Southern DHB Board Meeting

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

07/07/2020 09:30 AM - 11:30 AM

APOLOGIES

An apology has been received from Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Board
Date of Meeting:	7 July 2020

Summary:

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).

Additions to Interests Registers over the last month:

- Mike Collins' entry updated.

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	n/a
Workforce:	n/a
Other:	

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 19/06/2020

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Dave Cull (Board Chair)	09.12.2019	Daughter-in-law employed as a nurse by Southern DHB		
	25.02.2020	Board Member, Cosy Homes Trust		
	25.02.2020	President, Local Government New Zealand (until July 2020)		
	25.02.2020	Trustee, Weller Trust (Property investment)		
	25.02.2020	Director, Popaway Ltd (Property investment)		
David Perez (Deputy Chair)	13.05.2019	Director, Mercy Hospital, Dunedin	SDHB holds contracts with Mercy Hospital.	Step aside from decision making.
	13.05.2019	Fellow, Royal Australasian College of Physicians		
	13.05.2019	Trustee for several private trusts		
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	Secretary, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
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.	
	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.	
	09.12.2019	Employee, Findex NZ		
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
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		
Jean O'Callaghan	13.05.2019	Employee of Geneva Health	Provides care in the community; supports one long term client but has no financial or management input.	
	13.05.2019	St John Volunteer, Lakes District Hospital	Nil	Taking six months' leave.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd*		
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.12.2019	*Shareholder in Te Kaika		
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.	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)		
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
Andrew Connolly (Crown Monitor)	21.01.2020	Employee, Counties Manukau DHB		
	21.01.2020	Deputy Commissioner, Waikato DHB		
	21.01.2020	Southern Partnership Group		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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.	
Roger Jarrold (Crown Monitor)	16.01.2020	CFO, Fletcher Construction Company Limited		
	16.01.2020	Member, 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		

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
Kaye CHEETHAM	08.07.2019	Ministry of Health Appointed Member of the Occupational Therapy Board	
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
	21.05.2020	Director, New Zealand Institute of Skills and Technology	
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	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 Maori 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.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	

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
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	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.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	NASO Governance Group Member	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	Lead GM Perinatal Pathology	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.

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
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCL	Nil
	18.12.2017	Daughter, medical student at Auckland University.	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
		Specified contractor for JER Limited in respect of:	
	31.10.2017	H G Leach Company Limited to termination	Nil, Quarry and Contracting.
	21.10.2019	Member, Chartered Accountants Advisory Group	
Gilbert TAURUA	05.12.2018	Prostate Cancer Outcomes Registry (New Zealand) - Steering Committee	Nil
	05.04.2019	South Island HepC Steering Group	Nil
	03.05.2019	Member of WellSouth's Senior Management Team	Reports to Chief Executives of SDHB and WellSouth.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Gail THOMSON	19.10.2018	Member Chartered Management Institute UK	Nil
	22.11.2019	Deputy Chair Otago Civil Defence Emergency Management Group, Coordinating Executive Group	
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

Southern District Health Board
Piki Te Ora

MyLab

Briefing

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

MyLab

Southern District Health Board
Piki Te Ora

What is MyLab

- Interactive innovation centre.
  - Use of Personas (current versus future)
  - Latest Technology
- To support the change management process for the NDH,
  - new models of care and health pathways.
- Co-designing our future engages with staff and our community
- Opportunity for testing and feedback
- Research opportunities
  - Impact on our people
- National and International Partnerships

MyLab

Southern District Health Board
Pīki Te Ora

Vision (People Led, Technology Enabled)

Physical/Virtual Space

CREATE A **PHYSICAL** AND **VIRTUAL** SPACE WHERE WE CAN SHOWCASE NEW **DIGITALLY ENABLED** MODELS OF CARE

Enhanced Experiences

DEMONSTRATE TECHNOLOGIES THAT WILL BOTH ENHANCE THE **PATIENT AND STAFF EXPERIENCE** AND VALUE THEIR TIME

Co-design Shared Journey

A **CO-DESIGNED** INTERACTIVE JOURNEY USING **PERSONAS** SEEKING FEEDBACK TO THE WAY WE DELIVER HEALTHCARE.

Research Opportunities

RESEARCH IMPACTS ON THE CHANGE IN **BEHAVIOUR AND HEALTH OUTCOMES** AS A RESULT OF THE NEW DIGITALLY ENABLED MODELS OF CARE.

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

MyLab

Southern District Health Board
Piki Te Ora

What does success look like?

REDUCTION IN WAIT TIME AND IMPROVED PATIENT FLOW

IMPROVED STAFF AND COMMUNITY ENGAGEMENT

IMPROVE EQUITY WITHIN HEALTHCARE

RESEARCH OUTCOMES SPECIFIC TO THE CHANGES IN BEHAVIOURS AS A RESULT OF TECHNOLOGY ENABLEMENT

VALIDATION OF NEW AND EMERGING TECHNOLOGIES AND PRODUCTS PRIOR TO INCLUSION IN THE FACILITY DESIGN

Detailed measurable benefits will be developed for each success indicator.

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

MyLab

Southern District Health Board
Piki Te Ora

Partnerships

ESTABLISHMENT PARTNERS

(STEERING GROUP)

DIGITAL PARTNERS

(MYLAB SUPPLIERS)

STRATEGIC PARTNERS

(GRANT/FUNDING)

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

MyLab

Southern District Health Board
Piki Te Ora

Establishment Partnerships

WellSouth Primary Health Network
Hauora Matua Ki Te Tonga

TE TAI ŌHANGA THE TREASURY

MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HIKINA WHAKATUTUKI

DUNEDIN CITY COUNCIL | kaunihera a-rohe o Ōtepoti

UNIVERSITY of OTĀGO
Te Whare Wānanga o Otāgo
NEW ZEALAND

OTAGO POLYTECHNIC
Te Kura Matatini ki Otago

Southern District Health Board
Piki Te Ora

CallaghanInnovation
New Zealand's Innovation Agency

MINISTRY OF HEALTH
MANATŪ HAUORA

Establishment Team – Responsibilities

- Endorsing the scope and purpose of MyLab aligned to current and future needs.
- Provide strategic leadership for the creation of MyLab
- Review and monitor progress aligned to the implementation plan for MyLab
- Source funding and grant opportunities
- Endorse the MyLab budget and monitor expenditure

Learning Opportunities

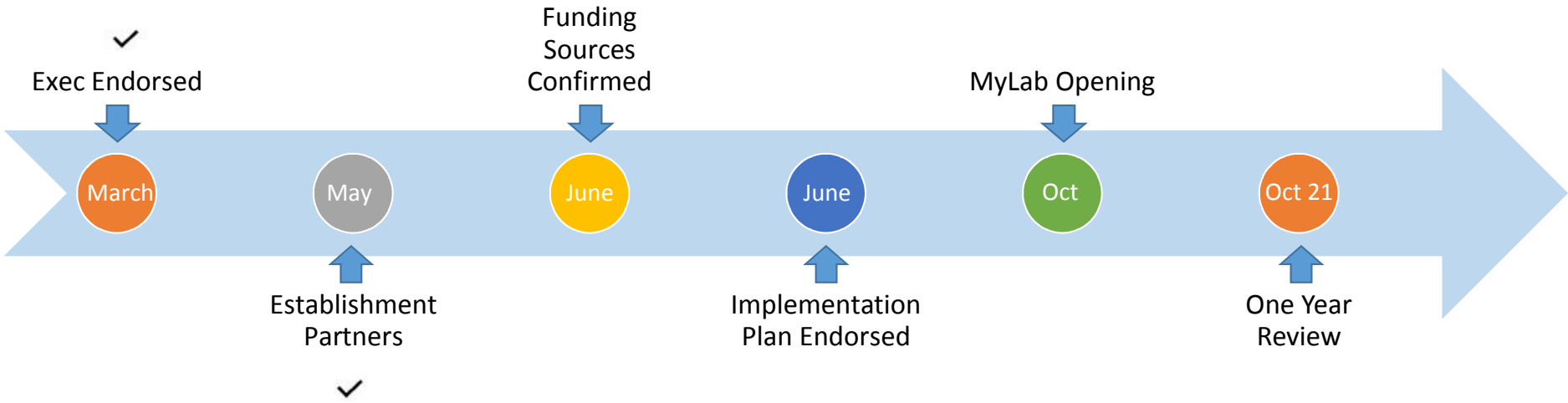
These are opportunities to engage with and utilise learnings from current similar centers such as:

- International
  - Flinders University (Australia)
  - University College London
  - Capital Enterprise
  - Edinburgh Bayes Institute
- National
  - I3 (Waitemata DHB)
  - CDHB Design Lab
  - Spark 5G Lab

MyLab

Southern District Health Board
Piki Te Ora

Timeline



Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

Next Steps

- Location being confirmed
- Terms of Reference Finalised
- Draft Implementation plan for endorsement
- Strategic Partners Grant/Funding Applications Progress Reports
- Briefings to appropriate Governance Bodies

MyLab

Southern District Health Board
Piki Te Ora

Getting Involved

Have some ideas, want to know more or express your interest in participating in MyLab.

Contact:

Erin Chadwick, IS Operations Coordinator

Erin.chadwick@southerndhb.govt.nz or 027 509 7501

INTRODUCTION

A discussion document was created in 2019 titled "Southern Health, Patient & Staff Experience Hub - The Simulation Hub'. This document was developed in response to the need for strong change management alongside the New Dunedin Hospital project. This proposal is building on the original discussion document to progress the concepts into a 'plan for action'. To date there has been significant support for the concepts within this paper and we now need to explain in more detail the vision and operating model that supports this new entity and service.

VISION - PEOPLE LED, TECHNOLOGY ENABLED

The vision is to create a physical space where we can showcase new Digitally enabled models of care and demonstrate technologies that will both enhance the patient and staff experience and value their time. Named 'MyLab', the facility and service will highlight to staff and patients what technologies can be leveraged in a digital health care environment and how these can be utilised within the new Dunedin Hospital and the wider Southern District.

We want to take people (patients, staff and our community) on an interactive journey through the possibilities, highlighting positive changes to the way we deliver healthcare.

The key point of difference that MyLab will provide is the ability to research and understand the impact on change in people's behaviour and health outcomes as a result of the new digitally enabled models of care supported by new and emerging technology and real-time data analysis.

MyLab will contain a combination of simulated and physical environments allowing for interaction and feedback that will showcase and provide a greater understanding of future opportunities. Some examples are:

- New health pathways and models of care across the health system, identifying information flow and technology enablers.
- Simulated clinical and non-clinical working spaces to gain feedback on design concepts.
- Visualisation of simulated patient flow through services across the health system and the impact on people.
- A space to provide feedback into design concepts and plans for new facilities and services.
- Prototype inpatient room acting as a "Proof of Concept" for new and emerging technologies.

The intent is for MyLab to be accessible across the region, country and internationally via technology networks. This is an important aspect as we need to ensure that we collaborate across all these dimensions, seeking feedback and identifying future opportunities. With the creation of MyLab we

acknowledge that Technology is not the answer, it supports the patient experiences and draws together processes.

MYLAB PURPOSE

The purpose of MyLab is to simulate future ways of delivering health care using a people centred co-design approach, collaborating with partners and digital solutions targeted at improving the patient and staff experience we have today.

MyLab will help clarify expectations specific to new ways of working and assist in managing perceptions in terms of what solutions are adopted.

MyLab will enable us to co-design ideas with people (our community, patients and staff) and use these to help:

- Design Future digital solutions
- Provide feedback on Health Pathways (Models of Care)
- Model digital information and data flow to support the Models of Care
- Showcase future technologies and assess emerging product capabilities
- Support the change process
- Understand the impact of change in people's behaviours
- Guide the physical architecture design to:
    - Gain benefits around improved patient and staff flow;
    - Reduce waste of investment
    - Provide feedback on design concepts
- Showcase a greater understanding of the implications that a new digital environment and models of care has on roles and teams
- Assist in enabling a multi-disciplinary team approach to patient care
- Engage with industry leading technology partners that contributes to equity of services

WHAT WILL SUCCESS LOOK LIKE?

We need to be able to measure the success of MyLab to ensure that we are achieving the purpose agreed upon. Below are some examples of success measures that we would track progress against:

- Reduction in wait time and improved patient flow
- Direct patient and staff feedback
- Improve equity within healthcare
- Research outcomes specific to the changes in behaviours as a result of technology enablement
- The measure of change in models of care and feedback received
- Validation of new and emerging technologies and products prior to inclusion in the facility design

COLLABORATION PARTNERS

The success of MyLab will depend on partnerships with other healthcare providers, government bodies, commercial suppliers and the education sector. With a common goal of improving the patient and staff experience.

We have world class tertiary providers within our region that we need to work in partnership with. There are research and employment opportunities that could engage with MyLab to assist in their research projects and to assist with innovative solutions.

Our collaboration partners will identify the key areas within MyLab that they are interested in developing and promoting.

Our establishment partners may include:

- Ministry of Health and Treasury
- Dunedin City Council via Centre of Digital Excellence (CODE)
- University of Otago
- Otago Polytechnic & Southland Institute of Technology
- Ministry of Business, Innovation and Employment (MBIE)
- Unions
- Community Health Council

DIGITAL PARTNERS

As well as our collaboration partners we will have Digital Partners to help deliver the technology and innovation options we intend to highlight and promote. There are many suppliers of healthcare solutions and we want to partner with those that are aligned to our values and strategic aspirations as a region.

THE MyLAB CONCEPT

PERSONAS

Using some pre-defined patient and staff journeys we can overlay the digitally enhanced experience using technologies and simulate what the new ways of experiencing healthcare services could be like.

Five patient journeys have already been created and workshopped at previous meetings. Taking the learnings from these journeys, we can anticipate the future technologies that we would be looking at to highlight on the persona walkthroughs.

Additional concepts for Personas include:

- Clinical Admin journey
- Primary to Secondary Journey
- Tertiary Journey (Training to Fully Qualified Clinician)

From an operational perspective within MyLab we can have all the personas running at once every day or cycle the stories across the week to all for changing content. Feedback Kiosks will be situated throughout the Persona journey's to allow for real time feedback.

COLLABORATION ZONE

We envisage this zone to be bookable for training to improve organisation wide digital literacy. The space could also allow for Presentations or workshops to Guest Speakers to present on upcoming innovations. MyLab could also run as a space for projects to take concepts from a design idea to a physical ward/room set up, allowing for flow simulation, testing and clinical input prior to deployment across the organisation.

FUNDING

The intent is to crowd source funding to establish My Lab from both our collaborative and digital partners. An operating budget will be prepared to show the costs associated with establishing and maintaining the service.

MyLAB OPERATION

Details pertaining to the operating model for MyLab will be further discussed with a working group of collaborative partners. The following are some ideas to consider and questions to answer from an operating perspective;

LOCATION

At this stage a location has yet to be identified but we will require a space that is closely located to the New Dunedin Hospital area.

Requirements for the MyLab space include:

- Large open communal space with additional rooms (warehouse)
- Clear point of entry with branding opportunities
- Access to fibre
- Ease of Access for the public

OPENING HOURS

Workshop/Speaker/Training/Project Concepts

Weekdays, 9am – 12noon

Public and Staff

Weekdays, 1pm – 4pm

Saturday, 9am – 12noon

TIMELINE

With work commencing on the new Dunedin Hospital build we need to be proactive in engaging with staff and the public. In order to provide an environment where collaboration and ideas are well received prior to solutions being designed/delivered, we need to aim at having this experience up and open to the Patients and Staff by August 2020.

It is anticipated that the initial concepts of MyLab will run for 2 years. Early success markers will be measured at the halfway point to allow for any alteration/review of technology and solutions being profiled. This will also be a point at which we can review the vision and purpose of MyLab and its future

PHYSICAL DESIGN

The MyLab design brief will be developed in collaboration with organisations that have been on a similar journey to understand the most effective design and flow. We want to learn what has worked well with other similar concepts and utilise the positive experiences.

BRAND AND IDENTITY

The MyLab brand has been developed, as you can see at the top of the document. The domain www.MyLab.nz has also been secured to build and promote a MyLab presence.

PROMOTING THE CONCEPT

Considerations on how we promote MyLab include:

- What is the plan for promoting MyLab?
- How do we get staff engaged and interacting?
- How do we encourage the public to come along and provide feedback?
- How do we engage with the less mobile members of our community? Can we provide some sort of interactive web-based option for people with accessibility issues?

RESEARCH AND FEEDBACK

We anticipate establishing some relationships with tertiary research providers to weave the knowledge and experiences learnt from MyLab into research projects. These projects being aligned to the Southern Health system vision for the future in terms of sustainable and strengthened health outcomes for all.

We anticipate using strategically placed Feedback Kiosks around MyLab allowing for Realtime feedback. Questions at each Kiosk will differ depending on the experience just completed with relevant questions that ensure we are meeting the Vision and Purpose of MyLab.

STAFFING

Consideration needs to be given to how MyLab will be run on a daily basis. How this looks or is staffed will be developed as we establish the operating model.

KEY MILESTONES

WHAT	WHEN	OUTCOME
Collaboration Partnership Workshop	April 2020	Discussion document feedback provided
Vision & Purpose Agreed	April 2020	Discussion document endorsed by appropriate group (ELT/SPG)
Funding Sources Confirmed	May	Funding endorsed by appropriate group (ELT/SPG)
Project Implementation Plan established	June	Detailed project plan and funding confirmed
Implementation / Establishment Phase	June/July/August	'MyLab' implementation plan progressed as per project plan
MyLab opened	October 2020	Successful launch of this new service 'My Lab'
MyLab 1-year Mark – Collaboration Partner Success Review	October 2021	Monitoring against measures and outcomes for the service

Minutes of the Southern District Health Board Meeting

Wednesday, 3 June 2020, 9.30 am
Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Dave Cull	Chair
	Dr David Perez	Deputy Chair
	Ms Ilka Beekhuis	*(by Zoom)*
	Dr John Chambers	
	Mrs Kaye Crowther	*(by Zoom)*
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	*(by Zoom)*
	Mr Tuari Potiki	
	Miss Lesley Soper	*(by Zoom)*
	Dr Moana Theodore	*(by Zoom)*
In Attendance:	Mr Andrew Connolly	Crown Monitor *(by Zoom)*
	Mr Roger Jarrold	Crown Monitor *(by Zoom)*
	Mr Chris Fleming	Chief Executive Officer
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer *(by Zoom)*
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement and Facilities
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 KARAKIA AND WELCOME

The meeting was opened with a karakia by the Chief Māori Health Strategy and Improvement Officer.

2.0 APOLOGIES

There were no apologies.

3.0 DECLARATION OF INTERESTS

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

It was resolved:

"That the Interests Registers be received and noted."

D Cull/T Potiki

4.0 PRESENTATION: FUNDING AND SOUTHERN DHB'S POPULATION

The Board received a presentation from Mr Rory Dowding, Strategy and Planning Manager, explaining the Population Based Funding Formula (PBFF) and outlining Southern DHB's funding, and population projections and characteristics (tab 4).

The Board noted that the next structural review of PBFF was due to take place in 2021 and requested that management report back in six months' time with a discussion document in preparation for that.

5.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 5 May 2020 be approved and adopted as a true and correct record."

L Kelly/T Potiki

6.0 MATTERS ARISING

There were no matters arising from the previous minutes that were not covered by the agenda or action sheet.

7.0 ACTION SHEET

The Board reviewed the Action Sheet (tab 7) and received the following updates from management.

- Emergency Department activity had increased following the move to COVID-19 alert level 3.
- MRI, CT and ultrasound had been added to the performance dashboard and x-ray would be added next month.
- The implementation of the short-term proposal to increase CT capacity had commenced.

8.0 ADVISORY COMMITTEE REPORTS

Finance, Audit and Risk Committee

Mrs O'Callaghan, Deputy Chair of the Finance, Audit and Risk (FAR) Committee, gave a verbal report on the FAR Committee meeting held on 21 May 2020, during which she advised that the Committee:

- Reviewed the Financial Report;
- Discussed the impact of planning for COVID-19 on hospital costs and noted the workforce responded well, in a short space of time, to the changes required for the pandemic response;
- Was concerned about the growth in annual leave liability;
- Discussed elective service recovery plans;

- Reviewed expenditure management plans, noting that whilst the target would not be met, progress had been made;
- Reviewed reports on capital projects;
- Discussed implementation of the Finance and Procurement Information Management (FPIM) system, which was a critical project for Southern DHB;
- Reviewed the year-end financial reporting timetable;
- Received the clinical risk dashboard, which was developed to ensure non-COVID-19 patients were monitored but would be useful for managing quality in future;
- Discussed the Strategic Risk Report and the need for the whole Board to consider key risks;
- Received the Health, Safety and Welfare Report, which outlined COVID-19 related activity, such as vulnerable worker risk assessments;
- Received reports on external and internal audit activity and would be monitoring the response to audit findings on behalf of the Board;
- Received a report on IT activity and again noted the exceptional work of the IT team in supporting pandemic planning;
- Considered a paper on SDHB's fire loss insurance and a recommendation from the Committee on that was included in the Board papers.

It was resolved:

"That the Board receive and note the verbal report on the FAR Committee meeting held on 21 May 2020."

D Cull/L Kelly

Insurance - Fire Loss Limit (tab 8.1.2)

The Executive Director Finance, Procurement and Facilities (EDFP&F) informed the Board that insurance cover for DHBs was co-ordinated annually at a national level. As part of that process, Southern DHB had reviewed its level of fire cover, noting that it was highly unlikely both Dunedin and Southland Hospitals would completely burn down at the same time. This approach was consistent with other DHBs and would mitigate the cost of insurance.

It was resolved:

"That the Board approve the maximum fire loss limit for 2020-2021 being set at 100% of the likely loss in a level II event, noting that cover will increase by $1,929,905 to a total of $156,089,345."

D Cull/T Potiki

<u>Community & Public Health and Disability Support Advisory Committees</u>

Dr Moana Theodore, Chair of the Disability Support Advisory Committee (DSAC), gave a verbal report on the joint meeting of the Community and Public Health Advisory Committee (CPHAC) and DSAC held on 2 June 2020, during which she informed the Board that:

- The Committees received an update on the draft Disability Strategy, which went out for consultation on 2 June 2020. Further updates on the Disability Strategy and work programme would be provided at the next meeting.
- The Community Health Council had been approached to co-opt a member from the disability community to DSAC.

- A presentation on HealthPathways was received from the Executive Director Quality and Clinical and Governance Solutions and the Quality and Performance Improvement Manager.
- The Committees reviewed their terms of reference and these would be submitted to the July meeting of Board for approval.
- The Strategy, Primary and Community and financial reports were received.
- Karen Browne, Chair of the Community Health Council (CHC) presented the CHC's quarterly report.
- The Executive Director Strategy, Primary and Community gave an update on the primary maternity facilities consultation and the Wanaka Maternal and Child Hub renovations. The Committees endorsed the new consultation timelines and noted the communications plan to support that.
- The Committees received a comprehensive COVID-19 Māori Response Action Plan and recommended that the Board approve it, noting that it had also been supported by the Iwi Governance Committee.

It was resolved:

"That the Board receive and note the verbal report on the DSAC/CPHAC Committee meeting held on 2 June 2020."

M Theodore/T Potiki

COVID-19 Māori Response Action Plan

The DSAC Chair conveyed the Board's thanks to Dr Sue Crengle and members of the Iwi Governance Committee who worked on the COVID-19 Māori Response Action Plan.

In presenting the Plan (tab 8.2), the Chief Māori Strategy and Improvement Officer also acknowledged the contribution of the Iwi Governance Subcommittee members and advised that:

- The Plan had been endorsed by the WellSouth Board, and
- Significant progress had been made across a number of milestones, with the support of many organisations.

It was resolved:

"That the Board approve the COVID-19 Māori Response Action Plan included with the agenda."

D Cull/T Potiki

<u>Iwi Governance Committee</u>

Mr Tuari Potiki reported that the Iwi Governance Committee (IGC) met in the morning of 2 June 2020, followed by a joint meeting with DSAC/CPHAC on the draft District Annual Plan (DAP). They then met again on their own to consider DAP issues related specifically to Iwi governance.

It was noted that the meetings had been positive and further feedback would be sought from IGC on how they would like to strengthen engagement with the Board.

Mr Roger Jarrold, Crown Monitor, joined the meeting at 10.50 am.

9.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 9) and the financial, volumes and performance reports (tab 10) were taken as read. During discussion the CEO highlighted the following items.

Financial Performance

- Understanding the effect of COVID-19 on financial performance was a challenge. Assumptions had been made that funding for primary care and Community Based Assessment Centres (CBACs) would be adequate and the Ministry of Health would provide planned care revenue to recognise that costs were largely fixed.

Volumes

- Activity was dramatically down during the COVID-19 lockdown and the significant reduction in cancer diagnosis during April 2020 was concerning. With the exception of Queenstown, Emergency Department activity across the district had bounced back.

Funding for 2020/21

- The detail of the funding envelope for 2020/21 would remain confidential until the District Annual Plan was approved by the Minister of Health.
- Until planning was completed, it was unknown how much of the 2020/21 funding increase was available for investment.

Annual Plan 2020/21

- The draft Annual Plan would be submitted to the Board next month for approval. A new draft had to be submitted to the Ministry of Health by 22 June 2020 but the Board would have the right to moderate it at its July 2020 meeting.

COVID-19

- There were no active cases of COVID-19 within the district, however public health capacity was expected to be maintained to cope with 24-34 new cases a day to ensure the country had the capacity to cope if there was a further outbreak.

Primary Maternity Facilities Consultation and Wanaka Hub

The Executive Director Strategy, Primary and Community (EDSP&C) reported that:

- The timeline for consultation on primary maternity facilities in Central Otago/Wanaka had slipped by 5-6 weeks due to the COVID-19 pandemic;
- A positive discussion was held at the Iwi Governance Committee meeting the previous day regarding engagement with Uruuruwhenua Health Inc;
- Other properties had been offered for housing the Maternal and Child Hub in Wanaka and were currently under discussion.

Planned Care

- The CEO advised that the Board would need to consider reconfiguring resources if conversations between primary and secondary care providers indicated a paradigm shift in the way services were delivered.

A wide-ranging discussion was held on opportunities to improve treatment models.

MyLab

- The CEO informed the Board that the Executive Director People, Culture and Technology would be presenting MyLab to the Board in July.

Management then answered questions on the approach to planned care recovery, Iwi and community involvement with the Alliance Leadership Team (ALT) and the ALT's reporting line.

It was resolved:

"That the CEO's report and financial, volumes and performance reports be noted."

D Cull/T Potiki

10.0 CHANGE MANAGEMENT PROGRAMME AND BENEFITS REALISATION PLAN - UPDATE

The Board considered a quarterly update on Change Management Programme activity (tab 11).

It was resolved:

"That the Board:

- **Note the background to, and overview of, Southern DHB's Change Management Programme and the accompanying indicative Benefits Realisation Plan as presented in Appendix 2; and**
- **Note the narrative commentary of Change Management Programme progress, as presented in Appendix 1 to the paper, and that further detailed updates will follow in August 2020 aligned to Southern DHB's District Annual Planning process."**

D Cull/L Soper

11.0 PRESENTATION: CLINICAL COUNCIL

The Board received a presentation on the Clinical Council from Dr Tim Mackay, Chair of the Clinical Council and Deputy Chief Medical Officer, Dr Nigel Millar, Chief Medical Officer, Jane Wilson, Chief Nursing and Midwifery Officer, Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer, and Gail Thomson, Executive Director Quality and Clinical Governance Solutions.

The presentation included an overview of the current state of Southern DHB's quality framework and clinical governance, the purpose and role of the Clinical Council, and a proposal to refresh and empower the Clinical Council so it could take its place in positively changing clinical performance (tab 14).

PUBLIC EXCLUDED SESSION

***At 12.30 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee, ▪ 21 May 2020 verbal report ▪ 29 April 2020 minutes	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.
Budget 2020/21	Annual Plan is subject to Ministerial approval.	Section 9(2)(f)(i) of the Official Information Act.
South Island Patient Information Care System (SI PICS)	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	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.

D Cull/L Kelly

***It* was *resolved*:**

"That the Board resume in open meeting and the business transacted in committee be confirmed."

The meeting closed at 2.30 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 29 June 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020	**Fleet Vehicle Management** (Minute item 5.0)	Quarterly progress reports to be provided.	EDFPF		~~June 2020~~ July 2020
Sept 2019 Oct 2019 Mar 2020 Apr 2020	**Valuing Patients' Time (VPT) - ED Escalation Pathway** (Minute item 9.0) (Minute item 4.0) (Minute item 7.0) (Minute item 6.0)	Update to be provided on the development of an ED escalation pathway. Timeframe to be provided. ▪ A timeline and précis of the plan to develop an escalation pathway to be submitted to the next meeting. ▪ Discharging patients earlier in the day to be made a priority. Progress report to be submitted to Board in July.	EDQCGS CEO/ EDSS EDSS	This has been raised on many times with the Clinical Council, as well as Clinical Leadership with very little traction. The ED escalation is on the Clinical Council work plan. Dr Nigel Millar (CMO) is the clinical lead for this work with the Medical and Clinical Directors groups and will provide updates at future Clinical Council meetings. *Updates as at 23 June 2020* A VPT dashboard is being developed and should be completed by August for presentation to HAC. CMO to draft an ED escalation strategy following a series of meetings with clinical and medical directors. The draft will then be consulted on.	July 2020
Feb 2020	**Resourcing Implication of PHARMAC Decisions** (Minute item 8.0)	Further information to be provided, including explanatory detail on the growth areas, eg the number of patients receiving high cost drugs over time and the clinical areas involved.	EDSPC	This has now shifted to a regional piece of work, with support from the SIAPO office and CEO sponsorship. A combined South Island DHB's paper is currently being developed, which will be available for the next meeting of the Board.	July 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020 Apr 2020 May 2020	**Performance Dashboard** (Minute item 9.0) (Minute item 9.0) (Minute item 9.0)	Caseweights per FTE to be added as a productivity indicator. Legibility of graphs to be improved by increasing the resolution and/or reducing them to six per page. Radiology by modality to be added to the dashboard.	EDQCGS EDQCGS EDQCGS/ EDSS	In development. Improvement made with more to come. MRI and CT on graph, Ultrasound and Plan X Ray to be added	~~April 2020~~ ~~May 2020~~
Feb 2020	**CT Capacity** (Minute item 9.0)	A business case (including the clinical case) for a second Dunedin CT to be developed in consultation with Southern Alliance.	EDSS	Business case for additional CT Scanner will be a part of the refreshing of the Annual Plan.	
Mar 2020	**Change Management and Benefits Realisation Plan** (Minute item 11.0)	Clinical input into the plan to be made explicit, equity embedded from the start, and a key added to the plan timeline chart.	CEO	Will be woven into the plan when it is updated, iteratively, in coming months.	
Mar 2020	**Annual Plan 2019/20 Progress Report** (Minute item 12.0)	▪ Further information to be provided on diabetes services. ▪ Progress reporting to be provided for all high risk areas. ▪ PHO performance indicators to be submitted to the Community & Public Health Advisory Committee.	EDSP&C	A more detailed report on what is being done to help meet national targets is currently being developed. New quarterly reporting formatting, with targeted high risk focus will be developed as a result of the new Annual Plan being finalised, and will be available from Quarter 1, 2020/21.	~~June 2020~~ October 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
June 2020	**Population Based Funding Formula** (Minute item 4.0)	Management to provide an update and discussion document in preparation for the 2021 PBFF review.	EDSP&C		December 2020

FINANCE, AUDIT AND RISK COMMITTEE MEETING, 18 JUNE 2020

- Verbal report from Jean O'Callaghan, Deputy Chair, Finance, Audit and Risk Committee.

SOUTHERN DISTRICT HEALTH BOARD
FINANCE, AUDIT AND RISK COMMITTEE
18 June 2020

RECOMMENDATION TO BOARD:

The Finance, Audit and Risk Committee recommends that the Board pass the following resolution.

Bad Debt Write-off

"That 18 Bad Debts over $50,000 be written off, totalling $2,955,519, previously provided for as Doubtful Debts and recognised against Accounts Receivable in the DHB Balance Sheet."

Southern District Health Board

Minutes of the Joint Meeting of the Community & Public Health Advisory Committee and Disability Support Advisory Committee held on Tuesday, 2 June 2020, commencing at 2.30 pm, in the Board Room, Wakari Hospital Campus, Dunedin, and via Zoom

Present:	Dr Moana Theodore	Chair, Disability Support Advisory Committee (DSAC) *(Meeting Chair)*
	Mr Tuari Potiki	Chair, Community & Public Health Advisory Committee (CPHAC)
	Ms Ilka Beekhuis	Deputy Chair, CPHAC
	Mrs Kaye Crowther	Deputy Chair, DSAC *(by Zoom)*
	Mr Dave Cull	Member, DSAC
	Dr John Chambers	Member, DSAC
	Mr Terry King	Member, CPHAC
	Dr Lyndell Kelly	Member, CPHAC *(by Zoom)*
In Attendance:	Miss Lesley Soper	Board Member *(by Zoom)*
	Mrs Jean O'Callaghan	Board Member *(by Zoom)*
	Mr Andrew Connolly	Crown Monitor *(by Zoom)*
	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer *(by Zoom)*
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Andrew Swanson-Dobbs	Chief Executive Officer, WellSouth Primary Health Network *(until 3.25 pm)*
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality & Clinical Governance Solutions
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME AND KARAKIA

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

2.0 APOLOGIES

An apology was received from Mr Roger Jarrold, Crown Monitor.

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

The Chair recapped the main items of business considered at the last meeting held prior to the COVID-19 lockdown.

It was resolved:

"That the minutes of the meeting held on 3 February 2020 be approved and adopted as a correct record."

T Potiki/I Beekhuis

5.0 HORIZON SCANNING

The Chair advised that this would be a standing agenda item to give the Committees time to consider high level strategic issues and priorities. As an introduction, the Committee Chairs gave the following updates.

Disability Support Advisory Committee (DSAC)

The DSAC Chair advised that:

- DSAC's role was to advise the Board on the disability support needs of the resident population of the Southern District Health Board and priorities for the use of disability support funding;
- The Executive Director Quality and Clinical Governance Solutions would be providing regular updates on the disability strategy and action plan work;
- An approach was being made to the Community Health Council to nominate a representative to DSAC.

Community and Public Health Advisory Committee (CPHAC)

The CPHAC Chair reinforced the need to focus on the strategic issues that the Committee could influence.

It was agreed that Iwi representation on the Committees would be followed up.

6.0 MATTERS ARISING FROM PREVIOUS MINUTES

Disability Support

The Committees received an update from the Executive Director Quality and Clinical Governance Solutions, during which she reported that:

- Consultation on the draft Disability Strategy and Action Plan had commenced that day and all the communication channels identified previously would be used for this;
- The Community Health Council was awaiting an invitation to put forward members to join DSAC/CPHAC;
- Other disability work (including workforce data and plans, analysis of training, data capture) had been delayed as the person leading it was on sick leave.

It was suggested that the Ministry of Health, as the funder of disability services, be invited to a future meeting.

Karen Brown, Chair of the Community Health Council, joined the meeting at 2.40 pm.

7.0 REVIEW OF ACTION SHEET

The Committees received the action sheet updates (tab 7).

8.0 PRESENTATION: HEALTHPATHWAYS

The Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) introduced Patrick O'Connor, Quality and Performance Improvement Manager (Q&PIM).

Mr O'Connor gave a presentation explaining HealthPathways (the patient's journey through healthcare services). This included an overview of Health Pathway's aims and principles, stages in the patient journey, enablers, understanding the use of resources across a pathway, and the selection of pathways to work on (tab 15).

Miss Soper left the meeting at 2.56 pm.

Management then took questions from members.

During discussion it was noted that, as well as reducing clinical risk, HealthPathways added value by enabling engagement with patients and clinician led conversations and solutions. The information gained from analysing situations where the pathway was not adhered to was used to continuously improve the pathway and develop a more robust system.

The EDQ&CGS and Q&PIM were thanked for their presentation.

9.0 REVIEW OF TERMS OF REFERENCE

The Committees reviewed their terms of reference (tab 9) and requested that:

- The acronym for the Disability Support Advisory Committee be standardised to DSAC;
- To align with the Disability Strategy and Action Plan, "those people" be changed to "disabled people" under the DSAC Function and Scope.

It was resolved:

"That, with the above amendments, the Committees recommend that the Board approve their terms of reference."

D Cull/I Beekhuis

10.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 10) was taken as read and the EDSP&C took questions.

Miss Soper returned to the meeting at 3.15 pm.

The Committees requested that a simple slide explaining the different Southern Health entities (including the Alliance Leadership Team) and how they assist the Board to achieve its objectives, be submitted to the next Board meeting.

It was resolved:

"That the report be received."

M Theodore/T King

11.0 FINANCIAL REPORT

The EDSP&C presented the Strategy, Primary and Community financial results for April 2020 (tab 11), then answered questions on the financial statements.

It was resolved:

"That the report be received."

M Theodore/I Beekhuis

The Chief Executive Officer, WellSouth Primary Health Network, left the meeting at 3.25 pm.

12.0 COMMUNITY HEALTH COUNCIL QUARTERLY REPORT

A quarterly report on the Community Health Council's activities was circulated with the agenda (tab 12) and taken as read. Karen Browne, Chair of the Community Health Council (CHC), outlined the process followed to form the CHC and its composition, then highlighted the following items from the quarterly report.

- There were about 100 people on the CHC advisor database. Many were involved in the FiT groups for the new Dunedin Hospital rebuild.
- The Quality and Safety Marker (QSM) system would be used to evaluate consumer engagement across the whole sector.
- Two consumers had commenced work on the new telehealth initiative, which had come to the fore during the COVID-19 pandemic, particularly in primary health.
- The CHC had also been working with primary care on Healthcare Homes.
- The CHC intended holding a workshop to review informative material for the public and staff.
- Because the CHC's facilitator had been off work for several weeks, much of the CHC's work had been paused.

Ms Browne then answered questions about the CHC's involvement in staff appointments and the CHC's membership.

Ms Browne was thanked for her report and left the meeting at 3.35 pm.

It was resolved:

"That the report be received."

13.0 PRIMARY MATERNITY FACILITIES CONSULTATION AND WANAKA HUB RENOVATIONS

The Committees considered a paper on the timeline for the delivery of the primary maternity facilities consultation in Central Otago/Wanaka and an update on the Wanaka Hub renovations (tab 13).

It was resolved:

"That the Committees:

1. **Endorse the new consultation project timeline;**
2. **Note the communications planned to support the new timeline;**
3. **Note the issues impacting the Gordon Road, Wanaka, renovation and that a final decision about progressing will go back to the Executive Leadership Team."**

T Potiki/D Cull

14.0 COVID-19 MĀORI RESPONSE ACTION PLAN

The Committees considered a draft COVID-19 Māori Response Action Plan (tab 14).

The Chief Māori Health Strategy and Improvement Officer reported that:

- The Ministry of Health would be funding some of the planned activity;
- A lot of progress had been made since the Plan was written and a number of DHBs had expressed interest in what had been achieved;
- The Plan had been considered and endorsed by the Iwi Governance Committee and the WellSouth Board.

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) and his team were congratulated on their innovative work.

The CMHS&IO acknowledged the contribution and support received from a number of people in developing the Plan, in particular from Dr Sue Crengle.

It was resolved:

"That the Committees recommend the Board approve the draft COVID-19 Māori Response Action Plan."

D Cull/I Beekhuis

The meeting closed with a karakia at 4.00 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

SOUTHERN DISTRICT HEALTH BOARD

Title:	**TERMS OF REFERENCE**	
Report to:	Board	
Date of Meeting:	7 July 2020	
Summary: The Disability Support Advisory Committee (DSAC) and Community and Public Health Advisory Committee (CPHAC) reviewed their Terms of Reference at their last meeting and recommended that they be approved with minor amendments *(refer to 2 June 2020 CPHAC/DSAC meeting minutes)*.		
Specific implications for consideration (FINANCIAL/WORKFORCE/RISK/LEGAL ETC.):		
Financial:	N/A	
Workforce:	N/A	
Equity:	YES	
Other:		
Document previously submitted to:	Chris Fleming Community and Public Health and Disability Support Advisory Committees	**DATE:** 18 May 2020 2 June 2020
Prepared by: **Date:** 16 June 2020	**Presented by:** Moana Theodore and Tuari Potiki DSAC and CPHAC Chairs	
RECOMMENDATION: **The Community and Public Health and Disability Support Advisory Committees recommend that the Board approve the attached terms of reference.**		

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)

Terms of Reference

Accountability

The Disability Support Advisory Committee (DSAC) is constituted by section 35, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of DSAC are to give the Board advice on:
   a) The disability support needs of the resident population of the Southern DHB
   b) Priorities for use of the disability support funding provided.

2) The aim of the Committee's advice will be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of disabled people within the Southern DHB's resident population:
   a) the kinds of disability support services the Southern DHB has provided or funded or could provide or fund for disabled people;
   b) all policies the Southern DHB has adopted or could adopt for disabled people.

3) The Committee's advice may not be inconsistent with the New Zealand Disability Strategy.

Responsibilities

The Committee is responsible for:

1) Providing advice on the overall performance of the disability support services delivered by or through the Southern DHB;

2) Providing advice on strategic issues related to the delivery of disability support services delivered by or through the Southern DHB;

3) Focusing on the disability support needs of the population and developing principles on which to determine priorities for using finite disability support funding;

4) Ensuring that the District Annual Plans (DAPs) of the Southern DHB demonstrate how people with disability will access health services and how the Southern DHB will ensure that the disability support services they fund or provide are co-ordinated with the services of other providers to meet the needs of disabled people;

5) Assessing the disability support services' performance against expectations set in the relevant accountability documents, documented standards and legislation;

6) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

All members of the Committee are to be appointed by the Board. The Board will appoint the chairperson.

The Committee is to comprise a number of Board members as determined by the Board Chair, supplemented with external appointees as required.

Membership will provide for Māori representation on the Committee. The Committee may obtain additional advice as and when required.

Where a person, who is not a Board member, is appointed to the Committee, the person must give the Board Chair a statement that discloses any present or future conflict of interest, or a statement that no such conflicts exist or are likely to exist in the future, prior to appointment.

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda, and it is the responsibility of each member to disclose any new interests which may give rise to a conflict.

Quorum

The quorum of members of a committee is —

(a) if the total number of members of the committee is an even number, half that number; but

(b) if the total number of members of the committee is an odd number, a majority of the members.

Meetings

Bi-monthly meetings, held collectively with the Community and Public Health Advisory Committee (CPHAC) will be scheduled, however the committee may determine to hold additional meetings if deemed necessary by the Chair, with or without CPHAC, up to a maximum of ten meetings per year.

Review

The Terms of Reference for this Committee shall be reviewed as and when required.

Management Support

The Chief Executive Officer shall ensure adequate provision of management and administrative support to the Committee.

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

Terms of Reference

Accountability

The Community and Public Health Advisory Committee (CPHAC) is constituted by section 34, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of CPHAC are to give the Board advice on:

   a) the needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the Southern DHB; and

   b) priorities for use of the limited health funding provided.

2) The statutory aim of CPHAC's advice is to ensure that the following maximise the overall health gain for the population the Committee serves:

   a) all service interventions the Southern DHB has provided or funded or could provide or fund for that population;

   b) all policies the DHB has adopted or could adopt for that population.

3) CPHAC's advice may not be inconsistent with the New Zealand Health Strategy.

Responsibilities

The Committee is responsible for:

1) Taking an overview of the population and health improvement;

2) Providing recommendations for new initiatives in community and public health improvement;

3) Addressing the prevention of inappropriate hospital admissions through health promotion and community care interventions;

4) Examining the role that primary care, disability support, public health and other community services - as well as hospital services - can play in achieving health improvement;

5) Ensuring better co-ordination across the interface between services and providers;

6) Focusing on the needs of the populations and developing principles on which to determine priorities for using finite health funding;

7) Interpreting the local implications of the nation-wide and sector-wide health goals and performance expectations;

8) Providing advice, in collaboration with the Iwi Governance Committee, on strategies to reduce the disparities in health status; especially relating to Māori and Pacific Island peoples;

9) Providing advice on priorities for health improvement and independence as part of the strategic planning process;

10) Ensuring the processes and systems are put in place for effective and efficient management of health information in the Southern DHB district, including policies regarding data ownership and security;

11) Ensuring the priorities of the community are reflected in the Annual Plan of the Southern DHB, and to ensure that appropriate processes are followed in preparation of the plan;

12) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

All members of the Committee are to be appointed by the Board. The Board will appoint the chairperson.

The Committee is to comprise of a number of Board members as determined by the Board Chair, supplemented with external appointees as required.

Membership will provide for Māori representation on the Committee. The Committee may obtain additional advice as and when required.

Where a person, who is not a Board member, is appointed to the Committee, the person must give the Board Chair a statement that discloses any present or future conflict of interest, or a statement that no such conflicts exist or are likely to exist in the future, prior to appointment.

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda, and it is the responsibility of each member to disclose any new interests which may give rise to a conflict.

Quorum

The quorum of members of a committee is —

(a) if the total number of members of the committee is an even number, half that number; but
(b) if the total number of members of the committee is an odd number, a majority of the members.

Meetings

Bi-monthly meetings, held collectively with the Disability Support Advisory Committee (DSAC) will be scheduled, however the Committee may determine to hold additional meetings if deemed necessary by the Chair, with or without DSAC, up to a maximum of ten meetings per year.

Review

The Terms of Reference for this Committee shall be reviewed as and when required.

Management Support

The Chief Executive Officer shall ensure adequate provision of management and administrative support to the Committee.

HOSPITAL ADVISORY COMMITTEE MEETING, 6 JULY 2020

- Verbal Report from Dr David Perez, Chair, Hospital Advisory Committee.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	7 July 2020

Summary:

Considered in this paper are:

- General information and emerging issues

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	As set out in the report.
Workforce:	As set out in the report.
Equity:	As set out in the report.
Other:	As set out in the report.

Document previously submitted to:	Not applicable, report submitted directly to the Board.	**Date:** n/a

Prepared by: Chris Fleming Chief Executive Officer **Date:** 1 July 2020	**Presented by:** Chris Fleming Chief Executive Officer

RECOMMENDATIONS:

1. **That the Board:**
   - **Note** the attached report;
   - **Discuss and note** any issues which they require further information or follow-up.

CHIEF EXECUTIVE OFFICER'S REPORT

1. 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. The Board are requested to:

- **Note** this report
- **Discuss and Note** any issues which they require further information or follow up.

2. ORGANISATIONAL PERFORMANCE

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

- Finance report
- High Level Volumes
- Performance Dashboard.

Financial performance for the month of May is unfavourable to plan by $3.447 million increasing the year to date unfavourable result to $9.574 million adverse to plan. The net deficit associated with COVID costs for the month were $4.678 million bringing the year to date net COVID costs to $8.7 million. It is difficult to calculate the exact cost savings from the work that was not performed (this will be mostly clinical supplies and consumables rather than labour), but it would be estimated that variable savings would have been about $4.0 million. This means the net unfunded impact of COVID-19 financially is estimated at $4.7 million to date.

- The impact of the under performance on planned care as a consequence of reducing activity to respond to COVID-19. On a year to date (YTD) basis we are now 1,314 caseweights behind plan. This equates to revenue of $6.85 milllion. The Ministry has confirmed that it will fund DHBs based on year to date performance to the end of February and to plan for March through June subject to the DHB achieving at least 85% of planned volumes in the month of June. Southern is forecast to achieve more than 85% of planned volumes for June and as such revenue is secure. Perversely, if Southern had chosen to optimise the financial performance we could have reduced outsourcing in June however we have chosen to focus on achieving recovery of the lost volumes as quickly as possible.
- Additional costs attributable to the COVID-19 response to the end of April net at $7.225 million. These costs are predominately:
  - Annual leave not taken $3.0 million
  - Special leave due to staff not able to work (70 years and over and/or immuno compromised) $1.8 million
  - Casual workers payment as per State Service Commission position $456k
  - Southern DHB response, additional staff, higher cost of supplies, additional cleaning etc $1.8 million

The other major impact for the May results has been the booking of an increased Holidays Act provision of $1.2 million. Based on the information we have to date,

this will be a similar result for June to align year end provisions to the extent we have available information. This $3.5 million ($1.2 million per month for three months) was not included in the budget and explicitly noted to be excluded in our annual plan.

From a volumes perspective, activity was also well down. Emergency Department (ED) activity is down 21.8% on the same month last year, with Dunedin down 22.9%, Lakes 17.2% and Southland 21.6%, these reductions are lower than we saw in April reflecting the increasing activity as New Zealand move down the alert levels. Medical caseweights are down 19.2% on the same month last year, surgical caseweights are down 17.4% (acute down 22.7% and electives down 13.4%). Maternity was down 3.6%. Mental Health bed days were down 12.3%. All of these activity indicators demonstrate the progressive returning to pre covid activity levels which have continued into June.

On the performance dashboard referral numbers for first specialist appointments have returned to close to normal levels. The modalities of CT, MRI, Ultrasound and X-Ray are now included in the completed within 42 days graph and it is clear that there is considerable room for improvement in all but plain X-Ray 42 day results. The other concerning result is the upwards trajectory in the use of restraint and seclusion in Mental Health. Most DHBs do not include Intellectual Disability statistics in this indicator, however Southern does as it better reflects the reality of the situation. The challenge is that both of these lines have an upward trajectory. Breaking this down between sites the issues appear to all be in Dunedin. The facilities in Dunedin will not be helping as there are limited low stimuli zones and facilities a modern Mental Health unit would have, however this does not explain the upward trend. The service is investigating actions that can be taken to address.

3. INCREASING PLANNED CARE AND REDUCING WAITING LISTS

In the government's budget they announced a one-off boost of $282.5 million over the next three years to be used to enable additional consultations, imaging and treatment for patients. This funding is a combination of capital and operating, but the split is unknown. If one assumed that the funding would be distributed on a population based funding (PBF) basis then Southern's share would be approximately $19.5 million or $6.5 million per annum. Recently (dated 24 June, but sent 26 June) the Ministry wrote to each DHB highlighting that they want a recovery plan which addressed:

- Strategies and actions for all surgical or medical services not meeting waiting time expectations (first specialist assessments (FSAs), follow ups, treatment) and CT, MRI and Ultrasound scanning
- Continuation of innovative delivery models that you may have implemented during the response to COVID-19
- New sustainable improvements we can implement
- Strategies to manage clinical risk and patient experience
- Strategies to improve equity
- Realistic trajectories to recovery for all services
- Milestones within our plan.

The request is for the plan to be submitted by 10 July. While there was already a request for a planned care recovery plan to be submitted by this date, the latest request is far broader (which is a positive step), but the timelines are exceptionally tight. At the very best a draft may be able to be submitted, but these timelines do

not allow any engagement at a Governance level. We will submit the recovery plan to the Board at the August meeting for information.

4. DIGITAL TRANSFORMATION PROGRAMME

The early works team for the Digital Transformation Programme is making good inroads into the identification of the work programme required for Southern DHB. The current estimates for the programme indicate a capital requirement of approximately $190 million over the next decade. Based on current forecasts, only around $80 million of this will be able to be funded from projected Southern DHB cashflows. This issue has been raised through the Southern Partnership Group and with the Ministry in terms of it being a critical dependency associated with the New Dunedin Hospital Programme. It is, however, important to recognise that this is a Digital Transformation Programme for the Southern Health System. While Dunedin Hospital is a critical piece of infrastructure it only functions successfully if it is truly integrated with the wider health system.

We are still working through the detail of exactly when the funding will be required however it will be essential if we are going to progress successfully we are able to retain the existing programme resources once the early works activity is completed.

5. ONGOING COVID-19 MANAGEMENT RESPONSE

The following provides an update on where we are in terms of management of COVID-19. However, presently we remain with zero active cases in our community. The Community Based Assessment Centres (CBACs) have been closed, however additional funding has been provided to the region for ongoing testing covering the period of 1 July through 30 September.

The majority of health services have now relaxed many of the restrictions put in place, and we continue to work with WellSouth Primary Health Network to try and embed some of the changes that have occurred during COVID into new practice. The work being supported through the Planned Care initiative is looking at how we can move more services into the community and virtual settings, a critical component of which must be ensuring that they are resourced appropriately.

A further challenge for which we have a plan is in the event the Government requests that Southern open up isolation facilities for returning New Zealanders to be isolated in. Presently the isolation facilities are in Auckland, Hamilton, Rotorua, Wellington and Christchurch. We are aware that there are a number of hotels in Queenstown which would be suitable. The difficulty is that utilising these facilities as isolation facilities would bring an injection of income into the region for hotel owners / operators, however unlike the other isolation sites who all have either secondary or tertiary hospital facilities near by, Queenstown does not. It is inevitable that there will continue to be cases identified in the isolation facilities, where this happens there is a requirement to then quarantine these people separate from others in isolation. The challenge for Queenstown would be in the event that any of these cases escalate to needing hospital level care. While Lakes District Hospital managed very admirably during the first wave of COVID-19, there is a difference between responding to your population and flying plane loads of people in for isolation purposes. Given the importance on containment and management of the virus, Public Health South has developed plans for in the event that we are asked to support isolation facilities in Queenstown.

Public Health Service

The two focus areas for the Public Health Service remain COVID-19 preparedness and returning to business as usual. As of 2 June, the Southern district has 216 cases of COVID-19. This is comprised of 186 laboratory confirmed cases and 30 probable cases. Two people died and all remaining 214 cases have recovered. No new cases have occurred in the district since 17 April.

Preparedness for Further Cases

The focus for COVID-19 planning is now the preparedness for further cases. The service has been required to produce a capacity uplift plan to show how we intend to create the capacity to manage up to 24 and 34 cases a day. A plan has been developed, but is based on a number of assumptions. These include that no border health work is required of the service, staff are released to support the response, the country is placed in a level of lockdown and that we have sustainable funding to support the capacity building that is required. A significant part of the capacity required is to support case management and monitoring which requires a nursing workforce. Weekly reporting to the Ministry of Health is required on our progress to have capacity to manage 24 cases a day by the end of June. Some progress has occurred with implementing our plan, in particular around training and some preliminary conversations about where additional staff could be accessed from. Two key roles identified in the planning are an additional Public Health Physician (recruitment is underway) and a COVID-19 Response Manager within the service to take a lead on this work. We will need to review our capacity uplift plan now that additional funding of $1,051,522 has been confirmed for the next 12 months.

Contact Tracing

As at the end of May Public Health started using the national contact tracing solution (NCTS) as a means of managing case and contact information for any future cases. The key functionality that we were waiting on (daily email follow up of cases and contacts) has now been introduced. We now have two super users, and key staff have been using the system. We are also participating in user testing and development to inform future upgrades.

COVID-19 and Business as Usual

Considerable work has been undertaken to review our business as usual (BAU). The Ministry of Health continues to advise that responding to COVID-19 and disease outbreaks remains our top priority. However, issues are emerging in Southern communities as a result of the lockdown and closure of the borders, in particular around community recovery and mental health and wellbeing. Staff are currently reviewing work with a COVID-19 lens to identify what is still current and needs to continue, what should be paused, what new priorities are emerging, what we need more data on and what needs to stop. Public Health sections of the 2020/21 District Annual Plan have been updated.

Community Based Assessment Centres and General Practice

Both the Primary Care and Community Services Emergency Operating Centres (EOCs) have ceased to formally operate, although significant work continues across both parts of the business to ensure we are not caught short if COVID-19 was to reappear in our district. For Primary Care, the focus is to work closely with general practice around operating a different model of care. Moving forward it is expected that up to 50% of all Primary Care consultations will be delivered virtually. The uptake of this type of clinical consultation has been widely acknowledged as the future of Primary Care in Southern DHB.

Close to $70m has been distributed to District Health Boards, Primary Health Organisations, General Practices and Pharmacies to support the primary care COVID-19 response, with $15m distributed directly to support General Practice on 31 March 2020 and $7.8m distributed to General Practices on a per COVID-19 test basis. This is an initial payment intended to contribute to Primary response (including virtual consultations) to minimise community spread.

CBACs continued to operate in Dunedin and Invercargill until 11 June, with the Queenstown CBAC closed in the first week of May given the significantly reduced demand. General Practice in all areas continue providing COVID-19 responses across the district in the form of designated practices. All of the CBAC facilities however remain available to re-open in the event this is needed.

The latest data from CBAC and General Practice COVID-19 activity is as below:

Level of activity at CBACs and General Practice

Facility Type	Seen	% Swabs Taken	% Symptomatic	% Fit Clinical Measure
Community Based Assessment Clinic	7,047	98.7%	75.5%	74.4%
General Practice	10,894	87.8%	93.1%	90.3%
Total	**17,941**	**92.1%**	**86.2%**	**84.0%**

Covid-19 activity by Territorial Local Authority (TLA)

Territorial Authority	Seen	Swab Rate Per 1000
Dunedin City	7,105	56.8
Invercargill City	3,749	55.8
Queenstown-Lakes District	3,214	74.7
Central Otago District	1,129	46.6
Waitaki District	966	36.5
Southland District	615	30.4
Gore District	602	31.7
Clutha District	544	33.4
Total	**17,941**	**142.2**

Rural Trust Hospitals

Rural Trust Hospitals are returning to business as usual (BAU) as the country moved from Alert Levels 4 to 2, and now Alert Level 1. At Lakes District Hospital (LDH) Emergency Department (ED) attendances were low early in May, however, by the end of the month attendances reflected May 2019. Overall attendances in May were down 15% on 2019. This is an improvement on April when ED attendances were almost 65% down on 2019. Rosters for senior medical officers (SMOs) and nurses were adjusted to reflect the change in demand. The SMO roster changes have maintained the flexibility required to return to previous staffing levels as the workload returns to normal levels. The nursing roster will be fully staffed at the beginning of June.

We are working with the Welfare Hub established by Queenstown Lakes District Council (QLDC) to take over the support for the community from the Civil Defence Emergency Management (CDEM) team. There is a significant welfare need emerging in the QLDC area, so agencies are working together to ensure people in need can access the support they require.

The requirement to maintain red and green streams in Rural Hospitals has been a challenge and incurred significant additional cost. These requirements have now been relaxed. New COVID-19 screening guidelines released in June have enabled hospitals to manage more efficiently.

Aged Residential Care – Community Services

This month, the Aged Residential Care (ARC) Review Team have followed up with facilities' Corrective Actions and Recommendations from their Preparedness Assessments, with some additional virtual visits and onsite visits conducted, and the development of a Report.

Contingency planning is continuing for a scenario of COVID-19 in an aged residential care facility. This work will continue over the next months and include Emergency Management, Public Health, and ARC facilities.

ARC watched NZ's number of COVID-19 cases steadily decline over the month of May, but continued to be on high alert to protect their residents. Major issues included barriers to entry and re-entry to aged residential care, visiting, and use of personal protective equipment (PPE).

Fear of COVID-19 prevented many facilities from accepting residents unless they had a negative COVID-19 test, despite the potential resident not meeting the case definition for COVID-19 testing. Guidelines and screening tools did evolve on a regular basis, which did generate some confusion and angst. However, over time ARC facilities started admitting residents on a routine basis.

Many facilities 'locked down' weeks in advance of NZ entering Alert Level Four, with the rest 'locking down' as we entered Alert Level Four, not accepting visitors, with only end of life situations being considered for limited visiting. At Alert Level Two, the Ministry of Health and Aged Care Association (ACA) issued guidelines, allowing controlled visiting, with most continuing to relax their rules by the end of the month. Tears were shed at many facilities as family members and older people reunited, reinforcing the importance that personal interactions have on our lives.

While the sector wanted evidenced-based advice from Ministry on PPE, they found the ever-changing and sometimes inconsistent documents published to be confusing and frustrating as they fronted this guidance to their staff. Our Southern DHB Infection Prevention and Control (IPC) staff were invaluable in supporting the ARC leaders to provide good leadership in their facilities. We are continuing to work with the sector on IPC and PPE.

A total of 180 ARC nurses received virtual training for COVID-19 swabbing from WellSouth. This has been well-received, and is a valuable resource if rapid testing at scale is required.

The ARC Locality Leaders structure had shown many benefits, and we are looking to evolve that into an ongoing ARC Steering Group.

Mental Health Addiction and Intellectual Disability (MHAID)

All MHAID services across primary care, non-government organisations (NGOs), and DHB provided mental health and addiction services progressively transitioned back

towards a new normal as New Zealand moved into level three and then level two COVID-19 restrictions. The sector again collaboratively worked together as planning occurred. Most services are optimistic and looking forward to bring the learnings and different ways of working along with them. Technology has been key to both delivering services and keeping connected with people. Examples of this are Zoom Psychology Groups and Psychiatry appointments across the district, weekly meetings with NGO providers.

Psychosocial response planning is underway to implement the psychosocial response in response to the Psychosocial Mental Wellbeing recovery plan. There has been consultation with the Mental Health and Addiction Network Leadership Group (NLG) with an agreement to start by developing an action plan for Central Lakes (the agreement being that this will be followed by other areas in the district) following consultation with the local network mental health group and service user engagement. An action group focussing on Central Lakes is being formed, and the draft action plan has been developed and being circulated for feedback.

6. SOUTHERN ALLIANCE

The senior leadership teams from Strategy, Primary and Community, WellSouth and the Māori Health Directorate held a planning Day on 9 June. The group reviewed the actions from the plan and agreed a refreshed set of priority areas for 2020/21. The areas agreed are Equity, Urgent Care, Planned Care, Integrated Mental Health and Addictions, first 1,000 days, CLIC, Care Co-ordination, Health Care Homes, rural health, locality network review, vaccination, health in all policies/psychosocial, ongoing COVID-19 response, community health hubs, health needs assessment and completion of the Primary Maternity Strategy Implementation. Each area has been assigned a lead from both the DHB and WellSouth. The joint leads will develop workplans over the next month and will identify objectives, actions, metrics and milestones. The group of leads will form the refreshed Strategy Implementation Group (SIG). This group will convene weekly to check in on progress and identify any issues / risks for escalation to the respective executive leadership teams and the Alliance leadership team.

It was agreed that a further planning session was required on the System Level Measures (SLM) Plan and that each of the workstreams will have to identify how their area contributes to the SLMs.

The direction of travel will be the subject of a presentation and discussion at next month’s Community Pand Public Health Adviosry Committee (CPHAC) Meeting.

7. PACIFIC RADIOLOGY GROUP (PRG)

PRG continue to redefine their service which impacts on other health service providers. An interim agreement has been reached with Gore Health and Clutha Health First to maintain PRG services in Gore and Balclutha for another year. PRG have also advised they will not provide a weekend or evening service in Queenstown. They have doubled their charges for reading films for Waitaki District Health Services. Work to create a sustainable service moving forward will be initiated within the next two months.

8. PRIMARY MATERNITY PROJECT

Work to determine the best configuration of primary maternity facilities in Central Otago/Wanaka continues. Following Board approval, the updated consultation

timeline and next steps have been communicated to stakeholders through updating the consultation website and emailing those who have made submissions. The paper outlining options for the configuration of services is under development and will be communicated to key stakeholders at a workshop for health providers, followed by a public meeting, in July. These would be advertised across print and social media channels, and through our stakeholder network.

Once the consultation is completed recommendations will be made to the Board in terms of where to locate the facility and we will then develop a business case for submission to the Ministry of Health.

9. REFUGEE HEALTH

The Ministry of Business Innovation and Employment (MBIE) has temporarily suspended accepting refugees for resettlement into New Zealand. As refugee resettlement is a highly controlled process, with significant health screening, this is expected to recommence later this year, however. Refugees that were at the Mangere Resettlement Centre during the NZ lockdown are now being resettled into Dunedin and Invercargill.

A total of 21 refugees (10 in Dunedin and 11 in Invercargill) were resettled in May.

COVID-19 Awareness and Concerns

The Refugee Health Navigators at WellSouth have been working with refugee families to answer any questions or concerns around COVID-19 risks. The Navigators report that during the Alert Level 3 to 2 transition a number of former refugee families felt that it was not safe to go to the hospital or send their children to school. The Navigators were able to respond to these concerns and consequently families have become more confident returning to school and attending hospital appointments.

Southern DHB partnered with Dunedin City Council (DCC) in recording lockdown safety announcements in Arabic, Chinese and Farsi (the three most commonly used languages besides English). These were disseminated via Otago Access Radio, WhatsApp, WeChat, and the South Island Chinese Newspaper App.

Interpreting

Phone consultations have proven effective as a stop-gap during lockdown, but we are receiving requests across all areas of health for a return to face-to-face interpreting.

Inability to access interpreter services for areas outside of health continues to cause challenges for those working with former refugee families in Southland. While the issue is not directly a health one the flow-on and potential health consequences are significant. In contrast, Southern DHB provides no-cost interpreters for NGOs in Dunedin via Dunedin City Council funding.

During the lockdown, the lack of ability to access interpreters readily has caused some challenges for patients and practices. This is being worked through at present, as it appears anecdotally that the experience of using of the telephone interpreting service is not a positive one, but this does need further work to understand the issues.

Refugee Mental Wellness during Lockdown

Rebecca Hennephof, WellSouth Mental Health Nurse, recorded and delivered wellness videos in Arabic, Farsi and Spanish and published these through WhatsApp

groups. The feedback from the former refugees has been very positive. These have helped them adapt to the significant changes we have all faced.

There have been several referrals this quarter that have involved domestic/family issues. The reporting of family violence to Oranga Tamariki and the co-ordination of assessment/care with services such as court forensic liaison staff, police, probation and lawyers, midwives, the Emergency Psychiatric Service, GPs and social agencies has been necessary. This has provided an opportunity to build capacity in new areas and has been received very positively by these services.

10. POPULATION HEALTH SERVICE

Population Health essential services continue to operate and planning is now in progress to return to business as usual activities. Some nursing staff remain partially deployed to Public Health in preparedness of COVID-19 possible resurgence. All other staff are now back working in their usual roles with a focus of re-engaging with priority schools, pre-schools and high deprivation areas and children, youth and families. The school based human papillomavirus vaccination (HPV) programme has been prioritised to ensure we can get as many consenting young people.

Highlights have included Population Health Outreach Mobile Immunisation Service partnering with Māori Directorate, Primary Care, Community Based Assessment Centres (CBACs) to provide Marae based Influenza vaccination clinics for Māori Communities - 'He Waka Eke Noa, We are all in this together'. Overall 195 vaccines were delivered 50% of which were Māori, the remaining numbers made up of other ethnicities who were part of the whanau bubbles and local community, 71% received Influenza vaccine for the first time.

In addition, the Immunisation Coordinators worked at pace to provide ongoing support to practices to ensure they received Influenza vaccination providing ordering advice and supporting many practices by redistributing supplies from other providers such as Occupational Health providers. Staff from Population Health also managed increased Southern DHB staff influenza vaccination demands.

The outreach program to children 'Immunisations on time every time' also continued as an essential service throughout the different COVID levels. Additional Public Health nursing staff were redeployed to Outreach and the service was able to take advantage of many families and whanau being at home to provide vaccine catch ups. In the first months of this year there was a decrease in percentage reach for vaccination and now after additional support to the Outreach team these percentages are now up, meeting target 95% for eight months and two years and stable at 92% for five years. Equity access has also improved for Māori up 5% for eight month olds and up 3% for two year olds. However, more work needs to be done for Pacific children, down 8%. The numbers are small so percentage differences are higher for this group.

The Before School Check (B4SC) programme is resuming based on advice for Well Child services provided by the Ministry of Health and this is expected to roll out with a focus on priority population services with equity lense. A catch up programme has also been planned for children that have missed the check during COVID-19.

The Vision Hearing Technicians (VHTs) team have returned to business as usual in different ways as under current alert levels staff were unable to enter pre-schools. Service provision is on a by appointment basis with priority children are being offered appointments in clinic settings with a focus on deprivation and with an equity lens.

New born screening continued on an essential service basis during the lockdown with addition of a seven day roster, screening only inpatients at Dunedin and Southland hospital maternity wards and neonatal units. With the move to Alert Level 2 screening resumed for outpatients and are now holding Community/Rural clinics once again. There were 276 babies to catch-up on at the end of the COVID-19 lockdown. Audiologists have been allocated those babies older than a gestational equivalent of 48 weeks. This is per the National Screening Unit (NSU) recovery protocol for Community Audiology clinics. COVID-19 triage forms and contact tracing has been completed for all clinics.

The cervical screening programme has been supporting practices to reach their priority women through information advice and data management. During Alert Levels 3 and 2 there was an emphasis on annual surveillance screening, those overdue and our priority populations with pre-appointment COVID-19 screening risk assessment. There have been no outreach events outside of practice during Alert Level 2.

Sexual Health continued to provide services by triaging prior to consultation during Alert Level 3. Under Alert Level 2 the service returned to business as usual. The service increased its provision of contraception to help cover the gap caused by Family Planning moving to remote consultations in April and having a long wait for services in May. A number of quality initiatives are again in progress to improve training and virtual opportunities to increase.

The Sexual Abuse and Treatment Service continued to provide essential service delivery across the district. Low numbers were reported during COVID-19. Plans are in place to commence a Sexual Harm Assessment Clinic mid-June 2020.

11. DISTRICT ORAL HEALTH SERVICE

With the move out of lockdown the majority of staff were cleared to return to work. A recovery plan is underway working with staff to adjust the working environment to ensure adherence to the restrictions that remain are observed. Strategies have been worked through with staff around the screening, time-frames for appointments, PPE and hygiene, currently everything is going well.

The Mobile Unit service is coming back online with a revision and rationalisation of the service capacity and the impact post COVID-19. Both units deployed to the Dental School in Otago and Southland Hospital are both back with the service and being redeployed to revised schedule sites.

Regular meetings are being held with the Dental Faculty and Oral Health Service to review and plan a joint approach to management of the general anaesthetic waiting lists and look at equity of access to oral health services across Southern.

The Southland Hospital clinic upgrade is now complete (it was started on 2 March 2020 and had to be halted during the lockdown).

The Lakes Oral Health Clinic has returned to the service and plans are being developed to review the service provided in the Central Otago area, a positive note is when the therapist position was advertised in Wanaka we received four applications for the position which has just closed.

Fluoride varnishing training program for dental assistants is underway again which is particularly important considering we are still unable to recommence the tooth-brushing programmes in schools at this time.

12. MENTAL HEALTH, ADDICTIONS AND INTELLECTUAL DISABILITY

Mental Health and Addiction Network Leadership Group (NLG)

The NLG met once during May. The group highlighted and discussed the following areas:

- Overall changes in service provision across the Southern Mental Health and Addiction system as we moved from Alert Level 3 to Alert Level 2. The group noted that service provision was becoming much more normalised whilst still adhering to the requirements of the prevailing alert Level.
- The NLG are concerned that the present levels of residential community based mental health bed availability is not matching or have the capacity to meet the needs of the service user group. This is flowing on to inpatient specialist services where service users are in hospital awaiting appropriate residential NGO community placements. NLG will review at the next meeting and consider any actions that can be taken prior to the pending whole of mental health and addiction review.
- Work continues on the development of psychosocial planning and the DHB's response related to the COVID-19 pandemic. We have recently received and are reviewing how the Ministry of Health's own Psychosocial and Mental wellbeing Recovery Plan (Kia Kaha, kia Maia, Kia Ora Aotearoa) provides context and a framework for our own local plans.
- Updates were received from each of the Local Mental Health and Addiction Networks (Waitaki, Southland, Central Lakes and Dunedin). NLG noted that the Networks are largely committed to actions and work related to recovery from the effects of COVID-19, this is particularly true of the Central Lakes Network.

He Ara Oranga – Integrated Primary Mental Health Programme Access and Choice

WellSouth are working towards the roll out of the Integrated Primary Mental Health Programme Access and Choice which will commence in July.

We have also received additional funding for suicide post vention services from the Ministry of Health. There is approximately $70k available for investment over an 18 month period commencing 1 April 2020. The funding is complimentary to existing funding for suicide prevention activities and which is invested in WellSouth. The additional funding is specifically provided for providing post vention support across the Southern DHB catchment and will be used to support the eight post vention support groups and the proposed Māori post vention group.

We continue to await the outcome of proposals for expansion and/or replication of existing Māori and Pacific primary services, increase in nurse practitioners and enrolled nurses in primary health, the youth primary mental health proposal as these have been delayed as the Ministry and services focus on COVID-19.

A further expression of interest to place a mental health nurse educator in the Emergency Departments in Dunedin and Invercargill and support to scope a NGO peer led crisis support service for people in distress presenting to ED has been submitted to the Ministry. This is similarly delayed.

Sole Clinician Caseloads

The service has commenced looking at the practice of having what is known as 'Doctor only' caseloads in the Otago Community teams to determine the process to move to a case management model. This model is not contemporary practice. The current model exposes the service to the risk of not being able to meet all its documentation and clinical review requirements and this has been brought to the

attention of the directorate leadership team by a number of the community psychiatrists. Other professional groups are closely looking at any implications to their practice that may result in a change to how caseloads are managed.

Associated with this work is the transition of care to general practitioners and this sectors capacity to be the lead health provider. A meeting is being arranged with the relevant primary health representatives to further progress this aspect. A group will be formed over the next month to review the mandatory documentation with a view to rationalising this while still meeting the requirements of standards and guidelines.

Transition Plans

Improving compliance continues to be a priority for the Directorate with an improvement over the previous month. Compliance has been maintained during the lockdown period with Specialist Addiction Services (SAS), Otago, being the major area of focus for improvement - the improved compliance statistics reflect that this was successful. Within the Otago Adult Services the priority is working with staff that require continued support to improve their compliance with recent results showing this is gradually being successful. Southland services have seen improvement in local transition plan data over this time and the focus is on SAS services and ensuring new people are having a plan completed. Southland has also been correcting some data to aid this. Team managers are working on their transition plans with identified individual people who have not met the target.

	Target	2019									2020				
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Closed referrals with three or more face-to-face contacts	-	33%	50%	53%	55%	55%	58%	57%	50%	48%	58%	51%	47%	51%	60%
Open referrals longer than one year with three or more face to face contacts	95% *(National target)*	50%	57%	58%	60%	62%	63%	65%	67%	68%	69%	70%	75%	76%	80%
Open referrals longer than three months with three or more face to face contacts	80% *(Local target)*	26%	40%	48%	55%	44%	42%	48%	48%	51%	49%	49%	59%	58%	61%

Health Quality Safety Commission (HQSC) programmes

The HQSC's programme of Zero Seclusion by 2020 has been picked up post COVID-19 and continues to be a priority with planning in place to work closer with the clinical teams through arranging a number of area specific workshops to more effectively engage with front line clinical staff. There is concern as seclusion rates particularly in Dunedin have risen dramatically. Improvements are evident in some areas and not so in other aspects. Our facilities do influence the need to utilise seclusion, our experience when Mental Health Facilities were redeveloped in Southland saw a marked reduction due to fit for purpose facilities including low stimulus areas, line of sight enhancements etc. It is acknowledged this is just part of the challenge, but a significant part and requires recognition and acknowledgement of the wider organisation. Planning is happening for a South Island regional virtual day by the HQSC to bring the DHBs' teams together to share our learnings.

The Connecting Care project has also been delayed by COVID-19, however the new ways of working with virtual meetings in the inpatient area for families will be picked up in phase two and elevated, due to comments from rural families about the ease of this and reduced travel time. We have met in Alert Level 2 to stocktake and plan the recommencement of the project. The team is reconvening on 3 June to complete the Plan Do Study Act (PDSA) cycles planned prior COVID-19 and to plan for the next pieces of scheduled work.

The Learning from Adverse Events workstream met weekly during May and has made considerable progress with the action plan identifying two areas of focus – early family engagement and consistency of process across the District.

13. SPECIALIST SERVICES PERFORMANCE

Hospital Advisory Committee (HAC) reporting has been re-focused to report on the key operational performance measures that the Ministry has included in the new performance monitoring dashboard. These measures are:

- Case weights (surgery)
- Discharges
- The ED 6 hour target.
- Cancer treatment <31 days
- First specialist assessments (ESPI 2)
- Elective treatment >4 months (ESPI 4)
- Medical Imaging – CT
- Medical Imaging – MRI
- Colonoscopy urgent – 14 days
- Colonoscopy non-urgent – 42 days
- Colonoscopy surveillance – 84 days.

Comprehensive reporting frameworks are being put in place to monitor and manage performance in these key areas.

We already have mature dashboards for outpatient (ESPI 2) and inpatient (ESPI 5) performance by specialty, we now have licenses that permit the service manager and clinical leader to have these reports on their desktop and we have asked our Power BI expert to systematically meet with all Service Managers with ESPI 2 and relevant clinical leaders to step through the dashboards with them so that they can use them as part of managing performance in these areas.

We have dashboards under development for radiology that will allow us to see performance against the 42 target on a weekly and month to date basis and as these dashboards are developed we will use them to monitor the various radiology activities with a view to targeting 95% performance for Dunedin CT in the first instance but ultimately 95% for CT district wide and 85% for MRI district wide, in line with Ministry targets.

We are developing a dashboard for the cancer target that will break down the tumour streams for us and the various flows, so that we can understand our cancer performance at a more granular level and start to manage the components that will achieve the overall cancer target.

We will then develop a performance framework around the following core meetings:

- Elective surgery performance – daily theatre call.
- Outpatient and Inpatient (ESPI 2 and ESPI 5) performance – separate weekly meetings for surgery and medicine, women and children.
- Radiology performance – weekly performance meeting.
- Cancer treatment – weekly performance meeting.
- Colonoscopy – brief weekly call with the General Manager and Clinical Leader initially (as a robust recovery plan led by the Clinical Leader is in place).

The intention with these performance meetings is to ramp up performance for ESPI 2 (as we know what is required to achieve the necessary results now), monitor the implementation of the radiology initiatives and learn what the drivers are for cancer treatment so that we can develop programmes to enhance performance in the longer term. A dashboard currently exists for the Executive Director and the General Manager Operations is undertaking initial work to understand the drivers for ED performance. We envisage a programme of work in the coming months that will require partnership with the Chief Medical Officer (CMO) and Chief Nursing & Midwifery Officer and which will link with Generalism.

14. ED 6 HOUR TARGET AND GENERALISM

Achieving the ED 6 hour target requires a combined focus on the number of presentations received into the ED in the first place – an issue that needs to be worked through with our primary care colleagues, the elapsed time until patients are assessed by an ED clinician, and then the elapsed time until patients who require an inpatient admission are assessed by a specialist senior medical officer (SMO), a bed is identified for them and they are discharged from ED and admitted into the wards. There are several pieces of work occurring with our CMO and Deputy CMO taking the lead in terms of seeking to establish more rapid assessments by the specialist SMOs. Our General Manager Operations has had a business intelligence dashboard developed in a tool that we are systematically rolling out across specialist services – 'Power BI' This is a business intelligence tool that is going to enable us to start to get really good insights from our data. She is using the tool to quantify where the delays are occurring and why, and this may inform a future work programme or support the flow work that is occurring under the auspices of valuing patient time.

An initiative that will make a meaningful difference to the ED 6 hour performance in Dunedin is Generalism. We have tied the Generalism case that we are developing into the colocation of a medical assessment unit next to the ED. In terms of creating additional ED space to prevent the overcrowding that occurs in ED at the height of winter this is the space we believe will give us the best return and maximum opportunities in terms of patient flow. A medical assessment unit with circa 20 beds, managed by the internal medicine generalist teams who can admit patients quickly from the ED, undertake rapid assessment and treatment and discharge them faster than if they were to be admitted to sub-specialities in the general wards will assist rapid assessment and inpatient admission (which will markedly improve the ED 6 hour performance), whilst also achieving the reduced average length of stay that we are setting out to achieve with the generalism business case. We are continuing to progress the business case, with a first draft now completed on the strategic case, economic case and financial case. We will continue to refine these cases and complete the concept design work of the medical assessment unit required for the commercial case, and the identification of change activity, protocols and procedures that will need to be demonstrated for the management case.

15. CANCER TREATMENT <31 DAYS

The radiation oncology forward wait list has continued to remain within reasonable parameters. The service likes to have a forward wait list of 50 patients and the wait list at the time of writing is 70 patients. One of our challenges with cancer more generally is that we do not have a view across all cancers (tumour streams) with this split out for surgery, radiation oncology and chemotherapy at an organisational level. We have therefore asked our General Manager Surgical and Radiology, who has previously worked in the General Manager Medicine role and is therefore uniquely placed to understand the full picture, to work with the Executive Director and our Business Intelligence expert to develop a comprehensive dashboard in Power BI. The dashboard will allow us to see the waiting times at key steps along the journey (e.g. waiting time for surgery, waiting time for subsequent radiation oncology) and will allow us to monitor and manage the components that drive the overall 31 day target and the faster cancer treatment targets.

We have also received some good news recently – after writing to the Ministry requesting additional capital funding to support the initiatives that need to be delivered for radiation oncology (including the installation of the second Linear Accelerator (LINAC)) in December of last year we have recently received confirmation from the Ministers' office that our request for $1.15m has been approved. This funding will allow us to manage capital over-runs in the LINAC project as well as purchase new stereo tactic hardware and software to replace the end of life software that is currently in place.

16. FIRST SPECIALIST ASSESSMENT (FSA) >4 MONTHS

This target is known as ESPI 2, and every patient who was accepted at triage for a FSA and has had to wait for over 4 months is a breach. Industrial action earlier in the financial year and COVID have exacerbated the ESPI breaches and there is a significant mountain to climb to get back to ESPI compliance in all services.

The fundamental issue that causes ESPI 2 breaches is that we are accepting more patients for a FSA than we have capacity to see. Last year we implemented a Ministry prioritisation tool in urology to address this imbalance. Essentially, the prioritisation tool requires the triager to complete a questionnaire using the information from the GP referral in ERMS (our electronic referral management solution), information on the prioritisation tool and information from a quality of life questionnaire which is populated by an outbound call to the patient.

If the initial questions which suggest high risk are answered the patient goes straight through and is accepted for a clinic appointment. If not, the information that is captured from the sources mentioned earlier is assessed and the patient receives a score. The service then determines the score at which it has the capacity to see patients and provided that this is a score that is felt to be safe by the clinicians this becomes the threshold at which patients are accepted for an outpatient appointment.

This process worked very well for urology and we managed to get them from being an service with 80 breaches to having zero breaches using this tool. Even during COVID they have managed to maintain almost nil breaches and they do not have an ESPI 2 problem. We also rolled this tool out to orthopaedics in Dunedin and now that we are seeking to recover performance we can see a clear pathway to compliance for that service. And we have rolled the tool out for general surgery in Southland. Unfortunately, we have had to roll the tool out with no project resources so the rate of progress has been slow. However, it is now opportune to ramp up the

use of this tool in the other surgical specialities in particular (noting that the tool is not ideal for some medicine specialities).

Another tool that we have rolled out to a number of specialities is the acuity basis for booking patients. The acuity tool assigns a score to a referral based on its priority and how long the patient has been waiting outside the clinically indicated timeframe for their appointment. It is a means of ensuring that high priority and long waiting patients both make it into clinic slots. The tool has been rolled out successfully in obstetrics and gynaecology in Southland recently and has been instrumental in improving ESPI 2 performance there.

And another tool that is an important part of the programme is the regular review and tidy up of the wait lists. The wait lists invariably contain data quality issues. For example, patients who are on the wait list but have been seen privately, patients who have left the district and are no longer under our care. And in some cases, patients who have already had their appointment. Investigating and clearing errors off our wait lists improves ESPI compliance.

We need to re-focus on ESPI performance now that we are out of COVID and it will be a resourcing challenge to get across all 40 specialities across both sites rapidly. Something we have not been able to do previously was to give clinicians access to the data. We have spent the last 12 months developing very comprehensive ESPI 2 dashboards in Power BI, but we have not previously had the licences to share this more broadly. We now have sufficient licences that will allow a much broader group of people to view the dashboards. By way of example, we took the clinical leader for neurology through his dashboard recently. He was very keen to have access to this on a regular basis and we are arranging for this. He was keen to manage the supply versus capacity imbalance issue with his colleagues and with access to the data he can take the necessary actions to get the service into balance, in conjunction with the service manager. Our goal now is to systematically roll the dashboards out to the clinical leaders across all specialities so that they can take a direct role, in conjunction with their service managers, in managing the ESPI compliance issues.

The prioritisation tool continues to be the most robust method to for ensuring that the surgical specialities get into balance (between what they accept for an outpatient appointment and what they have the capacity to see). We will continue to develop the core supporting capabilities, work with the specialities and roll out this tool. However, the neurology clinical leader demonstrated for us that that the tool does not work as well in some of the medical specialities and we will instead encourage the clinical leaders and service managers for these specialities to utilise their dashboards and devise alternative strategies for getting back into balance.

It should be noted that following COVID we have a steeper mountain to climb to get the services back into compliance. Perseverance and a continuous focus is required to eventually get there.

17. ELECTIVE TREATMENT >4 MONTHS

This target will be very challenging to achieve, as it requires access to additional theatre capacity in order for us to catch up on historic backlogs. Immediately prior to COVID we were about to take the Ministry up on an offer for additional funding to complete more orthopaedic surgery as we met the criteria for the funding (we were ahead of the surgery target pre-COVID). However, post COVID we have significant breaches in all services now.

The recovery funding will provide us a unique opportunity to catch up about one-third of our long waiting patients which is a unique opportunity we intend to

capitalise on. We have oriented our recovery programme to catch up the inpatient wait list deterioration by speciality first and foremost, and to then focus the remaining programme on the longest waiting patients across the specialities.

Eventually, as we limit the number of surgical outpatient referrals we accept to match the capacity we have to see these referrals, and as we limit what we accept for surgery to match our surgical capacity, we will get services into balance. However, we have a significant challenge in front of us in terms of addressing historic and COVID related backlogs, the recovery programme will only deal with circa one-third of the problem and we still need to think through what a robust solution would look like for recovering the rest of our historic backlogs.

18. MEDICAL IMAGING – CT AND MRI

With the Board approving an additional $980k per annum to improve CT capacity in Dunedin we are now in the process of monitoring the implementation of the proposal. The equipment for allowing the Spec CT machine to be used for regular CTs has been ordered and its arrival is imminent. The requests for hire have been approved. It is proving more difficult than envisaged to hire the medical imaging technologist (MIT) staff and we are about to start monitoring this closely on a weekly basis.

In parallel to this we were approached by the Ministry offering additional funding for June and July to catch up volumes. DHBs had to meet certain criteria related to matching prior years' performance, which we are able to. A proposal was made to the Ministry and we have received confirmation that we are eligible for funding with a contract to be signed this week. We have commissioned South Canterbury MRI capacity and are initiating other activities to utilise the funding.

The other issue the Board identified and supported was the need to acquire an additional CT scanner to be located in Dunedin. Presently Dunedin has three scanners, the main one in the radiology department, the SPECT scanner in radiology and a third scanner in radiation oncology, which is dedicated for the use of this service. The main scanner and the one located in radiation oncology are coming to the end of their useful lives, their leases were extended for a period of 24 months early this year. Therefore over the next 18 months we will need to acquire (either purchase or lease) three new scanners – the additional one plus the replacement of the other two. An request for proposal (RFP) process is about to commence with the expectation that delivery dates will be staggered to allow us to bring additional capacity on-line before we move to replace the existing machines. Concurrent with this however it the work that needs to occur in partnership with WellSouth to determine where we want to place the fourth scanner. The options are really only either within the existing radiology department (a space for which has been identified) or within a community health hub as they are developed. The decision-making should be informed by the work being undertaken on improving access to diagnostics. The benefit of locating separately would be that one would then deliberately separate the planned and acute activity. The disadvantage would be that there is less flexibility if there is a significant overload of acute work or unplanned outages. We will report further to the Board once this has been addressed.

On a similar basis to the other areas of performance, we are developing a dashboard that will enable us to have weekly performance meetings on the key modalities and we will use this as the basis for monitoring and managing performance on an ongoing basis.

We have also had an International Accreditation New Zealand (IANZ) annual assessment. Several years ago the DHB lost their IANZ accreditation and we have worked hard in the last couple of years to get this back again. We were successful in getting the accreditation back last year. This year the IANZ assessor was delighted with where the department has got to and gave a glowing appraisal at the close out meeting. One of the observations they made last year was that we needed to consider CT access in Dunedin and they are delighted with the steps we have taken to improve access to CT.

19. GASTROENTEROLOGY PERFORMANCE

The gastroenterology service recently had its two year bowel screening programme review. The programme has been very successful, for example, if participation rates are used as the key marker for success the Southern DHB programme has been the most successful in New Zealand – the overall participation rate is 70% against a nationwide average of 63%, and particularly pleasingly, the Māori participation rate has been 72% against a national performance of 55%. This is largely due to a very well run and targeted engagement approach in partnership with WellSouth and the Clinical Leader, Service Manager/Acting General Manager and Programme Manager. All those involved can feel justifiably proud of what they have achieved.

The programme has led to 1,250 plus pre-cancerous polyps being removed (significantly reducing the risk of cancer for those patients), and has led to 177 cancers being detected. With unprecedented success has come unanticipated burden on general surgery and on oncology as this level of additional cancer wasn't anticipated and therefore planned for. However, the impact of these specialities should reduce going forward as the first two years of the programme involved screening a completely unscreened population and the numbers needing screening will reduce going forward.

The gastroenterology service has also proactively identified a catch up programme that will see backlogs caused by COVID caught up in Dunedin by the first week of August. Further discussion will be had with the Clinical Leader and Acting General Manager to determine what assistance is required to facilitate catch up for Southland.

20. KEY BUILDING PROJECTS

The design and development of a fit for purpose air handling solution that would enable the second stage of the ICU (which has now been built) to be occupied is also a key building project. Frustratingly the latest mechanical engineers' report has not provided us with a definitive design and therefore a pathway to completion. We have reached the conclusion that we will have to apply a similar approach to that which we took to complete stage one of the ICU – where the Executive Director, Clinical Leader, General Manager Facilities and key project managers met with the architects (this time it will be mechanical engineers) on a weekly basis and reviewed in detail every aspect required to get to a final solution. We have initiated similar meetings which will commence in two weeks' time.

21. SHIFTING ACTIVITY FROM SECONDARY TO PRIMARY CARE

We have recently organised regular meetings with the WellSouth Chief Executive to discuss shifting activity from secondary care to primary care. In the initial meeting we discussed where a logical place to start from would be if we wanted to systematically shift activity from secondary to primary, in line with national planned

care guidance. We concluded that skin lesions was a good place to start for several reasons – firstly, the General Manager Surgery and Radiology has completed a fairly comprehensive piece of initial work on how minor procedures could be shifted to primary care; secondly, shifting minor procedures would reduce outpatient appointments, allowing the service to catch up on 338 ESPI 2 breaches that have occurred during COVID; thirdly, planned care guidance appears to provide latitude for the funding of minor procedures to shift to primary care; and finally, the shifting of this activity would also allow more capacity for surgery. We will now establish weekly meetings and we will use Health Pathways resources to initiate activity and take the actions necessary to move things forward.

22. MĀORI HEALTH DIRECTORATE

Māori mental health services have been integrated into Southern DHB Mental Health Addictions & Intellectual Disability (MHAID) services. To date, the process has gone well with staff working with specialist services. Māori general health services continue within the DHB with a focus on reducing admissions including addressing 'did not attends' (DNAs). We will have consolidated the review of the Māori Health Directorate review as at the end of June with the mental health budgets shifted from our budget codes.

Ambulatory Sensitive Hospitalisations (ASH) Respiratory 0-4 years Programme – Southland

In partnership with WellSouth, the ASH Respiratory 0-4 year programme is progressing well. WellSouth PHN will contract with Awarua Whānau Services, Invercargill to provide a Kaiawhina position, who will work with Māori whānau who have been admitted into the hospital. Whānau will be offered an assessment (using the Southern Harti Hauora Assessment Tool) with referrals and linkages to community and primary care services (e.g. car seats, warm homes, enrolment to child health services, general practice). The aim is support whānau to stay well at home and therefore reduce admissions to hospital. The Harti Hauora Assessment Tool has been implemented into Waikato DHB and has been shared with Southern and localised for this district.

Hauora Wellness Check Programme – Māori 50 years plus

In partnership with WellSouth, the Hauora Wellness Check Programme for Māori 50 years plus is in progress. This programme is a follow up in response to COVID-19. Māori enrolled with general practices will be identified and then contacted by the WellSouth call centre staff (registered nurses) to provide a Hauora Wellness Check. Consent is provided from the general practice, with WellSouth call centre staff ringing on behalf of the practice. The aim is to support whānau to re-engage with general practice and offer a funded GP visit and funded eligible screening programmes. It is hoped that we will be able to pick up non-enrolled patients and or other health related issues with other household members.

Māori Cultural Education Programme

Significant work has gone into the development of a suite of Māori cultural education programmes. This has been presented to the Southern DHB and WellSouth leadership teams with support to progress this. The programmes will sit within the New Zealand Qualifications Authority (NZQA) framework as a Level 3 Certificate. Delivery will include face to face and self-directed learning using a quality improvement framework. We will look to partner with Otago Polytechnic for micro-credentialing. Programmes will be delivered to Southern DHB staff, Rural Trust Hospitals, WellSouth staff, Māori Health providers, general practices and community pharmacies.

The programmes comprise of:

- Te Tiriti o Waitangi – understanding the origins of Te Tiriti o Waitangi and its relevance today and how this is applied within a clinical and non-clinical environment.
- Cultural Safety – incorporating cultural competency and Tikanga best practice guidelines to support clinical and non-clinical staff to work in a way with whānau that is culturally responsive.
- Cultural Humility – incorporates Southern DHB values of Manaakitanga, Pono, Whaiwhakaaro, Whanaungatanga and how these relate to individuals' own values and beliefs when providing care for whānau.
- Te Reo in Health – provides the basic introduction of Te Reo Māori language, mihi, the strength of building and maintaining engagement therapeutic relationships with whānau to improve health outcomes.
- Southern Health Orientation – support has been given to explore opportunities to facilitate and host new staff orientations on the marae. This is inclusive of WellSouth staff, with future options to open wider to the health sector. A core group will be established to look at these options.

Sexual Health Services – Messaging for Did Not Attends (DNAs)

There has been work undertaken with Southern DHB Sexual Health services to reduce their Māori DNAs. A script has been provided for staff to contact whānau who have DNA appointments. Staff have been provided with cultural education and an update on Tikanga best practice to increase their knowledge and engagement with whānau.

Regional Māori COVID-19 Communications Project

The Southern DHB has signed off a regional communications contract with Nelson Marlborough DHB to act as the regional lead for funding released from the Ministry for the purposes of regional COVID-19 Māori communications support. The funding aims to deliver communications activities throughout all the remaining phases of the pandemic response.

The Chief Māori Health Strategy & Improvement Officer is working towards setting up an approvals committee that will involve other Māori DHB representation, a district communications manager and procurement to review a limited tendering process with potential providers that have the following skill set:

- Māori media and communications capacity and capability with a proven track record of delivery to targeted Māori audiences.
- Knowledge and established relationships with South Island iwi, hapu and whānau structures and Māori networks.
- Experience in working in the health sector, including DHBs, Primary Care and with Kaupapa Māori Health Providers.
- TV and Radio communication experience including iwi radio and/or regional news.
- An ability to work with grass roots Māori communities and can support other COVID-19 campaigns like protect our whakapapa.
- Experience in audio visual technology, text messaging campaigns, social media and print media including posters and cards.
- Te reo Māori me ōna tikanga.

Other activities that are agreed between the DHB and the Ministry as being appropriate for the regional communications approach.

Puketai Interagency Group

The Southern DHB is participating on the Oranga Tamariki, Puketai Interagency Group that is aiming to improve health outcomes for children and young people in their care. As a result of the meeting on 16 June out of the total eight children in this local residential facility, six were of Māori ethnicity. The DHB is currently contracted to provide gateway assessments for these children and young people and they interface with our Mental Health, Addiction & Intellectual Disability services regularly. Section 141 of the Oranga Tamariki Act has been repealed and this will have implications for tamariki who require specialised out-of-home placements. This impacts on te tamaiti with high and complex needs which require caregiver or service providers that have disability expertise and in some cases require environmental adaptations.

COVID-19 Māori Health Data

We are working with the University of Otago to develop a series of Māori data sets that can measure the impact of COVID-19 on our region. The plan is to review Māori health indicator data and other external social and economic indicators such as the Integrated Data Infrastructure (IDI) under Statistics NZ. This project was identified as part of our COVID-19 Māori plan and has involved Justine Camp in her role with the University of Otago.

23. MEDICAL DIRECTORS AND CLINICAL GOVERNANCE

The Executive Director Quality and Clinical Governance Solutions facilitated a workshop for all Medical Directors at the end of May. The workshop focussed on the role of the Medical Directors in Quality and Clinical Governance in Southern DHB and that of the Clinical Directors in both driving and supporting service level Clinical Governance. The CMO and Deputy CMO participated in the workshop which was joined by the Executive Director People, Culture and Technology and the HDC, Coroners & ACC Investigations Officer. The workshop was productive, collaborative and team building. Participant feedback at the end of the workshop how useful they had found it and unlike any other gathering they had had before. A series of monthly sessions has been scheduled to ensure the actions taken away by the group stay on track.

24. EMERGENCY COORDINATION CENTRE - COVID-19

The Emergency Coordination Centre and Emergency Operations Centres wound down during May as the country moved down to alert level 3 then level 2. Weekly virtual meetings took place for a couple of weeks to support all hospitals, including rural hospitals, and to ensure consistent application of guidance on screening, streaming and visitors policy.

25. QUALITY AND PERFORMANCE

The Clinical Risk Dashboard continues to be refined and an equity lens is being developed to apply to the measures, in particular to upstream measures where possible such as CT wait times. The Releasing Time to Care (RTC) team are working on the Clinical Dashboard (concentrating on dehydration and nutrition) and reviewing RTC after COVID-19.

Most Valuing Patients' Time work has been postponed. The team are concentrating on work related to discharging patients. This includes criteria led discharge for surgical in Southland, discharge lounges preparation, aged residential care residents fracture flow, and discharge flow for the red stream.

26. HEALTH PATHWAYS

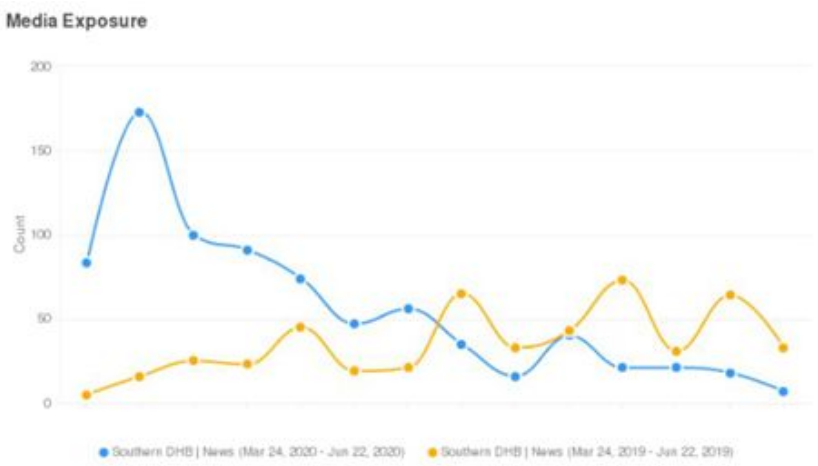
During the COVID-19 response the Health Pathways team responded with agility and collaboratively across various healthcare settings (primary, community and secondary). They delivered a lot of new pathways that provide important guidance on topics such as assessment and management of a child with suspected COVID-19, access to secondary care services during COVID-19 through to palliative care pathways for ARC and community settings. This work has been welcomed by health professionals across the sector and gained a lot of interest in other opportunities this way of working could support. A survey specific to COVID-19 Pathways has been added to the home page with WellSouth to forward a link out to general practices. A videoclip demonstrating how to use HealthPathways developed and circulated to ARC homes.

Clinical Engagement in HealthPathways

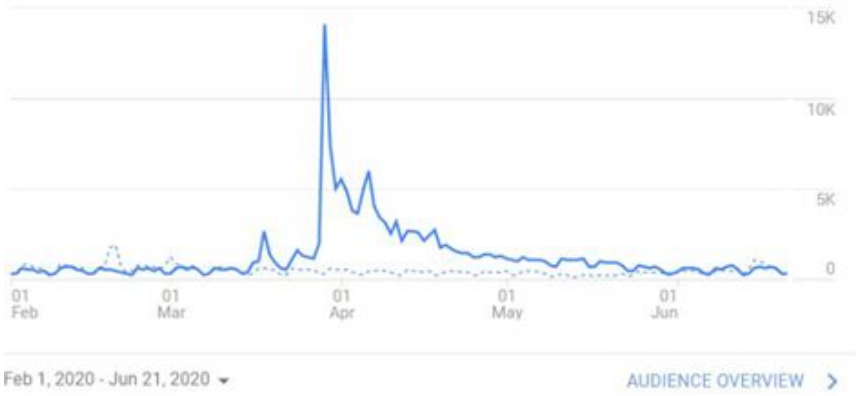
A GP Leaders Group was established during COVID-19 by WellSouth (Andrew Swanson-Dobbs and Dr Stephen Graham). An Acute & Planned Care Working Group at which GPs and hospital specialists met in May furthered discussions on the value of working collaboratively and the important role of Pathways within this environment as a key enabler to system change. An approach to progress HealthPathways across the system is being developed and includes equity, funding and metrics to monitor any changes implemented. Consideration is being given to investment in Hospital HealthPathways as a key enabler to 'join up' our health system and align activity including Valuing Patient Time, Choose Wisely and the Primary & Community Strategy.

27. COMMUNICATIONS

Daily media mentions can be seen returning to more normal volumes, and even trending below, the intense peak through March and early April, comparing the past three months of 2020 with the same period in 2019.



The reduction in media volumes are also reflected in a resumption to normal levels of website hits, following a peak in April, and a sharp increase in Facebook followers at the same time.



COVID-19 remains topical particularly as it relates to recovery efforts across primary and secondary care and wider social and well-being impacts on our communities. Internally, and across the Southern health sector, there is a strong focus on promoting the uptake of telemedicine, as well as communications efforts on supporting the resumption of screening programmes. Other areas of focus include the commencement of demolition for the New Dunedin Hospital and the consultations on primary maternity facilities for the Central Otago/Wanaka area and the Disability Strategy.

The Communications team is also supporting a system wide survey on COVID-19 experiences. Preliminary results show an overall very favourable view of the Southern health system's response to the crisis, with opportunities to learn from the experience. Themes for further reflection include the benefits of more flexible, technology-enabled practices.

Chris Fleming
Chief Executive Officer

1 July 2020

Southern DHB Financial Report

Financial Report for: 31 May 2020
Report Prepared by: Finance
Date: 15 June 2020

Report to Board

This report provides a commentary on Southern DHB's financial performance for the month and year to date ending 31 May 2020 and the financial position as at that date.

The net deficit for the month of May was $10.8m, being $3.5m unfavourable to budget. The net deficit for the period ending 31 May 2020 was $44.0m, being $9.6m unfavourable to budget. The increase in the Holidays Act Provision $1.1m ($2.3m YTD) and COVID-19 $4.7m ($8.7m YTD) contribute to the unfavourable variance. Without these two issues the result would have been $2.3m favourable to budget for the month of May and $1.4m favourable to budget for the period ending 31 May 2020.

On the 27 May 2020, the Ministry of Health (MoH) provided the following guidelines for reporting the financial performance to 31 May 2020.

- Inter District Flows (IDF) revenue and costs are to be accrued from March to June based on the YTD actual trend to February 2020.
- Planned Care Funding to be accrued from March to June based on funding schedules i.e. plan/budget.
- Personal Protective Equipment (PPE) Stock Treatment – value any PPE stock provided to the DHB centrally by MoH at zero cost.

The guidance is consistent with the assumptions we adopted for the Planned Care and the PPE provided by the MoH. However the methodology for the IDF revenue and costs was adjusted in May 2020 to align with the MoH guidelines.

During May 2020, Revenue was $4.5m favourable to budget, mainly due to COVID-19 'pass-through' funding while Workforce costs were $2.9m unfavourable to budget spread across all workforce categories. Clinical Supplies were $0.8m favourable to budget, reflecting the significantly reduced hospital activity due to COVID-19. The reverse is true for Provider Payments, $5.6m unfavourable due to NGO 'pass-through' payments reflecting the response by Primary healthcare services to COVID-19.

The Ministry of Health issued further guidance on 11 June 2020, which confirmed that Planned Care revenue would be received. We are reviewing the assumptions from the initial guidance against the recent advice and any financial impact will be recognised in our June 2020 financial results.

Financial Performance Summary

Revenue (Year To Date)

Government and Crown Agency revenue includes additional funding for Pay Equity, In Between Travel (IBT) and COVID-19 revenue which offsets the increased expenditure in Provider Payments.

On a year to date basis we are 1,314 caseweights behind our Planned Care volume delivery to our population. We have adjusted Planned Care revenue by $6.9m for the shortfall of 1,314 caseweights, including the IDF Outflow component.

Before activity commenced on the COVID-19 response, we were delivering Planned Care close to agreed targets. Therefore, in anticipation of COVID-19 support from the Ministry of

Health and in reliance on the guidance given, we have recognised an equivalent amount of funding ($6.6m) to offset the shortfall in Planned Care revenue (excluding the IDF component).

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 May 2020

Month Actual $000	Month Budget $000	Variance $000			YTD Actual $000	YTD Budget $000	Variance $000		LY YTD Actual $000	LY Full Year Actual $000		Full Year Budget $000
				REVENUE								
93,653	89,160	4,493	F	Government & Crown Agency	993,104	980,853	12,251	F	934,623	1,020,148		1,070,140
872	816	56	F	Non-Government & Crown Agency	10,128	10,469	(341)	U	11,131	11,892		11,252
94,525	89,976	4,549	F	*Total Revenue*	1,003,232	991,322	11,910	F	945,754	1,032,040		1,081,392
				EXPENSES								
41,503	38,568	(2,935)	U	Workforce Costs	407,426	399,733	(7,693)	U	378,457	451,823	*	437,490
3,817	3,476	(342)	U	Outsourced Services	37,815	36,100	(1,715)	U	35,692	39,624		38,754
7,605	8,370	765	F	Clinical Supplies	90,474	85,970	(4,504)	U	87,688	96,479		93,657
5,343	4,924	(419)	U	Infrastructure & Non-Clinical Supplies	53,877	52,012	(1,865)	U	49,322	60,062	**	56,777
44,212	38,611	(5,599)	U	Provider Payments	425,806	416,812	(8,994)	U	402,473	438,921		454,704
2,850	3,383	532	F	Non-Operating Expenses	31,855	35,142	3,287	F	31,637	34,476		38,522
105,330	97,334	(7,996)	U	*Total Expenses*	1,047,253	1,025,769	(21,484)	U	985,269	1,121,385		1,119,904
(10,805)	(7,358)	(3,447)	U	**NET SURPLUS / (DEFICIT)**	(44,021)	(34,447)	(9,574)	U	(39,515)	(89,345)		(38,512)

*Includes One-Off Increase in Holidays Act 2003 Provision $34,116k
**Includes One-Off Impairment of National Oracle Solution $5,127k

Expenditure (Year To Date)

Total Expenses year to date were $1,047.3m and include unbudgeted one-off costs for COVID-19 $16.8m, the Measles Outbreak $0.3m, Neurosurgery $1.4m (excluding IDF Outflows and additional hospital transfer team). Neurosurgery medical workforce is currently insufficiently resourced to maintain a safe roster. Therefore Canterbury DHB is providing the neurosurgery cover.

Workforce Costs are $7.7m unfavourable to budget year to date, including $7.2m for COVID-19.

Outsourced Services are $1.2m unfavourable year to date. This reflects the continued cover for SMO vacancies in Surgical and Medical Imaging and service provision to reduce waitlist backlogs.

Clinical Supplies are $4.5m unfavourable year to date. Clinical activity remained lower in May prior to the transition to Level 2, resulting in continued favourable variances across Treatment Disposables, Implants & Prostheses and Other Clinical Costs for the month. All of these areas however remain unfavourable year to date.

Other Clinical Costs include Air Ambulance activity, which has increased significantly with Neurosurgery patients being transported from/to Dunedin.

Infrastructure and Non-Clinical Supplies are $1.9m unfavourable year to date, the overspend primarily arising from Cleaning & Orderly Services, Software Maintenance and Telecommunications. The Cleaning and Orderly Services include the SECA settlement which increases the ongoing cost for these services. The increase in cleaning demand remains a focus as we have responded to COVID-19 with additional cleaning across all our facilities. Our Telecommunications costs continue to be reviewed to mitigate any ineffective spend.

Provider Payments are $9.0m unfavourable year to date. This includes $8.1m payments to Providers for COVID-19 activity, however this is offset by additional revenue received from Government and Crown Agency. Residential care is $1.3m favourable year to date, continuing to reflect lower volumes across all levels of care.

Non-Operating Expenses are $3.3m favourable year to date. The Depreciation charge is lower than budget, reflecting the timing and category of capital expenditure.

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 31 May 2020

As at 30 Jun 2019 $000		Actual 31 May 2020 $000	Budget 31 May 2020 $000	Budget 30 Jun 2020 $000	As at 31 May 2019 $000
	CURRENT ASSETS				
7	Cash & Cash Equivalents	51,800	7	7	8
47,353	Trade & Other Receivables	63,844	51,011	45,213	54,976
5,762	Inventories	5,900	5,105	5,235	5,156
53,122	*Total Current Assets*	121,544	56,123	50,455	60,140
	NON-CURRENT ASSETS				
323,050	Property, Plant & Equipment	328,603	344,647	346,288	327,136
4,505	Intangible Assets	6,459	12,503	10,393	3,294
327,555	*Total Non-Current Assets*	335,062	357,150	356,681	330,430
380,677	**TOTAL ASSETS**	456,606	413,273	407,136	390,570
	CURRENT LIABILITIES				
9,895	Cash & Cash Equivalents	-	44,304	44,587	26,013
63,925	Payables & Deferred Revenue	116,929	66,900	62,804	64,321
922	Short Term Borrowings	944	784	784	921
112,595	Employee Entitlements	105,578	97,753	91,680	73,246
187,337	*Total Current Liabilities*	223,451	209,741	199,855	164,501
	NON-CURRENT LIABILITIES				
1,568	Term Borrowings	1,099	790	783	1,572
19,362	Employee Entitlements	19,362	18,149	18,756	18,149
20,930	*Total Non-Current Liabilities*	20,461	18,939	19,539	19,721
208,267	**TOTAL LIABILITIES**	243,912	228,680	219,394	184,222
172,410	**NET ASSETS**	212,694	184,593	187,742	206,348
	EQUITY				
300,969	Contributed Capital	385,276	347,602	354,813	271,514
108,502	Property Revaluation Reserves	108,500	108,500	108,502	108,502
(237,061)	Accumulated Surplus/(Deficit)	(281,082)	(271,509)	(275,573)	(173,668)
172,410	*Total Equity*	212,694	184,593	187,742	206,348

Statement of Changes in Equity

192,584	Opening Balance	172,410	172,410	172,410	192,584
(89,345)	Operating Surplus/(Deficit)	(44,021)	(34,447)	(38,512)	(39,515)
69,878	Crown Capital Contributions	84,305	46,630	54,551	53,279
(707)	Return of Capital	-		(707)	
172,410	Closing Balance	212,694	184,593	187,742	206,348

Cash Flow Summary

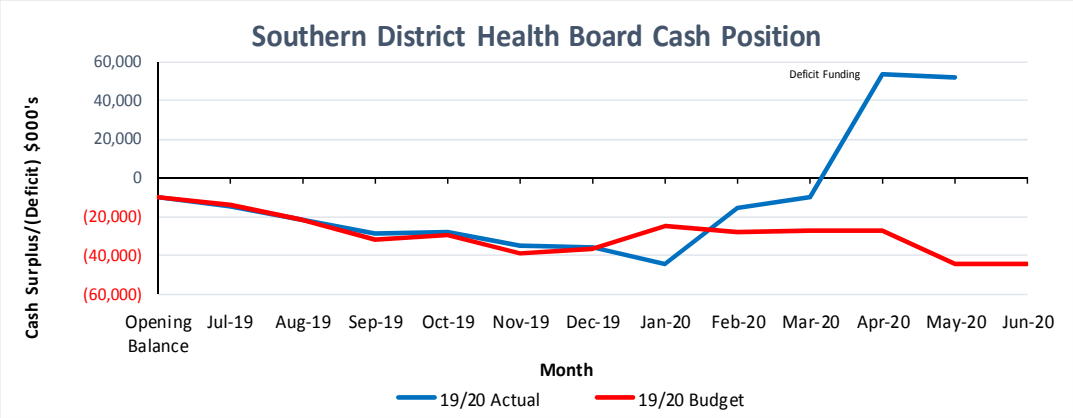
SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 May 2020

	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	1,011,935	978,116	33,819	1,071,528	925,738
Non-Government & Crown Agency Revenue	9,862	10,298	(436)	11,065	10,960
Interest Received	262	171	91	187	147
Cash was applied to:					
Payments to Suppliers	(619,685)	(597,285)	(22,400)	(649,567)	(576,174)
Payments to Employees	(392,030)	(410,402)	18,372	(453,068)	(372,454)
Capital Charge	(5,138)	(5,194)	56	(10,500)	(5,735)
Goods & Services Tax (net)	3,223	(599)	3,822	7	(1,102)
Net Cash Inflow / (Outflow) from Operations	8,429	(24,895)	33,324	(30,348)	(18,620)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	4	-	4	-	24
Cash was applied to:					
Capital Expenditure	(30,292)	(55,113)	24,822	(57,139)	(28,412)
Net Cash Inflow / (Outflow) from Investing Activity	(30,288)	(55,113)	24,826	(57,139)	(28,388)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	84,306	46,630	37,676	54,550	52,600
Cash was applied to:					
Repayment of Borrowings	(758)	(1,031)	273	(1,755)	(1,219)
Net Cash Inflow / (Outflow) from Financing Activity	83,548	45,599	37,949	52,795	51,381
Total Increase / (Decrease) in Cash	61,689	(34,409)	96,098	(34,692)	4,373
Net Opening Cash & Cash Equivalents	(9,888)	(9,888)	0	(9,888)	(30,377)
Net Closing Cash & Cash Equivalents	51,801	(44,297)	96,098	(44,580)	(26,004)

The improved cash position as at 31 May 2020 reflects the Ministry of Health cash advance, additional funding in response to COVID-19 and equity support. The additional expenditure on Clinical Supplies and Outsourcing contributes to the Payments to Suppliers being higher than budget, however the Operating cash flows are still favourable to budget by $33.3m. Payments to Employees were $18.4m lower than budget with the budgeted remediation of the Holidays Act 2003 yet to be completed and end of month pay period timing.

Investing Activity outflows are favourable to budget by $24.8m, reflecting the timing of spend on Capital Expenditure with unbudgeted COVID-19 clinical equipment only partially offsetting delays in other projects. The Capital Expenditure YTD is approximately $2m higher than the same time last year.

Cash from Financing is favourable to budget by $37.9m. The $80.0m equity support received in April 2020 being higher than budget as the Ministry of Health sought to address the weakness in our Statement of Financial Position.



9.1

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 31 May 2020

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend		FY19 YTD Actual $000	FY19 Full Year Actual $000
Land, Buildings & Plant	11,216	29,384	18,168	U	-	13,919	15,327
Clinical Equipment	12,228	12,995	767	U	-	10,435	12,574
Other Equipment	386	231	(155)	O	-	356	406
Information Technology	2,908	5,048	2,140	U	-	3,658	4,158
Motor Vehicles	3	-	(3)	O		-	44
Software	3,551	7,455	3,904	U	-	43	121
Total Expenditure	30,292	55,113	24,821	U		(28,412)	32,630

Property, Plant & Equipment and Intangible Assets are a combined $335.1m, being $21.4m less than the budget of $357.2m.

Land, Buildings and Plant are $18.1m underspent compared to budget on projects including Queenstown Lakes Hospital Redevelopment, Dunedin Hospital ICU, Southland MRI, Queen Mary and Deferred Maintenance. The Dunedin Hospital ICU project continues to be delayed by issues with the ventilation system.

Clinical Equipment is $0.8m underspent because project timing has been delayed as compared to budget for various items of equipment. However this has been offset somewhat by unbudgeted spend on clinical equipment to prepared for the COVID-19 pandemic.

Information Technology and Software are $6.0m underspent, with the timing of payments for FPIM (Oracle upgrade) and SI PICS (Patient Management) different to budget.

May-20				May-19	YEAR ON YEAR		YTD 2019/2020				YTD May-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,228	1,507	(279)	-19%	1,534	(306)	Acute	15,460	15,726	(266)	-2%	15,710	(250)
273	306	(33)	-11%	323	(50)	Elective	3,357	3,193	163	5%	3,292	64
1,501	**1,813**	**(312)**	**-17%**	**1,858**	**(356)**	**Total Medical Caseweights**	**18,817**	**18,919**	**(102)**	**-1%**	**19,002**	**(186)**
						Surgical Caseweights						
883	1,287	(404)	-31%	1,143	(260)	Acute	12,351	13,392	(1,041)	-8%	13,582	(1,231)
1,311	1,441	(131)	-9%	1,513	(203)	Elective	13,417	14,701	(1,284)	-9%	14,767	(1,350)
2,194	**2,729**	**(535)**	**-20%**	**2,657**	**(463)**	**Total Surgical Caseweights**	**25,768**	**28,093**	**(2,325)**	**-8%**	**28,349**	**(2,581)**
						Maternity Caseweights						
150	94	57	61%	112	38	Acute	1,139	976	163	17%	975	164
352	370	(18)	-5%	409	(57)	Elective	3,705	3,858	(154)	-4%	3,935	(230)
502	**463**	**39**	**8%**	**521**	**(19)**	**Total Maternity Caseweights**	**4,844**	**4,835**	**8**	**0%**	**4,910**	**(67)**
						TOTALS						
2,262	**2,888**	**(626)**	-22%	**2,790**	**(528)**	**Acute**	**28,950**	**30,094**	**(1,145)**	-4%	**30,267**	**(1,317)**
1,936	**2,117**	**(181)**	-9%	**2,246**	**(311)**	**Elective**	**20,478**	**21,752**	**(1,274)**	-6%	**21,994**	**(1,516)**
4,198	**5,005**	**(808)**	**-16%**	**5,036**	**(839)**	**Total Caseweights**	**49,428**	**51,846**	**(2,419)**	**-5%**	**52,261**	**(2,833)**

						TOTALS excl. Maternity						
2,111	**2,794**	**(683)**	-24%	**2,678**	**(566)**	**Acute**	**27,811**	**29,118**	**(1,307)**	-4%	**29,291**	**(1,480)**
1,584	**1,748**	**(164)**	-9%	**1,836**	**(253)**	**Elective**	**16,774**	**17,894**	**(1,120)**	-6%	**18,059**	**(1,286)**
3,695	**4,542**	**(847)**	**-19%**	**4,514**	**(820)**	**Total Caseweights excl. Maternity**	**44,585**	**47,012**	**(2,427)**	**-5%**	**47,351**	**(2,766)**

May-20				May-19	YEAR ON YEAR		YTD 2019/2020				YTD May-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,441	2,932	(491)	-17%	2,783	(342)	**Mental Health bed days**	28,474	31,686	(3,212)	-10%	29,604	(1,130)

May-20	May-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2019/2020	YTD May-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,000	3,893	(893)	Dunedin	37,389	41,257	(3,868)
642	775	(133)	Lakes	10,894	11,279	(385)
2,615	3,338	(723)	Southland	31,928	35,763	(3,835)
6,257	8,006	(1,749)	**Total ED presentations**	80,211	88,299	(8,088)

Performance Dashboard - Southern

Performance Dashboard - Dunedin

Performance Dashboard - Invercargill

9.3

SOUTHERN DISTRICT HEALTH BOARD

Title:	**QUARTER THREE 2019/20 REPORTING: SOUTHERN DHB PERFORMANCE REPORTING TO THE MINISTRY OF HEALTH**
Report to:	Board
Date of Meeting:	7 July 2020

Summary:

This report

- Provides an overview of DHB Performance Reporting to the Ministry of Health for Quarter Three 2019/20 including comment where targets or expectations have not been met.

9.4

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	
Workforce:	
Equity:	
Other:	

Document previously submitted to:	Executive Leadership Team	**Date:** 18 June 2020
Approved by Chief Executive Officer:		**Date: NA**

Prepared by: Strategy, Primary and Community **Date:** 11 June 2020	**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community

RECOMMENDATIONS:

1. **That the Board note the content of this paper;**
2. **Note that to free up resources and to allow impacted DHB and Ministry staff to focus on planning for the nationwide COVID-19 (novel coronavirus) response, the Ministry of Health made the decision to cancel most aspects of Quarter 3 non financial quarterly reporting:**
   - **Reduced reporting was required for some essential reporting items.**
   - **The Ministry still made the usual quarterly reporting data available for DHBs, and DHBs continued sending their submissions to the Ministry National Collections as usual.**

Southern DHB Performance Reporting Q3 2019/20

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

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

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

Progress towards each measure will be assessed and reported to the Minister of Health according to the reporting frequency outlined in the indicator dictionary for each measure (found on the NSFL https://nsfl.health.govt.nz/accountability/performance-and-monitoring/performance-measures/performance-measures-201920)
A resolution plan, that outlines the actions being taken to address poorer than planned performance, must be supplied where performance does not meet the agreed expectation. Where a performance measure description does not include specific assessment criteria, the following criteria will apply:

Assessment Criteria/Ratings for Performance Measures

Rating	Abbrev	Criteria
Outstanding performer/sector leader	O	1. This rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations. 2. This rating is applied when the DHB has met the target agreed in its Annual Plan and has achieved the target level of performance for the Māori population group, and the Pacific population group. Note: this rating can only be applied in the fourth quarter for measures that are reported quarterly or six-monthly. Measures reported annually can receive an 'O' rating, irrespective of when the reporting is due.
Achieved	A	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. For those measures where reporting by ethnicity is expected, this rating should only be applied when the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and the Pacific population group. 4. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	1. Target/expectation not fully met, (including not meeting expectations for Māori and Pacific population groups) but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved, and a resolution plan satisfies the assessor that the DHB is on track to compliance for the requirements not met.

Not achieved – escalation required	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

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

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

Assessment Criteria/Ratings for CFA Variations

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

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

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

Summary of Quarter 3 ratings 2019/20

This table summarises ratings for quarter three, by Ministry of Health rating. To free up resources and to allow impacted DHB and Ministry staff to focus on planning for the nationwide COVID-19 (novel coronavirus) response, the Ministry of Health made the decision to cancel most aspects of Quarter 3 non financial quarterly reporting. Reporting was required on the measures listed in the table below.

Code	Performance Measure	Final Rating	Page number
Child wellbeing			
CW05	Immunisation coverage: FA1 8-month old immunisation coverage	**N**	5
CW05	Immunisation coverage: FA2 5-year old immunisation coverage	**P**	7
CW03	Improving the number of children enrolled and accessing the Community Oral health service	**P**	5
CW08	Increased immunisation at 2 years of age	**P**	7
CW01	Children caries free at five years of age 2019	**A**	5
CW02	Oral Health- Mean DMFT score at school Year 8	**A**	5
Better population health outcomes supported by strong and equitable public health services			
	Care Capacity Demand Management	**A**	9
SS10	Shorter stays in emergency departments	**A**	10
Crown Funding Agreements (CFA) Variations			
CFA	DHB level service component of the National SUDI Prevention Programme	**S**	12

NA=Not applicable; FA=Focus area; NR=No report (not required Q3)

The table below summarises performance where data are available. During quarter 3, the Ministry still made the usual quarterly reporting data available for DHBs, and DHBs continued sending their submissions to the Ministry National Collections as usual.
NR is used to indicate that no ratings have been assigned by the Ministry of Health, even though data are available.

Code	Performance Measure	Final Rating	Up or down since last Q	Last quarter (Q2 19/20)
	Child wellbeing			
CW01	Children caries free at five years of age 2019	**A**	No change	**A***
CW02	Oral Health- Mean DMFT score at school Year 8	**A**	No change	**A***
CW03	Improving the number of children enrolled and accessing the Community Oral health service	**P**		No rating*
CW05	Immunisation coverage: FA1 8-month old immunisation coverage	**N**	↓	**A**
CW05	Immunisation coverage: FA2 5-year old immunisation coverage	**P**	No change	**P**
CW07	Improving newborn enrolment in General Practice	**NR**		
CW08	Increased immunisation at 2 years of age	**P**	No change	**P**
CW10	Raising healthy kids	**NR**		
Mental wellbeing				
MH03	Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	**NR**		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	**NR**		
	Better population health outcomes supported by strong and equitable public health services			
	Care Capacity Demand Management	**A**	No change	**A**
SS01	Faster cancer treatment (31 days) indicator	**NR**		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	**NR**		
SS07	Planned Care Measures - Planned Care Measure 6: Acute Readmissions	**NR**		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections: Focus Area 1: Improving the quality of data within the NHI	**NR**		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections: Focus Area 2: Improving the quality of data submitted to National Collections	**NR**		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections: Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	**NR**		
SS10	Shorter stays in emergency departments	**A**	↑	**P**
SS11	Faster Cancer Treatment (62 days)	**NR**		
	Better population health outcomes supported by primary health care			
PH04	Better help for smokers to quit (primary care)	**NR**		

	Crown Funding Agreements (CFA) Variations			
CFA	DHB level service component of the National SUDI Prevention Programme	S	No change	S

N/A=Not applicable; FA=Focus area; NR=No rating in Q3; * only reported in Q3 of each year

Summary of Southern DHB Performance Reporting – Quarter 3 2019/20

Measures of DHB Performance		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
Child Wellbeing		**Achieving Government's priority goals/objectives and targets**
CW01: Children caries free at five years of age 2019	A	Result: Number of children caries free at five years of age (2019): All children 69%; Maori children 56%; Pacific children 46%; "other" children 72%. Target is 70%. *MoH feedback*: Good result. The caries-free result of 69% achieves the DHB's target of 69.8% and is close to the 2018 result of 70%.
CW02 Oral Health- Mean DMFT score at school Year 8	A	Result: DMFT (decayed, missing due to caries or filled teeth) at school year 8: All children 0.68; Māori children 0.94; Pacific children 1.12; "other children 0.62. Target is 0.72. *MoH feedback*: Good result. The average DMFT result of 0.68 more than meets (i.e. is lower than) the DHB's target of 0.72 and the 2018 result also of 0.72.
CW03: Improving the number of children enrolled and accessing the Community Oral health service	P	Result: Percentage of 0-4 years olds enrolled: All children 84.5%; Māori children 62.6%; Pacific children 73.8%; Other children 90.8%. Target is greater than or equal to 95%. Percentage of children age 0-12 years not examined based on planned recall: All children 9%, Māori children 9%; Pacific children 15%; Other children 15%. Target is less than or equal to 10%. *MoH feedback:* A rating of partially achieved has been provided based on the pre-school enrolment rate of 85 percent and the good arrears result of 8.9 percent. Equity in enrolment of Māori and Pacific children remains to be achieved. Southern DHB report: • Unable to complete template correctly so final percentages of overdue not correct in the template, advised by Alan Henderson to complete anyway for submitting
CW05: Immunisation coverage: FA1 eight-month old immunisation coverage	N	Result: 92.3% total coverage; Māori infant immunisation coverage at 86.8% and Pacific infant coverage at 92.0%. Rank 6th out of 20 DHBs (total coverage). National result percent is 90.8% (total coverage). Target: 95%

Measures of DHB Performance		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
		MoH feedback: • Total immunisation coverage at eight months has decreased by 1.2 percent this quarter and coverage for Māori children has decreased by 1.9 percent. Your DHB has total coverage of 92.3 percent and Māori coverage of 86.8 percent at age 8 months. • As with the previous quarter and for the quarters ahead, improving equitable immunisation coverage is a key priority. It is important that your DHB commits fully to the actions you have set to address the increasing inequities. It is essential that Māori General Managers (Tumu Whakarae) and Pacific General Managers have oversight of all Māori-and Pacific focused work, respectively, in their DHBs. It is therefore the Ministry's expectation that your DHB Immunisation leads develop and maintain strong working relationships with your DHB's Māori and Pacific General Managers to ensure they have a clear line of sight into immunisation work. • We acknowledge the immense pressure DHBs are experiencing due to COVID-19, however, continuing to provide immunisation events on time, as per the National Immunisation Schedule, is critical for the health of our communities. The Ministry appreciates the mahi you and your teams do to ensure the delivery of the National Immunisation Programme is to the highest standard. Thank you for your ongoing determination, innovation and perseverance. Southern DHB progress report • Opt off Rate: 0.3% (3) no change • Decline Rate: 3.3% (29) ↑ 0.9%. • Missed: 4.0% (35) ↑ 2.00% • Southern DHB has not achieved 95% Coverage this quarter attributed to an increase in declines and missed events. It is disappointing to see the usual fluctuation rate to be greater than 0.5%. • The resourcing factor has also impacted on the SDHB ability to improve equity coverage for Maori and Pacific babies and is below target. *Actions to address issues/barriers impacting on performance* • The driver for not meeting target has been a resourcing factor such as staff on Christmas leave until late January and staff changes within the Southern DHB VPD team. The Southern DHB had recruited staff and was working towards orientating new staff, however the impact of COVID-19 has contributed to a decrease in staff capacity to deliver immunisations over this quarter. • The Southern DHB continues to follow national guidelines for childhood immunisations. We are working on a recovery plan to ensure children are immunised on time every time.

Measures of DHB Performance		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
		• Work is in progress to orientate staff into their new roles. • While other vaccination services are experiencing quieter periods (e.g. school based vaccination program) other vaccinators are being seconded into outreach to support extra work.
CW05 Immunisation coverage FA2: 5-year old immunisation coverage	P	*Result: 93.7* % for total population, 94.6% for Māori population and 90.9% for Pacific population. Rank 2nd out of 20 (total population). Target: 95%. National result is 90.1%. *MoH feedback:* • At age five years the total coverage has increased by 0.9 percent, coverage for Māori children has increased 1.1 percent. Your DHB has total coverage of 93.7 percent and Māori coverage of 94.6 percent at 5 years. Southern DHB progress report at 5 Years • Opt Off 0.5% (5) No Change • Declined 3.7% (35) ↓1.2% • Missed 2.1% (20) ↑ 0.7% • Southern DHB continues to maintain high coverage despite not reaching 95%. It is pleasing to see equity maintained • As with the 2 year old targets it is pleasing to see an increase in Maori coverage for the 5 year coverage.
CW07: Improving newborn enrolment with General Practice	No rating Q3	Measure: enrolment of newborn babies with a GP/PHO at six week and three months of age. Results: Newborn enrolment at six weeks of age: 70% for total population, 56.8% for Māori. Target: 55% enrolled at six weeks of age Newborn enrolment at three months of age: 91.5% for total population, 73.6% for Māori. Target: 85% enrolled by three months of age
CW08: Increased immunisation at 2 years of age	P	Result: 94.7% for total population; 93.9% for Māori population, 97.9% for Pacific population. Rank 1st out of 20 (total population). Target: 95 percent. National result is 91.7% *MoH feedback:* • Total immunisation coverage at two years has decreased by 0.2 percent this quarter and coverage for Māori children has decreased by 0.4 percent. National immunisation coverage at age 2 years is still below the 95 percent target and coverage for Māori is 6.3 percent lower than for non-Māori.

Measures of DHB Performance		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
		• Your DHB has total coverage of 94.7 percent, Māori coverage of 93.9 percent and Pacific coverage of 97.9 percent at 2 years. *Southern DHB p*rogress report at 2 Years • Opt O 0.8% (7) ↑0.6% • Declined 3.8% (34) ↓0.8% • Missed 0.7% (7) ↓0.1% Southern DHB has held consistency with Total Population but unfortunately dropped coverage for Māori children. Pacific coverage remains high with 1 child NFI in this cohort. Actions to address issues/barriers impacting on performance • The fluctuation in coverage for Māori children is a known risk in Southern DHB and data is being monitored by the NIR Team. • It is pleasing to see there has been an increase of 1.6% in Maori coverage in this quarter.
CW10: Raising healthy kids	No rating Q3	Results: Result for quarter 3 (referral sent and acknowledged): 99% (total); Māori 100% Target: 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions
Mental wellbeing		**Achieving Government's priority goals/objectives and targets**
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	No rating Q3	Result: Rolling annual waiting time data is provided from PRIMHD (3 months in arrears). i.e. the most recent data being referenced covers the period January 2019 to December 2019. Mental Health Provider Arm • 69% of 0-19 year olds were seen within 3 weeks (target – 80%) • 90% of 0-19 year olds were seen within 8 weeks (target 95%) Addictions (Provider Arm and NGO) • 74% of 0-19 year olds were seen within 3 weeks (target – 80%) • 91% of 0-19 year olds were seen within 8 weeks (target – 95%)
MH05: Reduce the rate of Māori under the Mental	No rating Q3	Result: For the period between January 19 and December 2019, the percentage (of DHB population) of patients under section 29 in Southern DHB who are: • 0.27% (Māori)

<table>
<tr><th colspan="4">Measures of DHB Performance</th></tr>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td colspan="2">Health Act: section 29 community treatment orders</td><td></td><td>• 0.09% (Non-Māori)
Due to data availability, data are 3 months in arrears for each quarter.</td></tr>
<tr><td colspan="3">Better population health outcomes supported by strong and equitable public health services</td><td>Achieving Government's priority goals/objectives and targets</td></tr>
<tr><td colspan="2">Care Capacity Demand Management</td><td>A</td><td></td></tr>
<tr><td colspan="2">SS01: Faster cancer treatment – 31 day indicator</td><td>No rating Q3</td><td>Result: 84.5 % achievement (target 85%), ranked 16th out of 20 DHBs. Last quarter 82.2%. National result: 86.7%
This report is based on patients who received their first cancer treatment (or other management) between 1 October 2019 and 31 March 2020).</td></tr>
<tr><td colspan="2">SS05: Ambulatory sensitive hospitalisations (ASH adult)</td><td>No rating Q3</td><td>Result: Standardised ASH rates, 12 months to December 2019 for those aged 45 to 64 years: Southern total (2,925/100,000), Southern Māori (5,275/100,000). National rate: 3,864/100,000
ASH target for Southern DHB: 2,865/100,000 (total rate for 45-64 year olds).</td></tr>
<tr><td colspan="2">SS07: Planned care measures Planned Care Measure 6: Acute Readmissions</td><td>No rating Q3</td><td>Result: Southern DHB rate 12.1%; National rate: 12.2% (Year to Dec 2019)
Southern DHB year end target for the acute readmission rate (standardised readmission rate): ≤11.7%.</td></tr>
<tr><td rowspan="2">SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections</td><td>Focus Area 1: Improving the quality of data within the NHI</td><td>No rating Q3</td><td>Indicator 1: NPF collection has accurate dates and links to NBRS, NMDS and NNPAC for FSA and planned inpatient procedures. Performance expectation: Greater than or equal to 90% and less than 95%.
Result: Not achieved (All indicators for this report use October to December 2019 data)
<table><tr><td>Collection</td><td>Numerator</td><td>Denominator</td><td>Percent</td></tr><tr><td>NBRS</td><td>1175</td><td>3088</td><td>38.1%</td></tr><tr><td>NMDS</td><td>894</td><td>3441</td><td>26.0%</td></tr><tr><td>NNPAC</td><td>7482</td><td>10199</td><td>73.4%</td></tr><tr><td></td><td>9551</td><td>16728</td><td>57.1%</td></tr></table></td></tr>
<tr><td>Focus Area 2: Improving the quality of data submitted to</td><td>No rating Q3</td><td>Indicator 2: National Collections Completeness. Performance expectation: Greater than or equal to 94.5% and less than 97.5%. Results: achieved (All indicators for this report use October to December 2019 data)
<table><tr><td>Collection</td><td>Numerator</td><td>Denominator</td><td>Percent</td></tr><tr><td>Primary MAT</td><td>N/A</td><td>N/A</td><td>N/A</td></tr></table></td></tr>
</table>

Measures of DHB Performance			
Measure		**Final Rating**	**Ministry of Health Comments and DHB Responses**
	National Collections		NMDS 18080 19012 95.10% NNPAC 152336 168726 90.29% PRIMHD 39934 39633 100.76%
	Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	No rating Q3	Indicator 3: Assessment of data reported to the National Minimum Data Set (NMDS). Performance expectation: Greater than or equal to 75% (All indicators for this report use October to December 2019 data) Result: Achieved (Percent value added 92.59%)
SS10: Shorter stays in emergency departments		A	Result is 84.3% for Southern DHB, an increase of 1.6% from last quarter. Rank: 15th out of 20 DHBs. National result is 87.3%. Target: 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. *MoH feedback:* Thank you for providing your Q3 SSED data. We greatly appreciate the effort that has gone into preparing for and responding to the COVID-19 pandemic. The assessor has applied an achieved rating as only data was required this quarter.

	Total Population			
Name of facility	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours Q3	% managed within 6 hours Q2
Dunedin	7,895	10,029	78.72%	75.29%
Lakes	3,027	3,194	94.77%	85.65%
Southland	8,006	9,302	86.07%	96.11%
DHB total	**18,928**	**22,525**	**84.03%**	**82.70%**

<table>
<tr><th colspan="3">Measures of DHB Performance</th></tr>
<tr><th>Measure</th><th>Final Rating</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th></th><th colspan="3">Maori ethnicity</th></tr>
<tr><td></td><td>Number stayed less than 6 hours</td><td>Total Presentations</td><td>% managed within 6 hours</td></tr>
<tr><td>Dunedin</td><td>677</td><td>833</td><td>81.27%</td></tr>
<tr><td>Lakes</td><td>118</td><td>129</td><td>91.47%</td></tr>
<tr><td>Southland</td><td>1,184</td><td>1,322</td><td>89.56%</td></tr>
<tr><td>DHB total</td><td>1,979</td><td>2,284</td><td>86.65%</td></tr>
</table>
<table>
<tr><th></th><th colspan="3">Pacific ethnicity</th></tr>
<tr><td></td><td>Number stayed less than 6 hours</td><td>Total Presentations</td><td>% managed within 6 hours</td></tr>
<tr><td>Dunedin</td><td>239</td><td>294</td><td>81.29%</td></tr>
<tr><td>Lakes</td><td>36</td><td>41</td><td>87.80%</td></tr>
<tr><td>Southland</td><td>245</td><td>267</td><td>91.76%</td></tr>
<tr><td>DHB total</td><td>520</td><td>602</td><td>86.38%</td></tr>
</table>
</td></tr>
<tr><td>SS11: Faster cancer treatment (62 days)</td><td>No rating Q3</td><td>Result: 70.8% achievement (target 90%), ranked 17 out of 20 DHBs. Last quarter 82.6%. National average: 85.5% Target is 90% (Data based on patients who received their first cancer treatment (or other management) between 1 October 2019 and 31 March 2020)</td></tr>
<tr><td colspan="2">Better population health outcomes supported by primary health care</td><td>Achieving Government’s priority goals/objectives and targets</td></tr>
<tr><td>PH04: Better help for smokers to quit (primary care)</td><td>No rating Q3</td><td>Result: 76.1% (total population) were given brief advice and support to quit smoking, (decrease of 3.0% from last quarter). 76.0 percent of Māori and 72.0 percent of Pacific populations were given brief advice to quit smoking.-Rank: 17th out of 20 DHBs (total population). National result: 80.8% (total population)
Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit.</td></tr>
</table>

Crown Funding Agreements (CFA) Variations

Crown Funding Agreements (CFA) Variations		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
CFA DHB level service component of the National SUDI Prevention Programme	S	

SOUTHERN DISTRICT HEALTH BOARD

Title:	**COLONOSCOPY SERVICES RECOMMENDATIONS – CONNOLLY REPORT**
Report to:	Board
Date of Meeting:	7 July 2020

Summary:

Considered in this paper are:

- Progress reporting on the implementation of the recommendations in the Connolly report on Colonoscopy Services..

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Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	As set out in report.
Workforce:	As set out in report.
Other:	As set out in report.

Document previously submitted to:	Not applicable, report submitted directly to the Board.	**Date:** n/a

Prepared: Chris Fleming Chief Executive Officer **Date:** 26 June 2020	**Presented by:** Chris Fleming Chief Executive Officer

Following significant concerns regarding access to Colonoscopy being expressed by the General Surgeons in Southland, and the clear breakdown in relationships between Gastroenterology and the General Surgeons in Southland a review was commissioned by the Chief Medical Officer using Phillip Bagshaw and Stephen Ding. The review was undertaken in 2019 and culminated in a report entitled *"Assessment of Diagnostic & Treatment Times for Endoscopic Cases".* The report contained a series of nine recommendations:

a. Benchmarking against national CRC management standards
b. Integration of community, hospital and university services into the organisational plan
c. Change to leadership style and organization of the Gastroenterology Department
d. Address serious resourcing issues
e. Changes to current local guidelines
f. Changes to current Southern DHB triage process.
g. Changes for staff of Southland Hospital
h. Long term follow-up

i. Clarification of the scope, implementation and monitoring of the national guidelines and local guidelines.

There were many views held about this report, and while some of the recommendations were able to be implemented rapidly at the heart of the review was the dysfunctional relationships and dynamics particularly between the Clinical Leader for Gastroenterology and the General Surgeons. Both sides of the debate had valid issues and concerns, but they were both as equally entrenched that they were unable to come together to put their differences aside and to focus on planning and changes to make the service safe and sustainable. The behaviours of both sides of the debate were different, but neither appeared to be focussed on building sustainable relationships.

To this end, as Chief Executive, I asked Andrew Connolly to come in and meet with the teams and to provide us with advice and guidance on how to try and take the service forward and to create the ability to develop sustainable relationships to move the service forward. At the time Andrew was independent of the DHB being a Collorectal Surgeon from Counties Manukau District Health Board and former Chair of the Medical Council. He was a member of the Southern Partnership Group. Subsequent to this Andrew has been appointed as a Crown Monitor on our Board. Andrew was concerned with what he found and felt the only practical way forward was to provide a series of what he considered pragmatic recommendations. The key staff involved had the opportunity to comment on the draft and then the Chief Medical Officer and I accepted the recommendations and tasked the Endoscopy Provider Group with leading the implementation of the findings.

The report attached sets out the recommendations, the progress at February and then the updated progress at the end of June. Unfortunately, with COVID-19 there has been some delays associated with actioning some of the results however progress is being made. The relationships however remain a critical issue.

RECOMMENDATION:

That the Board:

- **Note** the attached report;
- **Discuss and note** any issues which they require further information or follow up.

ENDOSCOPY PROVIDER GROUP (EPG) ACTION PLAN

Prepared by Tim Mackay, Chair of the EPG

This Action Plan shows progress against the recommendations from Andrew Connolly's report of 28 January 2020:
Recommendations to address various matters in relation to Colonoscopy Services at Southern DHB

Recommendation	Comment	Progress as at February 2020	Updated timeline June 2020
1. Application of the National Referral Guidelines	a. The Guidelines should only apply to non-GI specialist referrals seeking direct access. "Direct access" means the patient has NOT been clinically assessed by a recognised GI specialist. b. Referrals from GI specialists following clinical review of the patient should be accepted for access and prioritised according to the clinical risks/questions that need to be answered.	Effective immediately GI specialists across Southern DHB will no longer need to use the National Guidelines	Complete
2. Definition of a GI specialist surgeon	a. Both General Surgical departments should credential all surgeons based on the extent to which that surgeon routinely assesses patients with GI symptoms, especially in the out-patient environment. This is ideally done as part of Credentialing and Annual Appraisal for each SMO overseen by the Chief Medical Officer. b. Locums, if used, will need to be considered non-GI specialist unless agreed otherwise by the HOD/CD of surgery and gastroenterology.	Effective immediately The Southland Department of Surgery is granted a grace period expiring on Friday 30 April 2020 to ensure there is documented evidence of individual's credentials. As sign of good faith current staff will be able to undertake scoping if it is part of their current practice.	Extended to August 2020 as will be undertaking SMO credentialling with external reviewer.

Recommendation	Comment	Progress as at February 2020	Updated timeline June 2020
3. Function of the Review Panel	There is no role for the Review Panel in relation to a referral from a GI specialist who has clinically assessed the patient. a. The Review panel should focus only on those declined referrals emanating from non-GI specialist doctors. b. The Terms of Reference of the Review Panel should be reviewed and amended accordingly	Effective Immediately	Complete
4. Non-specialist medical staff	a. The Review panel continues to consider declined referrals submitted from surgical and gastroenterology staff who are not designated GI specialist unless the referral clearly annotates the referring doctor is acting on the instructions of the GI specialist who has clinically assessed the patient – in which case the referral is viewed as being from the GI specialist him/herself.	Effective immediately	Complete
5. Auditing of GI specialist referrals	a. A prospective audit should be commenced to document the referral patterns and the rates of detection of significant pathology – benign and malignant – to allow specialist GI clinicians to reflect on their referrals. This is an educative / change in practice process to enable consistency between clinicians. This also fits well with the coming changes to CPD as flagged by the Medical Council and supported by the RACS.	EPG workplan To be completed and implemented by 30 June 2020	To be rolled out Sept 2020 with new EPG Quality group

Recommendation	Comment	Progress as at February 2020	Updated timeline June 2020
6. Information supplied when a referral is declined	a. The DHB reviews the information supplied consider if the letter to the patient (and the referring doctor) adequately highlights the need to seek a GI specialist review if concerns remain.	EPG workplan To be completed and implemented by 30 June 2020	Extended to September 2020 once have GPs on EPG Governance Group
7. Surgeon Access to Endoscopy Lists	a. The DHB consider a business case for resourcing greater access to the Dunedin Hospital endoscopy suite. b. The DHB settle on an agreed scheduling system to allow the Invercargill surgeons to increase their elective scoping sessions. This may involve the need to review the timetables and rostering practices of the General Surgeons in conjunction with the Gastroenterology service especially given there are multiple demands on the facility in Invercargill hospital.	EPG workplan This needs to linked to current planning cycles and completed by 30 April 2020	Discussions with General Manager Surgery and Service Manager Southland – both agreed needed to ensure that this works on the Southland site, lists and surgeons have been identified at this stage. Complete by September 2020
8. Training	a. The DHB should actively consider training requirements when addressing endoscopy service provision.	EPG workplan	This will be part of EPG Quality group workplan. Longer term resolution
9. Composition of the Colonoscopy Lists	a. The surgeon must ensure timing of a request to perform an endoscopy on a specific patient is, where possible, appropriately coordinated with future plans. • The scope is best timed near to the potential elective surgery date.	Effective immediately	See comment at the end of the plan

Recommendation	Comment	Progress as at February 2020	Updated timeline June 2020
10. Acute Case scheduling	a. Acute case scheduling should remain in the hands of the clinicians on site with decision-making about timing decided between the clinician responsible for the patient and the clinician who would perform the endoscopy. b. The DHB should work to ensure such an acute case can go ahead without the need, where possible, to cancel an elective endoscopy case to facilitate the acute scope. In other words, the DHB ideally needs to be able to cater for elective list over-runs if an urgent case is added. c. The clinicians should consider periodic audit of acute scopes to ensure consistency of application of the decision to perform an acute endoscopy, to reflect on the types of pathology identified, and to identify how often the urgent endoscopy materially altered patient management	Effective immediately	See comment at the end of the plan
11. Role of CT Colonography	a. The DHB review the criteria for CT Colonography as there may be differing indications for the test other than simply applying the National Referral Guidelines.	EPG workplan Complete and implement by 31 May 2020	This will be placed on the Governance Workplan

Recommendation	Comment	Progress as at February 2020	Updated timeline June 2020
12. Credentialing of Services and Clinicians	a. The DHB, via the CMO, facilitates Departmental and individual credentialing in the relevant departments. The introduction of Multisource feedback to this process and, if necessary, training for the clinician tasked with feeding back of such information, is advised. b. The DHB should work with clinicians to establish mentoring and peer support as identified by the Bagshaw / Ding report.	Southland Department of Surgery to undertake this by 30 June 2020 EPG workplan and Credentialling Committee	Extended until August 2020 as planning underway for external credentialling Southland.

Specific comments for recommendations 9 and 10

The Chair has sought clarification from Andrew Connolly about the intent of surgeons having direct access to lists as there has been some confusion about patients' priority and reprioritisation. Andrew has clarified that a GI specialist's prioritisation should stand, and patients managed as such. This has been discussed with the General Manager, Clinical Director of Gastroenterology and Southland Surgeons and a pathway to resolve this confusion is near completion.

Closed Session:

RESOLUTION:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 18 June 2020 minutes ▪ 21 May 2020 minutes b) Iwi Governance Committee ▪ 2 June 2020 minutes c) Hospital Advisory Committee ▪ 6 July 2020 verbal report	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	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.
South Island Patient Care Information System (PICS)	Advice provided in confidence and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(f)(iv) and 9(2)(j) of the Official Information Act.
Draft Annual Plan 2020/21	Annual Plan is subject to Ministerial approval	Section 9(2)(f) of the Official Information Act.
Capex Budget 2020/21	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.
SDHB Performance Report	Advice provided in confidence	Section 9(2)(f)(iv) of the Official Information Act.
Contract Approvals	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.
Health and Disability System Review	Advice provided in confidence	Section 9(2)(f)(iv) 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 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.

The Board may also exclude the public if disclosure of information is contrary to a specified enactment or constitute 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.