Southern DHB Board Meeting

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

08/09/2020 09:30 AM - 11:30 AM

APOLOGIES

No apologies had been received at the time of going to print.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Board
Date of Meeting:	8 September 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:

- Moana Theodore and Roger Jarrold's entries updated.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 27/08/2020

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)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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.	
	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	No involvement in any decision making.	~~Taking six months' leave.~~ Recommencing 22.08.2020.
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.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings ltd	Coporate Body for apartment, Wellington	
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)		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	17.08.2020	Health Research Council Fellow		
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		
	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	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	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		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	

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~~	(05/08/2020 - Stood down from 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	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	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.
	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

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
	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.	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
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.
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.

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
	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

PRESENTATION:

UPDATE ON THE IMPLEMENTATION OF THE PRIMARY AND COMMUNITY STRATEGY

- Lisa Gestro, Executive Director, Strategy, Primary and Community

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Minutes of the Southern District Health Board Meeting

Tuesday, 4 August 2020, 9.30 am
Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Dave Cull	Chair *(until 2.00 pm)*
	Dr David Perez	Deputy Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	*(until 2.30 pm)*
	Miss Lesley Soper	*(until 2.30 pm)*
	Dr Moana Theodore	*(by Zoom)*
In Attendance:	Mr Andrew Connolly	Crown Monitor *(by Zoom)*
	Mr Roger Jarrold	Crown Monitor *(by Zoom from 9.54 am to 2.06 pm)*
	Mr Chris Fleming	Chief Executive Officer *(until 2.00 pm)*
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer
	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 *(by Zoom)*
	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 Chair welcomed everyone and the meeting was opened with a karakia by the Chief Māori Health Strategy and Improvement Officer.

2.0 PUBLIC FORUM

The Board received a presentation from Tracey Wright-Tawha, CEO of Nga Kete Matauranga Pounamu Charitable Trust, on the Māori model of care and service practice for mental health and addictions provided by Nga Kete Matauranga Pounamu and the challenges they faced as a result of funding reductions over a number of years (tab 11).

Mr Roger Jarrold, Crown Monitor, joined the meeting at 9.54 am.

Ms Tracey Wright-Tawha then responded to questions from members on the services provided by Nga Kete, including its low cost GP service, its client ethnicity, and how it supported whānau during and post the COVID-19 pandemic lockdown.

Ms Wright-Tawha was thanked for her presentation.

3.0 APOLOGIES

There were no apologies.

4.0 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/I Beekhuis

5.0 PREVIOUS MINUTES

Colonoscopy Services (page 3)

It was noted that the sixth paragraph should read: the recommendation … "for *the service* to periodically audit acute scopes, was … noted", as it was inappropriate for clinicians to audit their own work.

Valuing Patients' Time - ED Escalation Pathway (page 4)

Management advised that this initiative was to be renamed the *Hospital Escalation Pathway*, as the current title indicated that ED was the issue. The Clinical Council would be involved in the development of the pathway, following which it would be submitted to the Hospital Advisory Committee for consideration.

It was resolved:

"That, with the above clarification, the minutes of the meeting held on 7 July 2020 be approved and adopted as a true and correct record."

J O'Callaghan/K Crowther

6.0 ACTION SHEET

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

CT Capacity

The Board was informed that the second Dunedin CT was included in the Capital Programme and the procurement process for all three CTs had commenced. A report identifying the options, including where the CT should be placed, should be available in October 2020.

The Executive Director Specialist Services (EDSS) gave an update on the recruitment process for staffing the new CT initiative.

The Board requested that consideration be given to including the replacement of the fourth CT in the procurement process and the feasibility of locating the second Dunedin CT in ED.

PHO Performance

In response to members' questions, the Executive Director Strategy, Primary and Community, informed the Board:

- That performance reporting would be updated following approval of the new Annual Plan for 2020/21 and the first quarter's report should be available in October 2020;
- Management met with the PHO quarterly to discuss programme achievement and a substantial wash-up was undertaken in quarter 3.

It was resolved:

"That the action sheet be noted."

J O'Callagahan/L Soper

7.0 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 23 July 2020, during which she advised that:

- The Committee received advice confirming that progress reports would be provided bi-monthly on *Valuing Patient Time* and quarterly on addressing annual leave liability;
- The external auditor joined the meeting by Zoom and reported on the interim audit of Southern DHB. He advised the Committee that he was comfortable with management's responses to the issues raised.
- The Committee was provided with a report on the main findings of DHB audits, particularly in relation to the impact of COVID-19 on normal service delivery and financial and performance reporting. That report provided the Committee with a number of useful questions to consider.
- The Executive Director Finance, Procurement and Facilities (EDFP&F) reported on financial performance and the position for the year ended 30 June 2020.
- The Committee reviewed capital expenditure and recommended that the Board approve a further drawdown for interim works.
- The quality risk indicators were reviewed and the newly reconstituted Clinical Council would oversee performance and highlight any concerns.
- The monthly Health and Safety Report was presented and there had been continued improvement in the reporting of lead indicators.
- The Committee was updated on key IT projects and progress.
- The Committee requested that approval of the annual CFIS return be delegated to it.

It was resolved:

"That the Board receive and note the verbal report on the FAR Committee meeting held on 23 July 2020."

D Cull/T Potiki

Drawdown - Interim and Critical Infrastructure Works and LINAC Installation, Dunedin Hospital (tab 6.1.2)

It was resolved:

> **"That the Board request a further drawdown of capital funding from the Ministry of Health for Interim Works Projects, Critical Infrastructure Works Projects and an initial drawdown for Linear Accelerator installation, Dunedin Hospital."**

D Cull/J O'Callaghan

End of Financial Year Crown Financial Information System (CFIS) Reporting 2019/20

It was resolved:

> **"That the Board delegate authority to the Board and Finance, Audit and Risk Committee Chairs to approve the sign-off of the CFIS return and the letter of representation."**

L Soper/L Kelly

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee (HAC) meeting held on 6 July 2020 were circulated with the agenda (tab 6.2) for members' information and Dr David Perez, HAC Chair, drew the following items to the Board's attention.

- The Committee received an overview of *Valuing Patients' Time (VPT)* and would receive another presentation drilling down deeper into aspects of VPT.
- The Committee would be monitoring additional performance indicators, including the colonoscopy rates for the district.
- The Committee received a presentation on the hospital response to COVID-19 and a presentation on telemedicine was scheduled for its next meeting, following which the Committee expected to be in a position to make some recommendations to Board on continuing to develop the innovations identified during the COVID-19 response.
- The Committee reviewed its terms of reference and recommended a minor semantic change to point 5 under its responsibilities.

The monitoring of performance against the measures in the Statement of Performance Expectations (SPE) was discussed and it was agreed that the Advisory Committee Chairs and Executive Leads would meet to discuss how these would be allocated.

It was resolved:

> **"That the Board note the unconfirmed minutes of the Hospital Advisory Committee meeting held on 6 July 2020."**

D Perez/I Beekhuis

It was resolved:

"That the Board approve the revised Hospital Advisory Committee's terms of reference."

D Perez/L Soper

Movement of Activity from Secondary to Primary Care

It was agreed that the Board would be provided with a report clarifying funding arrangements for community skin lesion removal services.

Community & Public Health and Disability Support Advisory Committees

The Board received verbal reports from Mr Tuari Potiki, CPHAC Chair, and Dr Moana Theodore, DSAC Chair, on the joint meeting of the Community and Public Health and Disability Support Advisory Committees (CPHAC/DSAC) held on 3 August 2020, during which they advised that three external members had been appointed to the Committees - one to CPHAC and two to DSAC.

Mr Potiki reported that at their meeting the previous day the Committees received the following presentations as part of setting the scene to start connecting the Boards' plans and priorities to the SDHB and PHO actions and activities:

- An overview from the CEO WellSouth, which had a strong COVID-19 focus. CPHAC/DSAC indicated that they would like to receive ongoing updates from WellSouth;
- An overview of contracted Māori Health services. Further information had been sought, including clarification of whether all the providers were Kaupapa Māori services.

Mr Potiki reported that the Committees also received an update on options for the location of a new primary maternity facility in the Central Otago/Wanaka area and a recommendation on that was expected in September/October 2020.

Dr Moana Theodore, Chair of the Disability Support Advisory Committee (DSAC) reported that:

- Two members of the Donald Beasley Institute presented a summary of the feedback received on the draft SDHB Disability Strategy. The Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) would be reporting to the October 2020 CPHAC/DSAC meeting on implementing that plan, along with a presentation on the overall disability work being undertaken, eg on data capture and workforce issues.
- It was also suggested that the Ministry of Health attend the October 2020 meeting to explain disability funding.
- A DSAC workshop to inform strategic and district annual planning was being planned.

It was resolved:

"That the Board receive and note the verbal reports on the CPHAC/DSAC meeting held on 3 August 2020."

T Potiki/J Chambers

Iwi Governance Committee

It was noted that the Iwi Governance Committee (IGC) had met the previous day.

The Board Chair undertook to converse with the Iwi Governance Chair (IGC) on how IGC would like to engage with the Board.

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 7) was taken as read and the CEO drew the Board's attention to the following items.

Financial Result

The year-end forecast was achieved, albeit with some unexpected items, such as actuarial calculations, being higher than expected and COVID-19 costs.

The CEO reported that the final audited result could be impacted by the Ministry's decision on planned care recovery funding and COVID-19 testing costs.

Annual Plan 2020/21

The draft Annual Plan had been submitted to the Ministry of Health. The CEO advised that feedback had not yet been received on the financial section.

Gastroenterology

The CEO reported that the average wait times in Southland for colonoscopy were slowly reducing. He also informed the Board that an analysis of patients diagnosed with cancer in ED was being undertaken to determine whether they had been referred for endoscopy services in the preceding years. The results of that analysis would be reported to Board.

The Board requested that colonoscopy wait time data be reported to it monthly. This is to include median wait times, inflow and outflow information, the colonoscopy rate for Otago and Southland, and regional comparisons.

Meals on Wheels

Compass were trialling the production of meals on wheels in the hospital kitchens in Dunedin and Invercargill. The Executive Director Finance, Procurement and Facilities (EDFP&F) reported that Compass had extended the trials to northern DHBs and undertaken a lot of work on quality and food safety.

The Board requested an update on the trial.

Generalism

The Executive Director Specialist Services (EDSS) reported that four of the five sub-cases for the Generalism Business Case had been completed and work was continuing to determine cost offsets.

COVID-19 Management

The CEO informed the Board that swabbing was being undertaken in Queenstown that day, with the goal of testing 300 people for COVID-19. That target had been reached by mid-morning.

Management then responded to questions from members on Cherry Farm clinical record storage, COVID-19 testing, and allied health staff wellbeing.

It was resolved:

"That the CEO's report be noted."

D Cull/T Potiki

9.0 FINANCE AND PERFORMANCE

Financial

The EDFP&F presented the Finance Report to 30 June 2020 (tab 8.1).

Volumes

The volumes report to 30 June 2020 (tab 10.2) was taken as read.

Performance

The performance dashboard (tab 10.3) was taken as read and a number of data integrity issues noted. The Board requested that commentary be added to explain breaches.

It was resolved:

"That the financial, volumes and performance reports be noted."

I Beekhuis/J O'Callaghan

10.0 PATIENT LETTERS

A report on issues with letters sent to patients and a proposal to review current processes was circulated with the agenda (tab 9).

The EDSS reported that the Executive Leadership Team had asked for improvements to commence immediately ahead of the work required for the Patient Information Care System (PICS) project implementation.

It was resolved:

"That the Board note and endorse the recommendations in the report."

D Cull/T King

PUBLIC EXCLUDED SESSION

***At 11.38 am it* was *resolved*:**

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

D Cull/L Soper

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.

General subject:	***Reason for passing this resolution:***	***Grounds for passing the resolution:***
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 23 July 2020 verbal report b) DSAC/CPHAC ▪ 3 August 2020 verbal report c) Hospital Advisory Committee ▪ 6 July 2020 minutes d) Iwi Governance Committee ▪ 3 August 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.
CEO's Report - Public Excluded Business ▪ Strategic Plan ▪ Rural Health ▪ Energy Centre, Dunedin ▪ Planned Care Recovery	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.
Planned Care Wait List Improvement Plan	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.
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.

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

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

The meeting closed at 3.23 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 31 August 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2019 Oct 2019 Mar 2020 Apr 2020	**Valuing Patients' Time (VPT) - Hospital 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 a hospital 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 CMO EDSS CMO	This has been raised on many times with the Clinical Council, as well as Clinical Leadership with very little traction. The hospital 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* VPT dashboard to be included in the EDSS report to HAC for September and moving forward. CMO to draft a hospital escalation strategy following a series of meetings with clinical and medical directors. The draft will then be consulted on.	 Complete Paper on agenda
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	A costing and resource impact model is being developed in conjunction with the oncology department to quantify the impact of recent and upcoming PHARMAC funding decisions. This should be	~~July 2020~~ September 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				completed with a report on findings and recommendations by September 2020. [Note: The Southern Regional Hub of the Cancer Control Agency (CCA, formerly Southern Cancer Network) have recently approved work on an impact assessment of PHARMAC funding additional cancer drugs as part of their 2020/21 work plan. Coordination and collaboration between CCA and SDHB work is yet to be established, as is an indicative timeframe for this work.]	
Feb 2020 Apr 2020 August 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. ▪ Commentary to be added to explain breaches. ▪ All graphs to be labelled and "Staff Adverse Events" label to be checked. ▪ Data integrity issues to be checked, including: o Restraints o Short Notice Postponements to be defined. o Unplanned Readmissions graph to be checked.	EDQCGS EDQCGS EDQCGS EDQCGS EDSP&C EDQCGS EDQCGS	In development. Improvement made with more to come. ▪ The Dashboard at the time of viewing by the Board was in error, and this has subsequently been rectified. The restraint line should not have been zero.	~~April 2020~~ ~~May 2020~~ Included in CE report, will look to enhance into dashboard

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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
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
August 2020	**CT Capacity** (Minute item 6.0)	Consideration to be given to: ▪ Including replacement of the fourth CT in the procurement process; ▪ Feasibility of locating second Dunedin CT in ED.	EDSS	Noted and followed up with procurement. The option of locating the additional CT machine in the ED has been included in the medical assessment unit design scope so that this option can be tested. This is one of three options being worked up. The other two are locating the machine in the community and locating the machine in the current Radiology area.	
August 2020	**Performance Monitoring** (Minute item 7.0)	Advisory Committee Chairs and Exec Leads to discuss reporting lines and how SPE measures should be allocated across the committees.	EDSP&C	Scheduled for 7 September 2020.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
August 2020	**Movement of Activity from Secondary to Primary Care** (Minute item 7.0)	Board to be provided with a brief report clarifying funding arrangements for community skin lesion removal services.	EDSP&C	A meeting to confirm detail of this is scheduled for 4 September, so a verbal update will be provided at the meeting	September 2020
August 2020	**Gastroenterology** (Minute item 8.0)	Colonoscopy wait times data to be reported to Board monthly - to include median wait times, inflow/outflow information, the colonoscopy rate for Otago and Southland, and regional comparisons.	EDSS	Included in CE report.	Complete
August 2020	**Meals on Wheels** (Minute item 8.0)	Update to be provided on in-house production trial.	EDFP&F	Report attached.	October 2020

SOUTHERN DISTRICT HEALTH BOARD

Title:	**COMPASS – MEALS ON WHEELS TRIAL**
Report to:	Board
Date of Meeting:	8 September 2020

Summary:

The issues considered in this paper are:

- An update to the CEO commentary which was:

  A key service for us is the production of Meals on Wheels meals across the district, with approximately 90 processed daily in Dunedin and 60 processed daily in Invercargill. Historically, these meals have been produced centrally and then transported to Dunedin and Invercargill by our food service provider. However, COVID-19 has impacted on the service in a range of ways. Our food service provider has had a number of significant customer contracts cancelled, the suppliers have increased pricing to reflect higher costs incurred on supply and freight. In addition, transportation across the country is no longer as timely as it was before COVID-19. As a result our food service provider began a review of their service delivery models in mid-April 2020. During early May 2020 discussions commenced and our food service provider began a trial from 12 May 2020 to process the meals locally through the hospital kitchens at Dunedin and Invercargill. These meals are similar to the hospital inpatient meals. The food service provider is also undertaking trials at other DHBs and the process is being managed and monitored by NZ Health Partnerships Limited on behalf of the DHBs.

Southern DHB

Timeline of events:

24 April 2020 – Email notification from Compass Dietician to DHB Professional Lead Dietician of trial. Communication included proposed menu, outlined nutrient value of meals and included information re methodology for ensuring meals complied with MoW nutrient requirements.

29 April 2020 – Email notification to Heather Fleming, Service Manager and Food Contract Manager.

7 May 2020 – Email notification to Justin Moore, Service Manager with oversight for Meals on Wheels and Philippa Greco.

8 May 2020– Age Concern notified by Compass Dietician.

12 May 2020 – Trial commences

15 May 2020 – Dieticians, Justin Moore, Philippa Greco and Heather Fleming invited to a taste test in the Dunedin kitchen. Opportunity to discuss, taste, understand production process and food safety mitigation, and compare with frozen meal which had been heated.

25 May 2020 – Trial commenced at Southland Hospital. Red Cross in Invercargill notified as distributor of meals.

The Trial:

Process

The protein component is the same in the Meals on Wheels (MOW) meal as for the hospital inpatient meal (meat or vegetarian alternative). The product arrives frozen, is thawed and cooked with locally prepared vegetables and sauces in the hospital kitchen.

Food is blast chilled and held overnight, plated cold the following morning (day of service), rethermed and distributed to clients.

The MoW clients meals are prepared in accordance with MoW standards. The MoW Standard is very clear "each meal must provide at least 25 g protein and 3 MJ energy (one-third RDI). Calcium must also be provided at least 15% of the RDI – 200 mg per meal.

Food Safety

The MOH standard has a direct food safety standard reference - New South Wales Food Authority – Safer Food Clearer Choices, Guidelines for food service to vulnerable persons – Part 6 and Appendix 3[1].

Both hospital kitchens meet these requirements and, as part of their food safety plan, hold temperature chart records that are available for viewing by the DHB.

Quality - Results to Date

Initial feedback from clients is positive and feedback is used as part of menu review. Menu reviews are undertaken regularly and involve kitchen production team, dieticians and client feedback.

Auditing is undertaken by the Professional Lead Dietician on both hospital sites. The auditing on the Dunedin site initially identified issues with underweight meals or components of meals. Much work has been undertaken to address those findings and an audit on the Dunedin site in the week beginning 24 August 2020 identified no issues.

Meals are audited by weighing each component of the meal – protein, vegetables and starch.

Concluding comments

The results to date are positive, with clients largely enjoying their meals. The audits are showing compliance with MoW nutrient requirements and food safety and MoW uptake, particularly in Dunedin, has increased. The menu cycle is now four weeks instead of three weeks, increasing variety for clients.

The trial continues until February 2021.

Specific implications for consideration (financial/workforce/risk/legal etc):	
Financial:	
Workforce:	
Equity:	
Other:	

Prepared by:	**Presented by:**
Heather Fleming Non-Clinical Services Manager **Date:** 26/08/2020	Julie Rickman Executive Director Finance, Procurement and Facilities
RECOMMENDATION: **That the update be noted.**	

FINANCE, AUDIT AND RISK COMMITTEE MEETING, 20 AUGUST 2020

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

Southern District Health Board

Minutes of the Joint Meeting of the Community & Public Health Advisory Committee and Disability Support Advisory Committee held on Monday, 3 August 2020, commencing at 1.30 pm, in the Board Room, Wakari Hospital Campus, Dunedin, and via Zoom

Present:	Mr Tuari Potiki	Chair, Community & Public Health Advisory Committee (CPHAC) *(Meeting Chair)*
	Dr Moana Theodore	Chair, Disability Support Advisory Committee (DSAC) *(by Zoom)*
	Ms Ilka Beekhuis	Deputy Chair, CPHAC
	Mrs Kaye Crowther	Deputy Chair, DSAC
	Mr Dave Cull	Member, DSAC
	Dr John Chambers	Member, DSAC
	Mr Terry King	Member, CPHAC
	Dr Lyndell Kelly	Member, CPHAC
	Dr Kim Ma'ia'i	Member, CPHAC *(by Zoom)*
	Ms Paula Waby	Member, DSAC *(by Zoom)*
In Attendance:	Miss Lesley Soper	Board Member
	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
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Andrew Swanson-Dobbs	Chief Executive Officer, WellSouth Primary Health Network
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality & Clinical Governance Solutions *(by Zoom)*
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME AND KARAKIA

The Chair welcomed everyone, in particular the newly appointed Committee members, Dr Kim Ma'ia'i and Ms Paula Waby, and members of the public. The meeting was then opened with a karakia.

2.0 APOLOGIES

Apologies were received from Mr Kiringāua Cassidy, DSAC Member, Ms Odele Stehlin, DSAC and CPHAC Member, and 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

It was resolved:

"That the minutes of the meeting held on 2 June 2020 be approved and adopted as a correct record."

T Potiki/D Cull

5.0 CHAIRS' UPDATE

Disability Support Advisory Committee (DSAC)

Dr Moana Theodore, DSAC Chair, extended a warm welcome to the two new Committee members, Paula Waby and Kim Ma'ia'i, then:

- Briefly backgrounded the process followed in co-designing the draft Disability Strategy;
- Reported that the next meeting would cover disability workforce data and plans, analysis of training and data capture, and an invitation would be extended to the Ministry of Health, as funder of disability services, to present to the Committees;
- Signalled that a DSAC planning workshop would be held post the October meeting;
- Encouraged DSAC members to contact her if they had any priorities or matters they wished to raise.

Community and Public Health Advisory Committee (CPHAC)

Mr Tuari Potiki, CPHAC Chair, endorsed Dr Theodore's welcome to the new Committee members and introduced Dr Kim Ma'ia'i, newly appointed CPHAC member.

6.0 REVIEW OF ACTION SHEET

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

Southern Health Entities

A diagram depicting the Southern Health system configuration was circulated with the action sheet.

The Committees requested:

- Further information on each Southern Health entity's role, respective responsibilities and accountabilities, and that the diagram be broadened, eg to include SIAPO, and that this information be circulated to all Board Members.
- That the Committees' terms of reference be included in future agenda books for information.

7.0 PRESENTATION: WELLSOUTH

Andrew Swanson-Dobbs, Chief Executive Officer (CEO) of WellSouth presented an overview of the WellSouth Primary Health Network, COVID-19 activity and reflections, General Practice today and its future direction, the HealthCare Home (HCH) model, and the next steps for WellSouth (tab 16), then responded to members' questions.

In thanking Mr Swanson-Dobbs for his overview, the Chair acknowledged the collaborative relationship between SDHB and WellSouth.

8.0 DISABILITY STRATEGY AND ACTION PLAN CONSULTATION FEEDBACK

Dr Brigit Mirfin-Veitch and Dr Jenny Condor from the Donald Beasley Institute presented (via Zoom) a summary of feedback on the Draft Disability Strategy and recommended revisions to the Strategy as a result of public consultation (tab 11), then responded to questions.

The Executive Director Quality and Clinical Governance Solutions (EDQ&CGS) advised that following formal endorsement by the Committees, the Disability Strategy would be published and communicated in various formats and an implementation timeline developed.

During discussion the Committees noted that the next step was to develop an action plan, with milestones and a budget, to implement the Strategy. The CEO advised that this should be developed alongside Southern DHB's overarching plans and would be impacted by decisions made nationally in response to the Simpson Report.

It was resolved:

"That the Committees approve the following recommended revisions to the draft Southern DHB Disability Strategy following the public consultation process:

1. **The title be reviewed to reflect that it is not inclusive of a detailed action plan, eg by changing it to *SDHB Disability Strategy and Actions*;**
2. **Disability Strategy Steering Committee members to be added to page 3 of the document;**
3. **Details regarding the consultation process to be appended to the document and referred to on page 3;**
4. **Sentence to be added to page 7 in relation to the Treaty of Waitangi and WAI 2575;**
5. **Further clarity in the actions related to the first goal in relation to "by Māori for Māori";**
6. **Ensure that the Strategy is available in all formats noted in the community feedback;**
7. **Liaise with the Community Health Council to ascertain what information would be most helpful to include in their suggested one page summary of the Strategy, for development by the Southern DHB design and communications teams."**

T Potiki/J Chambers

Drs Mirfin-Veitch and Condor were thanked for their work and presentation.

9.0 MĀORI HEALTH

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) presented a report on the provision of contracted kaupapa Māori health services (tab 9), which was provided in response to a request from the Committees for an overview.

The CMHS&IO noted that there were some gaps in the provision of services, particularly in the Central Otago and North Otago areas, and in the provision of Mental Health services in the community.

The CMHS&IO then responded to questions from members on Mauri Ora, the contracting process and investment in the sector, the definition of a kaupapa Māori provider, bowel screening uptake, immunisation rates, and WellSouth's reducing inequality voucher programme.

The Committees requested:

- That a copy of Whakamaua Māori Health Action Plan be added to the Diligent Resource Centre;
- Further information on how the work of the Māori Health providers connects to the Māori Health priorities in Southern DHB's Annual Plan, along with opportunities for improving collaboration and delivery.

The CMHS&IO was thanked for his report and it was noted that he would be providing updates on progress.

10.0 PRIMARY MATERNITY UPDATE

The Committees considered a report on possible options for the location of a new primary maternity facility in the Central Otago/Wanaka area (tab 10).

The Executive Director Strategy, Primary and Community reported that:

- Subsequent to the publication of the paper, two consultation meetings had been held in Cromwell with: (1) stakeholders and workforce, and (2) the general public;
- The options were out for consultation until 22 August 2020 and a recommendation would be made to the October 2020 meeting of the Committees.

Management then responded to questions on the proposed options.

It was resolved:

"That the Committees note:

- **The options presented to stakeholders on 15 July 2020 in Cromwell;**
- **An options paper for the location of primary maternity facilities in Central Otago/Wanaka was made public on 21 July 2020;**
- **The options were the subject of a public meeting on 23 July 2020 in Cromwell;**
- **The Central Lakes Locality Network and the DHB Project Team will make a joint recommendation in September/October 2020, taking into account public feedback, on the best option."**

11.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 12) was taken as read and the EDSP&C took questions. The following items were highlighted during discussion.

Mental Health

The EDSP&C reported that a procurement process was about to be undertaken for an extensive review of the continuum of Mental Health services delivered by secondary, primary and NGO providers. This process would involve a number of stakeholder engagement sessions across the district.

Housing - Kia Haumaru Te Kaika

Miss Soper reminded the Committees that Southland Warm Homes Trust was one of her declared interests and informed them that the Trust had discussed and supported the Kia Haumaru Te Kaika programme.

Aged Care

The Committees requested further information on care home waiting lists and whether the situation was getting better or worse, and home support services.

B4 School Checks Programme

The EDSP&C reported that B4 School Checks were back to business as usual but if there was a resurgence of COVID-19 the Population Health Team would be pulled back into contact tracing.

The EDSP&C was asked to report back on when B4 School Checks would be caught up.

District Oral Health

The Committees requested further information on the placement of drop-in varnish clinics and equity of access to these.

It was resolved:

"That the report be received."

12.0 FINANCIAL REPORT

In presenting the Strategy, Primary and Community (SP&C) financial results for June 2020 (tab 13), the EDSP&C advised that the report was complicated by the fact SP&C was both a funder and provider of services, and offered to provide members with a session to explain the report in detail.

The Committees requested that the financial tables be presented in a clearer format.

It was resolved:

"That the report be received."

13.0 ALLIANCE WORK PROGRAMME 2020/21

The EDSP&C presented a revised work plan for implementation of the Primary and Community Strategy (tab 14), then responded to questions.

It was suggested that the Committees be provided with the minutes of Alliance Leadership Team meetings.

It was resolved:

"That the Committees note the revised Alliance Leadership Team work plan."

14.0 IMMUNISATION PERFORMANCE

The Committees received a letter from the Director-General of Health on the low rate of influenza vaccination in the Southern district for Māori over the age of 65 (tab 15).

15.0 GENERAL

In closing the meeting, the Chair advised now that the Committees had received an overview of Māori Health, WellSouth and the Alliance, they could start monitoring priorities within each of those areas.

The CEO informed the Committees that planning for the 2021/22 year would commence in October 2020.

The meeting closed with a karakia at 4.00 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

HOSPITAL ADVISORY COMMITTEE MEETING, 7 SEPTEMBER 2020

- Verbal report from David Perez, Chair, Hospital Advisory Committee

IN CONFIDENCE

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Iwi Governance Committee Relationship Agreement**
Report to:	Board
Date of Meeting:	8 September 2020

Summary:

Seven Papatipu Rūnaka from the Waitaki River south cluster into two regions Murihiku and Araiteuru. They maintain mana whenua status across the Sothern DHB district as enforced under the Ngāi Tahu Settlement Act 1998. The Papatipu Rūnaka formed an Iwi Governance Committee with a specific focus on health and disability matters back in 2010. The Iwi Governance Committee has reviewed the original relationship agreement which is now inclusive of the Southern District Health Board (Southern DHB) and WellSouth Primary Health Network (WSPHN). This Treaty of Waitangi relationship is a governance to governance relationship with the Southern DHB and WSPHN.

The purpose of the agreement between the three parties is to clearly state why the partnership exists, what the parties will do within this partnership and how the parties will engage in this relationship.

All parties acknowledge that there will be other formalised and/or contract based relationships between the parties or constituents of the parties from time to time. Such formalised and/or contract based relationships are not the business of the Iwi Governance Committee. The relationship is intended to be transformational rather than transactional.

This proposed Relationship Agreement replaces the former Principles of Relationship between Murihiku and Araiteuru Rūnaka and the Southern DHB originally signed on 31 May 2011 and renewed and endorsed by Southern DHB on 2 May 2013 and 7 May 2015.

Purpose:

The overall purpose of the Iwi Governance Committee is to work collaboratively with the Southern DHB and WSPHN to improve the health and well-being of Māori living in the Southern region.

All three parties in the proposed partnership acknowledge that leadership is required in the improvement of health and wellbeing of all who live in the Southern region. It recognises the different mandate and responsibilities relevant to their respective roles and through collaboration these roles are seen as complementary and necessary.

Specific implications for consideration (financial/workforce/risk/legal etc.):		
Financial:	As set out in the report.	
Workforce:	As set out in the report.	
Equity:	The IGC Relationship Agreement provides the platform for a collaborative relationship that will address equity for Māori.	
Other:	As set out in the report.	
Document previously submitted to:	Iwi Governance Committee	**Date:** 3 August 2020
Prepared by: Gilbert Taurua Chief Māori Health Strategy and Improvement Officer **Date:** 27 August 2020	**Presented by:** Gilbert Taurua Chief Māori Health Strategy and Improvement Officer	
RECOMMENDATION: **That the Board endorses the Iwi Governance Committee Relationship Agreement.**		

Partnership Agreement

Between

Murihiku and Araiteuru Rūnaka

and

Southern District Health Board

and

WellSouth Primary Health Network

(Final Draft 27 August 2020)

1. Introduction

The seven rūnaka of Murihiku and Araiteuru have formed an Iwi Governance Committee with a specific focus on health and disability matters. The Iwi Governance Committee wish to have a Te Tiriti o Waitangi (Treaty) based partnership with the Southern District Health Board (Southern DHB) and WellSouth Primary Health Network (WSPHN). The Southern DHB partner is represented by the Southern DHB Chair and Board members. The WSPHN partner is represented by the Chair and other members of WSPHN Board as the WSPHN should determine. The Treaty Partnership is a governance relationship.

The purpose of this agreement between the three parties is to clearly state why the partnership exists, what the parties will do within this partnership and how the parties will engage in this partnership i.e. the *Principles of Partnership*.

All parties acknowledge that there will be other formalised and/or contract based relationships between the parties or constituents of the parties from time to time. Such formalised and/or contract based relationships are not the business of the Iwi Governance Committee. Our relationship is intended to be transformational rather than transactional.

2. Purpose

The overall purpose of the Iwi Governance Committee is to work collaboratively with the Southern DHB and WSPHN to improve the health and well-being of Māori living in the Southern region.

All three parties in this partnership acknowledge that leadership is required in the improvement of health and wellbeing of all who live in the Southern region. It recognises the different mandate and responsibilities relevant to their respective roles and through collaboration these roles are seen as complementary and necessary.

The Iwi Governance Committee in partnership is committed to addressing the findings of Wai 2575 and will leverage our collective influence with our partners to ensure that planning and resource allocation is sufficient for continuous improvement in Māori health and wellbeing.

The Southern DHB and WSPHN will engage with the Iwi Governance Committee, to agree our approach for broader

engagement with local iwi and taurahere. This will ensure that relevant health and disability priorities for Māori are identified and targeted by primary and secondary health service delivery.

3. Parties to this Partnership

Ka Rūnaka

3.1 The Iwi Governance Committee is made up of a representative from each of the seven rūnaka identified in Te Rūnanga o Ngai Tahu Act (1996) whose territory is in the Southern District Health Board region, namely:

- Ōraka Aparima Rūnaka
- Te Rūnanga o Awarua
- Waihōpai Rūnaka
- Hokonui Rūnanga
- Te Rūnanga o Ōtākou
- Kati Huirapa Rūnaka ki Puketeraki
- Te Rūnanga o Moeraki

3.2 These representatives have been mandated by their respective rūnaka to engage in a formal partnership with the Southern DHB and WSPHN.

3.3 Iwi Governance Committee representatives will be appointed by each of the seven rūnaka for terms to be determined by the respective rūnaka.

Where a rūnaka nominates a staff member of Southern DHB or WSPHN as their representative on the Iwi Governance Committee the staff member must discuss their role with their respective Chief Executive Officer in the first instance. The key principles to be considered are:

- That any perceived conflicts of interest are managed professionally through reference to a register at the start of each meeting.
- That in managing these conflicts representatives can fulfil the objectives of an Iwi governance role.

Southern District Health Board

3.4 The Southern DHB has statutory rights and obligations under the New Zealand Public Health and Disability Act (NZPHDA) 2000 to improve health outcomes for Māori in the Southern DHB region. Actions to address equity will be assessed to ensure that we are able to respond to Wai 2575.

The Southern DHB is represented under this agreement by the Southern DHB Chair and nominated Board members.

The Southern DHB representatives will be appointed for the District Health Board term.

WellSouth Primary Health Network

3.5 The WSPHN is represented under this agreement by the Chair, two Māori WSPHN Board members and one other WSPHN Board member.

All Parties

3.6 In addition to the membership, it is agreed that other Board members from the Southern DHB and WSPHN, may attend from time to time. The Chair of the Iwi Governance Committee also has the discretion to invite others to the meeting as and when appropriate.

4. Acknowledgements of Parties

The parties acknowledge:

4.1 The policy for health and disability services is determined by central government and advised to the Southern DHB by the Minister of Health and the Ministry of Health.

4.2 The partnerships created by this agreement are not exclusive and all parties reserve the right to create or maintain partnerships with any other group that may assist them in their respective objectives.

5. Legal Effect

This Partnership Agreement while not legally binding provides an opportunity for a substantive response to the findings of Wai 2575.

6. Values

The parties have identified values that underpin their partnership and the values for each of the parties is outlined in Appendix A to this Partnership Agreement.

7. Goals

7.1 To provide a comprehensive and evidence-based response to equity in Māori health and disability status across the Southern region.

7.2 To influence and shape strategic processes to achieve excellence in health outcomes for Southern Māori.

7.3 To ensure operational activities are underpinned by the findings of Wai 2575 and across relevant strategies and actions for Māori health are identified for Māori.

7.4 To agree annual objectives to ensure that localised needs are addressed.

8. General Scope

8.1 Oversee, monitor and provide strategic direction regarding Māori health. This includes supporting the partners to prioritise Māori health outcomes.

8.2 The Southern DHB and WSPHN will ensure Annual and Strategic Plans are presented to the Iwi Governance Committee with sufficient time for the committee to contribute to those plans in a meaningful way.

8.3 The Southern DHB and WSPHN will ensure that relevant reports and documents are provided to the Iwi Governance Committee in a timely way and that relevant documents that are produced within Southern are presented to the Iwi Governance Committee with sufficient time for the committee to contribute to those documents in a meaningful way.

8.4 To receive and consider relevant information and research regarding Māori health in the Southern region.

9. Reporting

9.1 The Iwi Governance Committee will work with the Southern DHB and WSPHN to develop an agreed suite of reports, which will be provided on a regular basis and be reviewed periodically by the Iwi Governance Committee. The purpose of the reports is to monitor progress against agreed plans and outcomes for Māori living within the Southern region.

9.2 It was agreed that some Health and Disability Commission (HDC) information could be included in the suite of reports

provided to the IGC, noting that the important issue is for IGC to know that consideration is given to inquiries. IGC will be advised of significant events and risk and be involved in solutions.

10. Consultation

10.1 The Southern DHB and WSPHN agree to seek advice from the Iwi Governance Committee for all matters that require formal consultation that significantly impact Māori. Such matters should include but not be limited to strategic directions, changes in service provision and new service design.

10.2 General discussions at scheduled meetings do not automatically represent formal consultation. The Southern DHB and WSPHN will clearly identify and agree when their discussions with the Iwi Governance Committee are formal engagement.

10.3 The Iwi Governance Committee will provide advice and direct support regarding best methods for consultation with Māori as relevant to the kaupapa at the time.

11. Meetings

11.1 The Iwi Governance Committee will work with Southern DHB and WSPHN to develop an induction programme for new Iwi Governance Committee members.

11.2 The Iwi Governance Committee will meet six times per year or as necessary.

11.3 There will be at least one wānanga each year for the purposes of education, professional development and training.

11.4 The schedule of meeting dates will be set out in the Iwi Governance Committee "work plan" to ensure meetings provide for timely input into key strategic processes.

11.5 A quorum for the Partnership will be six of the seven rūnaka representatives with provision for rūnaka to delegate their authority to the Chair of the Iwi Governance Committee for the purposes of a quorum.

11.6 The Chairs of the Southern DHB and WSPHN may delegate their authority to others for the purpose of a quorum. It is acknowledged that it is at the discretion of each partner whether they wish to send an alternative in their absence.

11.7 There is an expectation that members attend 67% (four of six) of the meetings per annum.

11.8 Meeting locations will be held between Otago and Southland and at a Marae a minimum of twice a year – one in Otago and one in Southland.

11.9 The Iwi Governance Committee is not a statutory committee and as such the meetings are not public meetings.

11.10 The Chairperson of the Iwi Governance Committee shall be appointed by the Iwi Governance Committee for a term of three years.

11.11 The Southern DHB Chief Executive Officer and the WSPHN Chief Executive will ensure provision of administrative support to the Iwi Governance Committee.

11.12 A meeting summary will be distributed to each Iwi Governance Committee member for general distribution within their respective rūnaka.

11.13 There is an expectation that, outside the membership, all Iwi Governance Committee meetings are supported by the following management members: the Chief Executive Officer, Southern DHB; the Chief Executive WSPHN; the Chief Māori Health Strategy and Improvement Officer and the Executive Director Strategy Primary and Community or their delegates. Management members have the discretion to invite other members of their respective teams as appropriate.

12. Remuneration

12.1 Remuneration to Iwi Governance Committee members will be aligned and consistent with those rates as set down for Statutory Committees of District Health Boards by the Public Service Commission.

12.2 The Southern DHB and WSPHN will agree an annual budget with the Iwi Governance Committee to support secretariat meeting and reasonable costs.

13. Communication

Iwi Governance Committee

13.1 The representatives from each of the seven Rūnaka will facilitate communication with their respective Rūnaka.

13.2 Southern DHB and WSPHN recognise that on occasions rūnaka members and/or members of the Iwi Governance Committee will communicate about health issues outside of their role as a representative on the Iwi Governance Committee. On these occasions the representative will acknowledge that their comments are NOT from the Iwi Governance Committee unless formally agreed.

Southern District Health Board

13.3 The Chief Executive Officer of Southern DHB and the Board Chair will facilitate communication within the Southern DHB with regards to Iwi Governance Committee work activities.

WellSouth Primary Health Network

13.4 The Chief Executive of the WSPHN and the WSPHN Chair will facilitate communication within the Primary Health Network with regards to Iwi Governance Committee work activities.

External Communication

13.5 Any communications related to the Iwi Governance Committee partnerships will be fronted in the first instance by the Chair of the Iwi Governance Committee and the Chair of the Southern DHB and the Chair of WSPHN as agreed by the Chairs at the time of the communication.

14. Dispute or Difference Resolution

14.1 All disputes and differences between the parties to this partnership shall be subject to agreed processes for mediation.

14.2 All disputes and differences between the rūnaka representatives on the Iwi Governance Committee shall be based on tikaka Ngai Tahu.

15. Review

The parties shall review this partnership agreement every 36 months or earlier from the date of signing and will amend this partnership agreement as necessary to achieve the objectives of the three parties.

Appendix A:

Ngai Tahu Values:

- Whanaungatanga – a relationship through shared experiences and working together which provides people with a sense of belonging.
- Manaakitanga – the process for acknowledging the mana of each party.
- Tohungatanga – expertise, competence and proficiency.
- Kaitiakitanga – guardianship, stewardship and trusteeship.
- Rangatiratanga – chieftainship, right to exercise authority, chiefly autonomy, authority, ownership and leadership.
- Tikanga – the customary system of values and practices.

Values for the Southern DHB:

- Manaakitanga (Kind) – Looking after our people: we respect and support each other. Our hospitality and kindness foster better care.
- Pono (Open) – Being sincere: we listen, hear and communicate openly and honestly. Treat people how they would like to be treated.
- Whaiwhakaaro (Positive) – Best action: we are thoughtful, bring a positive attitude and are always looking to do things better.
- Whanaungatanga (Community) – As family: we are genuine, nurture and maintain relationships to promote and build on all the strengths in our community.

Values for the WellSouth PHN:

- Whānau Centered – Whānau have a good experience of primary health care which meets their health needs.
- Equitable – recognising different people with different levels of advantage require different approaches and resources to get equitable health outcomes.
- Respectful – improve quality and safety of care; develop reliable integrated systems of care; improve the whānau experience of care.
- Transparent – working together with Iwi, hapū, whānau, Māori providers and communities.

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 July is a deficit of $1.9 million compared to a planned deficit of $2.2 million, and hence $0.3 million favourable to plan. Being the first month in the year it is too early to forecast year end performance, this will commence at the end of the first quarter.

It must be noted that as per the Ministry of Health instructions our budgeted deficit for the 2020/21 year of $10.9 million excludes any provision for Holidays Act implications or COVID-19. Both of these items will be singled out and will be excluded from comparison against the planned financial performance.

From a volumes perspective, overall activity remain down over the measures of case weighted discharges (2.3%), Emergency Department (ED) attendances (1.7%) and Mental Health bed days (3.2%) when compared to last July. There was however quite a mix change with elective surgery being up 11.5%, and Maternity up 10.5%, and ED in Southland up 2.8%. The biggest reductions were Medical case weights being down 12.1% and Surgical acutes being down 6.6%. These movements have created pressure particularly evident in the Surgical Wards and have placed the system under pressure despite the overall reduction in workload.

3. ANNUAL PLAN 2020/21

The second draft of the Annual Plan was sent to the Ministry on 23 June and feedback was received signalling overall acceptance of the plan, with the exception of financial templates, which needed to be reworked to reduce our initial forecast deficit. This work has been undertaken and a high level revised deficit was submitted on 10 July in line with Ministry expectations. The revised budget was reviewed and agreed at the Board meeting on 7 July prior to submission.

The draft Annual Plan was approved by the Board at their meeting of 7 July, subject to inclusion of Iwi Governance Committee (IGC) feedback being incorporated. Changes recommended by IGC have now been made.

The Ministry requested that DHBs address all remaining issues and send a revised version for a last check ahead of Board approval processes, by mid-July. The revised Annual Plan was sent to the Ministry on 21 July, for review and final feedback.

The Ministry will provide fast turn-around feedback to DHBs if there are any remaining issues that need to be resolved. DHBs are to finalise plans with Board sign-off expected to occur from the end of July and then to supply Board approved plans to the Ministry. The Ministry will submit DHB plans for Ministerial approval in August. Our Statement of Performance Expectations is to be published on our website by 15 August.

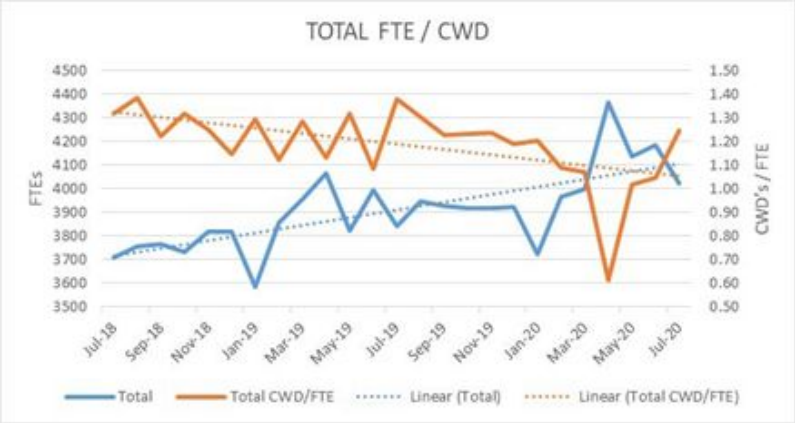
4. CASE WEIGHTS PER FULL-TIME EQUIVALENT (FTE)

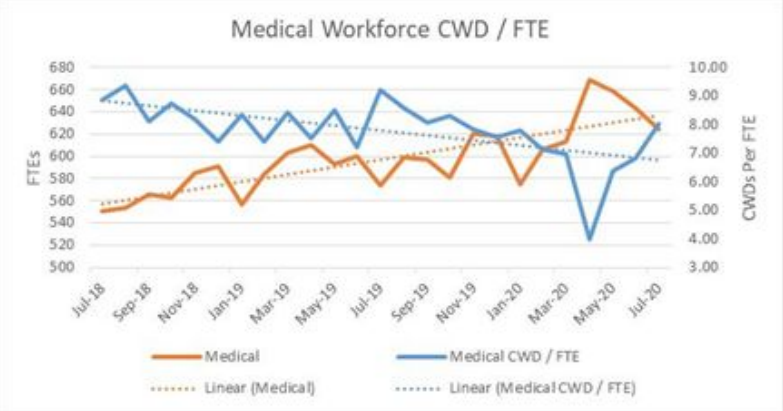
One of the Crown Monitors requested that we added case weights per FTE to the performance scorecard. At best this would show some form of proxy workload per FTE measure. Case weights only record inpatient activity so fails to recognise changes in workload that may be being experienced in outpatient activity, minor procedures, ED attendances, community based activity etc. However, it has historically been looked upon as a high level proxy indicator.

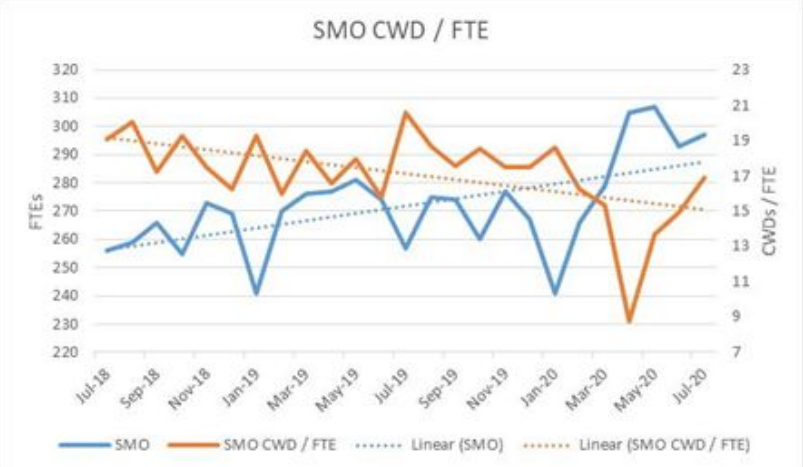
The graphs below are pulled from already reported information over the past two years. Each of the graphs show the impact of COVID-19 which largely shows up as a diamond in the right hand side of the graphs. The one exception being Senior Medical Officers (SMOs) which shows up more kite like as we have noticed that the majority of other staffing groups appear to have returned to taking annual leave while SMOs are generally applying for less over the past few months.

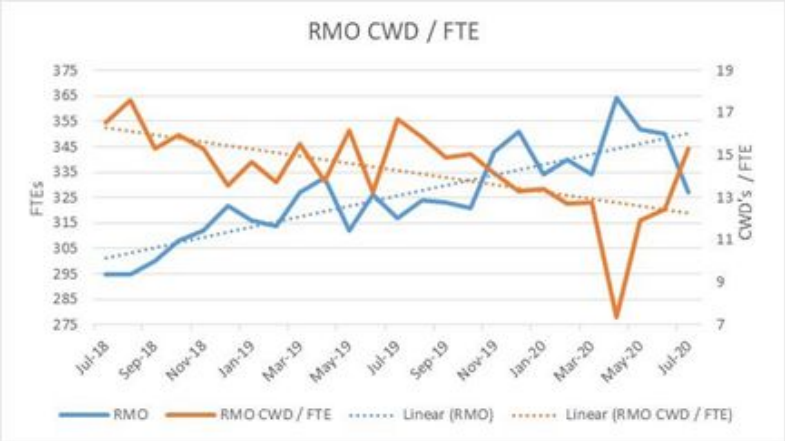
Overall the trends are concerning as all staffing groups are showing a reduction in case weights per FTE. There are some changes in staffing that have been overtly introduced for clinical safety. For Registered Medicals Officers (RMOs) there were the schedule 10 rosters in the Resident Doctors' Association (RDA) agreement which were focussed on health and safety which resulted in the need to increase FTEs while at the same time there was no overt increase in clinical workload. The same is true for Nursing with Safe Staffing / Care Capacity Demand Management. Once again this introduced more nursing FTE into the mix not necessarily being offset by increased clinical workload, but focussed on safe staffing. For Allied Health we deliberately increased Allied Health FTE in the 2019/20 budget post the Allied Health Review, but recruiting only really saw the FTE numbers start to increase in early 2020.

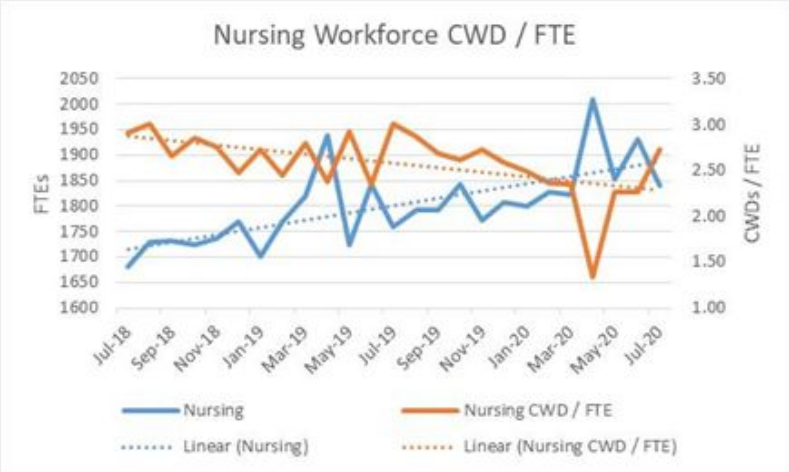
The picture is however very challenging as it shows a progressive reduction in productivity when compared against the proxy of case weights. While there will often be questions about complexity this should generally be reflected of case weights.


TOTAL FTE / CWD
FTEs
CWD's / FTE
Total
Total CWD/FTE
Linear (Total)
Linear (Total CWD/FTE)

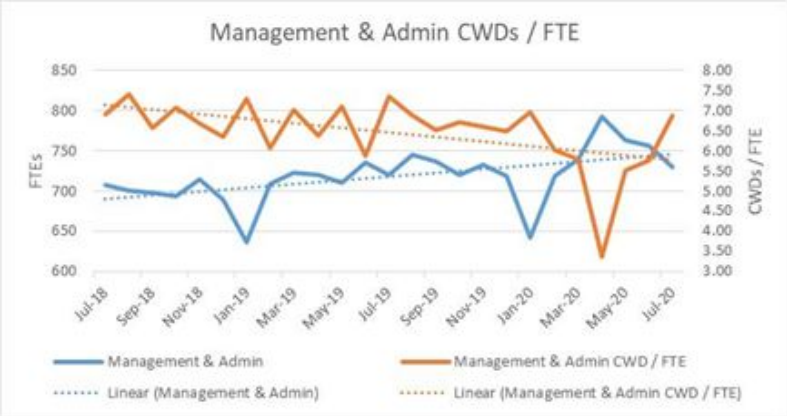

Medical Workforce CWD / FTE
FTEs
CWDs Per FTE
Medical
Medical CWD / FTE
Linear (Medical)
Linear (Medical CWD / FTE)


SMO CWD / FTE
FTEs
CWDs / FTE
SMO
SMO CWD / FTE
Linear (SMO)
Linear (SMO CWD / FTE)


RMO CWD / FTE
FTEs
CWD's / FTE
RMO
RMO CWD / FTE
Linear (RMO)
Linear (RMO CWD / FTE)


Nursing Workforce CWD / FTE
FTEs
CWDs / FTE
Nursing
Nursing CWD / FTE
Linear (Nursing)
Linear (Nursing CWD / FTE)


Allied Health CWDs / FTE
FTEs
CWDs / FTE
Allied
Allied CWD / FTE
Linear (Allied)
Linear (Allied CWD / FTE)



5. ONGOING COVID-19 MANAGEMENT RESPONSE

There is currently no transmission of COVID-19 in the community. A significant amount of work continues in this area, which is outlined in the following sections.

Resurgence Plans

During the month we had the unexpected return to Alert Level 3 in the Auckland region and Alert Level 2 for the rest of the country. This generated a lot of activity in terms of:

- Ramping up testing numbers to ensure that we picked up if there was any leakage of the Auckland Cluster into our region, as well as strengthening testing at the borders which for Southern means the ports in both Dunedin and Invercargill. This was a collaborative effort between the DHB and WellSouth Primary Health Network
- Ramping up our readiness for more extensive contract tracing within the Public Health Team
- Development of Resurgence Plans covering:
    - Public Health Capacity
    - Primary Care
    - Aged Care
    - Rural Hospitals
    - DHB Hospitals
    - Mental Health.

These plans are now well developed and we are working through with the respective teams to align staffing and other resourcing needs to ensure that if or when COVID-19 re-emerges in our community we are able to respond and react rapidly

Managed Isolation Facilities

A significant amount of work has been put into the preparation of potentially having managed isolation facilities (MIF) in Dunedin. This work was undertaken by a larger health team that included a variety of services across the DHB and WellSouth. This included external stakeholders such as the NZ Defence Force, Aviation Security, Police, Fire and Emergency, St John and the Dunedin City Council. A trip was made to Christchurch by two Public Health staff as part of a team of four including WellSouth and Infection, Prevention and Control to gather information on how

Canterbury DHB and their Public Health Unit are managing these facilities. This was a valuable trip and provided great insight into how things are being run, the amount of resource required and the types of systems they are using.

Following a visit to Southern by Minister Megan Woods and Air Commodore Darryn Webb on 16 and 17 July, it was decided that no routine managed isolation facilities would be established in Southern DHB area.

We have been advised that Queenstown may be considered for establishing a MIF for exceptional reasons such as supporting international sporting events. We are presently working this up with the Ministry of Business, Innovation and Enterprise (MBIE) and the Ministry of Health.

Support Services for Foreign Nationals

On 1 July, the Department of Internal Affairs (DIA) took over COVID recovery support services for foreign nationals across NZ. The DIA has contracted with Red Cross until 30 September to provide local recovery support services in areas where required. Prior to 1 July, COVID recovery was being managed through the collaborative efforts of Queenstown Lakes District Council (QLDC), Civil Defence, Southern DHB, Ministry of Social Development and non-government organisations (NGOs).

The volumes of welfare support applications that QLDC was receiving in June were averaging 140 per day. In contrast, Red Cross, during the month of July, has received fewer than 200 welfare applications for the entire Southern DHB region. Meanwhile, the food banks being run by Salvation Army and Happiness House have remained very busy.

Lack of data on numbers of people requiring support means it is difficult to understand the status quo and forecast COVID recovery needs across the resident and foreign national populations in Queenstown.

COVID-19 MĀORI COMMUNITIES OUTREACH AND SUPPORT – MĀORI HEALTH SUPPORT REQUEST FOR PROPOSAL (RFP)

The Southern DHB and WellSouth have released an RFP on 25 August for the purposes of COVID-19 Māori Communities Outreach and Support. The closed RFP has gone out to contract DHB Māori providers who can assist Māori communities in the Southern region affected by COVID-19. The funding is designed to be flexible for services and resources as needed to keep Māori whānau and communities and especially kuia and koroua healthy and independent during the COVID-19 outbreak. Services include outreach and wrap around support, taking a holistic model of care in line with kaupapa Māori principles. The delivery of services will be targeted towards COVID-19 priority groups including:

- pakeke, kuia and koroua, as they often will have other health conditions that make them more vulnerable to COVID-19;
- whānau members with underlying medical conditions such as respiratory issues, heart conditions, high blood pressure, diabetes and other long-term conditions;
- whānau members undergoing treatment for cancer and blood conditions, as treatments impact their immune systems, making them more vulnerable to COVID-19;
- whānau members caring for tamariki and rangatahi Māori during the COVID-19 outbreak;

- hapū māmā; whilst it is uncertain how COVID-19 impacts pregnant women, during pregnancy women experience changes in their bodies that may increase their risk from some infections;
- whanau without easy access to healthcare, including mental health and addiction services, primary care and disability support services.

The RFP closes on 11 September and a zoom meeting is scheduled on 1 September designed to answer questions and provide clarification specific to the RFP. Services may include outreach and wrap around support, taking a holistic model of care in line with kaupapa Māori principles.

6. SENIOR MEDICAL OFFICER COVER TO RURAL HOSPITALS THROUGHOUT THE DISTRICT

There is a shortage of Rural Hospital Medical Specialists working in the five main rural hospitals with acute inpatient beds in the district: Lakes District Hospital in Queenstown, Dunstan Hospital in Central Otago, Gore Health in Gore, Clutha Health First in Balclutha and Oamaru Hospital (Waitaki District Health Services Ltd). Two of the hospitals have reasonable senior medical officer (SMO) cover, but the other hospitals have a heavy reliance on locums. This is expensive, and also can affect the quality of the service provided as there is often limited continuity.

At Oamaru Hospital more than half the SMOs are locums. One of the Lakes District Hospital SMOs is providing some senior cover until the new Clinical Director starts in the middle of August. As part of this input, systems and processes will be implemented to mitigate any clinical risk. This involves internal changes at Oamaru Hospital, and also strengthening the links to key departments in Dunedin Hospital.

We are exploring the opportunity to have a more collaborative approach to recruitment and retention of this workforce. One of the biggest challenge to this however is that each organisation has its own employment agreements which mean that Senior Medical Officers are recruited on different terms and conditions. The District Health Board multi-employer collective agreement (MECA) is the more generous of the agreements, and is something that the Associated for Salaried Medical Specialists (ASMS) has advocated for over time. This of course would require funding to address.

7. DISTRICT-WIDE RADIOLOGY SERVICES

The reduction in private radiology services across the district has impacted on rural communities. As mentioned previously, this has put increasing pressure on some rural hospitals (Queenstown and Dunstan in particular). Health services in Gore and Balclutha have also been impacted. Discussions at the Rural Chief Executives group with some Executive Leadership Team members and Radiology Managers identified a need to develop a more strategic view to the sustained provision of Radiology services district wide.

8. PRIMARY MATERNITY FACILITIES CONSULTATION

Work to consider the best configuration of Primary Maternity Facilities for the Central Otago/Wanaka area is underway. Following an initial phase of consultation, which saw the DHB meet with key stakeholders and receive more than 300 online submissions, an options paper has been publicly released.

The following important issues were raised by stakeholders and the public throughout consultation and informed the options design process:

- 24/7 midwifery availability at birthing facilities
- Rapid access to urgent transport, especially a helicopter
- Equity of travel times and access to primary birthing facilities for all parts of the region
- Co-location with other health services
- Needs to take account of future population growth
- Quality of the whole pathway of maternal care
- Respectful treatment of Māori patients and whanau
- Charlotte Jean Maternity Hospital is highly valued by women and the community.

Prior to the release of the paper the DHB met with key stakeholders including midwives, primary care, St John and Māori communities. This was an opportunity to reveal the consultation themes and proposed options to them ahead of the public release for feedback. The meeting was well attended and the group was engaged in the issues. Key topics of discussion were:

The robustness of data supplied and how it underpins decision making:

- Public perceptions of safety and what co-location could offer in reality
- How 24/7 staffing might be implemented and its impacts on workforce
- How the model of care and service offering might be expanded in a single unit scenario
- Utilisation of a unit and the opportunity for community and stakeholder ownership

The paper released on 21 July 2020 details four potential options for the location of a new Primary Birthing Unit in Central Otago/Wanaka. The four options can be summarised as follows:

Option One:

- Locate a single new facility at Cromwell
- Decommission Charlotte Jean Maternity Hospital
- Supplemented by Maternal and Child Hubs in Wanaka, Alexandra and Ranfurly
- Emergency birthing facilities in Lawrence

Option Two:

- Locate a single new Primary Birthing Unit in Clyde at Dunstan Hospital
- Decommission Charlotte Jean Maternity Hospital
- Supplemented by Maternal and Child Hubs in Wanaka and Ranfurly
- Emergency birthing facilities in Lawrence

Option Three:

- Locate a new Primary Birthing Unit in Wanaka AND
- Retain the current unit in Alexandra (Charlotte Jean)
- Supplemented by Maternal and Child Hubs in Ranfurly and Cromwell

- Emergency birthing facilities in Lawrence

Option Four:

- Locate a new Primary Birthing Unit in Wanaka AND
- Relocate the current unit in Alexandra (Charlotte Jean) to be co-located with Dunstan Hospital in Clyde
- Supplemented by Maternal and Child Hubs in Ranfurly and Cromwell
- Emergency birthing facilities in Lawrence

The options paper was the topic of a Public Meeting in Cromwell on 23 July 2020. We sought to make participation in this as accessible as possible. The time of the meeting was determined as the result of a poll of community stakeholders. The meeting was promoted through advertisements in the Otago Daily Times, Central Otago News, Facebook, and significantly through our stakeholder list of around 300. It was streamed through Zoom, and a recording has been posted on our website.

The meeting was well attended with attendees including Lead Maternity Carers (LMCs), service providers, media, parents and the Central Otago District Mayor. The team was clear with attendees that there was no preference for a particular option currently held by the DHB and our attempts to engage and listen were genuine. Audience questions and comments covered a range of topics and perspectives including:

- Managing public perceptions of safety compared to the reality of what different colocation scenarios offer
- Financial commitment to a preferred option
- Expanding the service specification to drive utilisation
- Assessment of the available workforce
- Acknowledgment that a well-designed, run and funded unit would attract staff
- Discussing trade-offs under each options such as drive times, co-location with health services and access to helipad
- Acknowledgement that this development was long overdue and that the communities have been underserved for a long time
- Acknowledgement that Charlotte Jean Maternity Hospital provides a high quality service and that this quality needs to be maintained in whatever option is progressed
- Support from the Chair of Dunstan Hospital to accommodate a unit onsite if the quality, sustainability and funding is addressed
- Clarification from Dunstan hospitals Clinical Director that co-location did not mean access to obstetric services but that they do have rural generalist on staff who are certified in new born life support
- LMC and parent experiences of pregnancy and birthing in the area
- Some attendees felt strongly that if there wasn’t a unit in Wanaka, we would not have achieved an improvement

While there was some expression of preference for particular options from attendees, the conversation centred on understanding the trade-offs under each option and the complexity of the decision making process ahead.

The public meeting is just one element of the current phase of consultation. Over the next six weeks:

- An online survey is open (https://docs.google.com/forms/d/e/1FAIpQLSeFfIISHmB0jiCExr8xZOHbUgjnOyibYmKvZLqfc8x50IT-pw/viewform)
- Our engagement page will host a recording of the meeting and a copy of the paper (https://www.engage.southernhealth.nz/maternity)
- The public is able to contact us directly with their thoughts (maternity@southerndhb.govt.nz)
- We will continue to engage face to face and online with stakeholders.

Together with the Central Lakes Locality Network, a preferred option will be presented to the Board at their October meeting for endorsement.

9. PRIMARY CARE/HEALTH CARE HOME RECONFIGURATION

Health Care Home (HCH) has operated since July 2018, with 14 practices at a mix of one or two years in the programme. There are discussions around how the HCH model can best respond to the learnings from COVID-19. The recommendation, which is currently awaiting endorsement, is to offer all practices a programme that is shorter (two years, not three, per practice), simpler and more flexible in implementation, using processes and activities proven in the programme to date. The principles and core elements of the HCH model of care will stay. Based on practice feedback, the HCH team is confident significant benefit will still accrue to individual practices, and the overall benefit of the programme to the system will increase with more practices in it. This approach is consistent with that being undertaken by other New Zealand HCH programmes.

10. SURGICAL PERFORMANCE – CASE WEIGHTS AND DISCHARGES

We are still in discussions with the Ministry of Health concerning our elective surgery 'Production Plan' for 2020/21. In the meantime, we have rolled over last years' production plan as the starting point for this years' target. Key points that we want to discuss with the Ministry concerning this years' target (and the additional case weights we would need to deliver without additional funding) and an historic discharge 'stretch' that we are hoping to get agreement to at least partially address.

In terms of the case weight target, our quick validation checks suggest that an additional 270 case weights worth circa $1.5m have been asked for in the base Ministry plan this year without revenue to go with them. Agreeing to this would essentially stretch our target and we would have to complete circa $1.5m of activity without revenue funding in order to deliver this. The first point we want to check with the Ministry was if this was intentional or not. If unintentional, then it would be a relatively straight forward adjustment to move the equivalent case weights across specialities from 'additional funded' to 'base' and this would comprehensively close the gap.

The second point we want to work through with the Ministry is the discharge target. In the previous financial year, with the introduction of 'planned care' which replaced the ambulatory and elective initiative, we were supposed to be given the same effective discharge target as we had previously. However, because we had previously been able to count skin lesions and Intraocular injections as discharges, and we were no longer able to count them with the rule change, our discharge target was effectively stretched by approximately 1,100 discharges. At the time we

deliberately focused on the case weight stretch, as this had revenue implications for us (and we were the first DHB to agree their plan and we managed to get 100% of the case weight stretched removed). However, we would now like to tackle some of the discharge stretch if we can gain agreement on this, as this will baseline our discharge target into the future. We have managed to increase our level of discharging, as we have successfully fully recruited to our ophthalmology team (we haven't been fully recruited here for some years). This, and improved case turnaround has meant that we have been able to lift our underlying discharge performance by circa 550 case weights. We are therefore hoping to land on some form of agreement that would reduce their discharges target expectation of us by circa 550 case weights. This would balance our underlying capacity to our target. Discussion with the Ministry will start soon.

Elective performance for the month of July was in excess of the target (noting the target is currently last years' target rolled forward as we have yet to address the above issues). We achieved approximately 300 case weights more than target. Of this, 100 case weights was additional outsourcing associated with us initiating our recovery of surgery early (i.e. on the assumption that once guidance came from the Ministry about how recovery funding would be allocated we would be able to retrospectively apply it to the additional activity we have done. This accounted for 100 case weights, leaving us having delivered 200 case weights more than planned. We also ran Saturday elective lists at both Dunedin and Southland hospitals as part of our recovery efforts and this would have accounted for a reasonable proportion of the additional case weights delivered. We are still analysing where the additional case weights were delivered but at this stage they appear to be in fairly specific specialities such as cardiology, where we appear to be seeing a bow wave of late demand which we are attributing to the fact that the Catheter Laboratory was predominately closed during the COVID lockdown earlier in the year. We have higher than planned surgical consumables and prosthesis costs that are correlated to the extra volumes that have been delivered and we will may need to consider reducing elective activity in particular areas to bring our surgical clinical supplies costs back towards budget. We are initiating a savings project in late August to review how perioperative and implant and prosthesis costs are incurred with the intention of creating future state processes that will achieve savings and implementing these and thus realising savings. The majority of additional elective volumes (200 case weights) at Dunedin hospital are cardiothoracic cases 85 case weights greater than usual – we had a very clear run with practically no intensive care unit (ICU) related cancellations in July, and cardiology procedures, 70 case weights more than usual (we appear to have had a post COVID surge – we shut the Cath Lab during COVID for all elective activity). Additional weekend elective volumes and relatively low disruption due to acute pressure (noting this pattern did not continue into August) meant that orthopaedics and a number of other specialities were able to do a bit more than usual, too.

The development of the new Sterile Services Unit is now back on track following the procurement of architectural services for the detailed design work. This work will commence in the next week, with the signing of the contract with the architect now imminent. The current timeline for the design work is for this to be completed by December – January, with tendering for construction and then construction work itself to occur early in 2021 with a final completion date of January 2022 anticipated.

11. OUTPATIENT PERFORMANCE (ESPI 2)

We are now making reasonable progress with the implementation of the prioritisation tool for surgery. Urology Dunedin, Orthopaedics Dunedin and General Surgery in Southland have now all implemented the tool. The tool is in place and will be bedded in over the coming month or so for General Surgery Dunedin, tool.

By way of reminder, the tool allows us to match the underlying capacity of the service with what is accepted at triage on a weekly basis and check that we can safely balance the demands on the service with the underlying capacity within that service.

We are now starting to have more specific conversations with the Medicine, Women and Children specialities, as we have concluded that the prioritisation tool won't necessarily work as well for these services. A number of services in this directorate are now getting reasonably close to compliance and there are a couple of great initiatives underway. One of these initiatives is in the Obstetrics & Gynaecology service in Dunedin, where a telehealth first specialist assessment (FSA) is being completed on approximately ¼ of referrals at the time of triage. This means that for those referrals, they are not even coming on to the outpatient wait list. They are either being completed and discharged back to the general practitioner (GP), or moved straight onto the inpatient wait list. This appears to be having the right impact on the ESPI 2 breaches as these are starting to trend down nicely. Obstetrics and gynaecology in Southland has improved the rate of ESPI 2 compliance since bedding in the acuity basis for booking patients onto the outpatient wait list. However, there is an underlying capacity issue with more referrals being received on a weekly basis than able to be actioned. We will revisit discussions with the Service Manager and clinicians about implementing the prioritisation tool (we had initial discussions on this subject pre-COVID). It we implement the prioritisation tool and can demonstrate that at the cut off line (with all referrals stratified in priority order) those referrals at the cut-off point that must be returned to the GP in order for the service to stay in balance are inappropriate, this is the evidence that is required to make a case to say that the resourcing in this service is a high priority relative to the resourcing that is required in other services (which would be the foundation for a reasonable case in the investment priorities for the coming year).

Our overall ESPI 2 performance has steadily improved since COVID. Coming out of COVID lockdown we had 2,600 ESPI 2 breaches. As at the end of July we are down to 1,900 ESPI 2 breaches, as demonstrated from the following extracts from the relevant Power BI dashboards.

12. INPATIENT PERFORMANCE (ESPI 5)

Inpatient performance has been very challenging. Whilst the services are almost without exception in balance on an ongoing basis (what is being accepted onto the inpatient wait list each week matches the volume that is attended to and existed

from the inpatient wait list each week), the accumulated impact of strikes in the last two years, together with the impact of COVID means that there are now 1,000 patients who have waited more than eight months for their surgery.

To make some initial progress on the 'tail' of these long waiting patients we have identified some initial criteria to focus on:

a. All patients waiting longer than eight months who have a score of 85 or greater, and;

b. All patients who have waited longer than 24 months.

These criteria produce a relatively small number of patients to be reviewed when this is broken down by speciality and location, as follows. The intention with this initial criteria is to focus on potential risks that are sitting on our wait list (category A), followed by addressing the patients who have waited the longest.

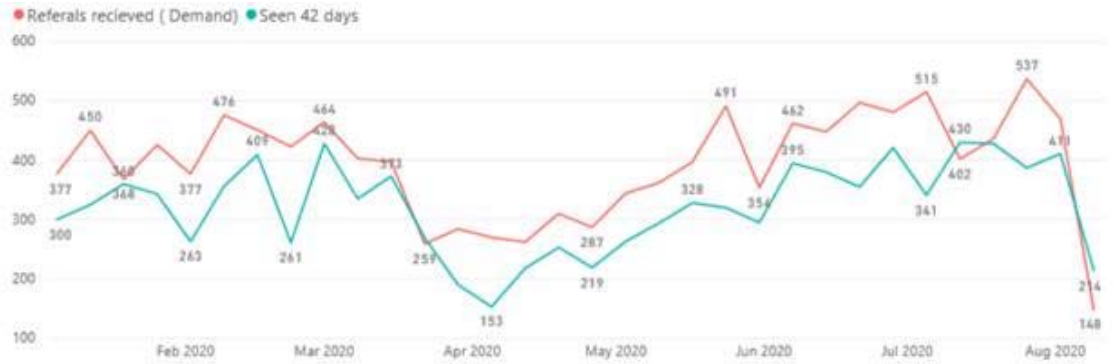
We have asked the relevant Service Managers and specialties to review these patients, in conjunction with their relevant administration support with the express purpose of either correcting these as data quality issues (e.g. surgery has already occurred, surgery occurred in private, patient left the district and is under the care of another DHB etc), review the necessity for surgery or book them onto an available clinic slot in the coming two weeks.

Our biggest opportunity in terms of moving patients off this wait list is to give them surgery and the recovery funding and recovery initiative will be important in terms of addressing these long term structural issues and allowing substantial change to these historic wait lists to take place. However, the recovery money will at best stretch to cover about 60% of the long waiting wait list, so in parallel it will be important to progressively review the data, fine tune the order in which we book and move the long waiting patients through.

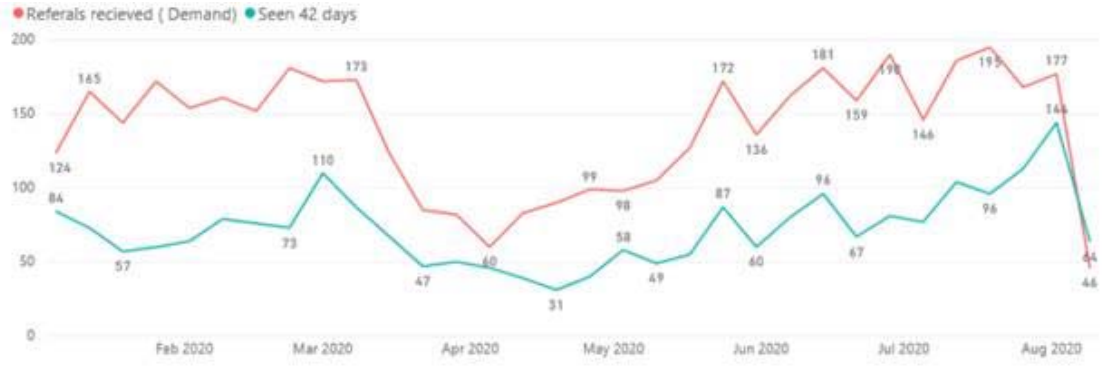
13. MEDICAL IMAGING DIAGNOSTICS

The following extracts from Power BI demonstrate that the volumes received (demand) has climbed steadily since COVID in April. Volumes seen have also climbed, steadily, however, assisted by a small sum of one-off recovery money that we applied for from the Ministry and received ($211k).

14. COMPUTED TOMOGRAPHY (CT) SUPPLY AND DEMAND



15. MAGNETIC RESONANCE IMAGING (MRI) SUPPLY AND DEMAND



The performance of the modalities against the 42 day elective target from the Ministry has slowly but steadily increased. CT performance was 51.8% in April, but had improved to 65.58% by July. MRI performance had dropped to 26.32% during April (COVID lockdown) but had improved to 45.54% by July. And Ultrasound performance had dipped to 42.6% in April but had improved to 50% by July.

The radiology team has advised that two of the Medical Imaging Technologist (MIT) staff required for the new CT initiative have now been hired and will commence at the end of August. Following orientation, the team envisages being able to run extra elective sessions which will enable 20 additional patients per week to be scanned from mid-September). The full CT initiative will be implemented as the remaining staff (particularly the Registrar) are hired and commence in the roles over the remainder of the year. Opportunistic use of the Spec CT machine for additional scanning is already occurring, and as the MIT and nursing staff settle into the new positions we will progress towards the additional sessions that were outlined in the CT business case.

The additional outsourcing that was made possible with the modest additional Ministry of Health funding for June and July has not made a significant difference to the numbers waiting, as demand has risen steadily (per the previous notes). However, there has been a pleasing reduction in the average wait times. MRI Dunedin average wait times have decreased from 65 days (May) to 49 days (July), whilst CT Dunedin wait times have decreased from 63 days (May) to 50 days (July). The change for both Dunedin and Southland is per the following table.

	May 2020		**June 2020**		**July 2020**	
	Electives waiting and (Planned)	**Median wait time Electives (days)**	**Electives waiting and (Planned)**	**Median wait time Electives**	**Electives waiting and (Planned)**	**Median wait time Electives**
MRI Dunedin	728 (495)	65	710 (487)	75	724 (477)	49
MRI Southland	346 (333)	59	258 (250)	62	182 (257)	32
CT Dunedin	816 (604)	63	819 (604)	71	806 (637)	50
CT Southland	96 (366)	27	209 (374)	12	165 (345)	17

Unfortunately, after month end the MRI in Dunedin failed and while the supplier was onsite promptly to attempt to repair it the parts required has meant that it will be out of action for approximately two weeks. We are working with both Pacific Radiology Group and with South Canterbury DHB to mitigate this, but it will unfortunately have a negative impact on performance next month.

16. ED PERFORMANCE – ED 95% 6 HOUR TARGET

We have been able to acquire a complete data set of ED attendances for both Dunedin and Southland dating back to 2015, so we have completed a more thorough investigation of what activity occurred during the COVID months and then subsequently as the hospitals returned to normal during June and July.

The following table shows the key ED volumes information for the months of April, May, June and July from 2015 to 2020. Prior to 2018 volume growth had been fairly static. However, in the April to July period from 2019 volumes had grown reasonably substantially on the prior year with 5% growth experienced in Dunedin and 4% growth experienced in Southland, respectively. This appeared to be borne out in the pressures being experienced in the ED last year.

Count of NHI	Month				
Hospital	Apr	May	Jun	Jul	July YOY % Chg
Dunedin Hospital	21,315	22,608	21,913	23,977	
2015	3,589	3,829	3,700	4,147	0%
2016	3,885	3,928	3,719	3,991	-4%
2017	3,850	3,786	3,724	3,939	-1%
2018	3,785	3,909	3,586	3,834	-3%
2019	3,921	4,104	3,775	4,185	9%
2020	2,285	3,052	3,409	3,881	-7%
Southland (Kew) Hospital	17,420	18,505	18,421	18,897	
2015	2,908	3,081	2,858	3,045	0%
2016	3,004	3,033	3,026	3,024	-1%
2017	3,030	3,072	3,169	3,173	5%
2018	3,153	3,323	3,082	3,183	0%
2019	3,356	3,334	3,341	3,245	2%
2020	1,969	2,662	2,945	3,227	-1%

Dunedin Hospital

April 2020 vs April 2019	42%
May 2019 vs May 2020	26%
June 2019 vs June 2020	10%
July 2019 vs July 2020	7%

Southland Hospital

April 2020 vs April 2019	41%
May 2019 vs May 2020	25%
June 2019 vs June 2020	12%
July 2019 vs July 2020	1%

Dunedin Apr-Jul Growth 2019 vs 2018	871	5%
Southland Apr-Jul Growth 2019 vs 2018	535	4%

As noted previously, due to COVID, during April and May a reasonably large proportion of our regular ED activity did not arrive – in Dunedin our volumes were down 42% compared to the previous April, and 26% compared to the previous May. Volumes continued to be down (by 10%) compared to the previous June, too, and even in July volumes are down (by 7%) compared to July of the previous year. Despite lower volumes (year on year) in July, the total numbers admitted onto the ward increased from 926 to 958 year on year (3%), which is reflected somewhat in the busyness pressure that has been reported back to us by the inpatient teams during July and subsequently into August.

However, the picture for Southland is subtly different. April was down 41% compared to last year, May was down 25% and June was down 12%. However, July

has been very busy and is within 1% of regular ED volume. Unfortunately the admitted numbers for Southland do not appear to have been coded correctly, which prevents us from gaining an accurate picture for how much of the Southland ED busyness led to a year on year growth in ED originating presentations onto the ward.

Another interesting observation is that the age of ED attendances appears to have increased. Using the July month, in 2019 the overall average age of attendance was 41 years, for 2020 the overall average age of attendance is 43 years. This is also evident in the median age of attendance, which was 37 years for July 2019 (across both hospitals) and is 40 years for July 2020. This warrants further investigation and we will drill into this as part of our ongoing ED analysis.

Average of Age at Admission	Month	
	2019	2020
Hospital		
Dunedin Hospital	41	43
Southland (Kew) Hospital	40	43
Overall Average	**41**	**43**
Median Age	**37**	**40**

There was a 5% reduction in European presentations at Dunedin Hospital when July 2019 and July 2020 were compared, but a 15% reduction (345 in 2020 versus 402 in 2019) when Māori presentations were compared. We will pass this along to our colleagues in the Māori Health Directorate to determine whether this is significant enough to warrant further investigation. There was no notable reduction in either ethnicity in Southland.

Our final brief piece of analysis is perhaps the most interesting. When comparing July 2020 with July 2019, in Dunedin there has been a slight decrease in the time spent waiting for a doctor after having been triaged (4 minutes), but this is essentially offset by a longer wait before being discharged (a 14 minute increase) with a longer overall wait time between triage and discharge.

In Southland, however, there appears to have been a significant reduction in the time spent waiting for a clinician (29 minutes), and the overall time spent waiting between triage and discharge (51 minutes). Unfortunately, the month of July by itself is not a comprehensive data set to draw comparisons from (and we can't compare a greater number of months because of the anomalies caused by COVID). However, the outward indications are that the work we have heard about to review and treat patients more quickly in Southland appears to be producing results.

Average Patient Wait to See a Doctor and Average Patient Wait from Triage to Discharge by Site

	Month	
	July Months	
Hospital	Average of TriageToDrSeen	Average of TriageToDischarge
Dunedin Hospital	**114**	**273**
2019	116	266
2020	112	280
Southland (Kew) Hospital	**77**	**246**
2019	92	272
2020	63	221

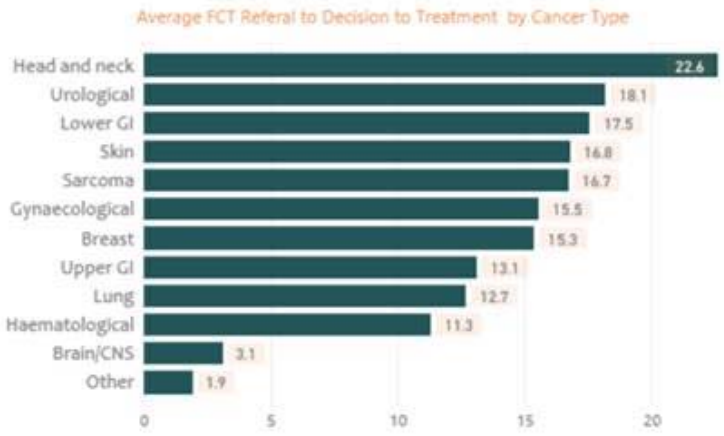
Dunedin Dr wait 2019-2020	**-5**	**-4%**
Triage - Dischg 2019-2020	**14**	**5%**
Southland Dr wait 2019-2020	**-29**	**-32%**
Triage - Dischg 2019-2020	**-51**	**-19%**

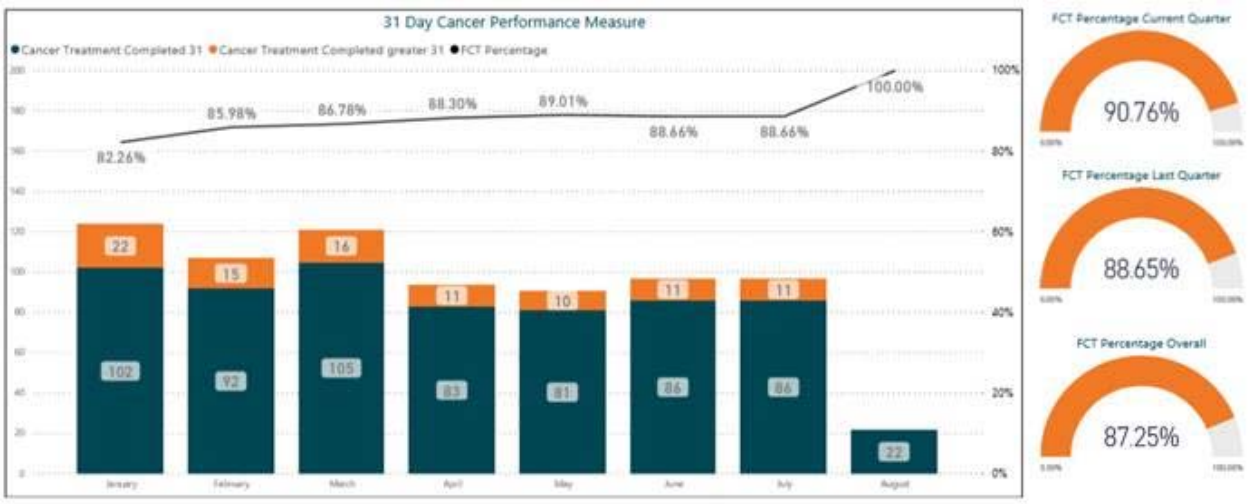
- There are a number of ED initiatives now underway, with the aim of improving ED performance.
- In Dunedin the General Manager Operations and the Chief Medical Officer are leading a piece of work to improve escalation criteria that will lead to faster patient reviews and decision making).
- In Southland the Executive Director Specialist Services is initiating a small working group comprising of the General Manager, Director of Nursing and relevant clinical leaders to systematically improve ED performance against the 6 hour target, with the objective of determining a work programme that would systematically shift ED performance to achieving 90% against the 6 hour target within two years and 95% within four years.

The Southland initiative is likely to involve a combination of maintaining rapid assessment and discharge / admission, reducing ED volumes at the front door and a combination of ED and assessment unit beds to cope with peak volumes (which occur regularly) in ED. The clinical teams are signalling that it is crucial that we improve conditions in the ED in Southland and we will carefully investigate and then make appropriate cases for the improvements that are required. In a similar manner to Dunedin, assessment unit capacity is likely to most positively impact on the ED 6 hour target, i.e. if patients are discharged from the ED, admitted into an assessment unit and are then under the care of a specialist their flow through the ED will be improved. Our working group will carefully explore the type of capacity that will make the best improvement to flow, will develop an appropriate case which takes into account the capital and operating requirements of the solution and will then promote the proposed solution (once identified) at an appropriate level of priority for future investments (when considered alongside secondary care and the wider organisation's other investment priorities).

17. ONCOLOGY 31 DAY TARGET (85%)

The oncology 31 day measure is the time from when cancer is from decision to treat until the first treatment has occurred. Our dashboard has now been completed in first draft and an interesting snapshot is as follows:





Some high level observations from the dashboard:

- The average wait for each tumour stream is less than the 31 day target (from diagnosis to treatment). Head and neck have the longest average wait, but these are very low volumes. The urological cases have a relatively long average wait and a relatively high number of cases. The most common first treatment is surgery (approximately 75% of first treatments is surgery).
- Of those waiting treatment the majority category – urological - has 40% of those awaiting treatment also waiting on a CT scan, which underscores the importance of getting the CT capacity established as quickly as possible.
- Of those who missed the deadline, approximately 84% were waiting on surgery, and of those, the majority category (38%) were waiting on urological surgery.

Overall, performance is tracking at 87.25% (performance to date during the current reporting period), which is over the 85% target.

Having this information presented to us in this manner has given us some powerful insights. For example, by working between the urological speciality and medical imaging to try to get long waiting urological scans completed more quickly, we will be able to improve the overall 31 day waiting times even further. This information also helps to validate our proposal to the Ministry that urological surgery be one of our focal areas for planned care wait list improvement planning / recovery purposes.

Our radiation oncology wait list has drifted up and we now have in the region of 90 patients on our wait list waiting for an FSA (pre-COVID we were over 100 but during COVID we managed to get this down to circa 60). We are working on the following initiatives:

a. Hiring another trainee registrar to provide us with additional capacity, whilst we await the appointment of a sixth radiation oncologist.

b. Progressing with initiatives that we were considering pre-COVID to undertake GP led follow up clinics and to run additional clinics.

A review of the relevant dashboard suggests that during COVID demand remained relatively steady at circa 20 FSAs accepted per week. However, also during COVID with the high availability of Radiation Oncologists we were able to see in the region of 22 FSA referrals per week. Since the start of June demand has remained relatively

steady, averaging about 21 referrals per week. However, we have only been able to maintain an average of 17 FSAs seen per week, which has led to the upward drift of the FSA volumes.

18. GASTROENTEROLOGY

The gastroenterology team have worked hard to catch up the backlogs caused by COVID and at the time of writing the urgent (14 day target) and bowel screening (30 day) volumes are up to date and we are achieving this target. The non-urgent (42 day target) volumes are also up to date and we are also very close to achieving this target. This is across both sites and is a great achievement when we consider that during COVID lock down scoping had to be halted. Further work is occurring to catch up on the 84 day (surveillance) target. Bowel screening, urgent symptomatic and non-urgent symptomatic patients have broadly been prioritised over surveillance as there is a much higher likelihood that a cancer or other sinister pathology will be found in these groups.

A dashboard is under construction which will be available in the next HAC reporting cycle. The dashboard will demonstrate the following performance:

- Performance against the 14, 42 and 84 day Ministry measures split by site (Dunedin and Southland) but also with the ability to consolidate.
- Performance against the national bowel screening measures.
- Average and median wait times by category (14, 42 and 84 day targets).

In the meantime, the following chart has been developed manually, which shows performance against the 14, 42 and 84 day targets and average and median wait times in each of these categories (urgent, non-urgent, surveillance).

Average, shortest and longest wait, together with numbers of patients by category as at 2 August 2020

	Dunedin					Southland				
	NBSP	A (14)	B (42)	C (84)	Surveillance	NBSP	A (14)	B (42)	C (84)	Surveillance
Average	24	8	32	32	105	21	11	40	110	159
Shortest	2	4	3	3	1	2	5	3	3	1
Longest Wait	152	11	158	75	294	174	26	178	234	388
Patients	26	4	79	68	318	18	4	40	74	394

Ministry of Health colonoscopy waiting time indicators (district)

Urgent (14 days)	92% (target 90%)
Non-urgent (42 days)	66% (target 70%)
Surveillance (84 days)	36% (target 70%)

19. MENTAL HEALTH, ADDICTIONS AND INTELLECTUAL DISABILITY (MHAID)

Smokefree

Clinical staff remain proactive in working with people to maintain a smokefree environment. We have one client who is unable to comply with smokefree restrictions. A case conference was held including Dr Hayden McRobbie and smokefree coordinators to identify strategies to support the patient to not smoke in

bedroom or on grounds. There are significant health and safety and fire risks for this patient and others.

Independent Review of the Southern Mental Health and Addiction System Continuum of Care

Work continued preparing the procurement papers for release in early August. The review terms of reference were further updated during July and finalised in early August. The steering group for the review is currently being put together.

Ward 10A

Registered nurse vacancies and acuity continue to have a significant impact on service delivery in Ward 10A. A high proportion of the double shifts within the Directorate have been in this ward due to the vacancies and the number of patients on 1:1 care due to acuity and risk. The health and safety issues related to this additional work are closely monitored and plans are being developed to manage the situation on the ward. In response to these issues the beds on the ward have been capped at nine (usually 12), except for admissions required under the Intellectual Disability (Compulsory Care and Rehabilitation) (IDCCR) Act. This is reviewed on a weekly basis. The physical environment exacerbates the situation on Ward 10A and staff work hard to manage issues with a number of strategies. This situation is expected to improve with new staff coming on board in August.

Sole Clinician Caseloads

Work continues to move from the current model of having a number of single clinician caseloads to a case management model. This change will require a number of work streams, which have been established and have been active during July.

Transition Plans

Improving compliance continues to be a priority for the MHAID Directorate with a significant improvement over the previous year. Compliance across the service has improved with open referrals longer than one year with three or more face to face contacts is 84% compliance, a significant improvement over the last year. We are advised that national compliance across all DHBs is currently 75%. The national target is 95%.

Compliance within the specialist teams in Otago has been sustained sitting at 82.7% across the teams. Work continues to reach the 95% target. Forensic Team compliance is impacted by the inclusion of prison liaison contacts, which don't require transition plans, but which impact on the data and Te Oranga Tonu Tanga is complicated due to kaioranga being intervention 2 and not required to complete plans, but compliance only at 20% – work is occurring to resolve this.

Compliance within the Adult (Otago) teams is continues to gradually improve with open referrals longer than one year still at 77% while referrals longer than three months with three or more face to face contacts sits at 54%. A separate project on the single clinician (SMO) only model continues and until this comes up with an alternative model. It will remain a challenge to improve the Adult service compliance significantly.

Southland teams continue to focus on plans and understand the rolling nature of the target, i.e. new people who come due to have a plan completed. There has been an increase in compliance by Specialist Addiction teams which is aiding a steady gradual overall improvement. Compliance is currently 81% with a focus on working with individual clinicians who are outliers to improve performance overall.

Rural Child and Youth SMO Cover

Work continues to finalise Consultant Psychiatrist cover for the Central Lakes team. While a resolution appears in sight this does have flow on effects for other rural teams, which is now being worked through. The Operational Leadership Team has supported Dr Garcia's proposal for increased use of telehealth in the rural Child and Youth teams and a meeting was held with rural Child and Youth clinicians seeking feedback. The date for feedback has closed and it will be collated and reviewed prior moving forward.

Specialist Addiction Services

Increasing workloads and staff gaps have contributed to significant capacity concerns at the Specialist Addiction Service (Otago). Contributing factors include high opioid substitution treatment (OST) caseloads (currently 430 for specialist prescribing when contracted for 238 places), a focus on maintenance OST rather than dose reduction, alcohol and other drug (AOD) acceptance criteria including those with low need contributing to average caseloads of about 50 and staff absences caused by sickness and resignations. A meeting is arranged with the team early August to work through these issues with an initial focus on managing service entry to facilitate a review of processes for flow through the service and closer engagement with other providers.

20. REFUGEE HEALTH

For Quarter 4 of 2019/20 there were a total of 896 refugees requiring 1,016 appointments across all health services within and beyond the DHB. Patient did not attend (DNA) occurrences for refugees remain lower than the general population (3% versus 9%). This is indicative of strong former refugee engagement with a health system that is new and quite different from their countries of origin. Further, most care is taking place in a community setting, either via Primary Care (44%) or Community Providers (22%).

Primary care is by far the most prevalent type of care being delivered to former refugees (35%). Due to pre-existent issues upon arrival in NZ, oral health is quite high (12%). ED (2%) and Inpatient (1%) are highly favourable, suggesting that care requirements are being met in the community setting. Outpatient – DHB (15%) and Outpatient – Community Providers (4%) reflect Outpatient services not otherwise specified by other noted types (e.g., oral health, mental health, diagnostics, etc.).

As part of the Southern DHB Refugee Health Programme, a total of 6,705 health appointments were provided to former refugees resettling in Dunedin and Invercargill.

The DHB partners with WellSouth in the provision of primary health services that financially support GP access, pharmaceuticals, face-to-face interpreters and health navigators who assist in refugee integration and who are also able to identify and address any pathway access issues encountered by refugees. The DHB also contracts with the University of Otago Dental School in addressing the oral health issues that former refugees often suffer from.

Southern DHB invests in packages of care in mental health so that former refugees can receive support for trauma experienced offshore that would have typically been covered by ACC if such trauma took place in New Zealand. As indicated above, mental health was the third most frequently utilised service within the refugee health programme (11%) for Quarter 4. Other services remained relatively static in engagement across the year. This indeed suggests the success of the programme,

as service utilisation for ED, paediatrics and inpatient hospital stays are markedly low, especially for a population that is understood as being vulnerable.

21. CARE CAPACITY DEMAND MANAGEMENT (CCDM)

Please find attached as Appendix 1 the CCDM National Implementation Report for Quarter 4 2019/20.

The Director of the Safe Staffing Healthy Workplace (SSHW) Unit has noted that it is clear to see especially when comparing to 2019 that Southern DHB has improved the implementation considerably and is doing well to achieve the June 2021 target of full implementation.

22. SOUTHERN BLOOD AND CANCER SERVICE

Nursing Structure and Future Nursing Model

The Southern Blood and Cancer Service (SBCS) nursing structure and future nursing model was presented to the Chief Nursing and Midwifery Officer and Director of Nursing recently. SBCS has structured education programmes for all nurse coming into oncology as well as registered nurse and senior nurse development roles. In addition, data on satellite sites activity, in particular Southland Oncology role comparisons, was presented. What this demonstrated was a consistent structure.

When considering respective workloads across the district including Invercargill, Balclutha, Dunstan and Oamaru – Invercargill has a growing number of medical day stay patients; Dunstan numbers for a two day service are very high and possibly pose a risk to staff and patients and Dunedin has been extremely busy during July. The second part of this discussion was future workforce requirements and when a comparison was made between registered nurse prescribers, clinical nurse specialist +/- prescribing and nurse practitioner roles using a matrix of time in service, academic requirements, credentialing, number of possible positions / timing, influence on nursing practice and cost. The service believes that registered nurse (RN) prescribers and clinical nurse specialist (CNS) roles offer the best service delivery and flexibility.

Māori Cancer Nurse Specialist

A meeting with the Māori Health Directorate leadership was held to discuss the need for Māori Cancer Nurse Specialist which would be funded by the Māori Health Directorate and sit within SBCS. The position description is being further developed prior to a wide consultation process for the role. The key purpose of the role is to better support equitable health outcomes for Māori as well as system change and quality improvement.

SBCS Telehealth/Videoconference clinics

These are underway in Invercargill with an RN in the clinic room with the patient. They complete any hands on clinical assessment, provide patient information and complete referrals to hospice, social worker or counselling as required. This RN closes the appointment and discusses any issues or questions with the SMO and documents this in MOSAIQ. Appears to be working well, with positive feedback from patients. FSA appointments are rolling out next week. Patients appreciate not having to travel to Dunedin. Next step is to have the patient in their home, the RN in Invercargill and the SMO in Dunedin which Dr McLaren is keen to pilot.

23. PATIENT SAFETY NURSING AND MIDWIFERY LEADERSHIP ROUNDING

Nursing Leadership Patient Safety Rounding has commenced and this will be a regular activity involving the Director of Nursing, Charge Nurse Manager, Associate Charge Nurse Manager and Ward Educator. The associated Service Manager and the Releasing Time to Care Charge Nurse Manager will also be invited. The focus of the rounding is patient safety so there will be a deep dive into individual patient care based on common nursing sensitive indicators of safe care, early warning score, pressure injuries, falls, and delirium, dehydration, and urinary tract infections. A meeting was held with the Quality Improvement and Patient Safety teams to discuss data and reporting so that we are all using 'one agreed source of truth' to measure improvement. In addition to this the Directors of Nursing have all been spending a significant amount of time looking Safety1st incidents and working through specific themes within their areas to prioritise improvement efforts.

24. HARTI HAUORA PROGRAMME (ASH PROJECT)

The Associate Māori Health Strategy & Improvement Officer – Secondary/Tertiary is involved in the implementation of the Harti Hauora Programme which continues to progress well. WellSouth PHN has contracted Awarua Whānau Services to employ a Kaiawhina (Deli Diack) who is working with Māori whānau in the Children's Ward at Southland Hospital to implement the programme. The Kaiawhina role is working closely with the Respiratory CNS Nurse, hospital staff and the RN from Te Huinga Tahi to implement the Harti Hauora Programme and better understand why their child/children 0-4 years with respiratory conditions have multiple hospital presentations and admissions and support whānau to find positive solutions to address this.

25. TE RAUTAKI MANAAKI MANA STRATEGY - EXCELLENCE IN EMERGENCY CARE FOR MĀORI

The Māori Health Directorate is working with the Emergency Departments in Dunedin and Southland on the Te Rautaki Manaaki Mana Strategy 2019-2021. The focus of the strategy is to provide excellent, culturally safe care to Māori, in an environment where whānau and staff feel valued and where we actively seek to eliminate inequities. The intention is to support Southern DHB Emergency Departments to develop a localised implementation plan using the framework of Pae Ora (healthy futures for whānau); Mauri Ora (healthy individuals); Whānau Ora (healthy whānau) and Wai Ora (healthy environments). ED staff and consumers will be involved in the development of the plan with some actions specific to their own workplace environment, prior to implementation.

26. PATIENT/WHĀNAU CONTINUUM OF CARE – CARDIOLOGY SERVICES

The Māori Health Directorate is working with WellSouth (Outreach Service) and Māori Health Providers to better support patient/whānau journey through the Southern health system. The aim is to ensure patients/whānau are well informed and supported in decision making and navigation of health through community, primary care and hospital services that results in reduced hospital admissions. We have engaged with the hospital cardiology services through the Planned Care pathway, to identify what Māori workforce is required to support hospital staff and whānau receiving cardiology services. Māori Health Provider clinical and Whānau Ora navigators, WellSouth Outreach Nurses, Māori Health Directorate Kaiawhina will meet with the Cardiology team and identify gaps in workforce and map the patient continuum of care through community, primary care and secondary care Cardiology

Services. This will be facilitated by the Māori Health Directorate. The intention is to work alongside Respiratory and Diabetes services also.

27. SOUTHERN CULTURAL EDUCATION PROGRAMME

Māori Health Directorate

Cultural Education team is progressing the Welcome Orientation, Online Mandatory Training, Opening of the Māori Resource Collection and Bicultural Competency Programme.

Welcome Orientation – Marae based

There has been considerable discussion on how this will be rolled out across the district during this time due to COVID-19 restrictions. In Southland, Murihiku Marae will host the first Marae based orientation commencing in October/November 2020. In Dunedin, we will continue with the Southern DHB Board room creating an environment that continues to reflect and strengthen tikanga commencing in October 2020. The intention is for Dunedin to move to a marae based orientation in 2021 when restrictions change for some Marae.

Opening of the Māori Resource Collection - Southern DHB Libraries

The Māori Health Directorate teams have been working with the Southern DHB Library staff to establish a Māori Resource Collection in both Dunedin and Southland Hospital libraries. Additional books and an online resource repository has been established along with taonga donated for the collection. We are very excited to celebrate the openings across the district with invitations sent to stakeholders, Rūnaka and Iwi in September 2020.

Bicultural Competency Programme

The Pou Taki Education team with support from the Kaumatua is progressing the development and implementation of the NZQA Level 4 Certificate in Bicultural Competency. Southern DHB intends to partner with the Otago Polytechnic for the programme which consists of four core modules: Tiriti o Waitangi; Cultural Safety; Cultural Humility and Te Reo in the Workplace. Each module has face to face and self-directed learning with moderators marking resources provided. The intention is to celebrate and launch the Bicultural Competency Programme October 2020.

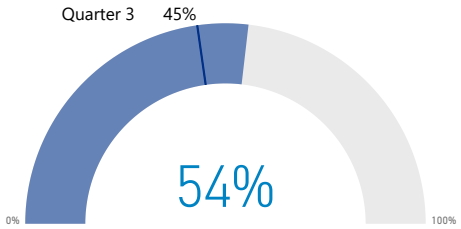
Chris Fleming
Chief Executive Officer

31 August 2020

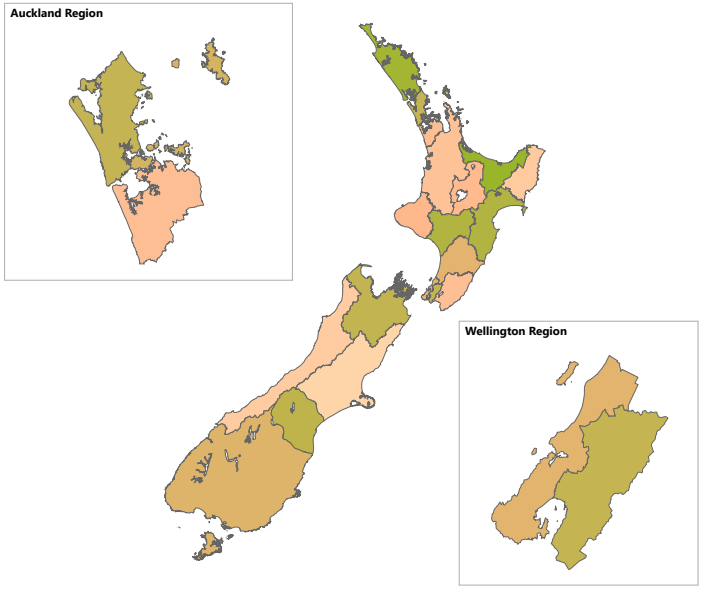
Care Capacity Demand Management (CCDM) implementation overall progression

Quarter 1 (July to September 2019) to Quarter 4 (April to June 2020)

1. Overall implementation as at quarter 4



2. Implementation heat map by DHB

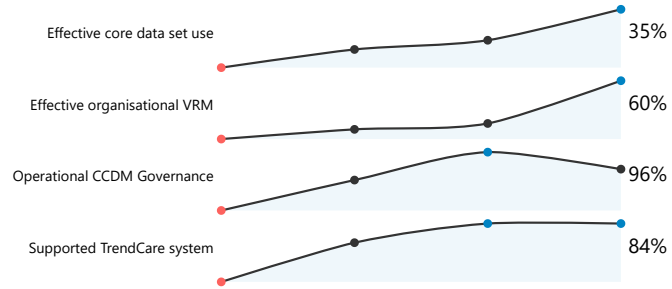


0% **25%** **50%** **75%** **100%**

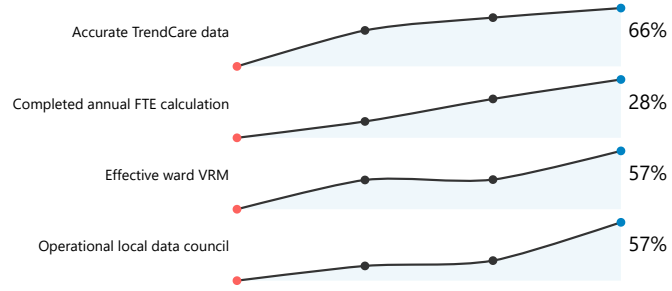
-Results approved for submission by each DHBs' CCDM council.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 28 July 2020.

3. Progress against all milestones

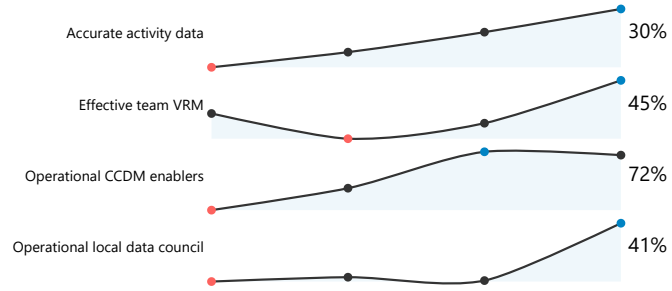
Site milestones progression as at quarter 4



Ward milestones progression as at quarter 4

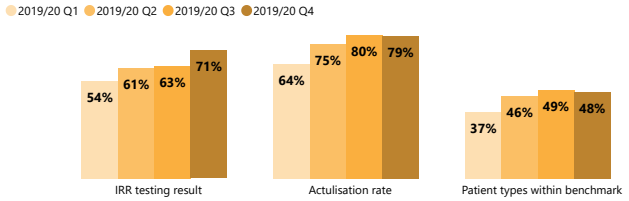


Team milestones progression as at quarter 4

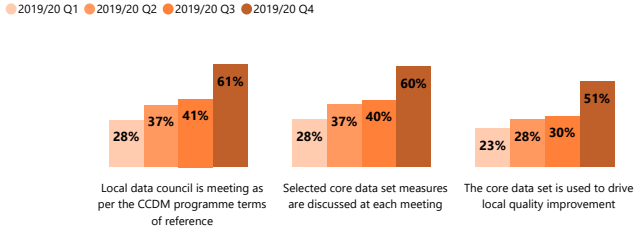


4. Breakdown of ward milestones

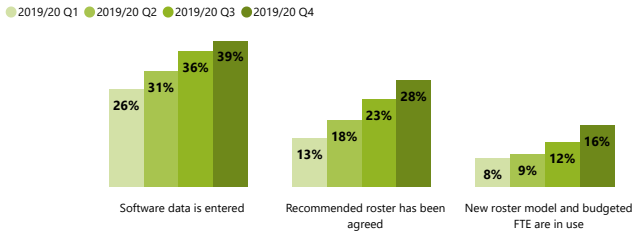
Accurate Trendcare Data



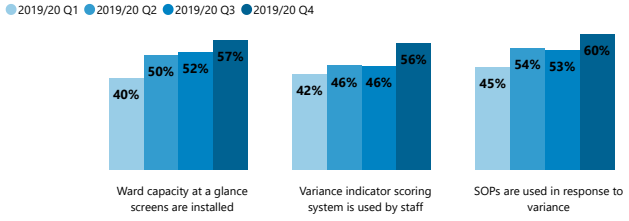
Operational Local Data Council



Completed Annual FTE Calculations



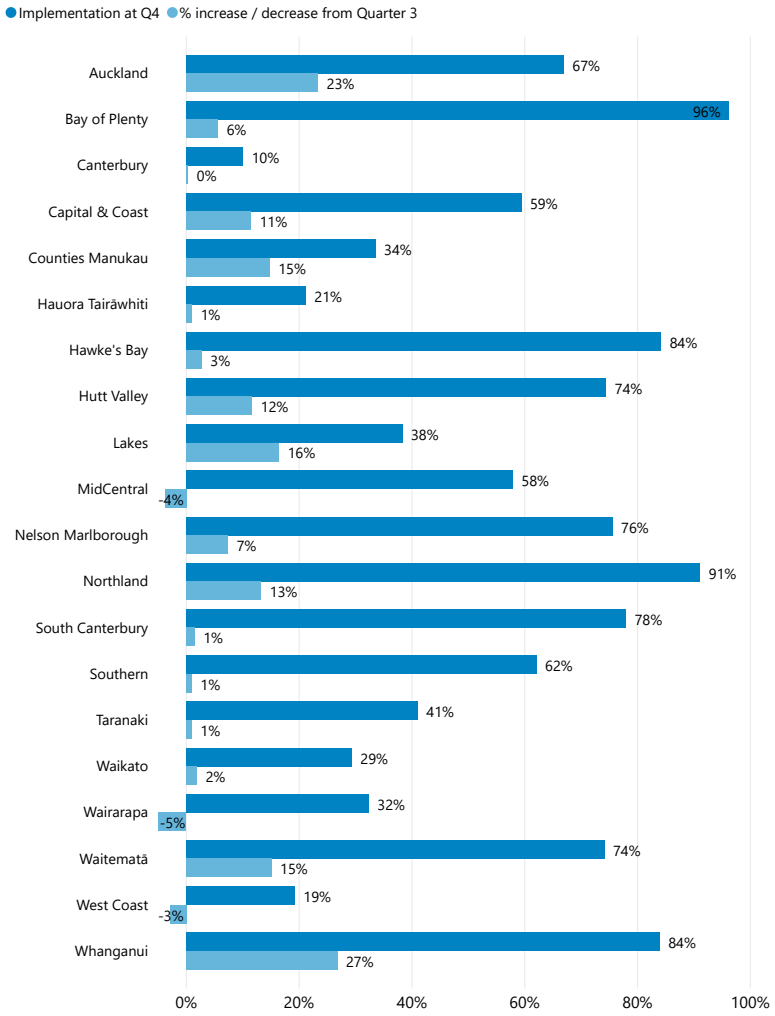
Effective ward VRM



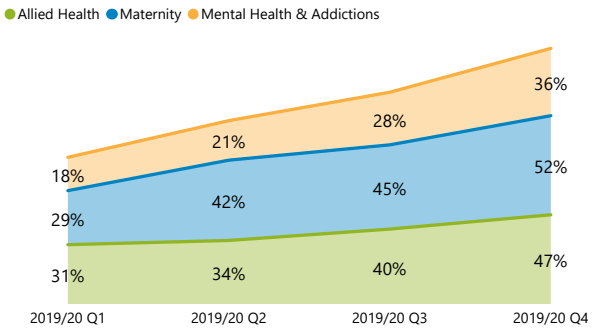
Care Capacity Demand Management (CCDM) progress by DHB

Quarter 1 (July to September 2019) to Quarter 4 (April to June 2020)

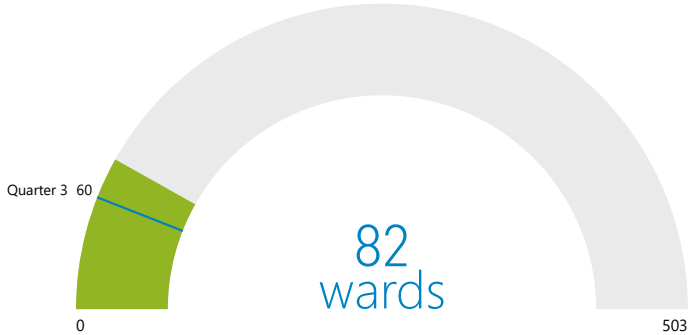
5. DHB implementation rate quarter 4



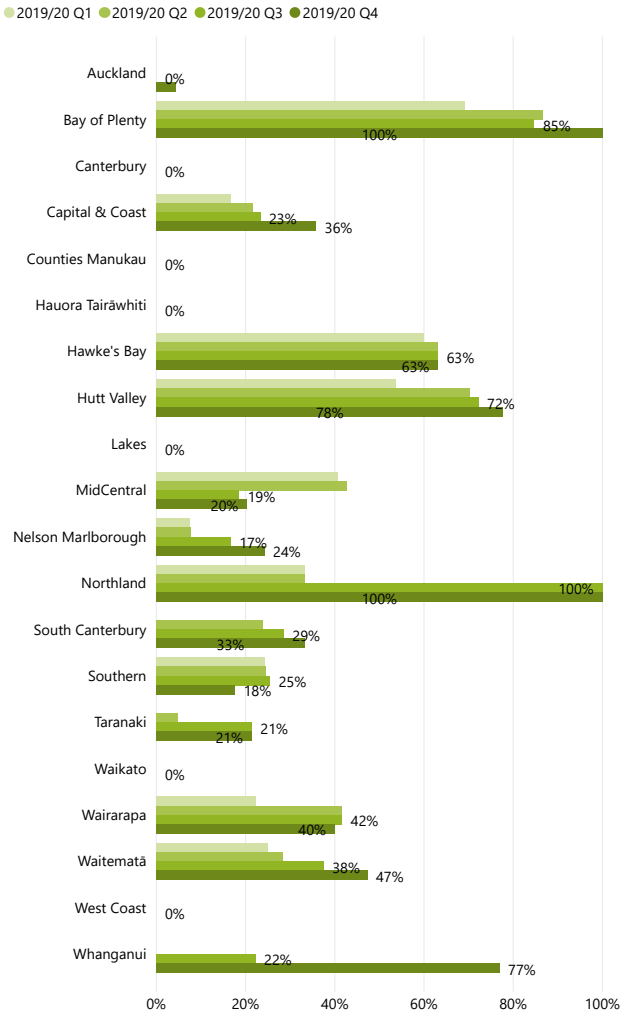
6. Progress in Allied Health, Maternity and Mental Health services



7. Count of total wards completed FTE calculations

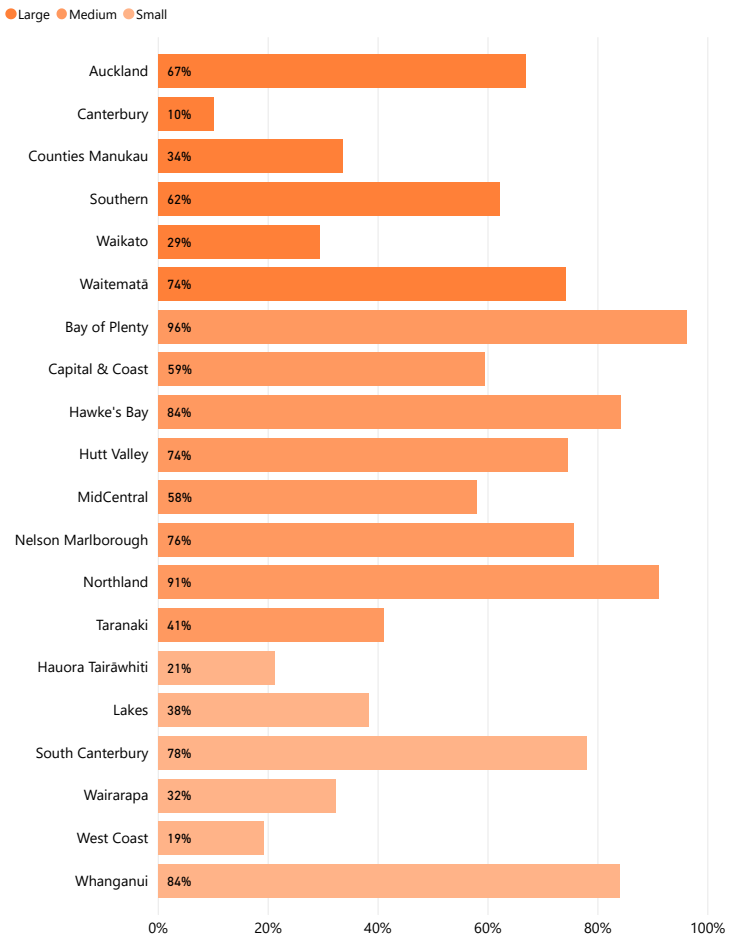


8. Progress with annual FTE calculation as at quarter 4



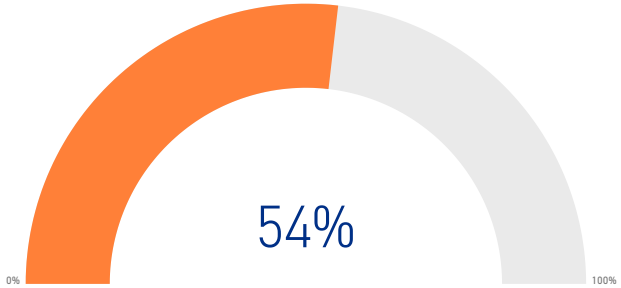
Care Capacity Demand Management (CCDM) Implementation April to June 2020 Quarter 4

1. DHB implmentation varies by DHB size

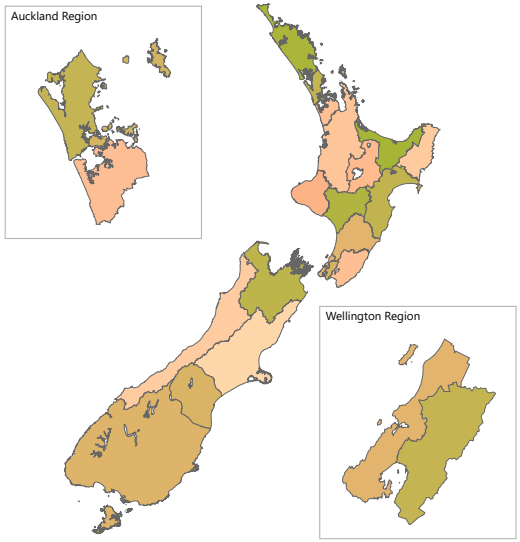


-Results approved for submission by each DHBs' CCDM council.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 28 July 2020.

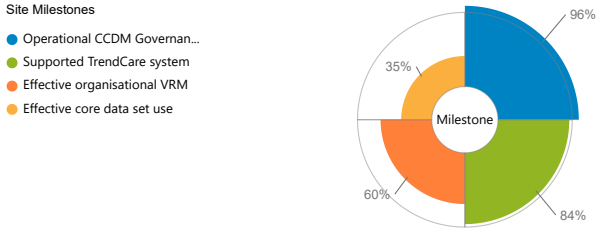
2. National implementation for all 20 DHBs is 54%



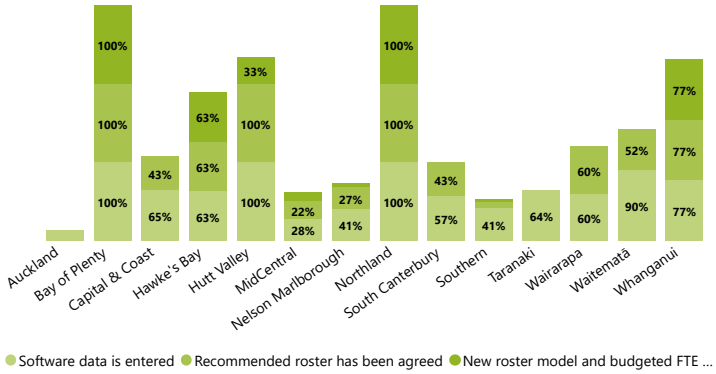
3. Implementation heat map by DHB



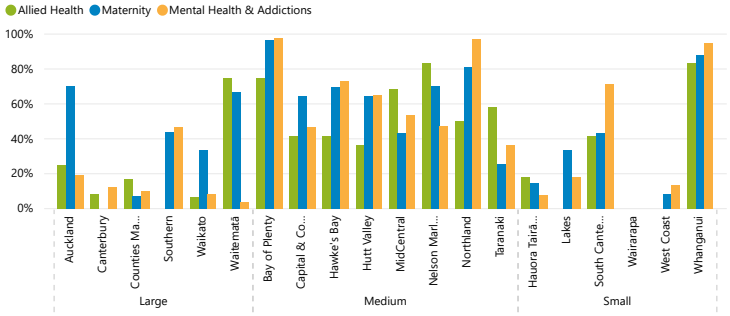
4. Milestone progression for Sites



5. 14 out of 20 DHBs are making progress with annual FTE calculations

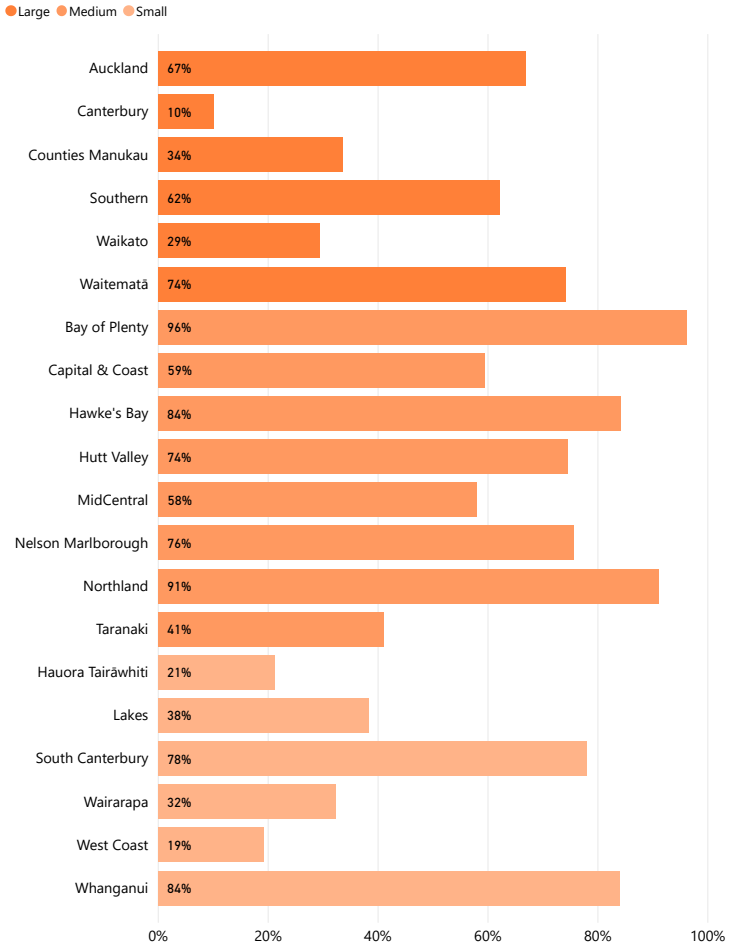


6. Allied health, Maternity and Mental health services are making varied progress across DHBs



Care Capacity Demand Management (CCDM) Implementation April to June 2020 Quarter 4

1. DHB implmentation varies by DHB size



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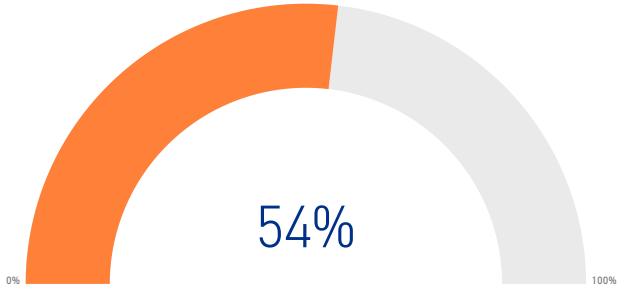
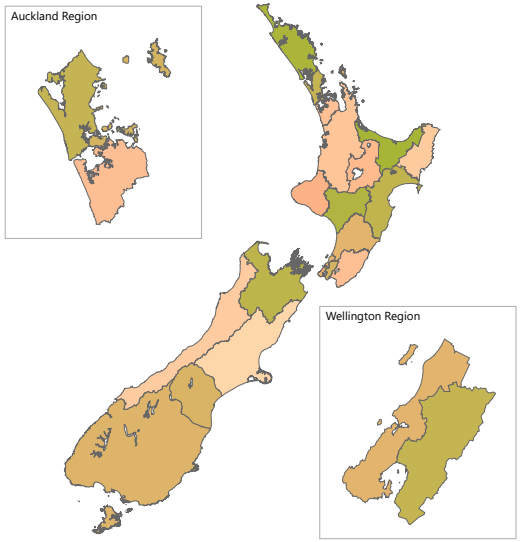
-Updated 28 July 2020.

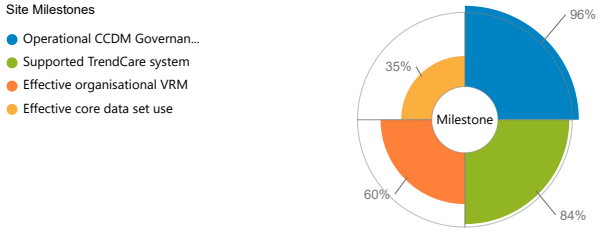
2. National implementation for all 20 DHBs is 54%



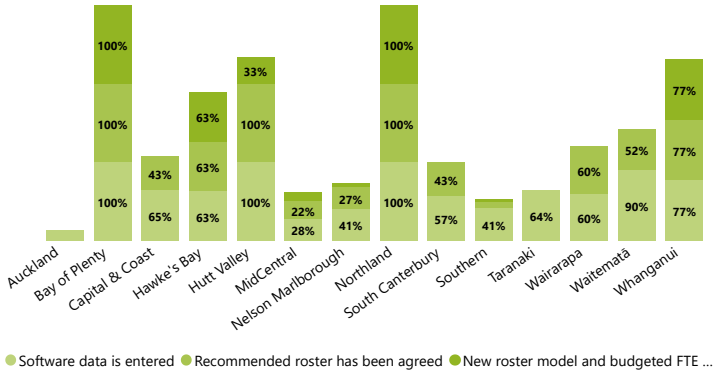
3. Implementation heat map by DHB



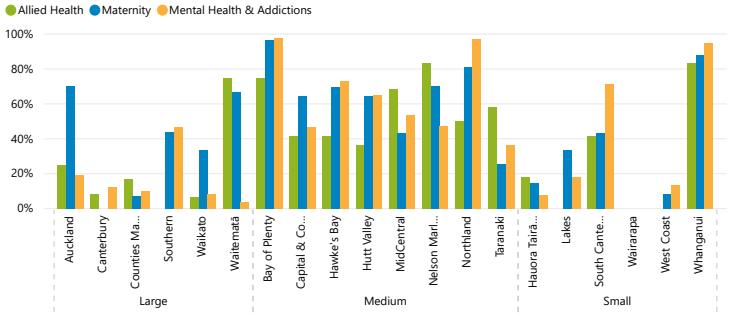
4. Milestone progression for Sites



5. 14 out of 20 DHBs are making progress with annual FTE calculations

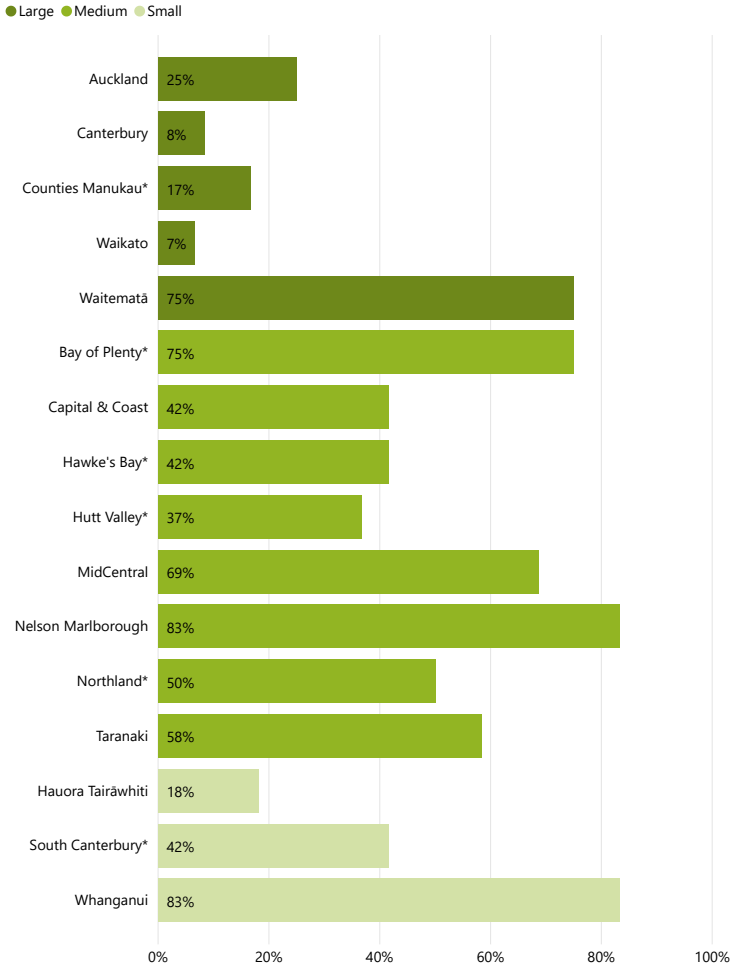


6. Allied health, Maternity and Mental health services are making varied progress across DHBs

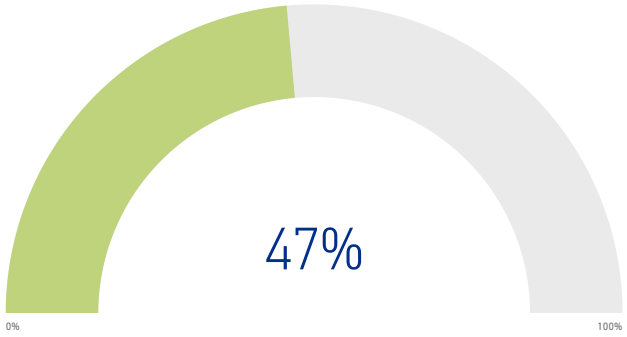


Allied Health CCDM Implementation April to June 2020 Quarter 4

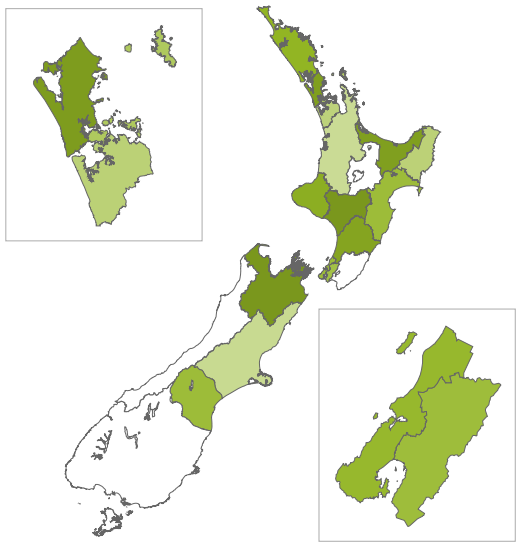
1. DHB implmentation varies by DHB size



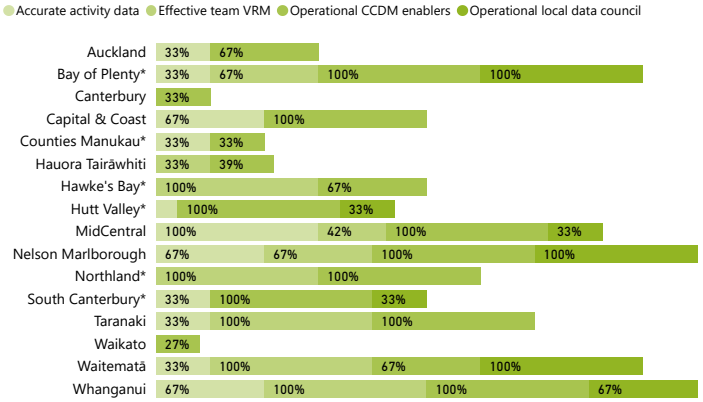
2. Allied Health implementation for all 16 DHBs is 47%



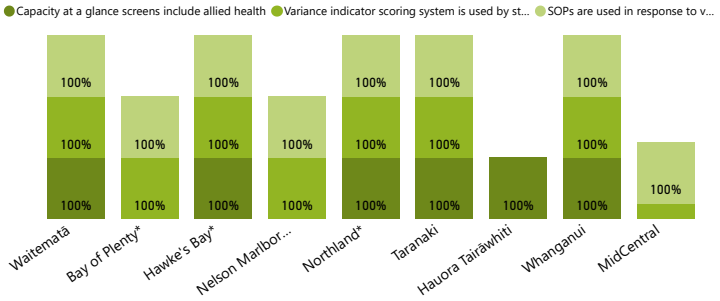
3. Implementation heat map by DHB



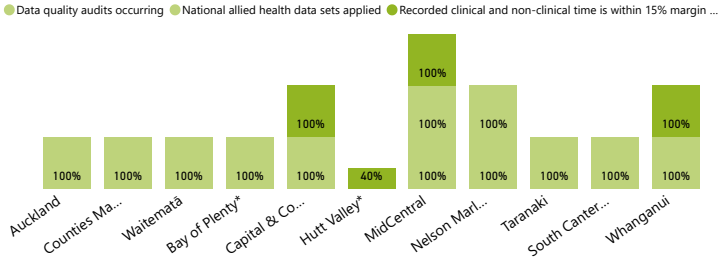
4. Milestone progression for DHBs (Allied Health)



5. 9 out of 16 DHBs are making progress with Effective team VRM



6. 11 out of 16 DHBs are making progress with Accurate activity Data

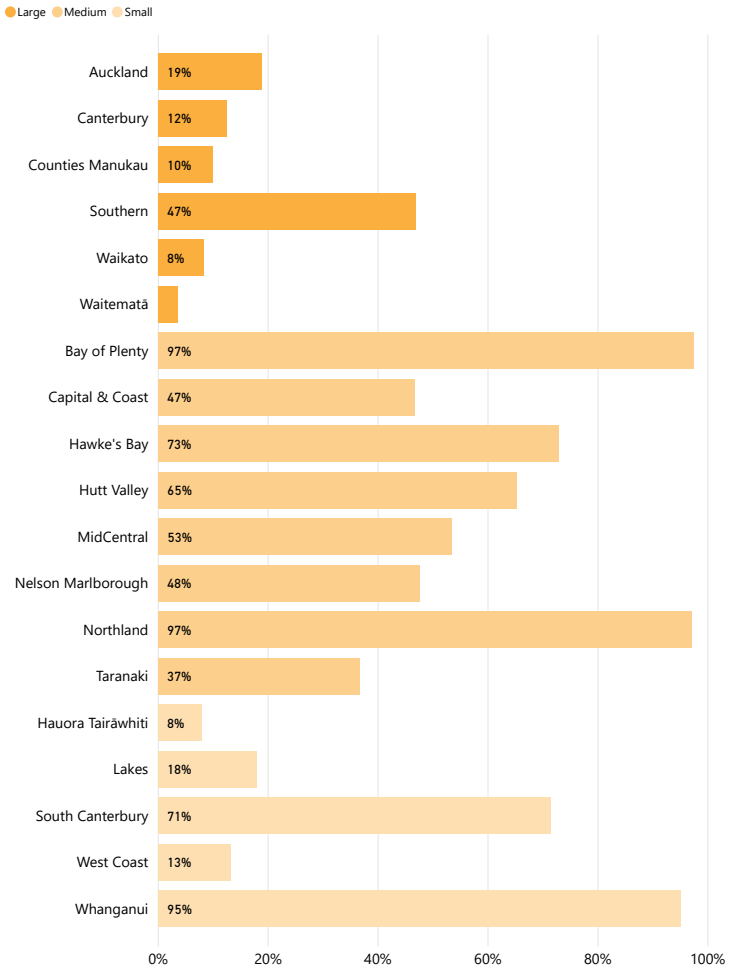


-Results approved for submission by each DHBs' CCDM council.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 28 July 2020.

9

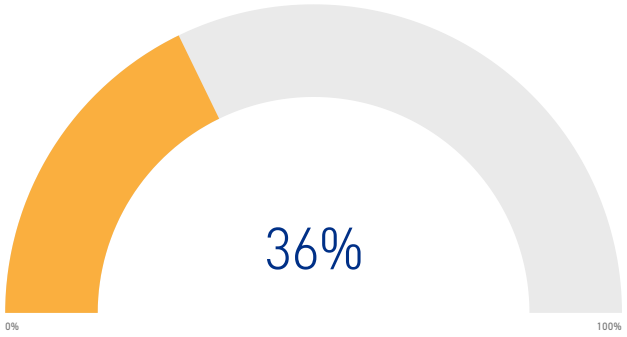
Mental Health & Addictions CCDM Implementation April to June 2020 Quarter 4

1. DHB implmentation varies by DHB size

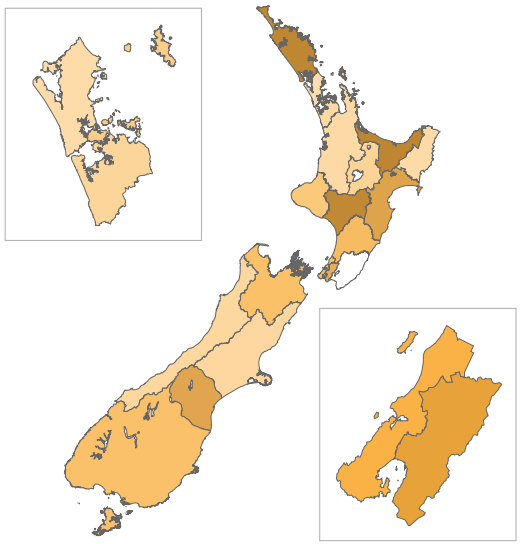


-Results approved for submission by each DHBs' CCDM council.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 28 July 2020.

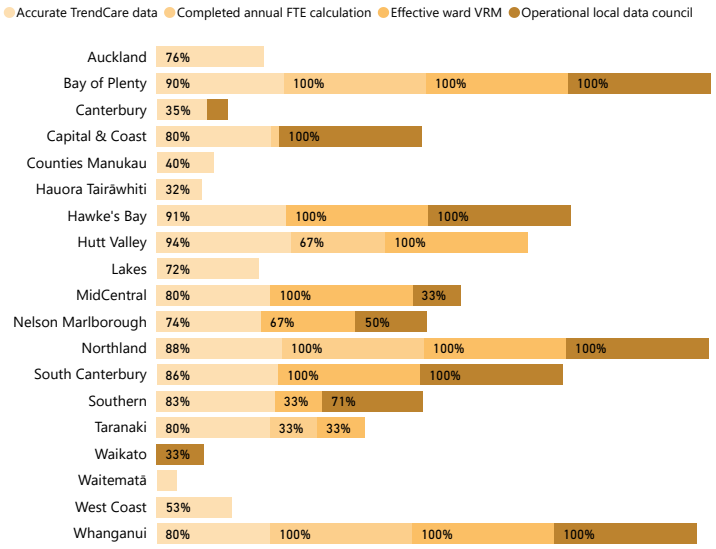
2. Mental Health & Addictions Implementaiton for 19 DHBs is 36%



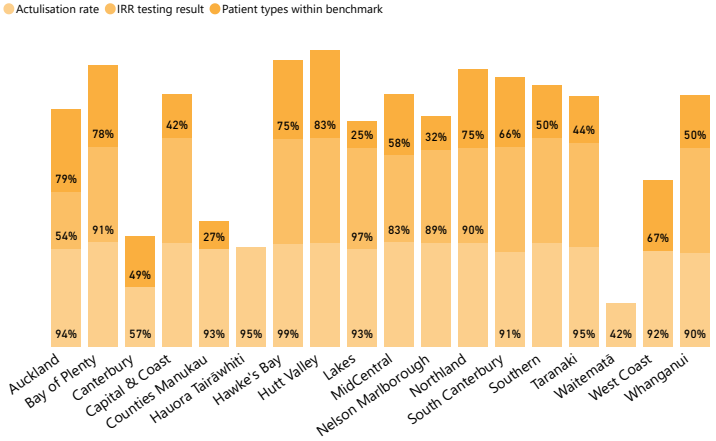
3. Implementation heat map by DHB



4. Milestone progression for DHBs

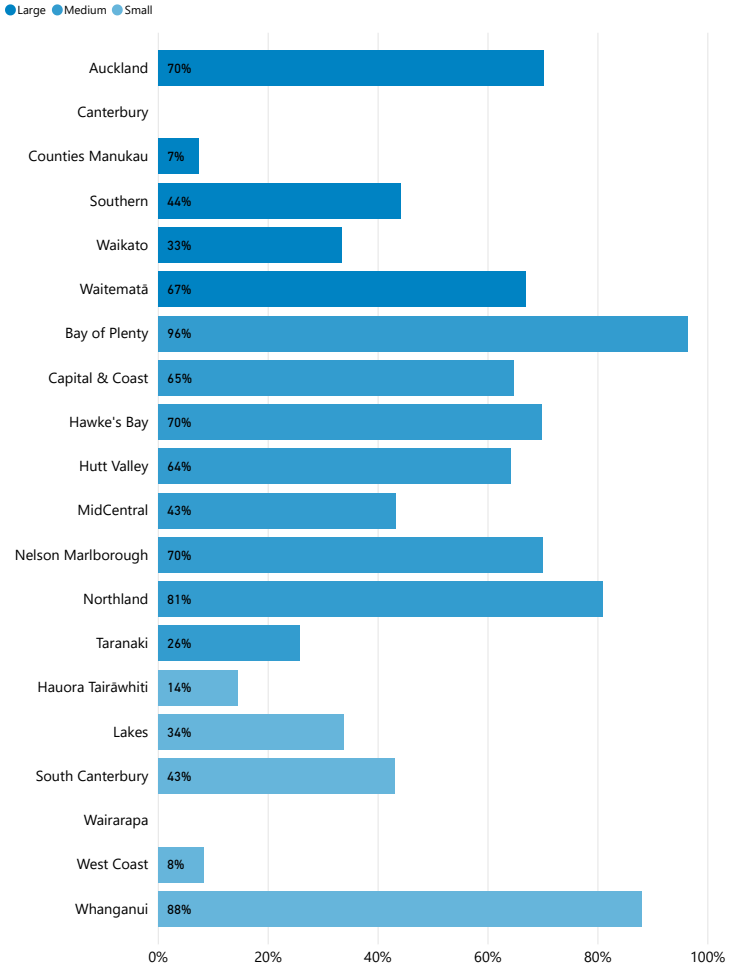


5. 18 out of 19 DHBs are making progress with Accurate TrendCare data



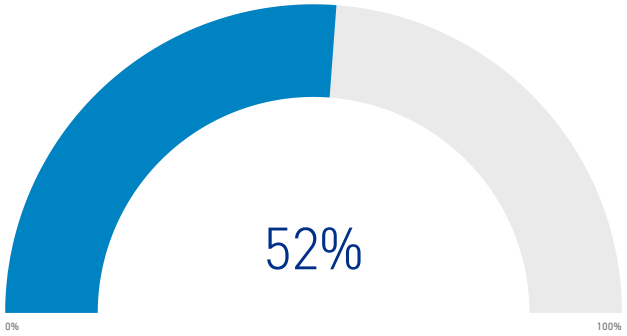
Maternity CCDM Implementation April to June 2020 Quarter 4

1. DHB implmentation varies by DHB size

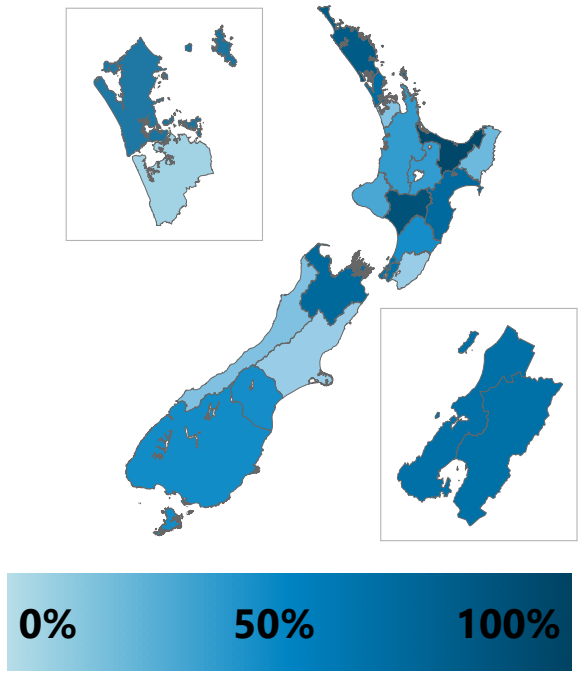


-Results approved for submission by each DHBs' CCDM council.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 28 July 2020.

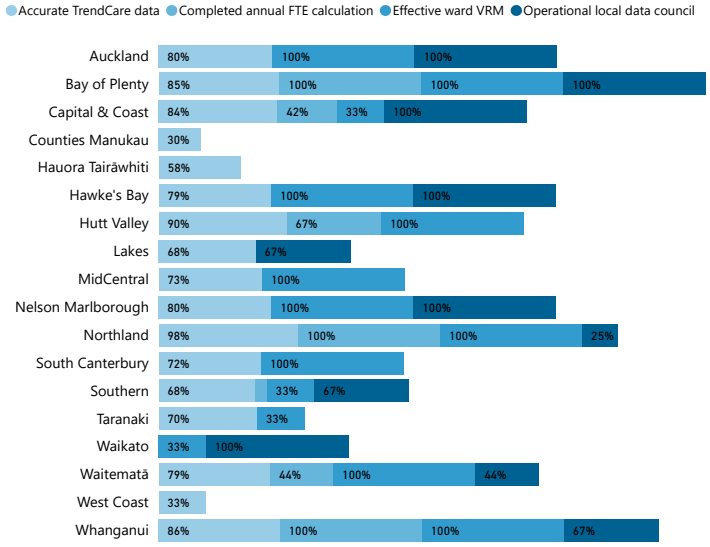
2. Maternity implementation for 20 DHBs is 52%



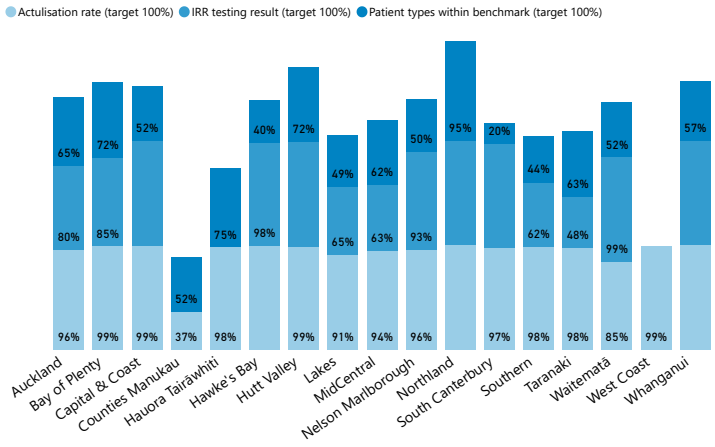
3. Implementation heat map by DHB



4. Milestone progression for DHBs (Maternity)



5. 17 out of 20 DHBs are making progress with Accurate TrendCare data



Southern DHB Financial Report

Financial Report for: 31 July 2020
Report Prepared by: Finance
Date: 13 August 2020

Report to Board

Period Ending 31 July 2020

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the month and period ending 31 July 2020.

The net deficit for the period ending 31 July 2020 was $1.9m, being $0.3m favourable to budget.

During July 2020, Revenue was $1.6m favourable to budget, mainly due to $0.7m COVID-19 'pass-through' funding and $0.5m recognised for the Recovery Plan. Workforce costs were $0.8m favourable to budget, predominantly reflecting the phasing of Leave Revaluation for Management and Administration at $0.3m. Clinical Supplies were $0.9m unfavourable to budget, reflecting the Recovery Plan activity for the month. Provider Payments were $0.7m unfavourable due to NGO 'pass-through' expenses for the response by Primary healthcare services to COVID-19.

Annual Leave continues to be a major concern as the workforce have taken minimal leave since the beginning of Alert Level 4. The focus is on how to enable our workforce to take leave and maintain momentum with the Recovery Plan and preparedness for COVID-19. Annual Leave taken, based on dollars, during July 2020 was 25% less than in July 2019, with 34% in SMOs, RMOs and Management & Administration Personnel and 12% less in Nursing Personnel. Nursing Personnel leave taken has not been as low in comparison to last July's leave due to most areas of Nursing rostering cover for employees on leave.

Financial Performance Summary

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

Month Actual $000	Month Budget $000	Variance $000			YTD Actual $000	YTD Budget $000	Variance $000		LY Full Year Actual $000	Full Year Budget $000
				REVENUE						
98,205	96,384	1,821	F	Government & Crown Agency	98,205	96,384	1,821	F	1,089,940	1,155,951
678	877	(199)	U	Non-Government & Crown Agency	678	877	(199)	U	11,047	10,528
98,883	97,261	1,622	F	*Total Revenue*	98,883	97,261	1,622	F	1,100,987	1,166,479
				EXPENSES						
38,419	39,223	804	F	Workforce Costs	38,419	39,223	804	F	450,139	462,125
4,194	3,738	(456)	U	Outsourced Services	4,194	3,738	(456)	U	41,837	43,556
9,487	8,566	(921)	U	Clinical Supplies	9,487	8,566	(921)	U	99,345	96,871
5,124	5,149	25	F	Infrastructure & Non-Clinical Supplies	5,124	5,149	25	F	58,569	60,354
40,365	39,679	(686)	U	Provider Payments	40,365	39,679	(686)	U	466,197	474,021
3,158	3,105	(53)	U	Non-Operating Expenses	3,158	3,105	(53)	U	34,951	40,469
100,747	99,460	(1,287)	U	*Total Expenses*	100,747	99,460	(1,287)	U	1,151,038	1,177,396
(1,864)	(2,199)	335	F	**NET SURPLUS / (DEFICIT)**	(1,864)	(2,199)	335	F	(50,051)	(10,917)

Revenue (Year To Date)

Government and Crown Agency revenue includes additional funding for COVID-19 revenue, offset by increased expenditure in Provider Payments while additional funding for the Recovery Plan is offset by increased expenditure in Outsourced Clinical Services.

Expenditure (Year To Date)

Total Expenses year to date were $100.7m which is $1.3m unfavourable to budget.

Workforce Costs are $0.8m favourable to budget year to date, which includes $0.3m benefit from the phasing of the Management & Administration annual leave revaluation in July 2020, rather than being spread across the year.

Outsourced Services are $0.5m unfavourable year to date. This reflects outsourced procedures for the recovery plan.

Clinical Supplies are $0.9m unfavourable year to date. Clinical activity was high again in July 2020 with the change in COVID-19 alert levels enabling the focus on the Recovery Plan. As a result, Clinical Supply use of Treatment Disposables, Implants & Prostheses and Other Clinical Costs increased in the month.

Infrastructure and Non-Clinical Supplies are on budget year to date.

Provider Payments are $0.7m unfavourable year to date for payments to NGOs for COVID-19 activity, however this is offset by additional revenue received from Government and Crown Agencies.

Non-Operating Expenses are on budget year to date.

Financial Position Summary

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

As at 30 Jun 2020 $000		Actual 31 July 2020 $000	Budget 31 July 2020 $000	Budget 30 June 2021 $000
	CURRENT ASSETS			
31,011	Cash & Cash Equivalents	27,205	14,418	7
51,012	Trade & Other Receivables	52,154	52,414	47,830
6,095	Inventories	6,069	5,665	5,235
88,118	*Total Current Assets*	85,428	72,497	53,072
	NON-CURRENT ASSETS			
331,152	Property, Plant & Equipment	331,554	331,950	355,122
3,307	Intangible Assets	3,464	10,841	20,149
334,459	*Total Non-Current Assets*	335,018	342,791	375,271
422,577	**TOTAL ASSETS**	420,446	415,288	428,343
	CURRENT LIABILITIES			
-	Cash & Cash Equivalents	-	-	16,261
81,967	Payables & Deferred Revenue	82,052	82,091	75,367
961	Short Term Borrowings	963	1,226	955
112,353	Employee Entitlements	112,072	108,244	75,038
195,281	*Total Current Liabilities*	195,087	191,561	167,621
	NON-CURRENT LIABILITIES			
1,091	Term Borrowings	1,018	774	693
19,810	Employee Entitlements	19,810	18,756	18,756
20,901	*Total Non-Current Liabilities*	20,828	19,530	19,449
216,182	**TOTAL LIABILITIES**	215,915	211,091	187,070
206,395	**NET ASSETS**	204,531	204,197	241,272
	EQUITY			
485,956	Contributed Capital	485,956	485,956	531,749
108,500	Property Revaluation Reserves	108,500	108,500	108,502
(388,061)	Accumulated Surplus/(Deficit)	(389,925)	(390,259)	(398,979)
206,395	*Total Equity*	204,531	204,197	241,272

Statement of Changes in Equity

172,410	Opening Balance	206,395	206,396	206,396
(50,051)	Operating Surplus/(Deficit)	(1,864)	(2,199)	(10,917)
84,743	Crown Capital Contributions	-	-	46,500
(707)	Return of Capital	-	-	(707)
206,395	Closing Balance	204,531	204,197	241,272

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 July 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	97,878	95,983	1,895	1,157,983	88,977
Non-Government & Crown Agency Revenue	651	858	(207)	10,296	855
Interest Received	26	19	7	232	38
Cash was applied to:					
Payments to Suppliers	(57,817)	(57,498)	(319)	(674,204)	(53,867)
Payments to Employees	(42,262)	(47,975)	5,713	(501,409)	(37,417)
Capital Charge	-	-	-	(12,605)	-
Goods & Services Tax (net)	464	631	(167)	(486)	1,124
Net Cash Inflow / (Outflow) from Operations	(1,060)	(7,985)	6,925	(20,193)	(290)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	1	-	1	-	1
Cash was applied to:					
Capital Expenditure	(2,672)	(8,545)	5,873	(72,294)	(4,861)
Net Cash Inflow / (Outflow) from Investing Activity	(2,671)	(8,545)	5,874	(72,294)	(4,860)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	-	-	-	8,621	-
Cash was applied to:					
Repayment of Borrowings	(74)	(64)	(10)	(542)	(115)
Repayment of Capital	-	-	-	37,143	-
Net Cash Inflow / (Outflow) from Financing Activity	(74)	(64)	(10)	45,222	(115)
Total Increase / (Decrease) in Cash	(3,805)	(16,594)	12,789	(47,265)	(5,265)
Net Opening Cash & Cash Equivalents	31,011	31,011	0	31,011	(9,888)
Net Closing Cash & Cash Equivalents	27,206	14,417	12,789	(16,254)	(15,153)

The cash position as at 31 July 2020 compared to Budget reflects a combination of several significant variances to the draft 2021 Annual Plan.

Cash flow from Operating Activities is favourable to budget by a net $6.9m. The Government & Crown Agency inflows reflects additional "pass-through" funding for COVID-19 and the payments received from Trade & Other Receivables.

Cash flow from Investing Activities is favourable to budget by $5.9m. This is largely driven by the timing of the Capital Expenditure Plan approval by the Minister of Health and ongoing project delays. Overall, Capital Expenditure cash spend is $2.2m less than last year.

Cash flow from Financing Activities is close to budget being $10k unfavourable, at $74k for the month.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure - Cash Flow
For the period ending 31 July 2020

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	FY19 YTD Actual $000
Land, Buildings & Plant	713	1,629	916	U	1,925
Clinical Equipment	1,152	1,937	785	U	2,236
Other Equipment	85	263	178	U	87
Information Technology	342	4,481	4,139	U	51
Motor Vehicles	-	-	-	-	-
Software	380	235	(145)	O	562
Total Expenditure	2,672	8,545	5,873	U	4,861

At 31 July 2020, our Financial Position on page 3 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $335.0m, which is $7.8m less than the budget of $342.8m.

The delays with projects including Dunedin Hospital ICU, Southland MRI, Queen Mary and Deferred Maintenance continue to contribute to the underspend in Property, Plant & Equipment, including Buildings and Clinical Equipment. These are likely to progress rapidly once a more "business as usual" environment returns.

Information Technology and Software is $4.0m underspent, including Radiology RIS, Cherwell Automation and Patientrack projects.

To date only those projects that are urgently required to progress have commenced in the new financial year. For the most part, we are awaiting the approval of the 2021 Annual Plan by the Minister of Health.

Jul-20				Jul-19	YEAR ON YEAR		YTD 2020/2021				YTD Jul-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,533	1,503	29	2%	1,761	(228)	Acute	1,533	1,503	29	2%	1,761	(228)
336	251	84	33%	365	(30)	Elective	336	251	84	33%	365	(30)
1,868	**1,755**	**113**	**6%**	**2,126**	**(257)**	**Total Medical Caseweights**	**1,868**	**1,755**	**113**	**6%**	**2,126**	**(257)**
						Surgical Caseweights						
1,146	1,196	(50)	-4%	1,226	(81)	Acute	1,146	1,196	(50)	-4%	1,226	(81)
1,606	1,341	265	20%	1,440	165	Elective	1,606	1,341	265	20%	1,440	165
2,751	**2,537**	**215**	**8%**	**2,667**	**85**	**Total Surgical Caseweights**	**2,751**	**2,537**	**215**	**8%**	**2,667**	**85**
						Maternity Caseweights						
122	94	29	30%	99	23	Acute	122	94	29	30%	99	23
423	371	52	14%	395	28	Elective	423	371	52	14%	395	28
546	**465**	**81**	**17%**	**494**	**52**	**Total Maternity Caseweights**	**546**	**465**	**81**	**17%**	**494**	**52**
						TOTALS						
2,800	**2,793**	**8**	0%	**3,087**	**(286)**	**Acute**	**2,800**	**2,793**	**8**	0%	**3,087**	**(286)**
2,365	**1,963**	**401**	20%	**2,200**	**165**	**Elective**	**2,365**	**1,963**	**401**	20%	**2,200**	**165**
5,165	**4,756**	**409**	**9%**	**5,287**	**(121)**	**Total Caseweights**	**5,165**	**4,756**	**409**	**9%**	**5,287**	**(121)**

						TOTALS excl. Maternity						
2,678	**2,699**	**(21)**	-1%	**2,988**	**(309)**	**Acute**	**2,678**	**2,699**	**(21)**	-1%	**2,988**	**(309)**
1,941	**1,592**	**349**	22%	**1,805**	**137**	**Elective**	**1,941**	**1,592**	**349**	22%	**1,805**	**137**
4,619	**4,291**	**328**	**8%**	**4,793**	**(173)**	**Total Caseweights excl. Maternity**	**4,619**	**4,291**	**328**	**8%**	**4,793**	**(173)**

Jul-20				Jul-19	YEAR ON YEAR		YTD 2020/2021				YTD Jul-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,662	3,286	(624)	-19%	2,751	(89)	**Mental Health bed days**	2,662	3,286	(624)	-19%	2,751	(89)

Jul-20	Jul-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Jul-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,704	3,895	(191)	Dunedin	3,704	3,895	(191)
1,247	1,281	(34)	Lakes	1,247	1,281	(34)
3,088	3,004	84	Southland	3,088	3,004	84
8,039	8,180	(141)	**Total ED presentations**	8,039	8,180	(141)

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Performance Dashboard**
Report to:	Board
Date of Meeting:	8 September 2020

Summary:

Of note on this month's dashboard are:

- Mortality title changed to death as it's a number illustrated, not a rate
- Theatre utilisation – this report currently shows all theatre utilisation and as such is indicating theatre utilisation hovers between 50 to 60%. The cause of this is that the acute theatres are open 24*7, however only life and limb surgery is performed overnight. Normal practice is to include only in hour scheduled theatres in the theatre utilisation calculations It is proposed that acute theatres and weekends are removed in future reporting so that only Monday to Friday 'elective' usage is reflected. Currently elective theatre usage (Monday to Friday 8:00am to 4:00pm) is averaging around 80%.
- Case weights reflected in the dashboard are a cumulative total, reported in negative during COVID-19 wave 1 and related lockdown. A refresh or reset back to '0' has occurred on 1 July to reflect the start of a new financial year. Since 1 July 2020 we are 200-300 case weights in positive this year. The Southern (district) chart illustrates the correct number which includes any outsourced activity. Invercargill and Dunedin volumes don't therefore add up to the exact total.
- Short notice postponements are the monthly number of patients who have their surgery postponed after it has been scheduled. This includes on the day of surgery.
- Readmissions recorded are that that occur within seven days of discharge for the same or related condition. The rate of readmissions (readmissions/discharges) is 3-5% across the whole DHB. The top eight specialities are medical with surgery patients being ninth highest.
- ESPI 2 and 5 120 day breaches – these breaches demonstrate a historical lack of compliance with the Ministry's policy expectation. The requirement is if we accept a FSA referral then we are required to see the patient within four months, likewise if we accept them on to the surgical waiting list a further four month expectation is placed on us. Unfortunately, there have been some services who have historically placed people on the waiting list even though it is clear that we do not have the capacity to treat them. We now have patients for whom we have given them certainty of care and they have been waiting more than two years. The service has been requested to develop a plan to make substantial improvements before the end of the year.

Specific implications for consideration (financial/workforce/risk/legal etc):			
Financial:	n/a		
Workforce:	No specific implications		
Other:	n/a		
Document previously submitted to:			**Date:**
Approved by Chief Executive Officer:			**Date:**
Prepared by: Gail Thomson Executive Director Quality and Clinical Governance Solutions 27 August 2020		**Presented by:** Gail Thomson Executive Director Quality and Clinical Governance Solutions 8 September 2020	
RECOMMENDATION: That the Board **notes** the Performance Dashboard			

Performance Dashboard Tile Definitions (Southern)

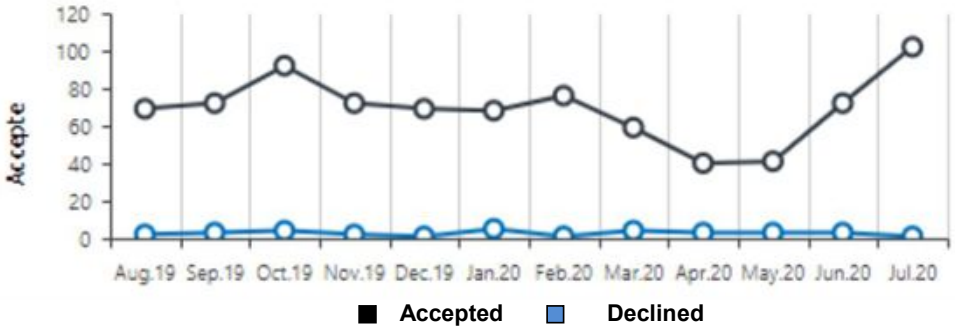
Tile Image	Tile Description
	Safety 1st data. *Complaints* The number of internal complaints (from website, phone, email, letter, health and disability, comment form, etc) per month. *Resolutions* The percentage of complaints that were resolved within 35 working days.
	*Restraints* Safety 1st data. The number of restraint events per month. *Seclusions* iPM and HCS data. The number of seclusion events per month.

10.3

iPM data.

Events
The number of patients re-admitted acutely to any inpatient specialty within the same hospital within 7 days, excluding short stay events.
IP Days
Number of admissions to any inpatient specialty.
Rates
Re-admissions / total admissions * 100

Refferals Recied & Declined

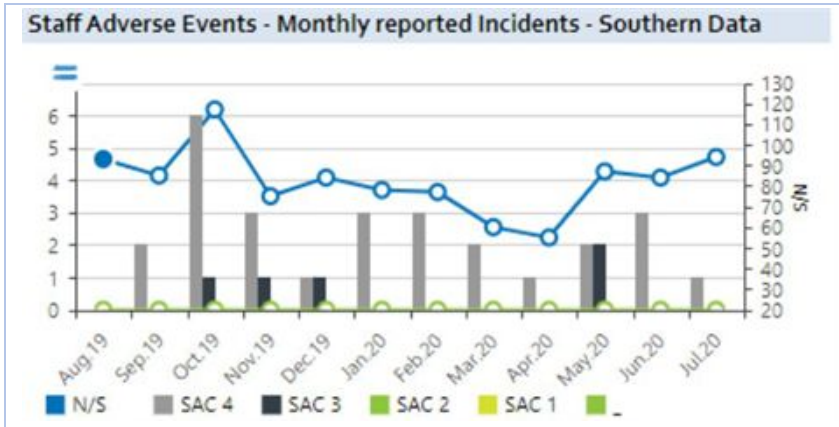


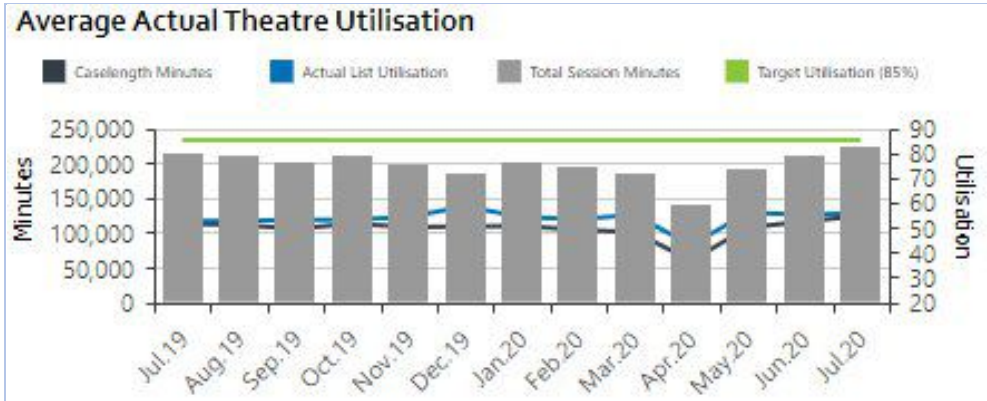
iPM data.

Accepted
The monthly number of First Specialist Appointment (FSA) referrals received and accepted. Some FSA referrals received will be awaiting an outcome, they are not displayed.
Declined
The monthly number of FSA referrals received and declined. Some FSA referrals received will be awaiting an outcome, they are not displayed.

Dunedin and Invercargill have different methods for recording hospital codes hence referral counts within Southern DHB are split between Dunedin and Invercargill using hospital codes and the source PMS:

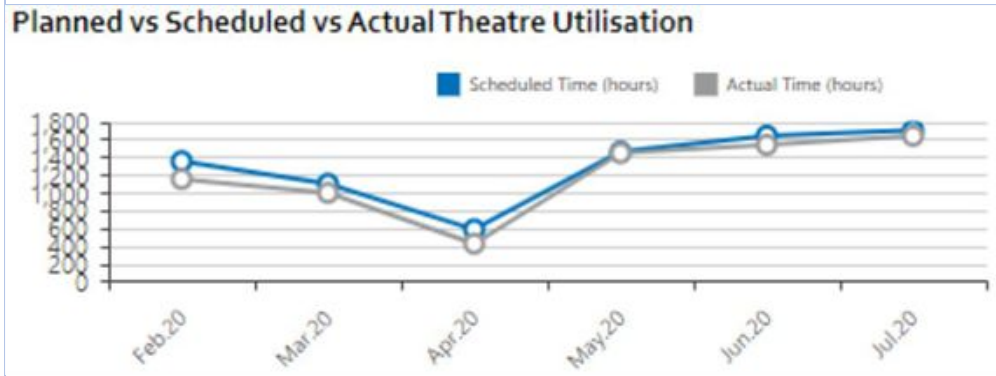
- Dunedin referrals count = referrals in either iPM with a Dunedin iPM hospital code + referrals in the Dunedin iPM with no hospital code
- Invercargill referrals count = referrals in either iPM with an Invercargill iPM hospital code + referrals in the Invercargill iPM with
no hospital code

	Safety 1st data. The monthly number of reported staff adverse events categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).
	iPM data. The number of deaths in hospital based on iPM discharge type.



iPM data.

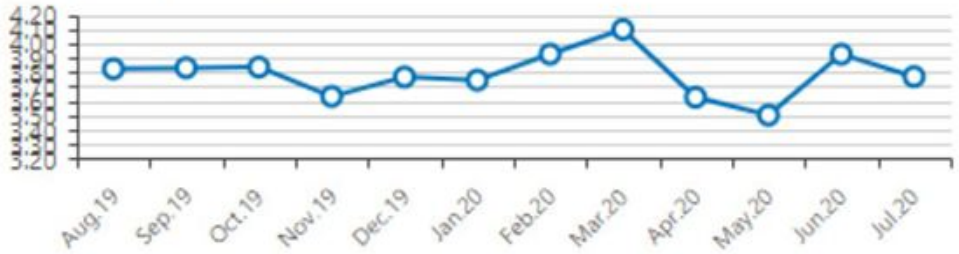
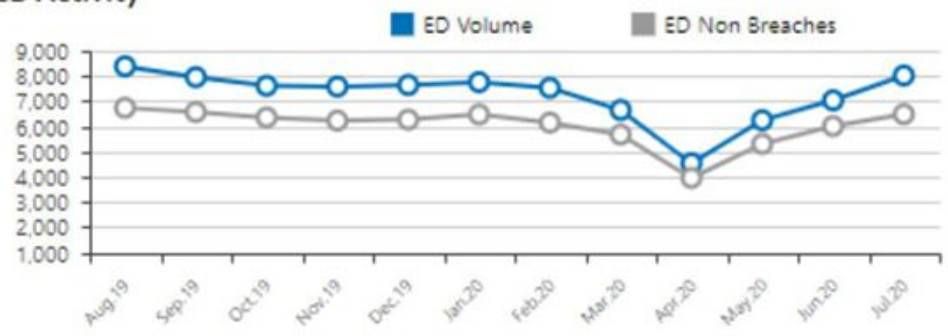
Caselength Minutes
The monthly number of caselength minutes. Caselength = anaesthetic time
(a) plus the procedure time (p) for all specialties and theatres.
(a) = anaesthetic start time to ready for procedure start time,
(p) = procedure start time to procedure completed.
Actual List Utilisation
Actual list utilisation = caselength utilisation / total session time. For all specialties and theatres.
Total Session Minutes
For all specialties and theatres.
Target Utilisation (85%)
The agreed target theatre utilisation rate.



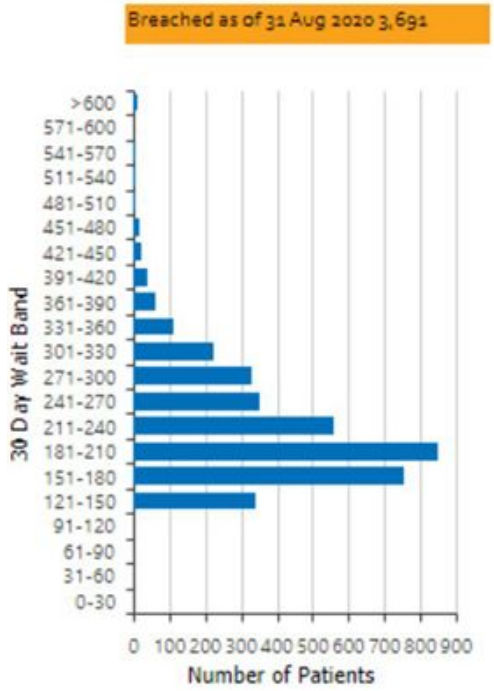
Scheduled Time (hours)
The monthly number of hours that the included theatres were scheduled to be in use.
Actual Time (hours)
The monthly number of hours that the included theatres were in use.

Both series display the theatre times for a subset of theatres. Dunedin tab: DNTH1 to DNTH9 inclusive
Invercargill tab: OR1 to OR4 inclusive
Southern tab: Dunedin tab theatres and Invercargill tab theatres

The time period is limited to the most recent six (rather than 12) complete financial months for performance reasons.

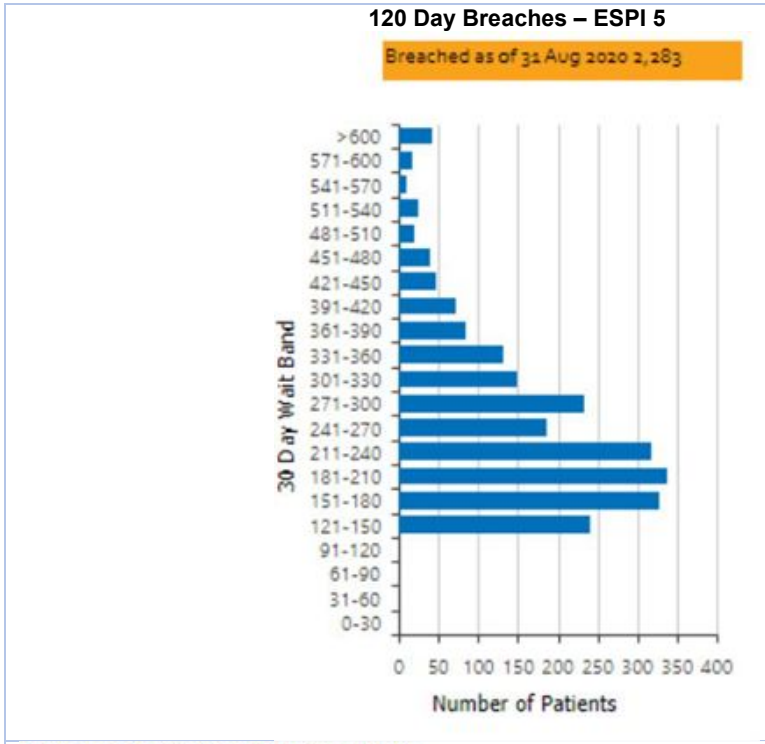
Short Notice Postponements 	The monthly number of patients who have their procedure postponed after their surgery is scheduled.
Average Hospital Length - ALOS 	The monthly average number of days that patients stayed in hospital.
ED Activity 	*ED Volume* The monthly number of presentations to ED. *ED Non Breaches* The monthly number of presentations to ED that went from triage to departure within six hours.

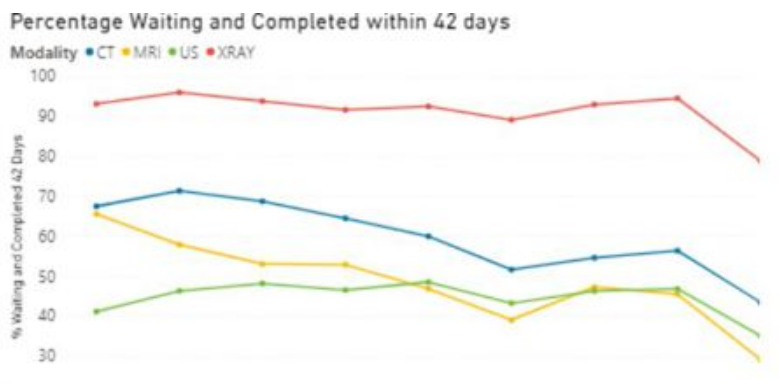
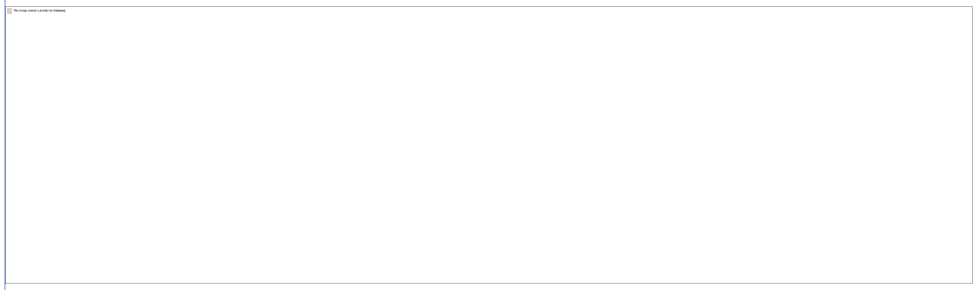
120 Day Breaches – ESPI 2



The number of patients whose wait for a First Specialist Appointment (FSA) will exceed a four month wait, and hence breach ESPI 2, by the end of the current financial month if no more appointments are made.

The number of patients who have been waiting longer than four months for an FSA displayed in 30-day time-waiting bands.

	The number of patients whose wait for surgery will exceed a four month wait, and hence breach ESPI 5, by the end of the current financial month if no more surgeries are completed. The number of patients who have been waiting longer than four months for surgery displayed in 30-day time-waiting bands.
	The monthly number of patients who have been discharged with a length of stay greater than seven days.

	The percentage of CT/ MRI/ US/ XRAY examinations completed each month within the MoH target of 42 days from request date.
	Column chart showing the cumulative total variance from plan. The graph shows how ahead or behind the actuals are for the most 12 last complete financial months. Data from: • iPM (Dunedin and Southland) • MKM • In flow and out flow IDF files. • Southern DHB planned amounts for case weight and discharge volumes The case weight definition is as per MoH WIESNZ17. Service relates to productivity – the work done in Southern DHB facilities - the Southern DHB's own population minus outflows plus inflow. The table below shows the admission types and targets used for comparing case weight and discharge volumes to 'budgets' in Board.

Admission Types and Targets

		2017/18		2018/19	
		Target	Actual	Target	Actual
MoH	Elective	AA WN 11 WAA	WN 11	WN 11 AA WAA	WN 11 AA WAA
	Acute	AC	AC AA WAA	AC	AC
PVS	Elective	WN 11	WN 11	WN 11 AA WAA	WN 11 AA WAA
	Acute	AC AA WAA	AC AA WAA	AC	AC

Table Key

Admission type code	Description	Source
11	Elective wait list	IPM
AA	Arranged admission	IDF
AC	Acute admission	IPM
WAA	Arranged admission seen within seven days	IPM
WN	Elective admission	IPM

N.B. The admission types for the MoH targets changed between the 2017/18 and 2018/19 financial years

10.3

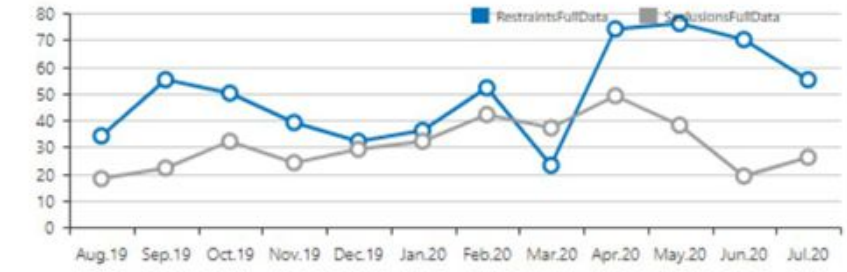
Performance Dashboard Tiles September (Dunedin)

Tiles

Complaint Rate and Resolution

Planned vs Scheduled vs Actual Theatre Utilisation

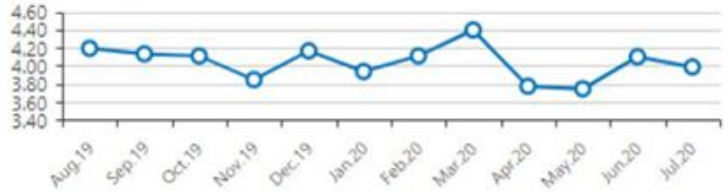
Restraint & Seclusion



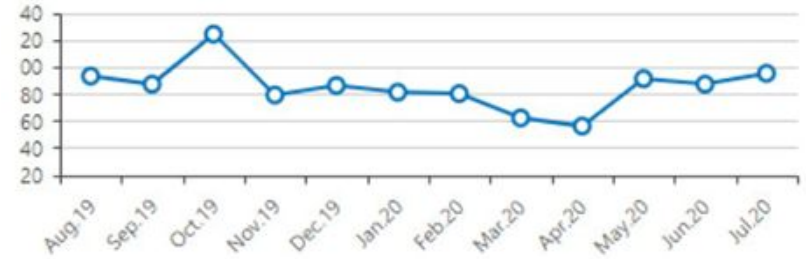
Short Notice Postponements

Staff Adverse Events - Monthly reported Incidents - Southern Data

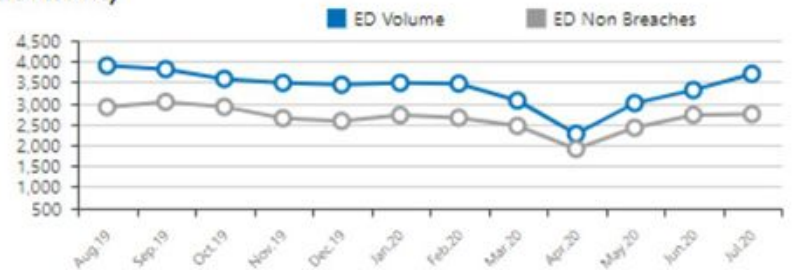
Average Hospital Length - ALOS



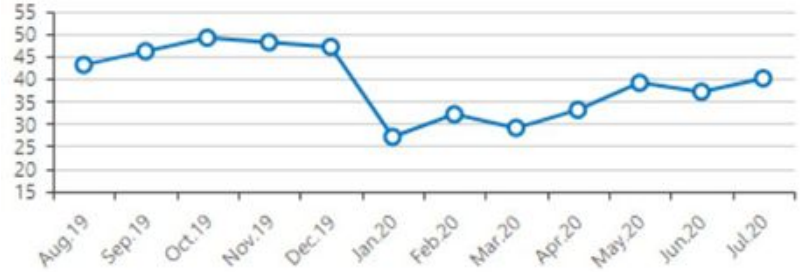
Staff Adverse Event Count - Southern Data



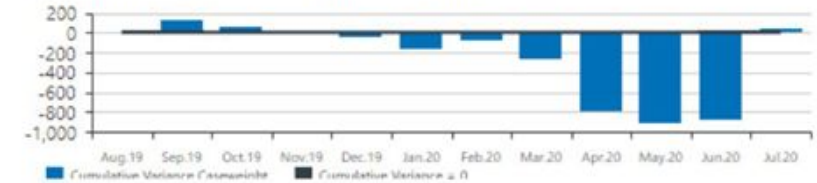
ED Activity

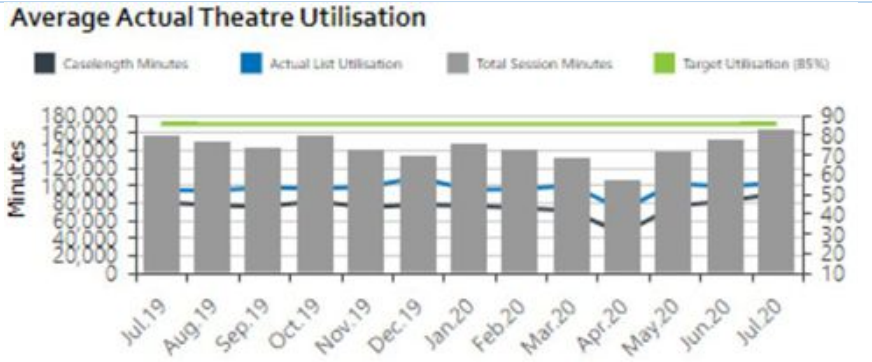


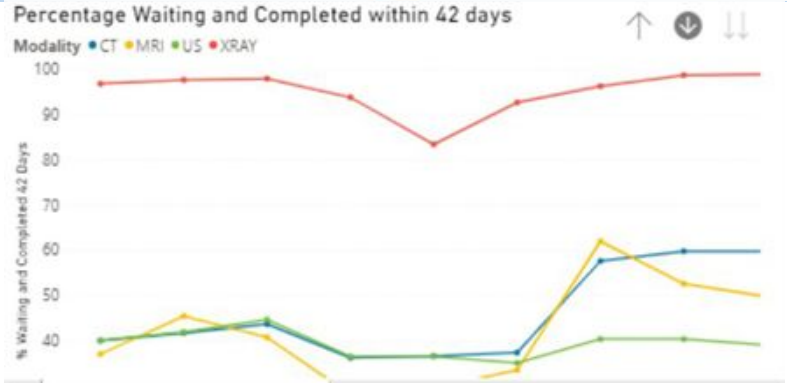
Death



Cumulative Variance Caseweight - Service Provider



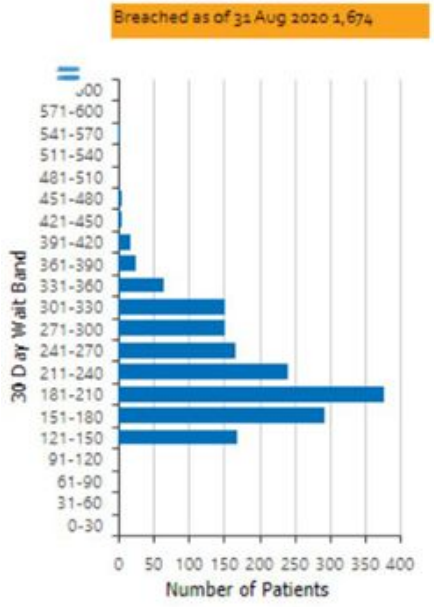


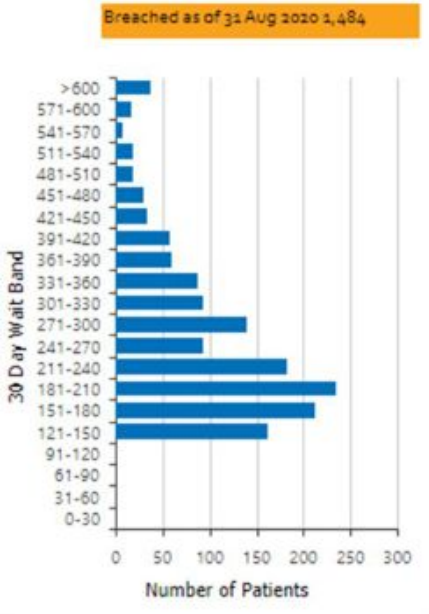


ESPI 2

Referrals Received & Declined

ESPI 5

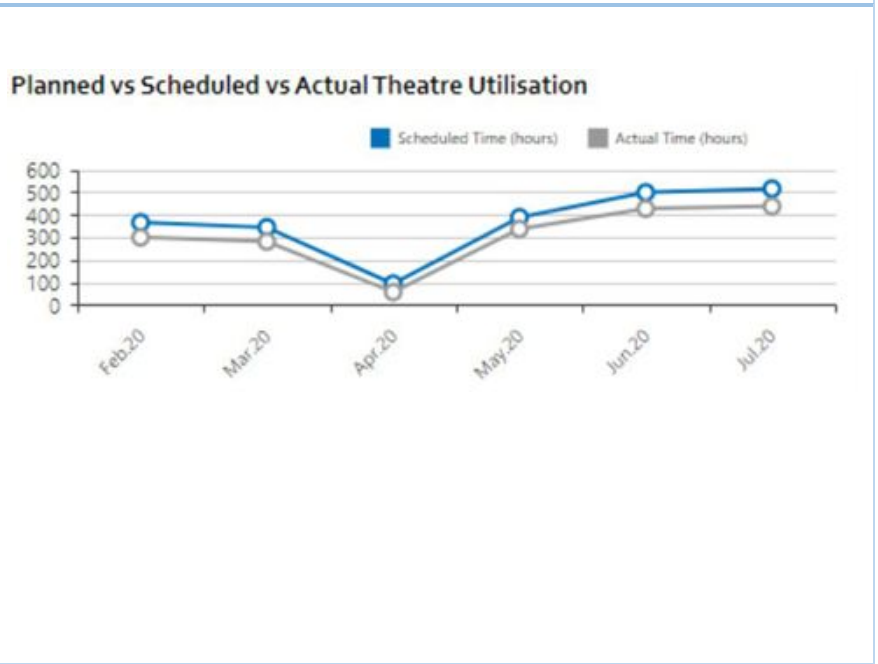

Breached as of 31 Aug 2020 1,674
571-600
541-570
511-540
481-510
451-480
421-450
391-420
361-390
331-360
301-330
271-300
241-270
211-240
181-210
151-180
121-150
91-120
61-90
31-60
0-30
30 Day Wait Band
0 50 100 150 200 250 300 350 400
Number of Patients

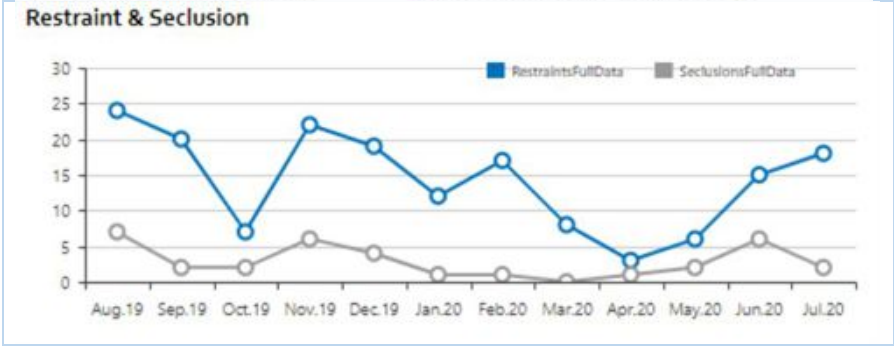

Breached as of 31 Aug 2020 1,484
>600
571-600
541-570
511-540
481-510
451-480
421-450
391-420
361-390
331-360
301-330
271-300
241-270
211-240
181-210
151-180
121-150
91-120
61-90
31-60
0-30
30 Day Wait Band
0 50 100 150 200 250 300
Number of Patients

10.3

Performance Dashboard Tiles September (Invercargill)

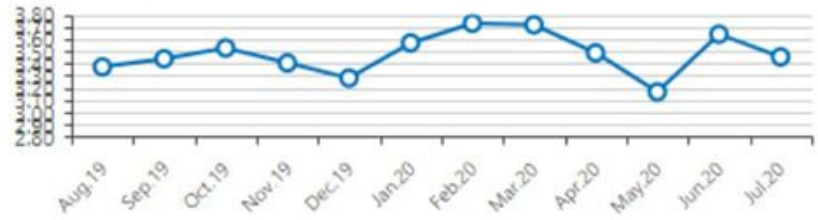
Tiles



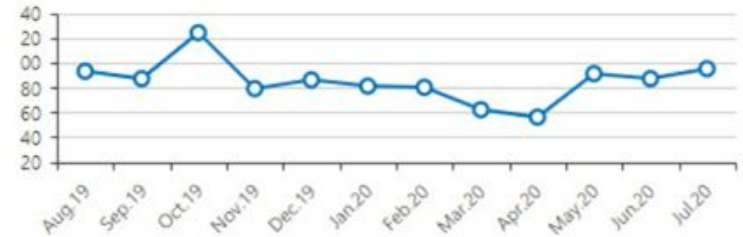


Staff Adverse Events - Monthly reported Incidents - Southern Data

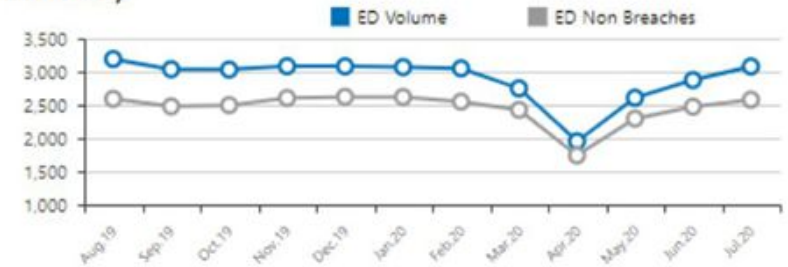
Average Hospital Length - ALOS



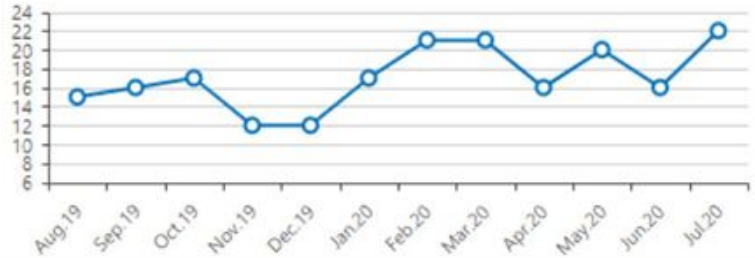
Staff Adverse Event Count - Southern Data

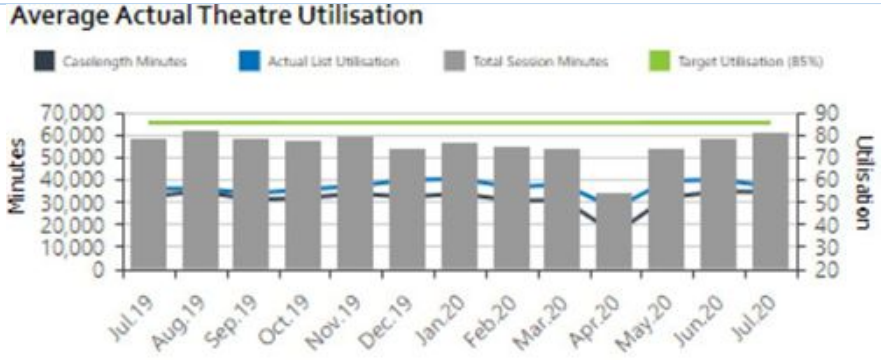


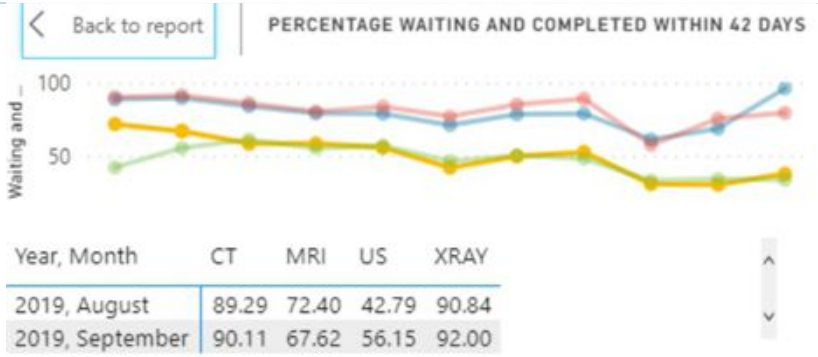
ED Activity



Death

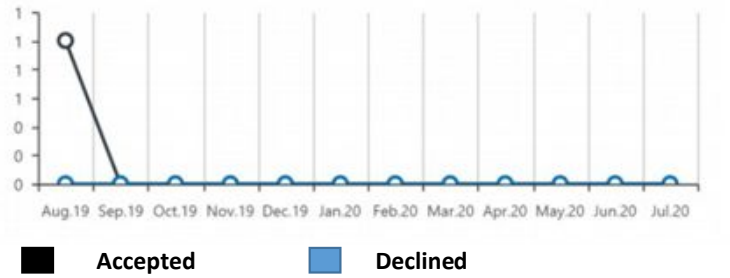




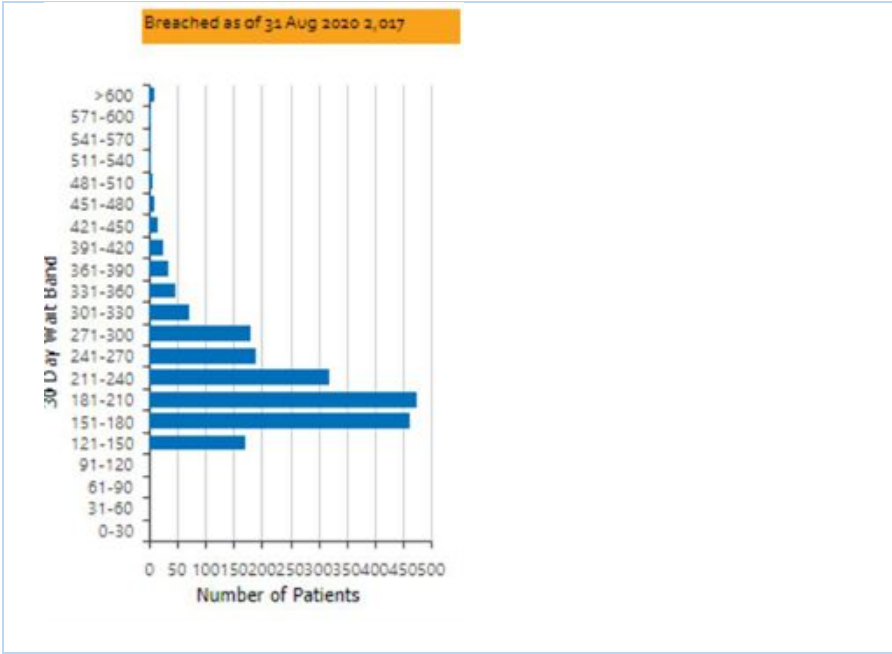


ESPI 2

Referrals Received & Declined



ESPI 5


Breached as of 31 Aug 2020 2,017
30 Day Wait Band
>600
571-600
541-570
511-540
481-510
451-480
421-450
391-420
361-390
331-360
301-330
271-300
241-270
211-240
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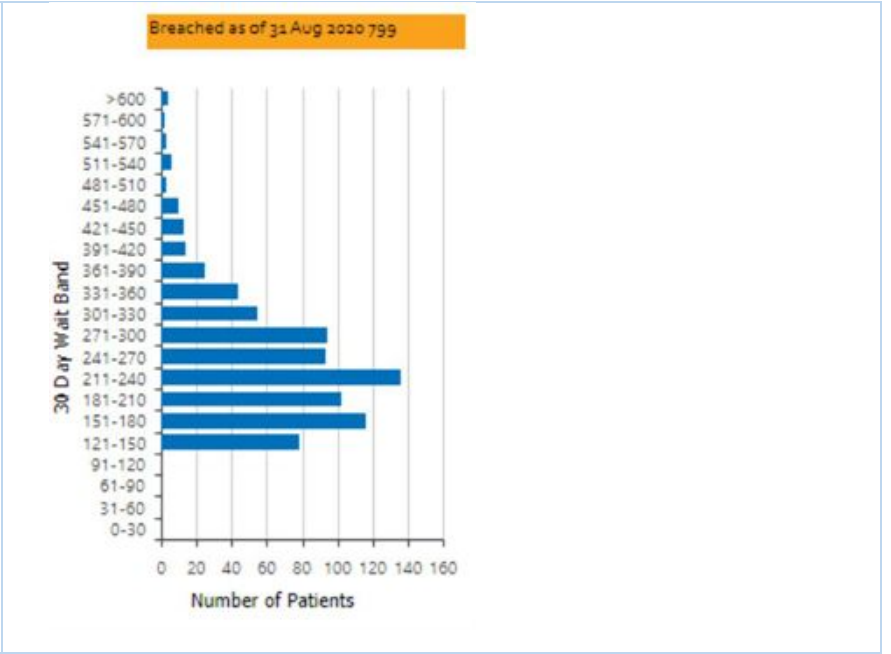
121-150
91-120
61-90
31-60
0-30
0 50 100 150 200 250 300 350 400 450 500
Number of Patients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30 Day Wait Band
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571-600
541-570
511-540
481-510
451-480
421-450
391-420
361-390
331-360
301-330
271-300
241-270
211-240
181-210
151-180
121-150
91-120
61-90
31-60
0-30
0 20 40 60 80 100 120 140 160
Number of Patients

10.3

SOUTHERN DISTRICT HEALTH BOARD

Title:	**ENVIRONMENTAL SUSTAINABILITY UPDATE**
Report to:	Southern DHB Board
Date of Meeting:	8 Sept 2020

Summary:

In 2017 Southern DHB started the environmental sustainability journey and having come from an organisation where sustainability was a strong focus area I felt that Southern had many opportunities to strengthen sustainability across the organisation. There were pockets of sustainability improvements taking place but this was not necessarily connected and there was little executive support and leadership. We considered a dedicated resource for driving sustainability but it was decided back then that sustainability was everyone's responsibility and that I would sponsor and provide leadership in this space on behalf of the Executive Leadership Team. There was no strategy or action plan but there were a number of likeminded staff wanting to assist in environmental sustainability change.

We contracted some co-ordination support part time for eight months to help us develop the Green HealthCare SDHB strategy and action plan that we have today. A steering group was established and remains today responsible for quarterly reporting on the action plan. Supporting the steering group we have also established a network for green champions who assist in enabling change and escalate any road blocks to the steering group for assistance when required. We have had exceptional input and leadership from a number of staff including Matt Jenks Consultant Anaesthetist who has completed the carbon footprint assessment for Southern DHB as part of his sabbatical.

The environmental sustainability action plan is progressing well and a copy is attached to this briefing paper. The strategy and action plan is included within the annual plan and progress is reported to the ministry on a regular cycle.

Specific implications for consideration (financial/workforce/risk/legal etc):		
Financial:		
Workforce:		
Equity:		
Other:		
Document previously submitted to:		**Date:**
Approved by Chief Executive Officer:		**Date:**
Prepared by: Mike Collins Executive Director People, Culture & Technology **Date:** 27 August 2020	**Presented by:**	

RECOMMENDATIONS:

1. **Board to note this briefing paper and that progress on strategy and action plan will be submitted quarterly in Ministry of Health reporting.**

Detailed Green Healthcare Strategy Action Report (as at 27 August 2020)

GREEN HEALTHCARE STRATEGY GOAL 1: MEASURE, MONITOR AND REPORT					
Goal	Headline Action	Activity	Status	Lead	Commentary
1. Measure, monitor and report the carbon footprint of Southern DHB	Reduce the carbon footprint of Southern DHB 80% by 2030	1.a. Complete a baseline carbon footprint assessment for the financial year 2016-2017		Matt Jenks	2016-2017 Completed
		1.b Join CEMARS (Certified Emissions Measurement and Reduction Scheme) by Enviromark™ to measure and reduce annual greenhouse gas emissions.		Matt Jenks	Completed
		1.c. Appoint Green HealthCare SDHB Manager to undertake annual carbon footprint reporting.		Matt Jenks	Declined by ELT
GREEN HEALTHCARE STRATEGY GOAL 2: ENERGY					
Goal	Headline Action	Activity	Status	Lead	Commentary
2. Energy Supply and Efficiency	Zero coal use at Southern DHB by 2030 10% Reduction in electricity consumption by 2030	2.a. Join Dunedin Energy Leaders Accord		Paul Pugh	Paul Pugh and Facilities Team now members. Business case for new Dunedin Energy Centre developed.
		2.b. Feasibility study to convert Dunedin Energy Centre to carbon neutral sustainable fuel		Paul Pugh	Option paper tp ELT next week 8 Sept 2020

Key

Not yet Started | On Track | Delayed | Completed | Next Financial Year

		2.c. Feasibility study with Pioneer Energy to convert Southland Hospital coal boilers to wood chip		Paul Pugh	Pioneer have provided initial requirements for testing. Testing to be completed Aug/Sept
		2.d. Collaboration agreement with EECA		Paul Pugh	Ongoing - Meeting held awaiting collaboration agreement.
		2.e. Reduce Electricity use through behaviour education campaign		Paul Pugh	Education about best practice required.
GREEN HEALTHCARE STRATEGY GOAL 3 WASTE					
Goal	Headline Action	Activity	Status	Lead	Commentary
3 Waste	50% reduction in waste to landfill by 2030	3.a. Establish waste committee		Heather Fleming	Set up but has since disbanded. Replaced by Green Health Group
		3.b. Waste audit and stocktake of recycling facilities		Heather Fleming	Completed
		3.c. Upgrade and standardise recycling facilities		Heather Fleming	Facilities reviewed which identified issues with staffing and management of bins in loading dock. Additional funding and Executive support required

Key

Not yet Started | On Track | Delayed | Completed | Next Financial Year

		3.d. Extend PVC recycling to Invercargill		Heather Fleming	
		3.e. Feasibility study of food waste composting		Heather Fleming	
		3.f. Eliminate single use plastic cups, straws, and cutlery		Heather Fleming	RMO Water bottle programme
		3.g. Behaviour education campaign on waste minimisation		Heather Fleming	

GREEN HEALTHCARE STRATEGY GOAL 4 TRAVEL

Goal	Headline Action	Activity	Status	Lead	Commentary
4 Travel	50% of fleet vehicles EV by 2030 10% reduction in patient NTA (National Travel Assistance) claims by 2030 50% of staff biking/walking or public transport to work by 2030 5% reduction in staff passenger km flown by 2030	4.a. Increase use of telehealth (as part of existing telehealth strategy)		Heather Fleming	Report to be provided by Talis L.
		4.b. Transition staff vehicle fleet to electric vehicles (EV) and Hybrids		Heather Fleming	New fleet vehicles now includes hybrids. 18% completed.
		4.c. Southern DHB E-Bikes		Dr Ulla Reymann and Chris Tait	ELT agreed. Now with procurement for next steps.

Key

Not yet Started | On Track | Delayed | Completed | Next Financial Year

		4.d. Establish an annual staff commute survey		Hamish Brown	NDH conducted survey. To access results.
		4.e. Increase active transport (cycling and walking) for staff through education campaigns and facility development		Comms	Communications Campaign required
		4.f. Enhance access to videoconferencing for meetings, conferences, etc. (as part of existing telehealth strategy)			
		4.g. SDHB to initiate own "Great Things" programme eg: BNZ Great Things – helping in our Community			

GREEN HEALTHCARE STRATEGY GOAL 5 PROCUREMENT					
Goal	Headline Action	Activity	Status	Lead	Commentary
5 Procurement	100% of procurement contracts to have Green Healthcare criteria Align N20 use with comparable DHB by 2030 50% reduction in paper use by 2030	5.a. Develop sustainability criteria for procurement policies, tender documents and contracts.		Ian Caird	Now included in business cases and reports
		5.b. Reduce carbon footprint of anaesthetic gases through education and behaviour change		Ian Caird	

Key

Not yet Started | On Track | Delayed | Completed | Next Financial Year

		5.c. Investigate high use of N20 at Dunedin Hospital		Matt Jenks	Leak tests completed. Use has reduced but still high in comparison with other DHB. More work is required.
		5.d. Digital Hospital Strategy to reduce paper use (part of existing Digital Hospital Strategy)		Mike Collins	Link to NDH Digital workplan
		5.e. Paper use reduction behaviour change campaign		Mike Collins	
GREEN HEALTHCARE STRATEGY GOAL 6 BUILT ENVIRONMENT					
Goal	Headline Action	Activity	Status	Lead	Commentary
6 Built Environment	New and refurbished SDHB buildings to have an Environmentally Sustainable Design (ESD) plan.	6.a. Green Healthcare Leadership Group to work with project leaders of new Dunedin Hospital to develop and implement ESD plan.		Paul Pugh	Completed but with new architects/engineers means it need to be revisited.
		Green Healthcare Leadership Group to work with Facilities and Property SDHB to establish ESD policy for refurbishment projects.			

Key

Not yet Started | On Track | Delayed | Completed | Next Financial Year

GREEN HEALTHCARE STRATEGY GOAL 7 ENGAGEMENT OF STAFF AND CULTURE CHANGE					
Goal	Headline Action	Activity	Status	Lead	Commentary
Engagement of staff and culture change	Ensure Green Healthcare is built into decision making across SDHB. Develop a staff culture of commitment to the principles of Green Healthcare	Develop a Green Healthcare SDHB policy.		Matt Jenks and Jo Baillie	Policy written yet to be formally endorsed
		Require all new policy and policies up for review to address principles of Green Healthcare outlined in Green Healthcare SDHB policy			
		Build sustainability into service planning and performance planning			
		Set up DHB wide "Green Healthcare Champions" network similar to Infection Control and Prevention representative network			
		Develop a Green Healthcare SDHB SharePoint page			
		Run Green Healthcare workshops			
		Develop online training and self---assessment tools			

Key

Not yet Started  On Track  Delayed  Completed  Next Financial Year 

GREEN HEALTHCARE STRATEGY GOAL 7 ENGAGEMENT OF STAFF AND CULTURE CHANGE					
		Develop robust communication strategy to share success stories and communicate progress			
		Provide tools and funding for developing and implementing Green Healthcare initiatives			
		Foster research links (in particular with the University of Otago, Southern Institute of Technology and Otago Polytechnic)			
		Join community sustainability initiatives e.g. city council environmental strategies			
		Due regard for Green Healthcare and climate change is written into staff job descriptions and provider agreements			
		Maximise opportunities to promote the "Green Healthcare SDHB Strategy" within the wider health care sector and when working with other sectors and our partner agencies			
		Lead community projects aimed at drawing attention to sustainability issues.			

Key

Not yet Started ● On Track ● Delayed ● Completed ● Next Financial Year ●

GREEN HEALTHCARE STRATEGY GOAL 7 ENGAGEMENT OF STAFF AND CULTURE CHANGE	

Key

Not yet Started  On Track  Delayed  Completed  Next Financial Year 

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Power of Attorney – Chief Executive**
Report to:	Board
Date of Meeting:	08 September 2020

Summary:

The Delegations of Authority Policy delegates various authorities to the Chief Executive. From an operating expenditure perspective, the authority delegated has no limit subject to the expenditure within the Annual Plan other than for gifts, sponsorship and staff travel, hospitality entertainment and recruitment for which more constrained authority is delegated.

There is a provision in the Crown Entities Act however that specifies that any agreement which needs to be entered into by a deed must be signed:

> "- by 2 or more of its members or, if the entity is a corporation sole, by the sole member; or
> - By 1 or more attorney appointed by the entity under section 129(1)"

Section 129 states that the appointment must be in writing and then binds the organisation.

The most common deed that the DHB enters are deeds of lease. We lease a multitude of small properties mostly for community based services. An example which is currently awaiting signing is a lease of space in the Savoy building in Dunedin which houses some of our Community Mental Health Services.

With the Commissioner model in place the Commissioner was empowered to make decisions at any time, however the Board model requires all decisions of the Board to be made at a formal meeting. While this is entirely appropriate for significant decisions it is very inflexible for small leases which are within the existing budgets.

The Board are therefore requested to approve the attached power of attorney appointing the Chief Executive, noting that it limits the authority to be within the delegated authorities policy.

It should be noted that there are strict limits imposed on leasing property included in the Operating Policy Framework all DHBs are required to comply with. If the DHB wishes to lease any of its land and buildings for a period exceeding five years, then Ministerial approval is required. There are also strict rules in place for entering into arrangements for the DHB to lease land and buildings for periods exceeding five years. Therefore, the power of attorney in this instance could only be used after the OPF requirements have been met, and seeking Ministerial approval would require Board support in the first instance.

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

Financial:	Nil
Workforce:	N/A
Equity:	N/A
Other:	None

Prepared by:	**Presented by:**
Chris Fleming Chief Executive Date: 29/08/2020	Chris Fleming Chief Executive

RECOMMENDATIONS:

That the Board:

1. **Approve appointing the Chief Executive as an Attorney for the purposes of the Crown Entity Act requirements;**
2. **Delegate the signing of the Power of Attorney to the Chair and Deputy Chair.**

POWER OF ATTORNEY

SOUTHERN DISTRICT HEALTH BOARD

12

CHRISTOPHER REX FLEMING

Power Of Attorney

DEED dated **2020**

Appointment

Southern District Health Board a statutory corporation created pursuant to the New Zealand Public Health and Disability Act 2000 ("Southern DHB") appoints its **Chief Executive Officer, Christopher Rex Fleming** of Dunedin ("Attorney") as its attorney to, within his level of delegated authority, execute any and all documents on behalf of the Southern DHB that are required by Section 127(2) of the Crown Entities Act 2004 to be entered into in the manner prescribed by Section 127(2) of the Crown Entities Act 2004.

1. Southern DHB declares and agrees that:

a. the Attorney has the power in its name to enter into any deed under this power of attorney.

b. no person or corporation dealing with the Attorney need be concerned about the enforceability of any deed signed by the Attorney in Southern DHB's name under this power of attorney.

c. Southern DHB will allow, ratify (if necessary) and confirm everything that the Attorney lawfully agrees to by deed pursuant to this power of attorney.

Executed as a Deed pursuant to the provisions of the Property Law Act 2007 by:

Signed by **SOUTHERN DISTRICT HEALTH BOARD** by its two of its members in the presence of:

Name of member

Signature of member

Signature of witness

Name of witness

Occupation

Address

Name of member

Signature of member

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Dunedin Hospital Escalation Plan**
Report to:	Board
Date of Meeting:	8 September 2020

Summary:

Considered in this paper is an escalation plan :

- An escalation plan can provide a systematic approach to signaling and responding to delays in patient flow through the hospital system and thereby mitigate risk and distress in the Emergency Department.
- A hospital-based plan is a useful starting point for a later whole of system model. A plan is in development with the goal of implementation in October. The appendix to this report is a work in progress and just provided as a guide to the type of actions which are likely to be incorporated

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: Nigel Millar Chief Medical Officer **Date:** 28 August 2020	**Presented by:** Nigel Millar Chief Medical Officer

RECOMMENDATION:

1. **That the Board:**
   - **Note** and support the ongoing work.

FINAL

Dunedin Hospital Escalation Plan

Board Update

1 Executive Summary

An escalation plan can provide a systematic approach to signaling and responding to delays in patient flow through the hospital system and thereby mitigate risk and distress in the Emergency Department.

A hospital-based plan is a useful starting point for a later whole of system model. A plan is in development with the goal of implementation in October.

2 Recommendation

That the Board note and support the ongoing work

3 Problem statement

Dunedin Hospital Emergency Department has frequent episodes of overcrowding that create practical obstructions to care, risk and distress to patients and families.

The Emergency Department of an acute hospital that has flow constraints becomes the barometer for the whole hospital. An overcrowded ED does not necessarily mean that the problem lies within that service it is just that this is the point in the system where a flow problem becomes visible. The Emergency Department team can make positive improvements to their operation but cannot directly influence issues elsewhere that are delaying flow.

This represents failure in the systems supporting patient flow. These are multifactorial including:

- Lack of immediately available inpatient beds (access block)
  - Delays in discharge
  - Staffing constraint – Allied Health
  - Assessment delays
  - Investigation delays
  - Delays in acute theatre flow
  - Variation in inpatient bed demand
  - Staffing constraints

- Patient assessment delay
  - ED patients – due to overcrowding, surge of volumes
  - Prospective in-patients
    - In-patient medical teams workload out of hours
- Delays in transport of patients to in-patient wards

The complexity of these issues, which involve all components of patient flow make it difficult to respond rapidly and accurately to address problems when patient flow is constrained. There is potential for tension between patient teams when there are delays and teams do not appreciate the full workload of other teams. Tension between services can make resolving flow issue more difficult.

The primary response to delayed patient flow is a whole of hospital and whole of system programme with a series of defined elements – this is the basis of the Valuing Patient Time programme.

A useful component of such a programme is a process to respond to immediate issues of flow in a systematic way that is transparent and supports good teamwork. A standardised escalation system provides a framework for this that can give a clear signal of the status of flow, visible right across the system. Aligning the escalation (alert) levels to a set of planned actions can assist in mitigating immediate risk. This ensures clear expectations are known by all stake holders within the system. In addition, continuously recording the flow – as indicated by delays in ED - will give over time information on performance and identify patterns and further opportunities for improvement.

An escalation plan will not in itself solve flow problems and should not been seen as a way to resolve flow issues apart from mitigating risk in the short term. The issues identified in the process will provide a substrate for improvements in the system.

4 Progress

Development of a defined, documented and widely understood whole of hospital escalation process is underway. The CMO and the GM of Operations lead this with support from key nursing and medical leaders.

An outline framework has been developed (Appendix 1). This has been shared with clinical teams including some suggested response actions.

Data analysis in relation to referral patterns and response times to inpatient specialty teams has occurred and been presented to the teams.

The work to be completed is:

- Confirm the escalation indicators for each level – Green to Black. These will be based on the demand and risk characteristics in ED.
- Processes and authority to change (raise or lower) the escalation status.
- Response actions by individuals – from RMOs to the Chief Executive (in a sever event)
- Systems to propagate and make hospital escalation status visible to all relevant staff and perhaps the public.

Some of these will required detailed discussion with clinical services. A thoughtful process in line with our values is an important component of this. It would be easy for such a programme to be seen as a blame process when in fact staff are working to the best of their ability in a complex and constrained system that needs continuous improvement.

5 Key timeline dates

- 07/09/2020 – Agreement on trigger levels
- 07/09/2020 – Circulate first version of planned responses
- 21/09/2020 – Second version of planned responses circulated
- 21/09/2020 – Implementation plan complete
- 05/10/2020 – Confirmation of final version
- 19/10/2020 – Implementation
- 16/11/2020 – First review of function

DRAFT DEVELOPMENT DOCUMENT version 3

DUNEDIN HOSPITAL ESCALATION PLAN

GREEN Score [ED tool}	▪ Normal business

⇩

YELLOW VRM Score [XXX] Early Overload	ED Actions ▪ [ADD Here the general ED actions] In Patient Clinical Team Actions – when 2 and 3 apply ▪ [ADD here the general inpatient team actions] Organisational response ▪ Duty manager liaises with ED ACNM to assess situation and expectations		
High ED Volume		Delays assessing referred patients	Lack of IP bed capacity
[ADD ED action list]		▪ List all patients not yet seen and currently being assessed by service and make visible – online whiteboard ▪ If more than 2 patients unseen for a service notify responsible SMO by text message ▪ If unseen + in-progress > 5 notify responsible SMO	▪ Ward CNM reviews and expedites discharges ▪ AHP teams notified to expedite discharge ▪ Prospective bed lsit compiled and made visible in ED

⇩

ORANGE VRM Score [XXX] Overload	ED Actions ▪ [ADD Here the ED actions] In Patient Clinical Team Actions – when 2 and 3 apply ▪ [ADD here the Inpatient team actions] Organisational response ▪ On-call GM attends ED to assess and ensure responses are resourced and active ▪ On-call MD attends ED to asssit coordination of IP assessments and transfers to wards		
High ED Volume		Delays assessing referred patients	Lack of IP bed capacity
[ADD ED action list]		▪ Complete Yellow actions ▪ ED SMO calls service SMOs to advise outstanding numbers and critical issues ▪ On call MD assists ED SMO in coordinating with IP teams ▪ On-call MD contacts X-ray and other support service where there are delays ▪ Move patients to wards when safe to complete assessment there	▪ Complete Yellow actions ▪ ACNM on wards assesses case mix and CDRM and opens additonal beds where possible ▪ GM Authorises additional nursing resource to open additional bed capacity ▪ Inpatient teams advised of overload to expedite discharges

⇩

DRAFT DEVELOPMENT DOCUMENT version 3

RED VRM Score [XXXX] Extreme overload	ED Actions ▪ [ADD Here the ED actions] In Patient Clinical Team Actions – when 2 and 3 apply ▪ [ADD here the IP team actions] Organisational response ▪ Executive Member attends ED to assess and assit with coordination of response ▪ Chief Executive notified ▪ Red alert level notification to Primary Care, After Hours Services and St John		
1. High ED Volume		2. Delays assessing referred patients	3. Lack of IP bed capacity
Complete Orange Actions [ADD ED action list]		▪ Complete Orange actions ▪ All SMOs attend ED where there are delays in seeing or assessing patients referred to their services ▪ Transfer referred patients to IP beds	▪ Complete Orange actions ▪ Expand bed numbers beyond CDRM capacity as advised by Director of Nursing ▪ Review all possible discharges – IN-paptient teams

BLACK Critical Situation	ED Actions ▪ [ADD Here the ED actions] In Patient Clinical Team Actions – when 2 and 3 apply ▪ [ADD here the IP team actions] Organisational response ▪ Executive Member attends ED to assess and assit with coordination of response ▪ Establish EOC and mobilise emergency response team ▪ Advise transport providers ▪ Chief Executive attends ED and EOC ▪ Board Chair Informed		
High ED Volume		Delays assessing referred patients	Lack of IP bed capacity
Complete Red actions [ADD ED action list]		Complete Red actions	Complete Red actions

DRAFT DEVELOPMENT DOCUMENT version 3

ED-SMO to Inpatient-SMO Admission Process

Protocol for patient being sent to the ward by an ED Senior Doctor when the ED is in red or black overload:

Step ONE: Has the ED SMO personally reviewed the patient?

- **Must be:** Yes

Step TWO: Does this patient, in the ED SMO's opinion, need admission to an Inpatient Service?

- **Must be one of:**
  - ☑ Unable to safely cope at home. **OR**
  - ☑ Medically too unwell to go home. **OR**
  - ☑ Need for diagnostic work-up that cannot be done as ambulatory

Step THREE: Is this patient SAFE to go to the ward without Inpatient Registrar review?

- **Must be both:**
  - ☑ Both the In-Patient SMO and the ED SMO happy to admit? **AND**
  - ☑ If Patient EWS of ≥ 5, both the ED SMO and the IP SMO must be aware and happy with this.

Step FOUR: If patient REQUIRES ADMISSION, and is CONSIDERED SAFE then they may go to the ward with agreement from the Inpatient SMO, WITHOUT prior Inpatient Registrar review.

- **Actions – ED Senior Doctor must complete all:**
  - ☑ Necessary steps here
  - ☑ And here
  - ☑ And here

13

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 ▪ 23 July 2020 minutes ▪ 20 August 2020 meeting minutes ▪ NZHPL SPE 2020/21 ▪ NZHPL Procurement Catalogue ▪ Collective Insurance Programme Premium Approval b) Hospital Advisory Committee ▪ 7 September 2020 verbal report c) Iwi Governance Committee ▪ 3 August 2020 minutes ▪ Draft Partnership Agreement	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
CEO's Report - Public Excluded Business ▪ Pay Parity and Pay Equity ▪ Generalism/Medical Assessment Unit ▪ Planned Care Wait List Improvement	To allow and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.
Gastroenterology Issues	To allow activities to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.
Contract/Lease 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.
Draft Statement of Service Performance (SSP and Financial Statements	Annual Report is not public until tabled in Parliament	Section 9(2)(f)(ii) of the Official Information Act.
Annual Plan 2020/21	Plan is subject to Ministerial approval	Section 9(2)(f)(ii) of the Official Information Act.
Home and Community Support Services Briefing	To allow activities to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.

*S 32(a), Schedule 3, of the NZ Public Health and Disability Act 2000, allows the Board to exclude the public if the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 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.