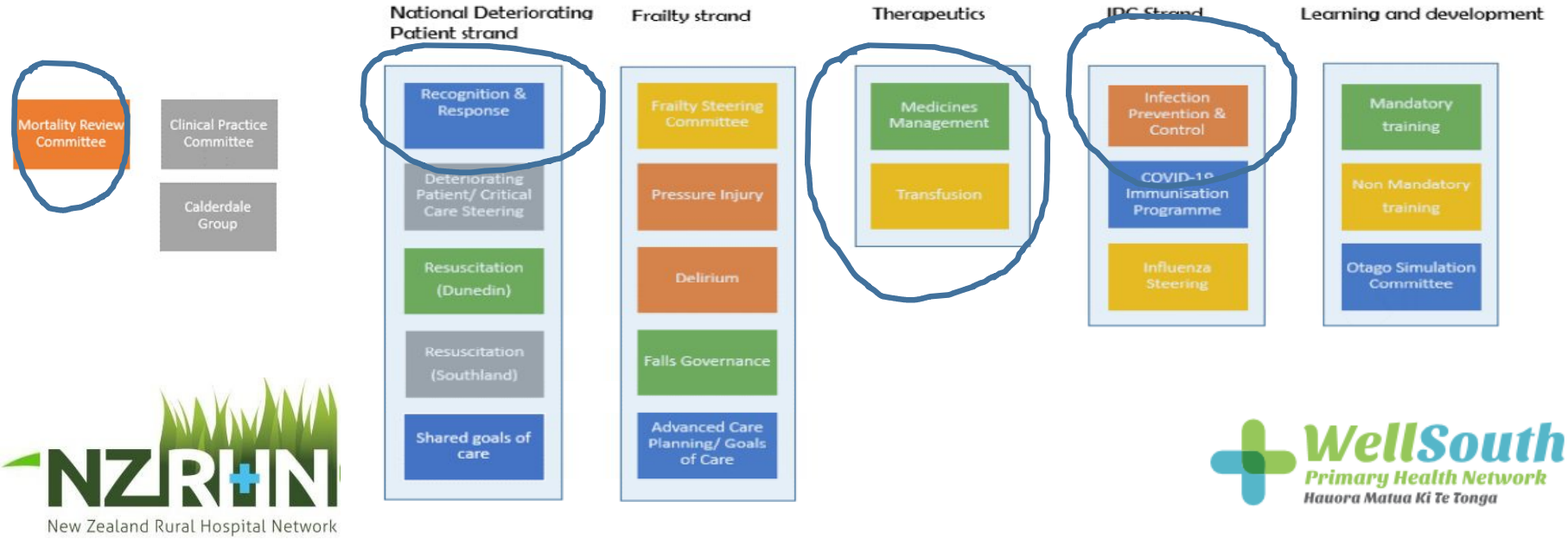
Identifying harms

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

CG oversight:- Stranding & Whole system



12.2

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

Identifying harms

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

Membership

- We have worked with IGC to establish what partnership looks like between the two entities. Jo Kingi has been approached by the council to represent **Māori** on behalf of the IGC

- We welcome a new **rural representative** Dr Jennifer Keys.

- We are in discussions to appoint a **Pacific representative**.

- CC Chair attending DHB board, CHC, **WellSouth CG group**

12.2

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

Identifying harms

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

Implementing systems
SDHB Clinical Governance Policy:- Ward to Board

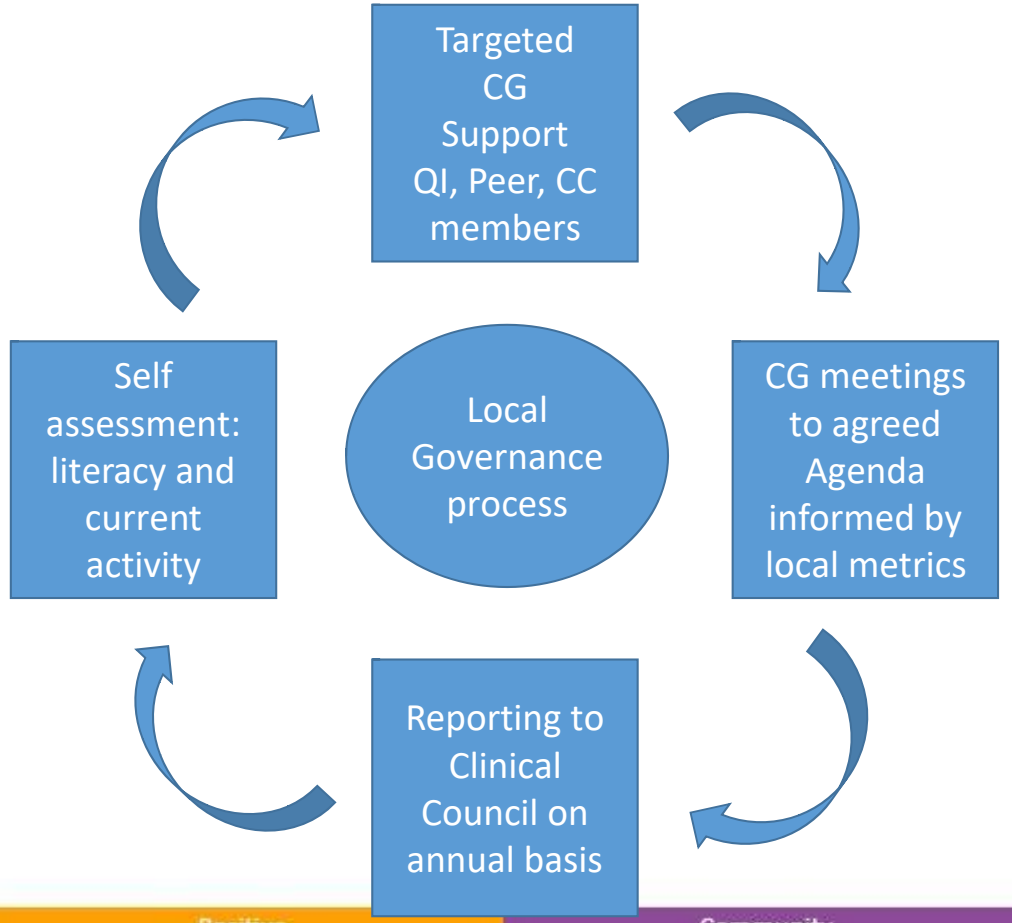
Quality & Clinical Governance
MEETING AGENDA

Date:

Service	
Time:	
Venue:	
Attendees:	
Attendance:	
Apologies:	

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

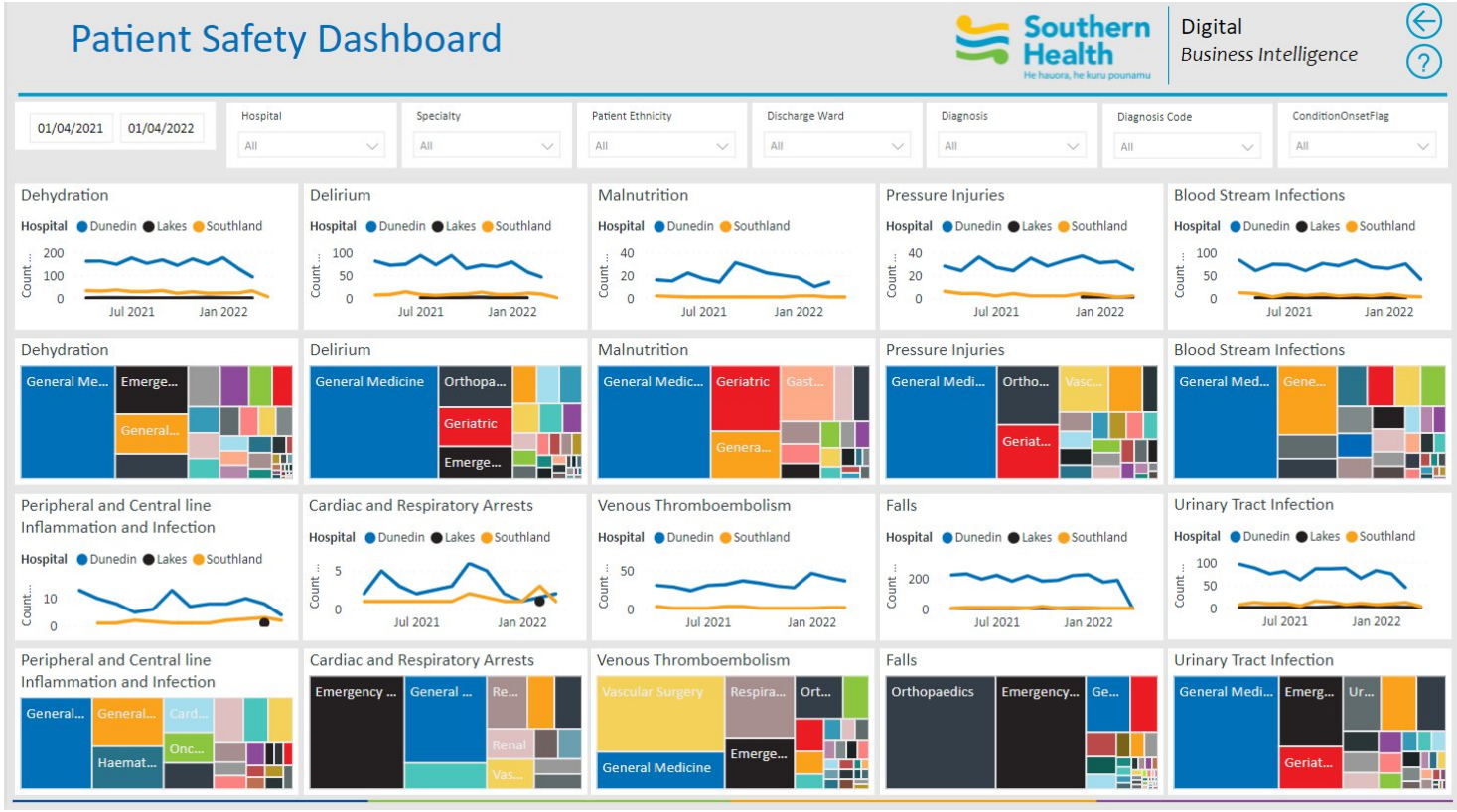
	Clinical Effectiveness	
	11. Clinical Outcomes: - Length of stay, Readmission rates, Cancelled procedures, Activity.	
	12. Patient Flow Metrics, SAFER Bundle, R2G	
	13. Mortality & Morbidity: - Review Themes and date of next formal M & M	
	14. Clinical Audit	
	Engaged Effective Workforce	
	15. Operational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



Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

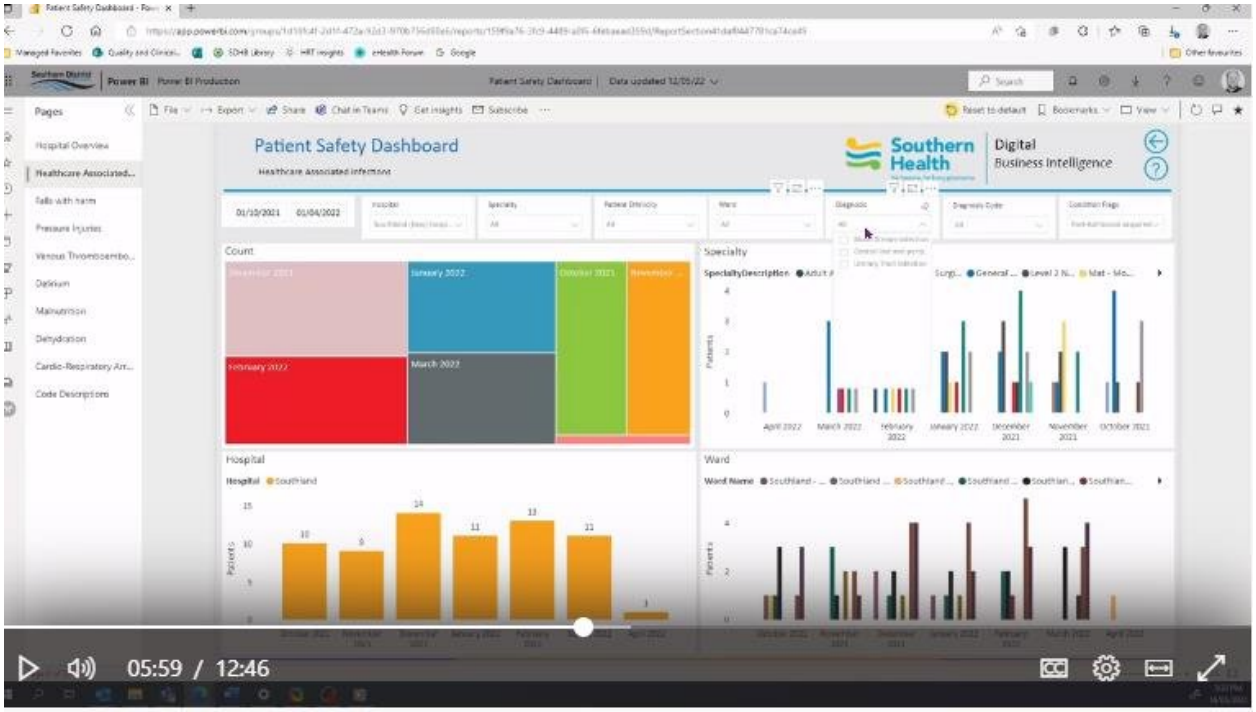
12.2

Helping teams monitor their local performance



Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

Online training package



12.2

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

Identifying and preventing hospital associated complications

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

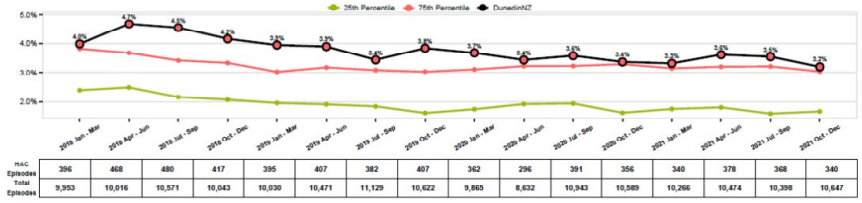
HACs

Hospital-Acquired Complications Summary for DunedinNZ

2021 Jan - 2021 Dec

3.4% of admitted episodes had a major hospital acquired complication.	4.9% of admitted patients experienced a major hospital acquired complication.	17% of bed days were occupied by a patient who experienced a major hospital acquired complication.
Peer Hospitals: 2.5%	Peer Hospitals: 3.7%	Peer Hospitals: 15%

4 Year HAC Trend For DunedinNZ



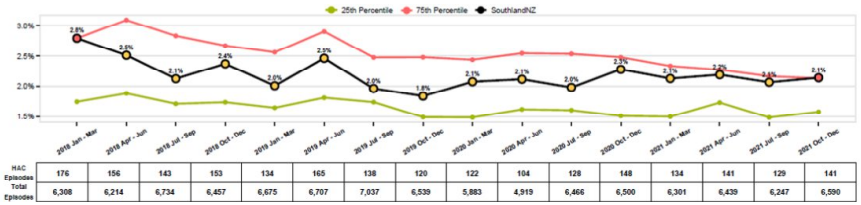
	2018 Jan - Mar	2018 Apr - Jun	2018 Jul - Sep	2018 Oct - Dec	2019 Jan - Mar	2019 Apr - Jun	2019 Jul - Sep	2019 Oct - Dec	2020 Jan - Mar	2020 Apr - Jun	2020 Jul - Sep	2020 Oct - Dec	2021 Jan - Mar	2021 Apr - Jun	2021 Jul - Sep	2021 Oct - Dec
HAC Episodes	396	468	480	417	395	407	382	407	362	296	391	356	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

Hospital-Acquired Complications Summary for SouthlandNZ

2021 Jan - 2021 Dec

2.1% of admitted episodes had a major hospital acquired complication.	3.0% of admitted patients experienced a major hospital acquired complication.	13% of bed days were occupied by a patient who experienced a major hospital acquired complication.
Peer Hospitals: 2.2%	Peer Hospitals: 3.2%	Peer Hospitals: 14%

4 Year HAC Trend For SouthlandNZ



	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

12.2

HAIs – Council's first port of call

3 - Healthcare associated infection details by diagnosis

Trends at DunedinNZ (2021 Jan - 2021 Dec)

Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
3.1 - Urinary tract infection per 10,000 episodes	41.9	28.9	41.9 45.8 40.3 46.5 42.9 48.7 40.4 35.7	35.7
3.2 - Surgical site infection per 10,000 episodes	10.5	8.2	16.2 8.1 9.1 17.0 9.9 13.4 7.7 16.9	16.9
3.3 - Pneumonia per 10,000 episodes	44.0	36.9	51.7 39.4 45.3 40.6 38.0 43.9 50.0 44.1	44.1
3.4 - Blood stream infection per 10,000 episodes	5.0	4.8	6.1 4.6 9.1 3.8 1.8 8.6 5.8 4.7	4.7
3.5 - Central line and peripheral line associated bloodstream infection per 10,000 episodes	15.6	8.1	13.2 15.1 10.1 9.4 6.8 21.0 18.3 16.0	16.0
3.6 - Multi-resistant organism per 10,000 episodes	8.9	5.2	7.1 4.6 10.1 10.4 5.8 9.5 12.5 7.5	7.5
3.7 - Infection associated with prosthetics/implantable devices per 10,000 episodes	3.1	3.0	3.0 6.0 9.1 1.7 5.3 1.9 3.8 2.8	2.8
3.8 - Gastrointestinal infections per 10,000 episodes	4.8	4.6	9.1 7.0 1.8 7.0 6.8 6.7 3.8 1.9	1.9
3.9 - Other high impact infections per 10,000 episodes	30.6	18.1	29.4 25.0 18.3 28.3 29.2 31.8 30.8 31.0	31.0

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

3 - Healthcare associated infection details by diagnosis

Trends at SouthlandNZ (2021 Jan - 2021 Dec)

Diagnosis	2021 Jan - 2021 Dec *	Peer Group Median	Quarterly Trend *	Latest Quarter
3.1 - Urinary tract infection per 10,000 episodes	27.8	26.4	28.9 24.4 37.1 26.2 31.7 26.4 30.4 22.8	22.8
3.2 - Surgical site infection per 10,000 episodes	10.2	8.2	6.8 10.2 12.4 21.5 5.5 10.3 9.5 10.6	10.6
3.3 - Pneumonia per 10,000 episodes	38.7	36.0	40.8 36.5 43.2 43.1 25.4 40.4 51.2 37.9	37.9
3.4 - Blood stream infection per 10,000 episodes	3.5	3.3	1.7 0 1.5 5.1 7.5 1.8 3.2 1.5	1.5
3.5 - Central line and peripheral line associated bloodstream infection per 10,000 episodes	5.5	6.5	1.7 3.0 3.1 4.6 9.6 3.1 4.8 4.6	4.6
3.6 - Multi-resistant organism per 10,000 episodes	1.2	3.7	3.4 2.0 1.5 3.1 0 0 3.2 1.5	1.5
3.7 - Infection associated with prosthetics/implantable devices per 10,000 episodes	2.0	2.0	1.7 2.0 3.1 0 0 3.1 1.6 3.0	3.0
3.8 - Gastrointestinal infections per 10,000 episodes	4.7	3.4	5.1 2.0 3.1 6.2 4.8 4.7 6.4 3.0	3.0
3.9 - Other high impact infections per 10,000 episodes	25.8	14.8	10.2 26.6 13.3 16.3 28.0 32.6 24.0 18.2	18.2

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

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

Current National Focus

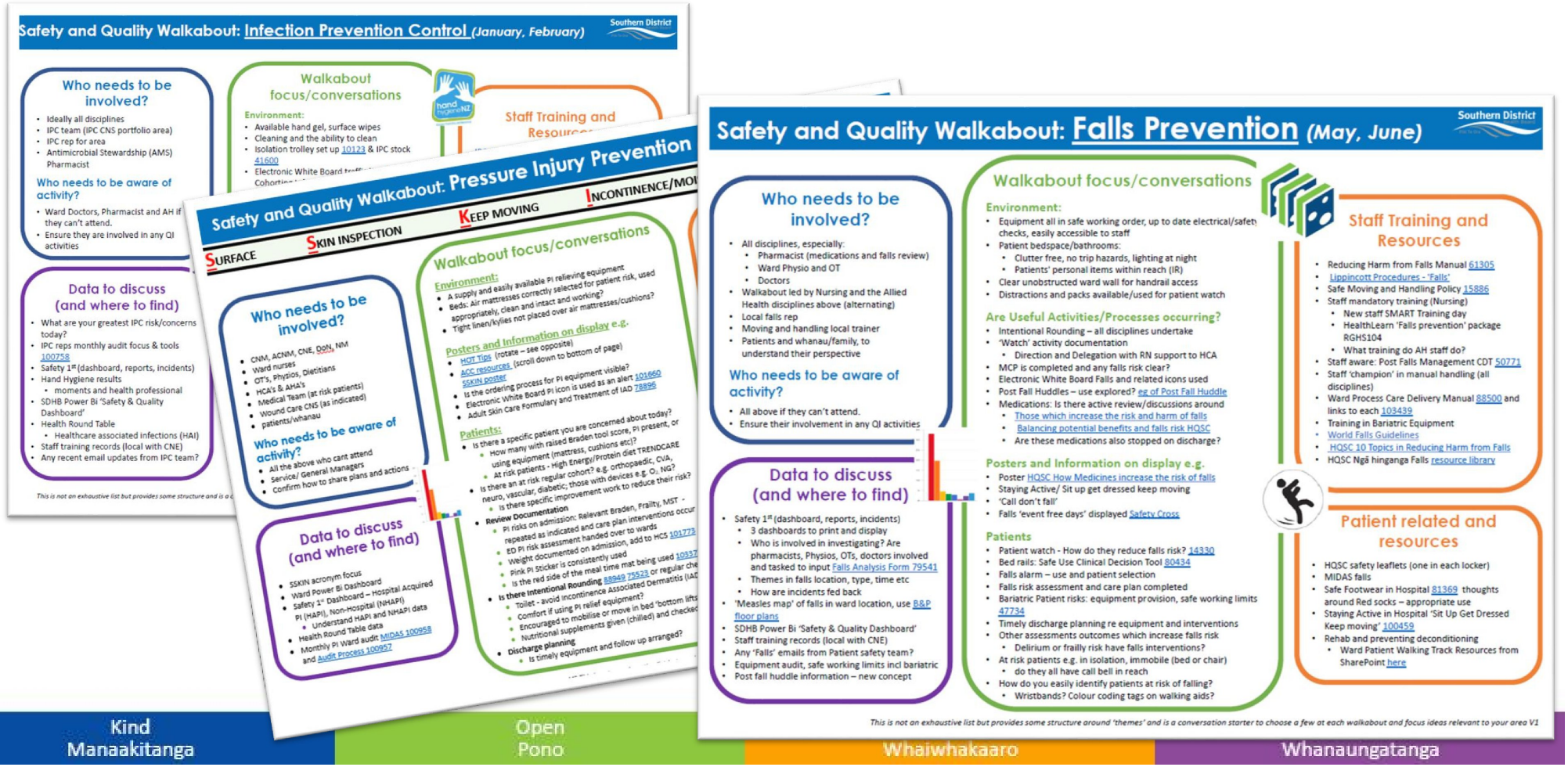
Table 7: HAI point prevalence by DHB

DHB	Number of patients		% with HAI (95% CI)
	Total	With HAI	
Auckland DHB[1]	700	59	8.4 (6.6–10.7)
Bay of Plenty DHB	271	15	5.5 (3.4–8.9)
Canterbury DHB[1]	661	38	5.7 (4.2–7.8)
Capital & Coast DHB[1]	301	32	10.6 (7.6–14.6)
Counties Manukau DHB[1]	642	38	5.9 (4.3–8)
Hauora Tairāwhiti	54	4	7.4 (2.9–17.6)
Hawke's Bay DHB	209	20	9.6 (6.3–14.3)
Hutt Valley DHB	167	4	2.4 (0.9–6)
Lakes DHB	99	9	9.1 (4.9–16.4)
MidCentral DHB	203	13	6.4 (3.8–10.6)
Nelson Marlborough DHB	149	9	6 (3.2–11.1)
Northland DHB	175	9	5.1 (2.7–9.5)
South Canterbury DHB	76	3	3.9 (1.4–11)
Southern DHB	315	23	7.3 (4.9–10.7)
Taranaki DHB	136	8	5.9 (3–11.2)
Waikato DHB[1]	550	34	6.2 (4.5–8.5)
Wairarapa DHB	50	0	0 (0–7.1)
Waitematā DHB	594	33	5.6 (4–7.7)
West Coast DHB	31	2	6.5 (1.8–20.7)
Whanganui DHB	86	8	9.3 (4.8–17.3)
National	5,469	361	6.6 (6–7.3)

[1] Regional referral DHB.
CI = confidence interval; DHB = district health board; HAI = healthcare-associated infection.

12.2

We supported intervention



Southern District Health Board

Date: ..... Ward: .....

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

Craigs 40058

Sign: .....

Designation: .....

Other Info/Notes: .....

.....

OPH
8MED
Stroke

12.2

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

Identifying and preventing hospital associated complications

Managing risk

Monitoring consumer engagement and promoting equity

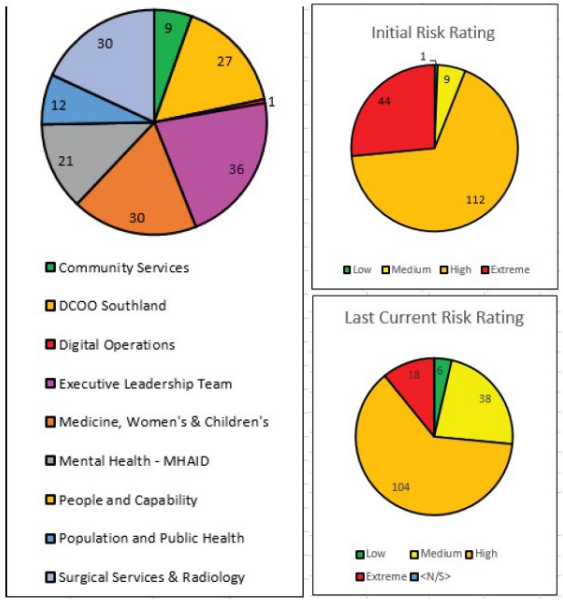
Implementing system improvements and sponsoring projects

Managing Risk:- 3 monthly Birdseye view. Monthly review of top 15 clinical risks

CLINICAL RISK REPORT – May 2022

Key Register	Total	Open
Directorate/Division	130	130
Organisation wide	36	36
Projects/ Programmes	0	0
Total	166	166

The reporting structure of Safety1st has now been amended to reflect the current SDHB organisational structure. New headings such as DCOO Southland; Digital Operations; Population and Public Health have been added.



12.2

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

Identifying and preventing hospital associated complications

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

Monitoring consumer engagement and promoting equity

Southern Pacific Heath Professionals and Pacific Trust Otago.

Presentation on equity within the DHB highlighted with some challenging patient stories.

Raised to CEO formally as Council supported the presenters view that inequity existed and acknowledged the

12.2

Clinical Council focus

Clinical governance oversight across the system

Clinical governance policy

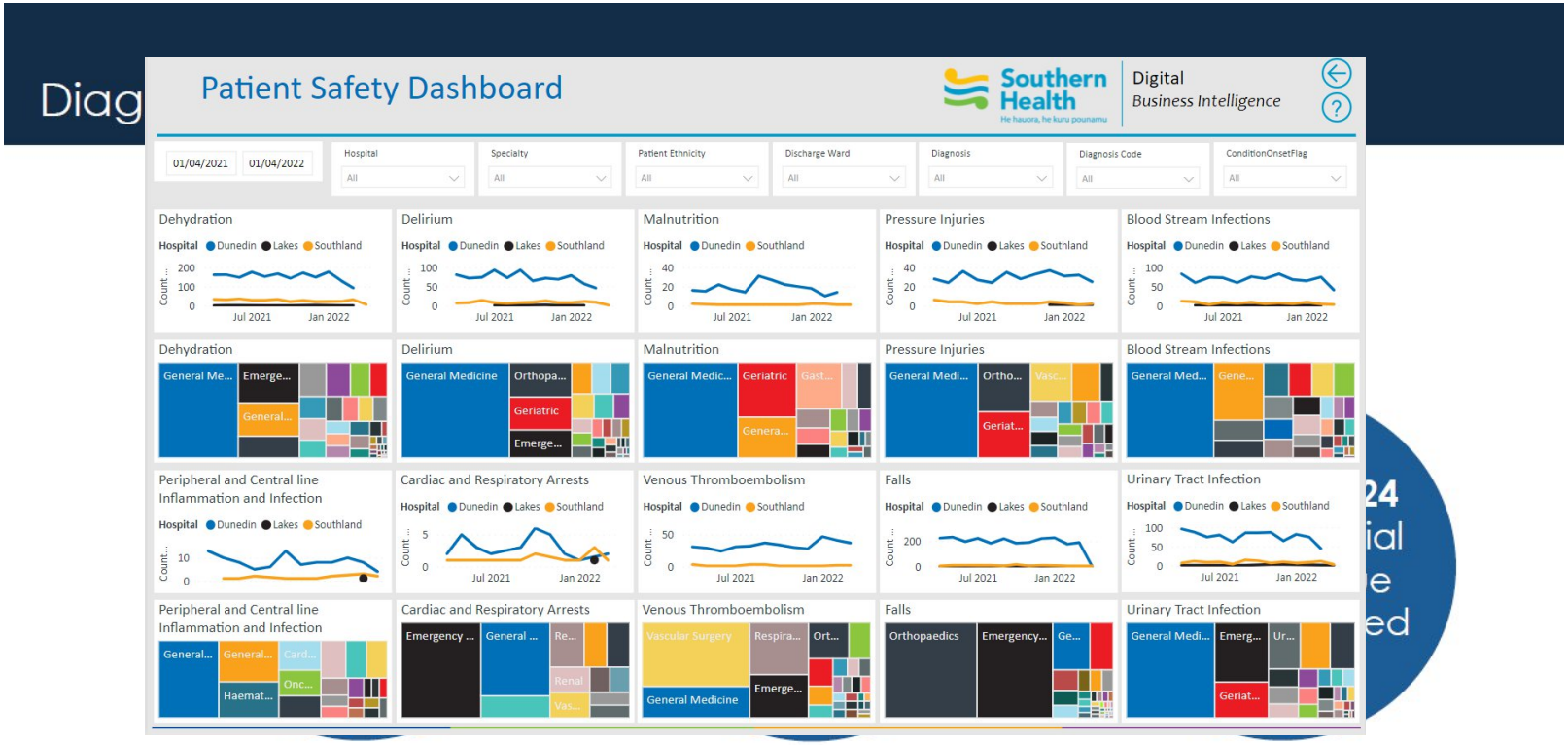
Identifying and preventing hospital associated complications

Managing risk

Monitoring consumer engagement and promoting equity

Implementing system improvements and sponsoring projects

Clinical documentation improvement



Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

12.2

Thank you for all your support

FOR INFORMATION

Item: Patient Flow - Metrics

Proposed by: Hamish Brown, Chief Operating Officer

Meeting of: 08 June 2022

Recommendation

That the Board **notes** the report.

Purpose

1. To provide updated data related to patient flow performance across the Southern Hospital sites.

2. To provide the Board with assurance that there is service level data.

Background

3. At the May 2022 Board meeting there was discussion regarding the availability of data at a service level to help guide responses to patient flow challenges.

4. Below are metrics that look at three key components of the patient journey acute admission process, inpatient process, and discharge process.

   The graphs show performance metrics for the period January 2020 through to April 2022. Note that there is variability across all metrics and the drivers are complex.

5. Displayed service level data is indicative not exhaustive and data is available on all services.

Discussion

6. This information represents only a portion of the detailed information that is available to guide service improvement.

7. The board should note that hospital flow exists as a dependency of system flow which encompasses the wider southern health system – primary and community care, rural hospital partners, ARC and NGO partners.

8. Whilst there is continuous improvement within our intrahospital processes. It is essential that improvements and actions focus on shaping demand to our acute services and creating downstream capacity within the health system.

Next Steps & Actions

9. Continue to refine data.

10. Establish the IOC/SOP's and district wide interaction.

11. Improvements in patient flow [MAU/Weekend Discharge Pilot/Discharge documentation/Additional Southland Beds].

12. Establish a greater focus on downstream capacity [Community care/Rural Hospitals/ARC/NGO's].

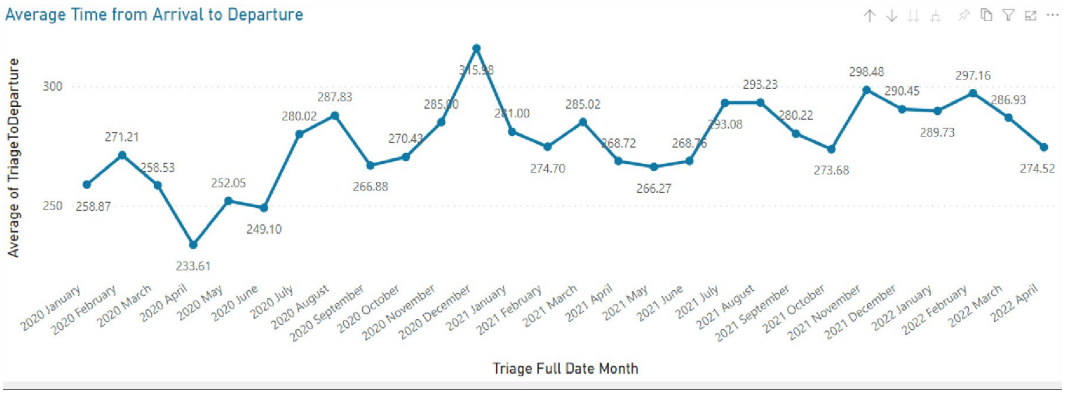
Appendices

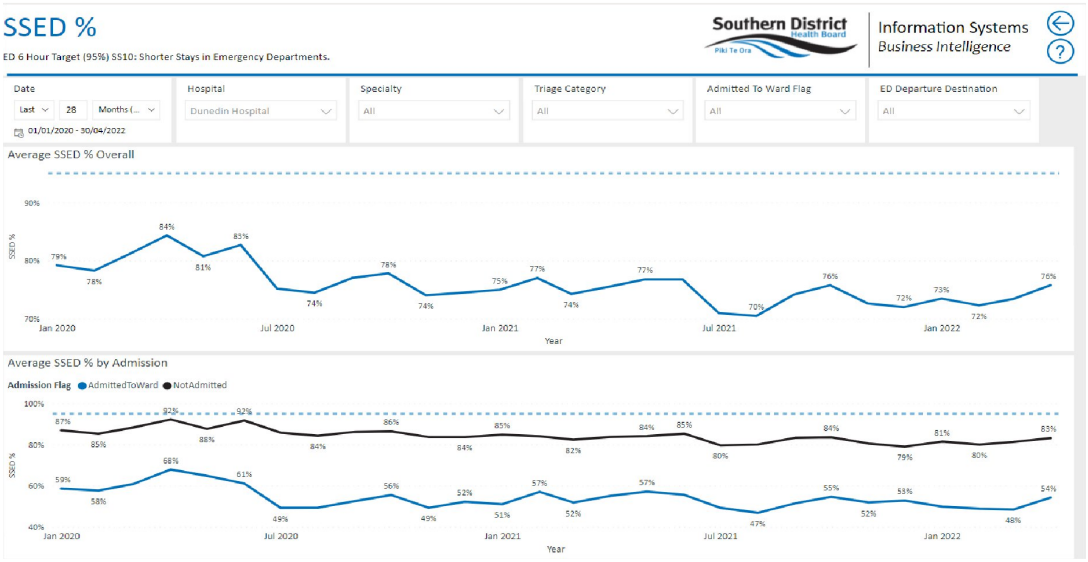
Appendix 1 Patient flow data.

Appendix One

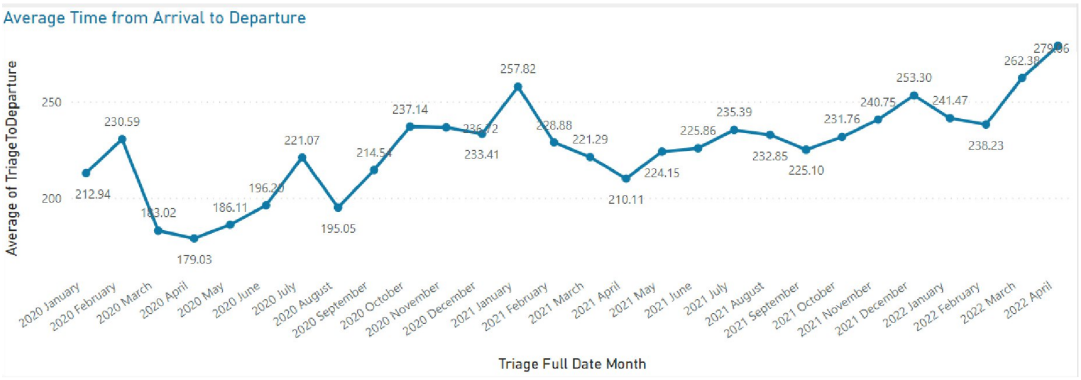
Inflow – Acute admission process via ED

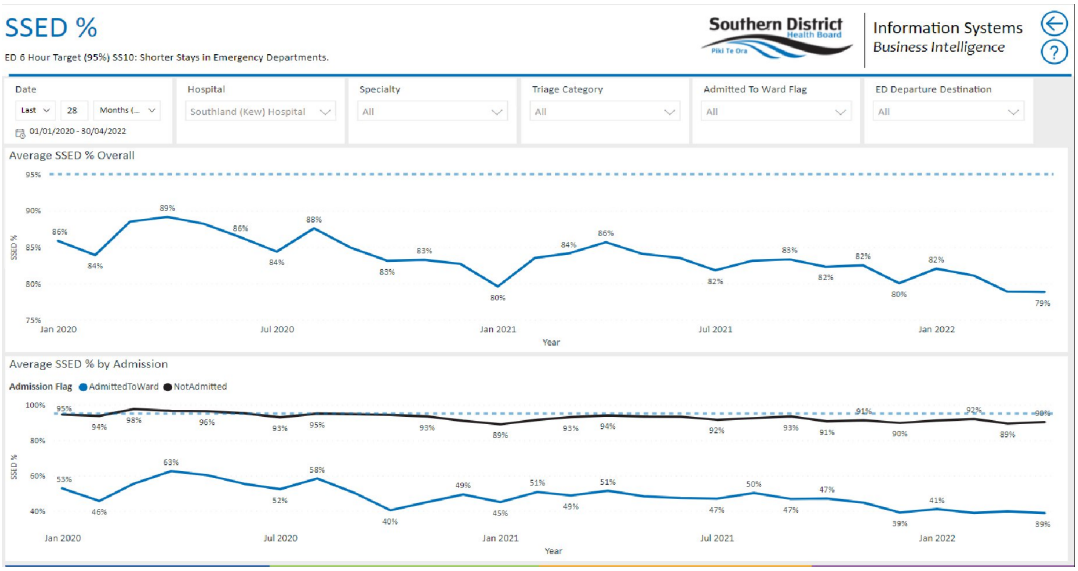
Dunedin average length of stay within the ED, and performance of SSED.



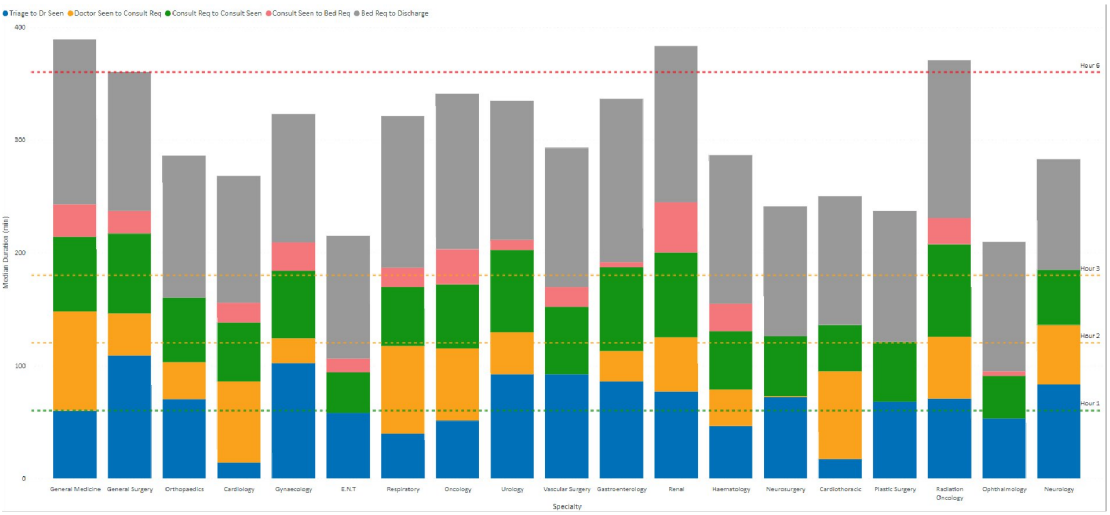


Invercargill average length of stay within the ED.

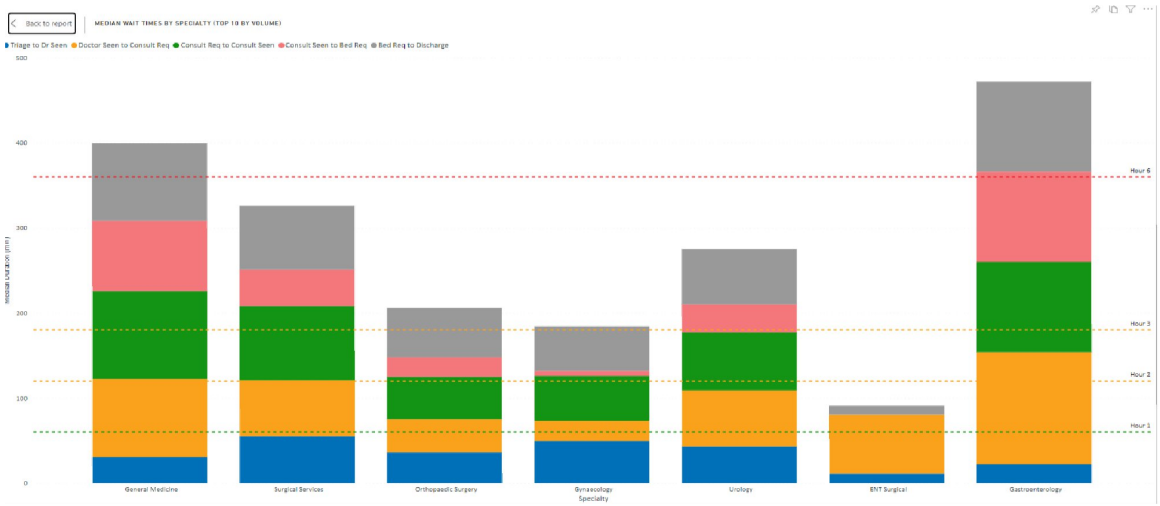




Dunedin Hospital Median Wait times by Specialty in the Emergency Department.

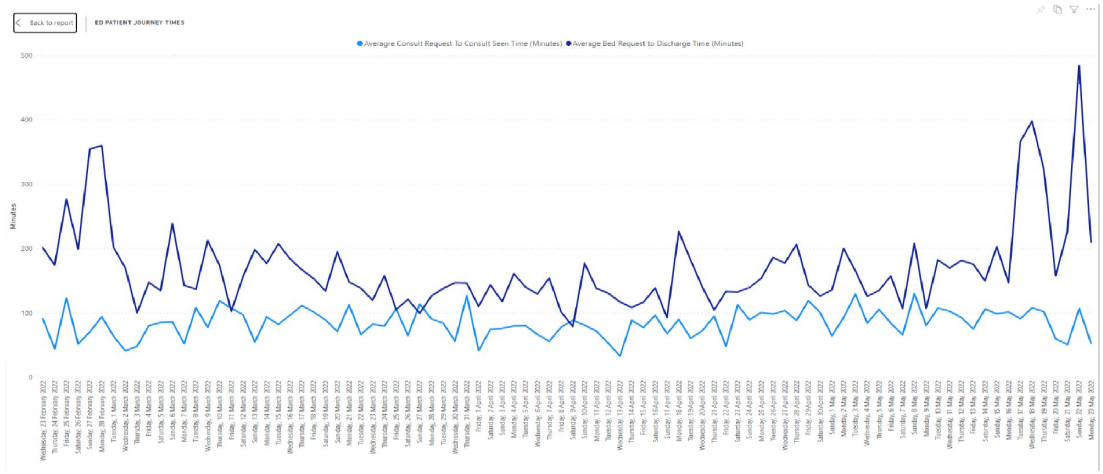


Invercargill Hospital Median Wait times by Specialty in the Emergency Department.



Dunedin Hospital ED- Daily Consult Request to Bed Request to Admission Times (average time – minutes).

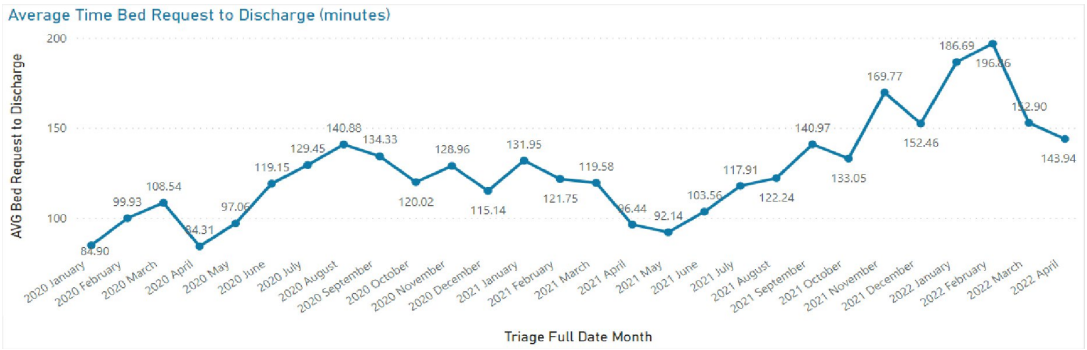
12.3



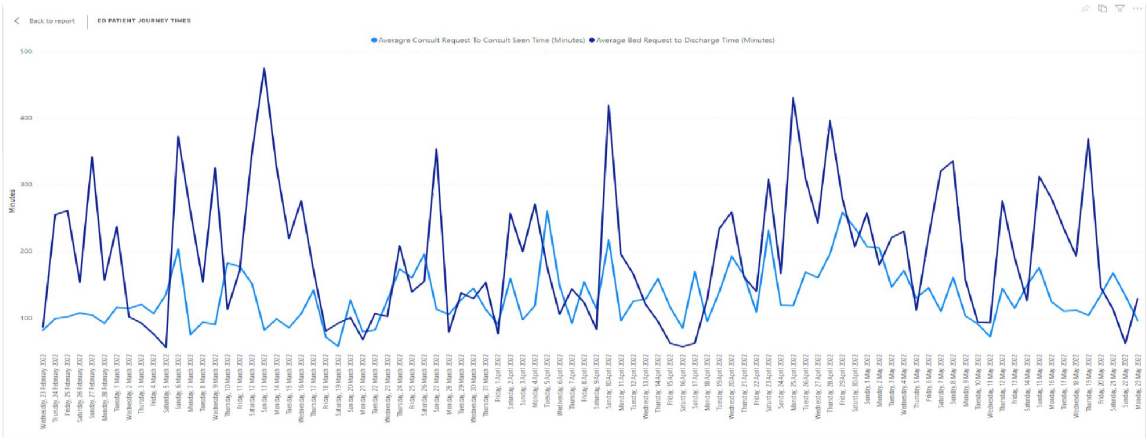
Dunedin ED – Average time from ED Doctor seeing patient to requesting a consultation from a Specialty Team (note data error in December 2021).

Dunedin ED average time for Inpatient Teams to Respond to Consultation Request.

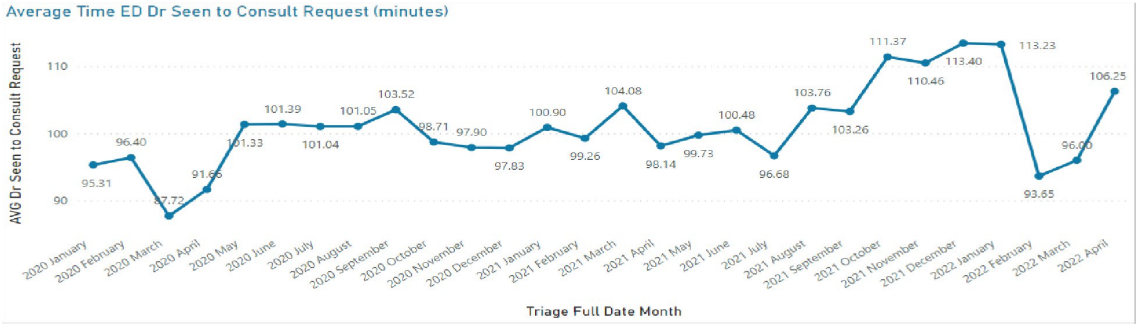
Dunedin Hospital – Average Time from Bed Request in ED until departure to the Ward.



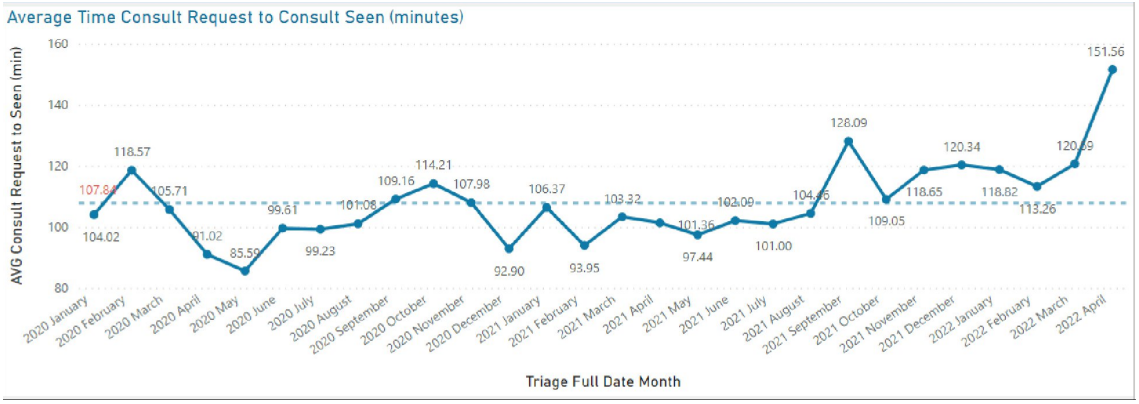
Invercargill Hospital ED- Daily Consult Request to Bed Request to Admission Times (average time – minutes).



Invercargill ED – Average time from ED Doctor seeing patient to requesting a consultation from a Specialty Team.



Invercargill ED average time for Inpatient Teams to Respond to Consultation Request.



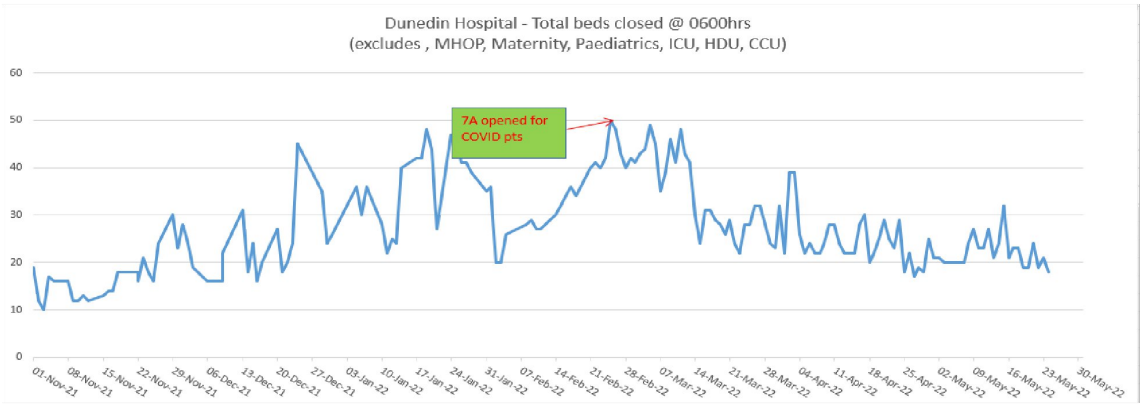
12.3

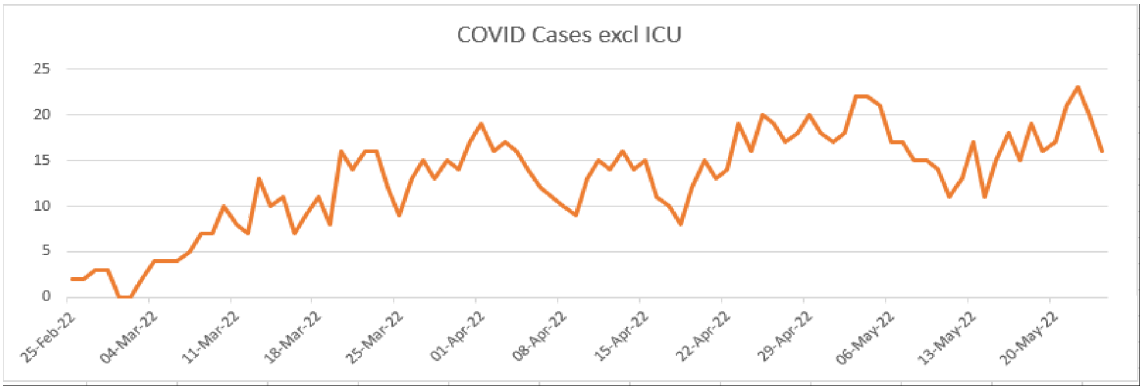
Invercargill Hospital – Average Time from Bed Request in ED until departure to the Ward.

Inpatient process

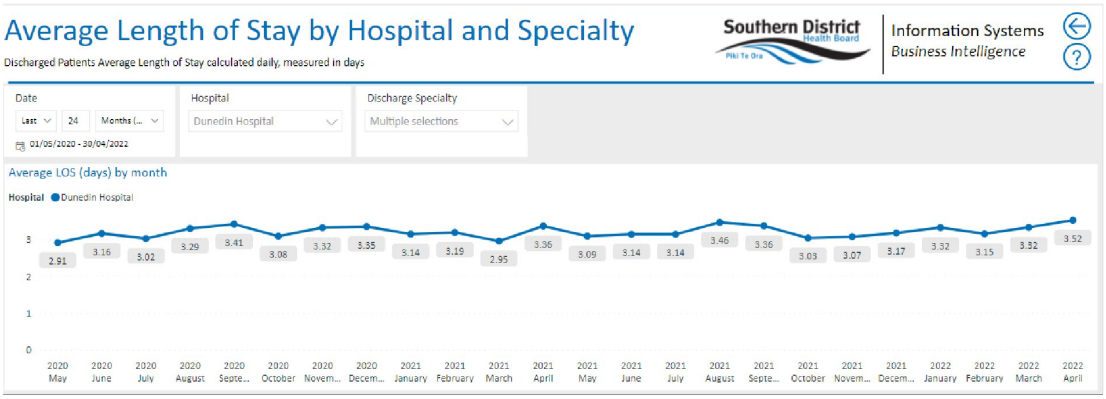
Dunedin Hospital – Daily Bed Closures

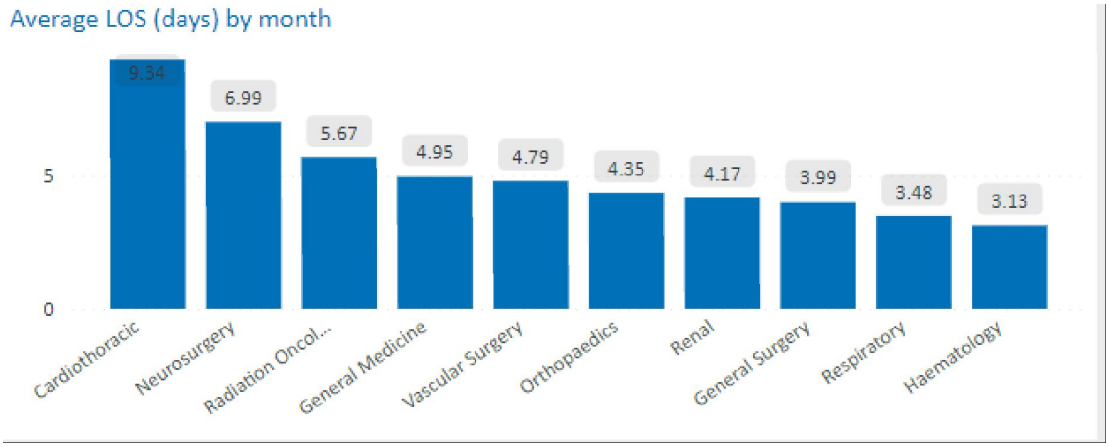
The below represents the beds closed in the adult wards



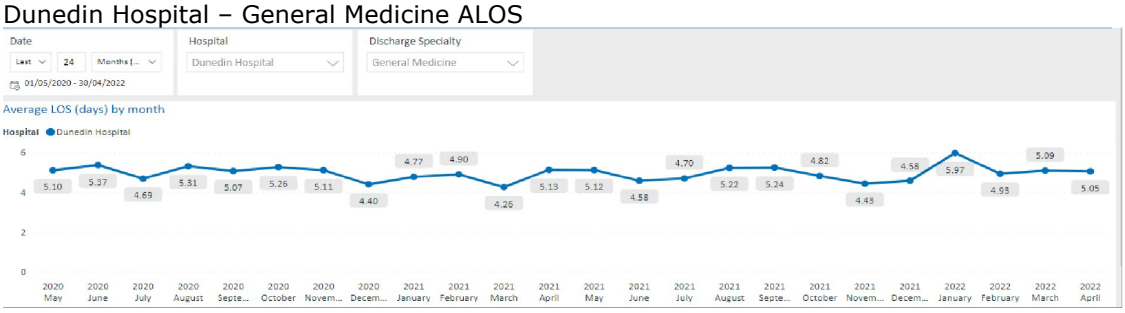


Dunedin Average Length of Stay





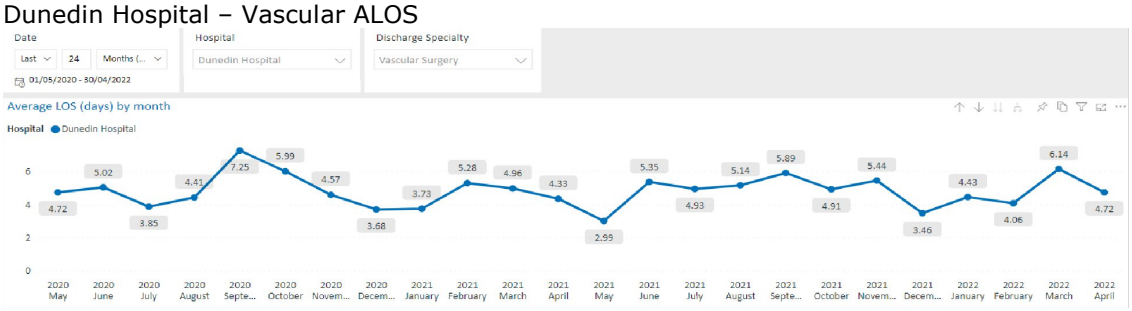
Dunedin Hospital – General Medicine ALOS



Dunedin Hospital – Orthopaedics ALOS

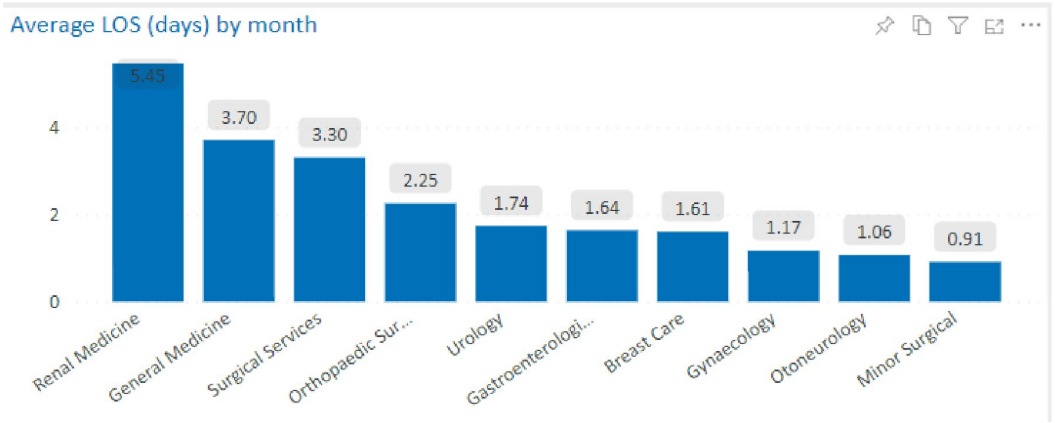
12.3

Dunedin Hospital – Vascular ALOS



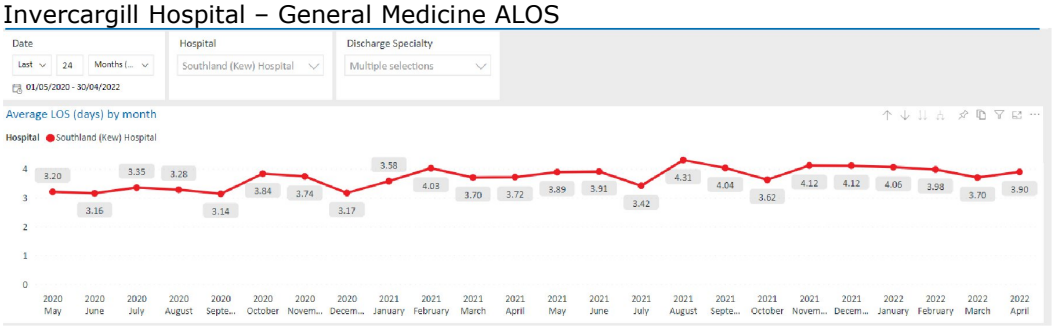
Dunedin Hospital – General Surgery ALOS

Invercargill Average Length of Stay



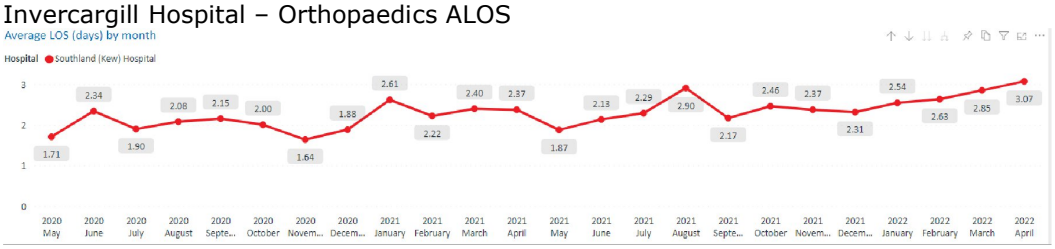
Note: Renal Medicine actually accounts for 3 patients in January – this specialty does not usually have inpatients.

Invercargill Hospital – General Medicine ALOS

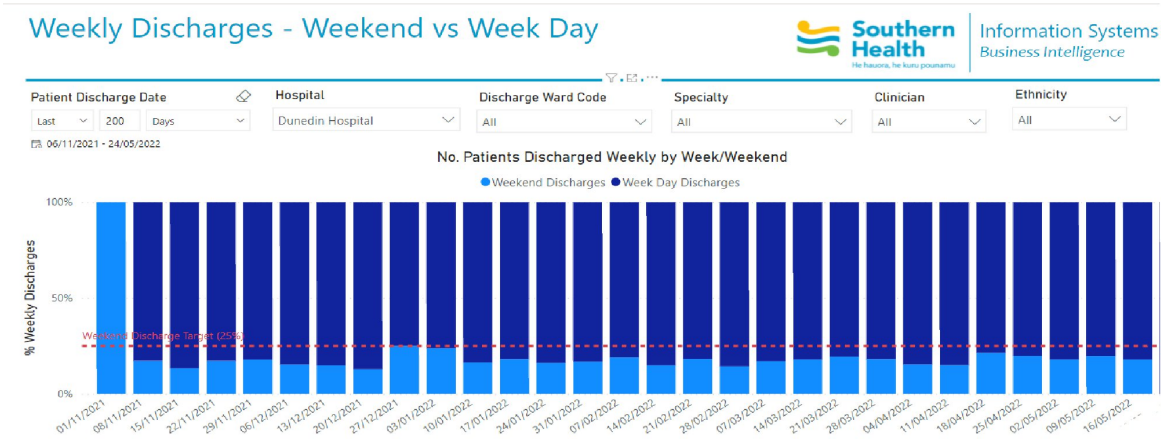


Invercargill Hospital – Surgical Services ALOS

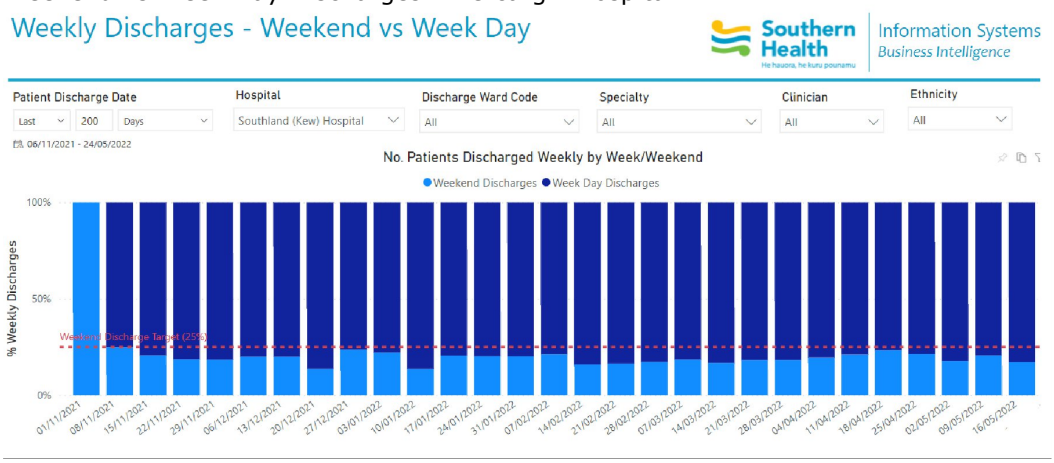
Invercargill Hospital – Orthopaedics ALOS



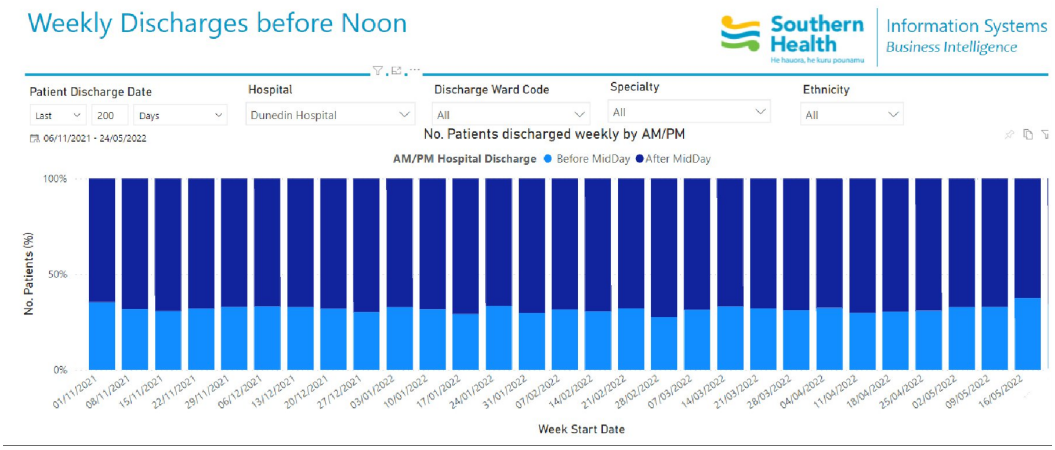
Weekend vs Week Day Discharges Dunedin Hospital

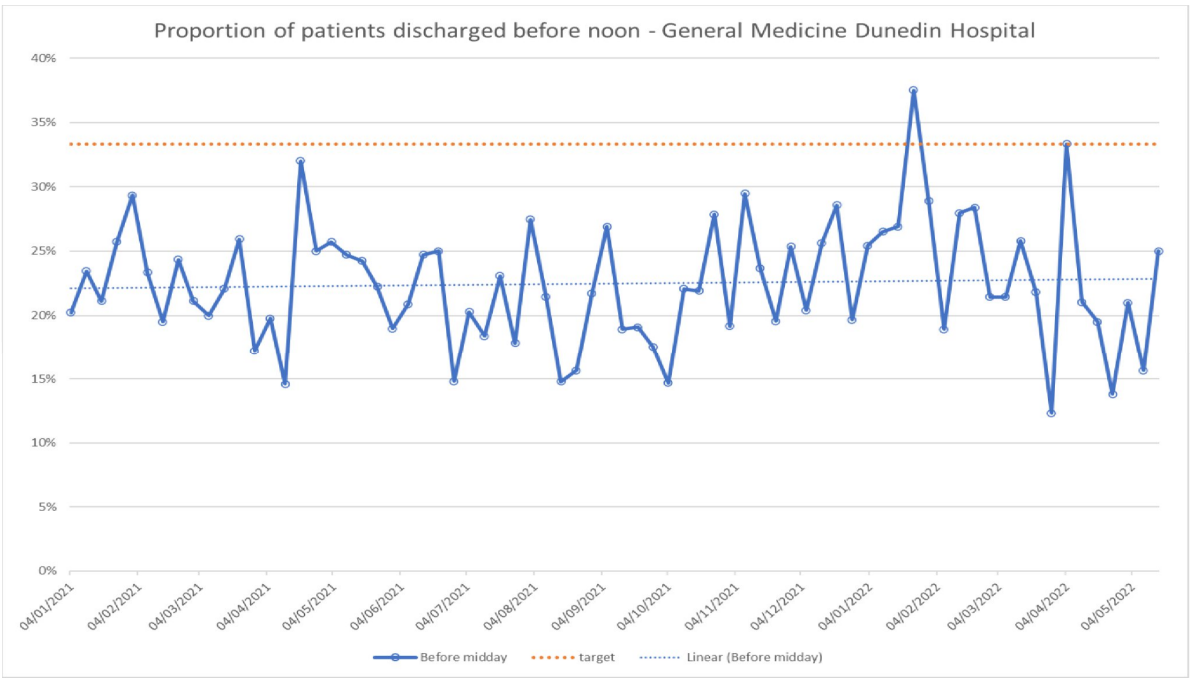


Weekend vs Week Day Discharges Invercargill Hospital

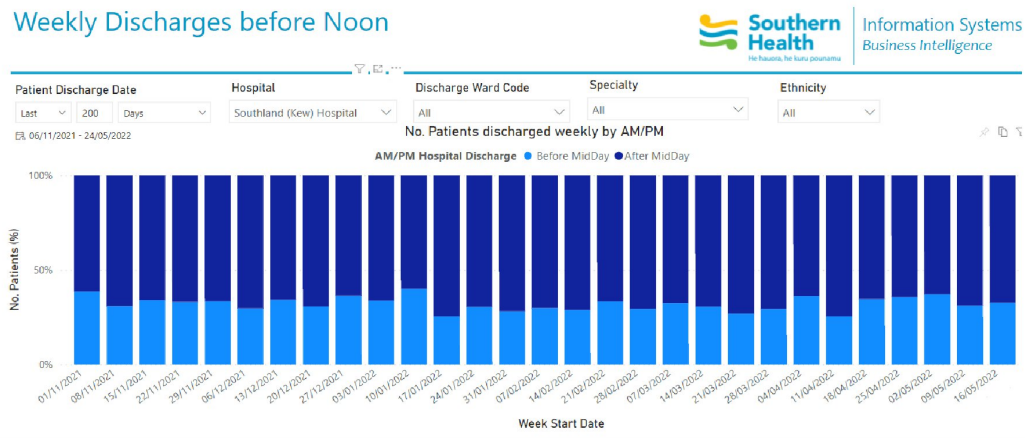


Dunedin Hospital Discharges before Noon





Invercargill Hospital



12.3

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) Iwi Governance Committee ▪ Unconfirmed minutes of 9 May 2022 meeting b) Finance, Audit & Risk Committee ▪ Verbal report of 7 June 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.
Interim Annual Plan 2022/23 (Final)	Subject to Health NZ/ Ministerial approval	Section 9(2)(f)(i) of the Official Information Act.
Capex ▪ Replacement of Digital Subtraction Angiography (DSA) Equipment, Dunedin Hospital ▪ Network Replacement	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 ▪ Strategy Primary and Community ▪ Rural Hospital Contract ▪ National Bowel Screening Contract ▪ St John Patient Transfer Service	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.