Mid Implementation Review

SDHB Primary Maternity System of Care

3 October 2019

Building a better working world

Table of contents

1. Executive summary

EY was engaged to provide an independent mid implementation review (the review) over the delivery of the Integrated Primary Maternity System of Care Strategy (the Strategy) of the Southern District Health Board (SDHB).

1.1 Our scope

The focus of the review was the implementation of the nine actions within the Strategy from the point at which it was published (10 August 2018) through until 31 July 2019[1]. The scope of the review focused on:

- The extent to which each of the required nine actions have been delivered to-date.
- Whether the activities planned will be sufficient to deliver any outstanding deliverables in respect of the required nine actions.
- Identification and prioritisation of any lessons learnt to support the delivery of any remaining actions and / or the delivery of future complex programmes of work.

1.2 Background

2016

In 2016 a Primary Maternity Project was established to develop a holistic, system wide solution to the delivery of primary maternity services. The project was completed in May 2017. Additional consultation was held with key partners (Ministry of Health, College of Midwives, and consumers) during August to November 2017, to build on the outcomes of the project and to define a three-tier system of primary maternity care aligned to the SDHB's Primary and Community Care Strategy.

2017

2018

In March 2018 the outcome of this work was released for consultation[2]. As part of the consultation process, 216 submissions were received, primarily related to the transition of the Lumsden facility from a Primary Birthing Unit (PBU) to a Maternal and Child Hub (Hub). Alongside consideration of these submissions an independent review into the southern district's midwifery workforce sustainability[3] was undertaken and released in May 2018.

The above forms the foundations of the Strategy which was approved by the Commissioner Team in late June 2018 and publicly released in August 2018. The decisions made were incorporated into nine key actions. These actions form the foundation of the Strategy and subsequently the focus of this review. The nine key actions are detailed in Appendix A.

2019

With reference to the nine key actions, at the time of this review, seven are in progress, one has been delivered (action nine), and one is not yet underway (action seven).

1.3 Accomplishments to date

SDHB is now 12 months into the implementation of the Strategy with the focus of work-to-date on stabilising the Wanaka and Te Anau districts' Lead Maternity Carer (LMC) workforce, introducing a remote and rural sustainability package for LMCs, and commencing the establishment of the Hubs in Te Anau, Wanaka, and Lumsden. Delivery of the actions to-date has resulted in:

[1] The scope of the work stated a date for the review through until the 30 June 2019. Given the timing of the work, the timeline was extended through to 31 July 2019.
[2] The document released for consultation was titled "Creating an Integrated Primary Maternity System of Care across the Southern District"
[3] SDHB – Midwifery Workforce Sustainability and Maternity Workforce Service Assurance (Aileone and Kyle, May 2018)

Contract Decisions	Additional Resourcing	LMC Sustainability	Service Improvements
Refreshed contractual terms and funding agreements for some PBUs. This has allowed operational and service planning to occur which was previously restricted due to short-term contracts (action eight).	The provision of additional SDHB funded emergency equipment and medicines at Hubs (action one).	Increased funding to 23 LMCs through a sustainability package offering payments to those working with women in remote and rural areas and a relief midwife service (action three).	The development and introduction of the key operational foundations for all Hubs. This includes the appointment of Hub coordinators (action one).
The decision to establish a primary birthing facility, based on a funded feasibly study, as a stand-alone facility alongside the Dunedin hospital (action nine).	Covering the rent and some consumable costs historically paid for by LMCs to run their practices (action three).	The provision of locum support in some locations enabling 60 hours of 'days off' cover as well as to provide back up support at births (action three).	Extension of the successful telemedicine obstetric clinic at Wanaka. (action two).

Refer to Section Three for a detailed overview of steps taken towards the implementation of the nine key actions. Refer to Appendix C for a timeline of the key events post the Strategy release.

1.4 Key observations and recommendations

Implementation of the Strategy was signalled to be progressed over a two-year period. Within the first 12 months, progress has been made towards this objective whilst balancing the management time required to address the on-going feedback and publicity relating to the transition of Lumsden to a Hub and the media coverage that the Strategy has attracted.

There is an opportunity now to reset the remaining programme delivery, to define the activities required to complete each action, and to facilitate more co-ordinated community / stakeholder engagement in their delivery and / or design.

Within the context of our scope, we have identified the following key observations / recommendations:

- The governance framework supporting the Strategy's delivery has been informal resulting in unclear accountabilities and inconsistent reporting, with a focus on operational matters and issue response management. Implementation would benefit from a governance framework that focuses on a greater level of strategic oversight and consistent monitoring of formal delivery and action plans.
- The absence of formalised project management practices, together with key personnel movements, has impacted the effectiveness of the implementation to-date. This has resulted in delivery being led by individuals as opposed to there being a co-ordinated delivery plan with clear milestones and timelines. Targeted communications and process / operational design, with clear lines of accountability and reporting, should be established to support delivery momentum and accountability in addition to maintaining community engagement.
- The communications and change management approach could have been better defined and targeted to identify and support those communities most affected by change (Wanaka, Te Anau, and Lumsden). More structure is needed to strike the right level of engagement required, to identify the correct stakeholders to engage with, and to determine the appropriate timing of messages required to communicate progress. To foster a more collaborative relationship between the SDHB and its communities', key stakeholders should be identified and ideally regularly engaged with. This will support improved engagement with, and better understanding of, the Strategy.

- There is a lack of clarity around the definition of a Hub from both a service design (what will be delivered) and service delivery (how delivery will occur / daily operations) perspective. This is resulting in confusion and a misalignment of expectations within the SDHB as well as between the SDHB and key stakeholders. A shared understanding should be defined, this should include:
  - Service components
  - Operational design and processes
  - Responsibilities and accountabilities.

Specific observations identified during the review and associated recommendations to address them are detailed in Section 2 of this report.

We would like to thank all of those involved in the review for their time, feedback, and honesty. There was a high level of engagement and this engagement has enabled both this review and supported the insights into how the SDHB might best deliver the remaining activities within the Strategy's nine key actions over the forthcoming 12-month period.

Ernst & Young Limited
Damian O'Connell
Partner - Advisory

Inherent limitations

Our work is not performed in accordance with generally accepted auditing standards in New Zealand and accordingly does not express any form of statutory audit opinion.

In performing our procedures, we have accumulated data, written various memoranda for our own use, and have had various meetings with representatives of the Southern District Health Board. The procedures performed, and related findings, are presented in the attached findings and observations.

The views expressed in our report are strictly limited to Ernst & Young Limited's area of professional expertise and your instructions as stated in the All of Government Consultancy Services Order dated 9 July 2019. Our report is strictly limited by the matters stated in it and is not to be applied by implication to any other matters.

Our fieldwork was completed on 23 August 2019. Our findings are expressed as at that date. We have no responsibility to update this report for events or circumstances occurring after that date.

Third party reliance

This report has been prepared at the request of the Southern District Health Board in connection with our engagement to perform Mid Implementation Review Independent Quality Assurance services. This report is solely for the benefit of the Southern District Health Board for the purpose set out in this report, and is not to be used for any other purpose or distributed to any other party or relied upon by any other party without Ernst & Young Limited's prior written consent.

Our Services are performed and our report is prepared for the Southern District Health Board only, and we disclaim all liability to any other party in connection with the Services and/or our report. Other than our responsibility to the Commissioner Team and Management of the Southern District Health Board, neither Ernst & Young Limited nor any officer or employee of Ernst & Young Limited undertakes any responsibility or liability arising in any way to any third party, in respect of this report.

2. Detailed observations and recommendations

This section contains our detailed observations and the associated recommendations. This incorporates the lessons learnt through the delivery of the Strategy through to 31 July 2019.

2.1 Informal governance practices

The governance framework supporting the implementation and delivery of the Strategy has been informal resulting in unclear accountabilities and inconsistent reporting. Governance has occurred through repurposing the existing weekly Operational Huddle Group and the establishment of a monthly Primary Maternity Strategy Implementation meeting. Discussions have tended to focus on operational matters and issue response management. Clear roles and accountabilities are not defined and aligned to required actions. Programme delivery risks have not been formally identified and managed through a defined risk management process. The absence of clear accountabilities has meant that clinical governance representation has not always been consistently considered.

In the absence of key artefacts such as standardised status reporting, risk frameworks, and defined escalation pathways, governance has strayed towards an operational focus as opposed to a delivery focus. Decision making has therefore become more reactive and issues driven, as opposed to referencing a defined plan linked to desired outcomes. The specific activities (and a definition of 'done') required to deliver the nine key actions is yet to be defined in detail and / or formally tracked.

We understand that the Alliance Leadership Team, including midwifery representation, is the likely governing body for the Strategy going forward as they already have strategic oversight of the Southern Primary and Community Care Strategy. It is recognised that both strategies need to be aligned. This understanding should be confirmed and reflected going-forward.

Reference	Recommendation
SDHB - 01	A clear and formalised governance structure should be put in place, building on the initial terms of reference for the implementation group. This would support decision-making with reference to intended strategic outcomes and requirements. This should include, but not be limited to: ▶ Formalising and defining accountability for each role and governance forum within the programme, including defining their decision-making authority and reporting requirements. ▶ Establishing (and scheduling) formal meeting and reporting timeframes and requirements. ▶ Identifying and communicating issue tolerances and associated escalation paths. This would support issues being clearly managed while not derailing or hampering wider project progress. ▶ Agreeing upon a standard reporting template for each governance forum to monitor delivery of the nine key actions (in-line with recommendation SDHB - 02). ▶ Implementing decision logs supporting both project and governance forum decisions. ▶ The capture and reporting of any risks (via a Risk Register) and barriers to implementation and their mitigation strategies and the ongoing success of the mitigation activities. ▶ Including clinical representation for oversight and governance related forums in order to best support the establishment of the new operating model. ▶ Promotion of the alignment to the Southern Primary and Community Care Action Plan[4].

[4] As detailed in the "Southern Primary and Community Care Action Plan"

2.2 Informal project management practices

The project management practices supporting delivery of the Strategy has been informal and has lacked the level of maturity required for a project of this scale. Additionally, the project has suffered from resourcing challenges with key staff movements. Resource planning has not been optimised to better support the change impact required with reference to the delivery of the nine key actions.

There is an absence of some core project documentation important to mitigating delivery risk, including:

- A formal, approved definition of each of the nine key actions.
- A breakdown of each action into key delivery components, associated milestones and delivery timelines (beyond the initial incomplete draft completed October 2018).
- Formalised allocation of roles and responsibilities for each of the nine key actions.
- Identified dependencies or activities that require consultation.
- Identified milestones or activities that require legal review, clinical review, commercial review, or procurement support.
- A standardised regular status update report tracking action delivery, financial metrics, key milestones, risks and mitigations.

As a result of the above, strategic planning requirements, decision-making authorities, and due diligence checks were not always identified resulting in some unstructured delivery, communication challenges, and some misalignment of expectations between SDHB and stakeholders. Examples of this include: complications with Hub chattels (misunderstandings about what items are included in lease contracts), equipment delivery timelines (with equipment arriving post Hub establishment), and supplier contracts (such as cleaning contract) delays.

Reference	Recommendation
SDHB - 02	The project delivery approach should be formalised and resourced to better support and enable the project team to deliver the nine key actions. This should include, amongst other things: ▸ Formally defining and approving each of the nine key actions. ▸ Completing a workshop session (or some other mechanism) to breakdown each of the nine key actions into its remaining deliverables (refer to Appendix A for assistance with this). This should incorporate defining: who is responsible for delivery, what resourcing is needed, an appropriate timeline, and what success looks like. ▸ Formalising necessary delegations supporting the sign-off on action completion (with reference to the definition of 'done'). ▸ Identifying and establishing an appropriate resourcing model in-line with recommendation SDHB – 07. ▸ Increasing clinical involvement through the leveraging of relationships with the Chief Medical Officer and Obstetric Teams. ▸ Consult on and co-design solutions (as initially intended) with the impacted communities with a focus on change management requirements and capturing service needs. ▸ Creating and documenting a project delivery plan supporting the delivery of the Strategy and the balance of the nine key actions. ▸ Completing regular status reporting incorporating and tracking the following (processes will need to be developed to support some of these): project actions, financial metrics, the delivery of key milestones, risks and mitigations, and emerging issues. ▸ Reviewing the remaining contractual requirements to complete actions (i.e. the lease for the Wanaka midwives' rooms and the service agreement for the Te Anau emergency room) and working with SDHB's procurement and legal teams to finalise these in a timely manner with adequate due diligence.

2.3 Impacts of key person movements

The implementation of the Strategy has been impacted by resourcing challenges and key personnel movements:

- Core roles have remained vacant during critical periods. For example the Strategy Project Manager role has been vacant since February 2019 and over this time would have been responsible for supporting the operational milestone delivery, such as contract oversight, co-design of the Hub model, ensuring the appropriate equipment and connections were in place for telehealth sessions to commence / be enhanced, facilitation of communications / messaging to communities, formally progressing work on the equalisation model and reporting on the progress of the establishment of the two hubs which opened in April 2019 (Te Anau and Lumsden).
- In addition to this, given the challenges with resource planning, there has been an expectation / need that both governance and delivery roles continue to be completed on top of the ordinary SDHB business as usual commitments. Examples of roles impacted by this include Executive Director Strategy, Primary and Community, General Manager Primary Care and Population Health and the Primary Maternity System Improvement Leader.
- Attrition and planned / unplanned leave (for example in key roles such as Primary Maternity System Improvement Leader and Project Manager) have also impacted the continuance of project delivery momentum.

These resourcing challenges have been exacerbated due to the need to respond to a large volume of Official Information Act requests and various media inquiries. Collectively this has had the impact of drawing the limited project resources available into issue remediation and response as opposed to project delivery and planning.

Reference	Recommendation
SDHB - 03	Appoint a dedicated Project Management (PM) resource to drive the planning and implementation of the Strategy over the next 12 months. This role should be supported by the reappointment of a Primary Maternity System Improvement Leader (PMSIL), or similar role providing primary maternity leadership and support, in line with recommendation SDHB - 08. The PM role / capabilities should include as a minimum: ▸ Project management delivery experience (ideally in similar project type situations and environments). ▸ The ability to build clinical relationships in order to plan and consult on action delivery and impact. ▸ Lead the various actions and processes in line with recommendation SDHB – 02. ▸ The ability to review and align the Hub coordinator position across facilities and with the other project resources and stakeholders so there is clarity on accountabilities for all Hubs. ▸ A proven ability to manage core project management related tasks (for example planning, budgeting, financial process tracking, workstream management, risk and issue management, etc)

2.4 Unstructured communications and change management approach

The project has suffered from the absence of a structured communication and stakeholder engagement plan. The impact of this has been amplified by the lack of a formal change management practice to support the delivery of the nine key actions. The absence of a consistent clinical voice supporting communications regarding the Strategy was readily identified through interviews and has further impacted this area.

Throughout the duration of the review activities, stakeholder interviews consistently identified that there was perceived variability in the communication and change management approach supporting the Strategy. It is perceived by the stakeholders that communication and change management planning has not been structured in a manner that prioritises those heavily impacted (for example, LMCs, Lumsden, and Te Anau) and / or has not been as consistently directed and delivered as frequently as desired by a number of stakeholders.

Feedback across stakeholder groups also identified inconsistency in the opportunity to engage with the SDHB team by way of face-to-face meetings (which were perceived as important), with some locations receiving multiple visits (Winton and Gore) and others receiving none (Maniototo). The requirement to travel to participate in consultation with SDHB was also highlighted as a detractor to ongoing communication in respect of the Strategy.

The impact of variable communication and the lack of a change management framework has left some stakeholders and communities with a sense of disengagement in respect of the Strategy. It has resulted in confusion (for example the definition of a Hub is vague and undefined), mixed and / or misinformed messages (such as the PMSIL was referred to as 'a rural liaison role'), and the expectation from some stakeholders in Te Anau that the Hub would be a separate facility. There is also, to a certain extent, some disillusionment with the Strategy as some stakeholders referred to long periods of silence in between communications from the SDHB and being left with the sense that no progress was being made on the actions that affected their respective locations. It is also noted from stakeholder interviews that feedback from the facilities / communities where the SDHB were able to more readily complete face-to-face visits reported better engagement and outcomes.

Reference	Recommendation
SDHB - 04	Complete a communication and stakeholder engagement plan for the remaining 12 months to promote transparency, rebuild trust, and foster engagement with those impacted by changes introduced to support the delivery of the remaining actions. This should include: ▶ Fostering (and driving) increased community involvement by considering the location, times, and virtual dial-in opportunities for attending sessions. There should be a broad attempt to be as inclusive as possible across the region. ▶ Leveraging lessons learnt from the Communications Consultant engaged by SDHB. ▶ Strengthening clinical engagement and leadership. Strong clinical leadership will help to promote, support and drive the remaining work and build trust with communities and stakeholders. ▶ A defined approach to change management in respect to the actions requiring delivery over the coming 12 months. ▶ Identifying critical communication points supporting action milestones. ▶ Underpinning any communication and stakeholder engagement planning with adequate resourcing for delivery. ▶ Identifying and communicating a contact point / role where questions and concerns can be directed pertaining to action delivery. ▶ Consider the delivery of a 'Strategy Roadshow' to communicate the accomplishments under the Strategy to-date, seek feedback on their implementation, and communicate the remaining delivery milestones.

2.5 Hub service components and operational delivery unclear

The delivery of action one, Hub establishment, would have been more effective if there was a commonly shared definition of the purpose of a Hub within the communities they operate. Confusion as to the definition and purpose of the Hubs was evident with a number of the stakeholders spoken to with the evolution of the individual Hubs being influenced to a degree by the appointed Hub coordinators.

In addition to the above, delivery of the Hubs should be supported by the identification of the minimum baseline of Hub requirements and the appropriate planning to identify these and deliver them ahead of respective transition dates. Acknowledging that Hubs were always intended to be co-designed with their communities, it has been identified that the lack of a standard model of care (service design) or operational design has introduced confusion and misaligned expectations with key stakeholders and communities (to varying degrees).

The lack of fulltime Project Management resource to work with local communities to co-design the Hub model and to coordinate the operations and logistics of the Hub transitions, has resulted in varying levels of engagement and communication with key stakeholders (including those intended to be coordinating the Hubs). This has been specifically highlighted through stakeholder interviews identifying frustration with some of the Hub components not being delivered ahead of the Hub transition dates. Examples of this include the contracts for use of facilities, training, access agreements, Hub coordinator contracts, and imprest supply list for clinical and pharmaceuticals supplies.

Reference	Recommendation
SDHB - 05	Finalise and consult upon the baseline Hub components (including a level of consistency across locations). This should include: ▶ Consulting with local communities and key stakeholders to confirm the model of care ▶ Complete circulating and testing an imprest supply list for clinical and pharmaceutical supplies, including definition of who is responsible for procurement and maintenance of the supplies. This may potentially be able to be based upon the lists used for Wanaka and Te Anau. ▶ Agreeing with LMCs what home birth consumables are provided by the SDHB versus what are provided by the LMCs themselves. ▶ Analysing if additional telemedicine or physical obstetric support should be built into Hub offerings in line with recommendation SDHB - 09. ▶ Introduce an annual review mechanism to ensure quality, safety and efficiency of services and design. ▶ Agreeing who is responsible for regular checks of SDHB provided equipment. ▶ Facilitating Hub coordinator sessions to promote continuous improvement and share lessons learnt. ▶ Document expected Hub operational procedures to set a baseline on design and delivery. ▶ Confirming what community and post-natal services are still provided by each Hub as well as replacement options if a particular service is no longer available (for example newborn hearing screening and breastfeeding support). ▶ Confirming who is the SDHB contact point for queries and escalation of Hub issues. ▶ Confirm responsibility for communicating the outputs of this Hub component establishment to the wider community.

2.6 Delivery of a decision document outlining the Central Lakes District Primary Maternity Facility is at risk

The location of the Central Lakes District Primary Maternity Facility (action seven) is considered to be at risk of not being delivered over the next 12 months as to-date, planning, analysis and consultation supporting this action has not commenced.

The decision deadline as set out in the Strategy for this action is June 2020 and will require an established Primary Model of Care for its introduction. It is possible that the timeline will need extension to support the delivery of this action because planning, analysis of all the appropriate data, locations and sites, and engaging / consulting widely across the Central Lakes district with communities and the workforce will take some time to complete.

Determining the future configuration of Primary Maternity Services across Queenstown, Wanaka and Central Otago, and widely consulting on the impact of such a change on the surrounding communities should be a priority for the SDHB. For example, the impact on the current midwifery workforce in the area, the facilities already operating in this area and also the distance for women and LMCs to travel to any new facility for birthing.

Reference	Recommendation
SDHB - 06	Once the three-tier system is understood and service specifications and Hubs are better defined (in line with recommendation SDHB - 05) determining current state, a plan around the consultation, engagement and information required to progress action seven (Central Lakes Primary Maternity Facility) should begin. This should include: ▶ Identifying the key milestones required for preparing an options paper and who will approve this. ▶ Identify the consultation / engagement requirements and timelines as part of articulating these milestones. ▶ Identifying future state requirements. ▶ Identify any further information required based on the analysis, or required reporting feeding through from other Hub locations and current Central Lakes primary birthing units to provide the data to underpin robust analysis and decision-making.

2.7 Sustainability package has had unintended consequences

The sustainability package has been accessed by 23 LMC midwives to-date and is supporting the ability for LMC practices to remain sustainable. However, the package has also unintentionally rewarded midwives with large(r) caseloads given it is financial renumeration based on volumes.

Additional initiatives implemented and provided by the SDHB, on top of the financial remuneration for caseload volumes, include: paid locum support, payment of rent, consumables (in the Hubs) and the funding of training (PROMPT). For example, in 2018 a locum midwife service was placed in Wanaka due to their only being one local LMC (a second was supported into practice in 2019), and monthly locum support has been provided to the sole LMC in Te Anau.

Recruitment of additional LMCs to some communities (as is referred to in action six of the Strategy), may result in unintended consequences. It will provide increased LMC cover but will also mean a decrease in the number of women booking per LMC with a subsequent drop in income. Sustainability of income will be an issue for some LMCs and may lead to them deciding to no longer practice as a midwife. Any case load analysis undertaken should include consideration of what number constitutes a sustainable income.

It was also noted that a review of the sustainability package is overdue per action reporting.

Reference	Recommendation
SDHB - 07	Plan for and resource a review of the current sustainability package to determine if it is having its intended impact, with a view to implementing any improvements if identified. The review should include: ▶ Considering the sustainability of the package if more midwives where to move into the district. Will additional funding be required to create a longer-term solution? ▶ Seeking to resolve or mitigate, where possible, any unintended disincentives that may have been introduced. ▶ Aligning the sustainability package to the LMC retention and recruitment initiatives under action six. ▶ Consider including within the package other sustainability initiatives beyond financial renumeration (such as supplying LMCs with consumables for use in the community). ▶ Considering the unintended impact of attracting more LMCs in some areas on existing individual caseloads.

2.8 The role and scope of the Primary Maternity System Improvement Leader was ambiguous

The job description for the currently vacant PMSIL could have been better defined and positioned alongside other SDHB positions such as the Director of Midwifery. Formalised decision-making authority, action accountability and scope has been unclear, overlapping with the Director of Midwifery. In addition, there was role 'creep' once the Project Manager role was vacated (this included, for example, management of Hub transitions and completing project reporting).

Feedback received suggests this role was well received by the LMCs and Hub coordinators but struggled to be effective without the programme management framework, including the Project Manager, behind it to define priorities and scope related to the role.

The initial intention of the role was to provide more direct assistance to rural LMCs and to assist with the development and implementation of the sustainability package. With the departure of the Project Manager the PMSIL role was expected to pick-up the various project management functions in addition to the core role. Additionally, stakeholder feedback suggested the involvement of the PMSIL role in the establishment of the Hubs resulted in a reduction in the role's prior effectiveness of working closely with LMCs.

Reference	Recommendation
SDHB - 08	If the PMSIL role is retained, or similar role providing primary maternity leadership and support, consideration should be given to the development of a new clearly defined job description and role profile. In determining the parameters of the job description and role profile, consideration should be given to: ▶ What the long-term requirements are for this role necessary to monitor, manage, support and maintain the quality of primary maternity care. ▶ How this role complements and aligns to the Director of Midwifery's role. ▶ How to manage any potential conflict that may arise through the role being both responsible for liaising with and delivering actions within communities. ▶ Defining the accountability and governance channels this role needs to provide reporting and feedback to.

2.9 Telemedicine obstetric support in its infancy

The introduction and expansion of virtual and actual obstetric support across the district has demonstrated success in key areas, such as Wanaka, by reducing the need for women to travel for secondary care appointments. Current service demand in Wanaka has led to the service being oversubscribed.

Despite these successes there is variation and inconsistency in the roll-out and progress of telemedicine service offerings across the various geographical locations. Some locations have just fibre installed, whilst others have the equipment but are yet to harness the capacity and service of the telemedicine obstetric support.

There are some locations within the SDHB region where telemedicine will save time, travel, and money for those travelling long distances to access services but where the telemedicine service is in its infancy or yet to be introduced (for example, Te Anau, Lumsden, and from within the home for women (and their LMCs) when access to a Hub is not practical.

Reference	Recommendation
SDHB - 09	Continue and complete analysis into virtual and actual obstetric support requirements based with reference to demand and requirements. Confirm Hub coordinators and all relevant staff are supported in its use and facilitation. The design and implementation of processes and its support is key to the success of the telemedicine service. Actions taken should include: ▶ Resolving the Wanaka teleobstetric service supply shortage (for example increasing these to twice a month if possible). ▶ Providing appropriate equipment and internet access to other Hubs where demand is present. Demand should be identified by a co-ordinated requirement gathering approach and addressed in order of greatest need. ▶ Considering what support is needed to be provided 'from home' for women and their LMCs to access if travelling to a Hub is not practical. ▶ Considering Obstetric capacity to deliver in an increased number of clinics.

2.10 Equalisation of funding has not formally progressed

Equalisation of funding across Primary Maternity Facilities (PMF) has not yet been formally progressed by the SDHB, however we note that some PMFs have received an increase in funding and attribute this to action eight. We also acknowledge the SDHB's intention towards the implementation of action eight. Stakeholders identified that there was some communication with the PMFs in October 2018 around this action with an analysis on the use of the Relative Value Units (RVU) model for future funding. There were issues with the data identified by the PMFs at the time, however it is unclear to associated stakeholders if further work is being done in respect of this action.

While we do not think this action is at risk, key stakeholders identified they are impacted by the delay in this action being progressed and they noted the potential impact with short-term contracts, on service delivery standards and longer-term investment. Retention of staff is impacted by the PMFs' ability to plan long-term with only 12-month contracts (for example, the uncertainty of work, and also their ability to pay salaries at a contestable rate).

Reference	Recommendation
SDHB - 10	To support an equitable primary maternity care system and the best use of resources the 'Next Steps with Primary Maternity' Report to the Commissioners (June 2018) around proposed funding options for the primary birthing units to foster sustainability and equalisation should be revisited and completed as part of action eight. This should reference whether: ▶ Each primary birthing unit's ability to obtain Section 88 funding. ▶ Analysis into if the RVU approach is more appropriate. ▶ If the RVU approach is adopted, support the compliance with National Minimum Dataset requirements for facilities where applicable. ▶ Consideration of increasing the sustainability of PMFs through other mechanisms such as attracting more post-natal stays.

2.11 Lessons Learnt

There have been a number of lessons learnt from the delivery of the Strategy to-date. A number of these have been incorporated into our observations and the recommendations made. Additionally, the following lessons have been learnt by SDHB:

- The need to communicate the bigger picture to the whole of the SDHB region.
- The need to proactively communicate messaging as opposed to only reacting to what has been raised in the media.
- Having highly visible clinical champions and spokespersons for the Strategy.
- Recognition of the level of change required by some communities / clinicians.
- The establishment of an independent Chair to facilitate meetings, as evidenced by the 'Gore Meetings' in July and August 2019, has supported the SDHB to re-establish communication and associated support with the Northern Southland LMCs and to a certain extent the Medical Trust (NSMT) as well.
- To increase the discipline associated with establishing commercial contracts and to rely on detailed schedules over working in good faith.
- The need to facilitate co-design of the Hubs with local communities.
- Not assuming that local practitioners / Trustees and the SDHB were 'talking the same language'.
- Visiting each facility in person to capture information and build out consumable, medicine, and equipment lists is a more effective approach than doing it via email.

3. Summary of action delivery

The following table details our view of the status of each of the nine actions, key milestones achieved, and the remaining high-level activities to be completed to confirm action delivery. Remaining activities are either in the process of delivery or are incorporated in one of the recommendations detailed in Section 2.

In the absence of any defined actions or action milestones by the SDHB, the key milestones and remaining activities presented here have been identified through our stakeholder interviews and documentation review. As a result, this is not an exhaustive list and it is expected it will be refined and expanded upon by SDHB as part of their next steps in the Strategy delivery.

Action	Key milestones achieved	Remaining activities
Action One		
Wanaka	▶ Temporary facility leased for Hub, including emergency birthing space (April 2018). ▶ New premises identified for future Hub and lease signed (Gordon Road, May 2019). ▶ Contract for service established (October 2018). ▶ Hub Coordinator role in place (October 2018). ▶ Telemedicine clinics run by Hub coordinator (Jan 2019). ▶ Equipment, consumables, medicines agreed and purchased. ▶ Emergency protocol established. ▶ Access agreements confirmed. ▶ LMC access to room after-hours in the Medical Centre.	▶ Refit and move into Hub (Gordon Road). Redistribute/arrange equipment, consumables, medicines etc once Gordon Road established. ▶ Source long-term Hub solution closer to helipad. ▶ Finalise rent negotiation for the extension of the Wanaka Lakes Medical Centre for midwives' room and emergency space. ▶ Communication with local LMCs crucial for success of the Hub. There are concerns re: access to helipad, where emergency equipment should be stored (medical centre / Hub) as well as continued communications / integration with medical team. ▶ Independent after-hours access for LMCs to Medical Centre room. ▶ **See recommendation SDHB – 05.**
Te Anau	▶ Lease for LMC room / emergency / rapid birthing space obtained (January 2019). ▶ Hub Coordinator appointed (April 2019). ▶ Telemedicine facilities available. ▶ Equipment, consumables, medicines agreed and purchased. ▶ Emergency protocol established. ▶ Access agreements confirmed (July 2019).	▶ Establish specialist support (virtual or actual). ▶ Finalise service contract (including Hub Coordinator specifications). ▶ Resolve telemedicine technology issues. ▶ Procure CTG. ▶ Plan hub-based education PROMPT. ▶ **See recommendation SDHB – 05.**

Action	Key milestones achieved	Remaining activities
Lumsden	▶ Lease for LMC rooms and emergency/rapid birthing space obtained (April 2019). ▶ Hub Coordinator appointed (June 2019). ▶ Equipment, consumables, medicines agreed, replaced and purchased. ▶ Emergency protocol established. ▶ Access agreements confirmed. ▶ Cleaning contract in place with Gore Health.	▶ Establish specialist support (virtual or actual) if required. ▶ Finalise service contract (including Hub Coordinator specifications). ▶ **See recommendation SDHB – 05.**
Maniototo	▶ Hub comprises of new rooms for LMC use (April 2019) and use of the emergency department at the hospital. ▶ Service agreement with Hospital updated which includes equipment, medicines and consumables (Sept 2018). ▶ Emergency protocol established. ▶ Access agreements agreed.	▶ Analysis around telehealth applicability. ▶ Evaluate and identify any improvements needed (including alignment of equipment). ▶ **See recommendation SDHB – 05.**
Waiau	▶ Hub offering pre and post-natal LMC support established with medical centre (October 2018). ▶ Service agreement held with Trust and Hub coordinator role included (October 2018). ▶ Medicines and basic equipment available through medical centre. ▶ Access agreements agreed.	▶ Analysis around telehealth applicability. ▶ Evaluate and identify any improvements needed (including alignment of equipment). ▶ **See recommendation SDHB – 05.**
Action Two		
Support extension	▶ Telemedicine being used in Wanaka and Lakes District Hospital for obstetrics. ▶ Offering of telemedicine being built into the service specifications contracts.	▶ **See recommendation SDHB – 09.**

Action	Key milestones achieved	Remaining activities
Action Three		
Sustainability package	▶ Consultation held with LMCs over sustainability package (October to December 2018). ▶ Sustainability package established with 23 midwives using this to date (June 2019). ▶ Locum support in place during transition (Lumsden, Wanaka, Te Anau). ▶ Increased DHB funded resources (rent, consumables, medicines etc). ▶ Winton lease extended to three yearly so staff able to be given a pay increase.	▶ Review the sustainability package for effectiveness and amend if required. ▶ **See recommendation SDHB – 07.**
Action Four		
Resourcing	▶ Primary Maternity System Improvement Leader and Project Management roles have been in place. ▶ Expansion of the Wanaka Hub Coordinator role to include some long-term planning establishing relationships with the medical team and running the establishment of the Gordon Road Hub. ▶ Hub Coordinators in place for all locations.	▶ Rewrite and advertise for PMSIL (or similar primary maternity leadership position) and PM positions. ▶ **See recommendation SDHB – 03.** ▶ **See recommendation SDHB – 08.**
Action Five		
Communications Plan	▶ Initial Communications Plan drafted (last updated April 2019). ▶ Community engagement meetings held (not in Lumsden or Te Anau). ▶ Communications specialist advice obtained (June 2019).	▶ **See recommendation SDHB - 04.**

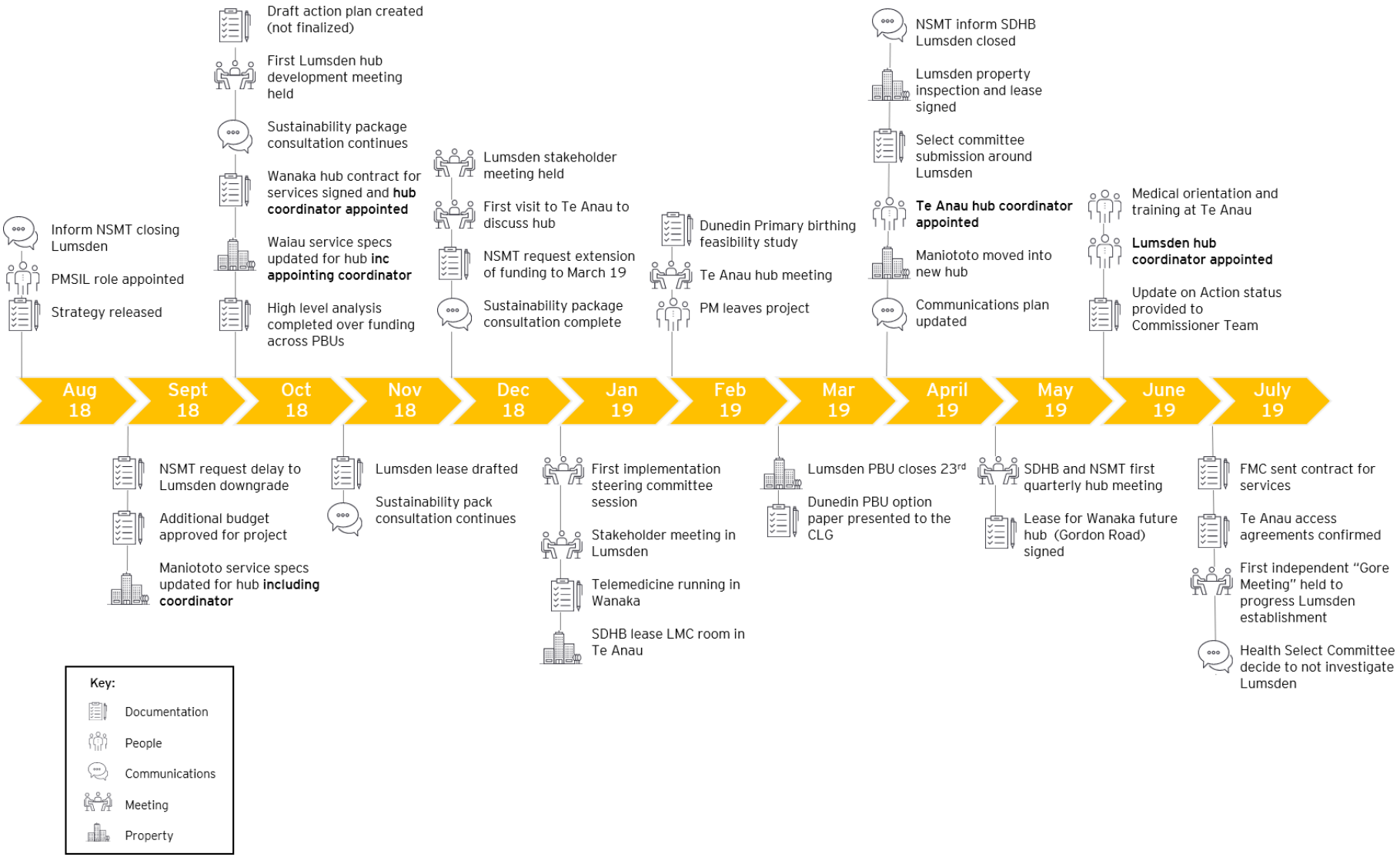
Action	Key milestones achieved	Remaining activities
Action Six		
LMC retention and recruitment	▸ Attracted additional LMC resource into the district. ▸ Relief midwife contracts in place for Wanaka, Te Anau, and Lumsden. ▸ Stabilised Wanaka urgent workforce issues (October 2018).	▸ Continue to resolve issues in Dunedin, Invercargill, Oamaru, Central Otago, Te Anau and Lumsden. ▸ **See recommendation SDHB – 07.**
Action Seven		
Central Lakes PMF	▸ Central Lakes Locality Network has been established with an appointed Chair (August 2019) to support the implementation of SDHB's Primary and Community Care Strategy and Action Plan and its alignment to action seven.	▸ Establish a plan, including consultation and data requirements to provide information for options analysis which has been signalled in the media in July 2019. ▸ **See recommendation SDHB – 06.**
Action Eight		
Equalisation model	▸ Additional payments have been made to Primary Birthing Units to foster sustainability (Alexandra, Balclutha and Winton). ▸ High level analysis completed (October 2018) on funding.	▸ **See recommendation SDHB - 10.**
Action Nine		
Dunedin PBU	▸ Feasibility study complete and presented to the Clinical Leadership Group (March 2019). ▸ An alongside Primary Maternity Unit was recommended and endorsed (March 2019).	▸ None. Action complete.

Appendix A Nine Key Actions

The nine key actions as identified in the Strategy are:

Action	Action Description
Action One	Work with the communities of Wanaka, Lumsden, Te Anau, Maniototo and Waiau to establish Hubs.
Action Two	Virtual and actual specialist support will be extended.
Action Three	Implement a sustainability package for LMCs who are serving rural remote women in our district.
Action Four	Dedicated resources will be appointed to the ongoing quality improvement of primary maternity services, and the leadership support provided to the LMC workforce. In addition, specific resources will be secured to implement the primary maternity system of care.
Action Five	A robust communications plan for primary maternity services in the Southern District to be developed.
Action Six	SDHB takes the lead on development of a recruitment and retention strategy for the LMC workforce across the Southern District.
Action Seven	Consideration to be given to the most appropriate location for a primary maternity facility within the Central Lakes district.
Action Eight	Agreement on an equalisation model to address traditional funding inequities across the primary birthing facilities in the Southern District is undertaken.
Action Nine	Consideration of a primary birthing unit in Dunedin, in conjunction with the new Dunedin Hospital rebuild, is undertaken by way of a feasibility study.

Appendix B Timeline of key events post Strategy release



Appendix C Our approach and interviewee list

We have taken the following approach in completing this review:

1. Conducted a series of interviews with 28 key internal and external programme stakeholders (detailed below).
2. Identified and reviewed 80 plus key artefacts against our expectations for a project of this size and type.

During this review we visited Dunedin, Gore, Te Anau, Winton, Lumsden, Alexandra, and Wanaka speaking to 23 people in their community settings and viewing the associated Hub or Primary Birthing Facility. We spoke to five people via conference calls representing Wanaka, Queenstown, Maniototo, and Waiau (covering all Hub facilities).

An initial stakeholders list was identified by the SDHB. Additionally, during the review other stakeholders were identified by EY or asked to participate in the review. Interviewees / potential interviewees were as follows:

Initial interviewees identified by SDHB	Initial interviewees identified by SDHB
Chris Fleming, CEO, SDHB	Jo Lundman, LMC, Te Anau
Lisa Gestro, Executive Director Strategy, Primary and Community, SDHB	Janese Priergaard-Petersen, Chair, Northern Southland Health Trust, Lumsden
Heather LaDell, Primary Maternity System Improvement Lead and Coordinator, SDHB	Sarah Stokes, LMC, Lumsden[5]
Kathy Grant, Commissioner, SDHB	Additional Interviewees identified by EY
Nicola Mutch, Executive Director Communications, SDHB	Glenda Maxwell, Quality Improvement Manager, Gore Health
Jane Wilson, Chief Nursing and Midwifery Officer, SDHB	Heather Hamilton, Nurse and Hub Coordinator, Fiordland Medical Practice
Jenny Humphries, Director of Midwifery, SDHB	Sue O'Brien, Hospital Quality Coordinator, Charlotte Jean Maternity Hospital, Alexandra
Mary Cleary Lyons, General Manager Primary Care and Population Health, SDHB	Peta Hosking, LMC, Wanaka
Karl Metzler, CEO, Gore Hospital	Bruce Kooman, Chair, Central Southland Health Trust
Dr Stephen Hoskin, GP, Fiordland Medical Practice	Debbie McDougall, Manager, Winton Maternity Centre
Averil Caird, Practice Administrator, Fiordland Medical Practice	Shelly Wesselson, Gore Facility Midwife, LMC and Hub Coordinator Lumsden
Dr Andrew McLeod, GP, Wanaka Lakes Health Centre	Geoff Foster, Manager Maniototo Health Services
Morgan Weatherington, LMC and Hub Coordinator, Wanaka	Jill Berry, Registered Nurse, Manitoto Health Services
Lyall Bailey, Accountant, Central Southland Health Trust	Ann Mackay, Midwifery Coordinator Lakes Maternity Unit, Queenstown
Deb Harvey, LMC, Wanaka	Jo Sanford, Manager Waiau Health Trust, Tuatapere

[5] This LMC requested questions via email instead of a meeting in person, questions were sent via email as requested however no response was received as at the time of issuing this report.

EY | Assurance | Tax | Transactions | Advisory

About EY

EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organisation, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. For more information about our organisation, please visit ey.com.