Southern DHB Board Meeting

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

06/10/2020 09:30 AM - 12:00 PM

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:	6 October 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).

Changes to Interests Registers over the last month:

- Dave Cull – no longer President, Local Government New Zealand;
- Moana Theodore – sister-in-law is no longer employed by Southern DHB;
- Tuari Potiki – appointed to the District Licensing Committee, Dunedin City Council;
- Chris Fleming – sister works for Arvida Group (aged residential care provider, North Island only). No longer Deputy Chair, InterRAI NZ;
- Julie Rickman – shareholder and Director, Inversionne Ltd (clothing wholesaler).

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 23/09/2020

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)~~	Removed 23.09.2020.	
	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		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company(.	
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		
	08.09.2020	Member, District Licensing Committee, Dunedin City Council (1 September 2020 to 31 May 2023)		
	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)~~	Removed 07/09/2020	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	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
Hamish BROWN	22.09.2020	Nil	
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	
	~~25.09.2016~~	~~Deputy Chair, InterRAI NZ~~	Removed 23.09.2020
	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	

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
	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.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
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	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	~~17.11.2017~~	~~Wife works for key technology supplier CCL~~	~~Nil~~
	18.12.2017	Daughter, medical student at Auckland University.	

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
	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
	04.08.2020	Shareholder and Director, Inversionne Limited	Nil, clothing wholesaler.
		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.
	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
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

Minutes of the Southern District Health Board Meeting

Tuesday, 8 September 2020, 9.30 am
Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Dave Cull	Chair
	Dr David Perez	Deputy Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	*(by Zoom)*
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	
	Miss Lesley Soper	*(by Zoom)*
	Dr Moana Theodore	
In Attendance:	Mr Roger Jarrold	Crown Monitor *(by Zoom 9.30 to 10.30 am and 12.45 to 2.55 pm)*
	Mr Chris Fleming	Chief Executive Officer
	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 *(from 10.00 am)*
	Dr Nicola Mutch	Executive Director Communications
	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 APOLOGIES

An apology was received from Mr Andrew Connolly, Crown Monitor.

It was resolved:

"That the apology be accepted.

D Cull/L Kelly

3.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda (tab 3) and the following updates notified:

- Dr Theodore – sister-in-law is no longer employed by Southern DHB;

- Mr Potiki – appointed to the District Licensing Committee, Dunedin City Council.

It was resolved:

"That, with the above amendments, the Interests Registers be received and noted."

D Cull/J O'Callaghan

4.0 PRESENTATION: UPDATE ON THE IMPLEMENTATION OF THE PRIMARY AND COMMUNITY STRATEGY

The Board received an update from the Executive Director Strategy, Primary and Community (EDSP&C) on Healthcare Homes, Community Health Hubs and Locality Networks, which included a summary of the objectives of each programme, what had been achieved and the next steps (tab 15).

The Chief Medical Officer joined the meeting at 10.00 am.

The EDSP&C then responded to questions from members on aspects of each programme.

5.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 4 August 2020 be approved and adopted as a true and correct record."

I Beekhuis/T King

6.0 ACTION SHEET

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

Performance Monitoring

The CEO reported that the Advisory Committee Chairs and lead executives had met the previous day and he would circulate a note to the Board on what was agreed about the focus of each of the committees.

Movement of Activity from Secondary to Primary Care

The EDSP&C reported that the meeting scheduled for 4 September 2020 to finalise the details of the skin lesion programme had been delayed. She confirmed that clinicians were involved in the discussions and consideration would be given to establishing a clinical oversight group.

Resourcing Implication of PHARMAC Decisions

The EDSP&C reported that work had been done on the flow-on costs from PHARMAC decisions and SDHB's population burden, both of which were key considerations in the Pharmaceutical Improvement Plan submitted to the Finance, Audit and Risk (FAR) Committee.

It was agreed that reporting on this issue would be submitted to the FAR Committee.

Compass – Meals on Wheels Trial

An update on the in-house production of meals on wheels was circulated with the agenda and taken as read.

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 20 August 2020, during which she highlighted the following items.

- Leave management and planning was discussed and it was agreed that HR indicators would be included in performance reporting.
- The need for comprehensive expenditure management plans was discussed
- Senior Medical Officer vacancies and plans to address shortages were reviewed and the length of time positions are vacant would be monitored. COVID-19 was impacting Southern DHB's ability to recruit from overseas.
- Other items covered included: capital expenditure, safe and efficient nurse staffing, the annual report and CFIS timelines, phased budget for 2020/21, and key IT projects.
- The Committee was reassured by the continuing attention being given to clinical quality risk measures.
- The Strategic Risk Report was discussed and a risk workshop scheduled for November 2020.
- Reporting on Health, Safety and Welfare was continuing to improve.

It was resolved:

"That the Board receive and note the verbal report on the FAR Committee meeting held on 20 August 2020."

D Cull/I Beekhuis

Community and Public Health and Disability Support Advisory Committees

The unconfirmed minutes of the Community and Public Health and Disability Support Advisory Committees (CPHAC/DSAC) meeting held on 3 August 2020 were circulated with the agenda (tab 8.2) for members' information, and the Committee Chairs highlighted key items.

It was resolved:

"That the Board receive and note the unconfirmed minutes of the CPHAC/DSAC meeting held on 3 August 2020."

T Potiki/M Theodore

Hospital Advisory Committee

Dr David Perez, Hospital Advisory Committee (HAC) Chair, gave a report on the HAC meeting held on 7 September 2020, during which he summarised the key points from the following presentations received by the Committee:

- Valuing Patients' Time (VPT);
- A Journey Towards Integration: a model of care for patients with rheumatological conditions;
- Telehealth for the Southern Health System.

Dr Perez reported that the Hospital Advisory Committee recommended that the Board support the continuation of two initiatives used during COVID-19: telehealth and exploration of a seven-day hospital service programme.

It was resolved:

"That the Board receive and note the verbal report of the Hospital Advisory Committee meeting held on 7 September 2020 and endorse in principle the inclusion of the following two programmes in the District Strategic Plan and 2020/21 Annual Plan, with periodic reporting back on progress:

1. **Exploration of seven-day hospital service provision, and**
2. **The comprehensive implementation of telehealth."**

D Perez/I Beekhuis

Mr Roger Jarrold, Crown Monitor, left the meeting at 10.30 am

Iwi Governance Committee

Draft Relationship Agreement

The Board considered a draft governance relationship agreement between Southern DHB, WellSouth Primary Health Network and the seven Papatipu Rūnaka from the Waitaki River south (tab 8.4.1).

The Board was informed that the Iwi Governance Committee (IGC) Chair had raised concern about the wording of clause 12.1 Remuneration, which aligned rates with DHB statutory advisory committees. She felt the language needed to be consistent and recognise the partnership relationship.

It was resolved:

"That the Board:

1. **Endorse the Iwi Governance Committee Relationship Agreement, noting that clause 12.1 remains to be clarified and confirmed, and**
2. **Delegate authority to the Board Chair to finalise and approve clause 12.1."**

D Cull/L Soper

It was suggested that the November 2020 Board meeting in Invercargill would be an opportune time to sign the agreement.

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 9) was taken as read and the CEO drew the Board's attention to the following items.

- *Organisational Performance* - One month into the new financial year the DHB was on budget fiscally but more work was required to understand activity volumes.
- *Caseweights per Full-time Equivalent (FTE)* – More work was required to understand the data, which appeared to be showing a progressive reduction in productivity.

  It was suggested that it would be useful to include First Specialist Assessments (FSAs) per medical staff FTE in reporting.
- *Ongoing COVID-19 Management Response* – A lot of effort had gone into resurgence planning, with an early focus on Public Health, Primary Care and Aged Care, with staff being trained and rostered to step up when needed.

  Work was being undertaken with the Ministry of Health and MBIE on potentially establishing a sporting managed isolation facility (MIF) in Queenstown for international sporting teams.
- *Senior Medical Officer (SMO) Cover, Rural Hospitals* – A collaborative approach to recruitment and retention of staff in rural hospitals was being explored, however pay parity was an issue.
- *Primary Maternity Facilities Consultation* – A public meeting was held in Cromwell on 23 July 2020 and another was scheduled for 9 September 2020 in Wanaka, with the aim of making a recommendation to Board in November 2020.
- *Access to Medical Imaging Diagnostics* – MRI waiting times had decreased, however performance would be negatively impacted by the MRI replacement in Southland and the failure of the MRI machine in Dunedin.
- *Mental Health, Addictions and Intellectual Disability (MHAID)* – A request for proposal (RfP) had gone out for a consultant to undertake an independent review of Southern DHB's MHAID services.

Mr Mike Collins, Executive Director People, Culture and Technology, joined the meeting at 11.20 am.

The Chief Nursing and Midwifery Officer presented the Care Capacity Demand Management (CCDM) progress report for quarters 1 to 4 (tab 9).

Management then responded to questions from members. During discussion, the Board requested:

- An update on Urology for the next meeting;
- That the walkabout to Ward 10A be rescheduled.

It was resolved:

"That the CEO's report be noted."

D Cull/T Potiki

9.0 FINANCE AND PERFORMANCE

The finance, volumes and performance reports to 31 July 2020 (tab 10) were taken as read and management took questions.

The CEO informed the Board that the performance report required some more work and advised that the accuracy of the following indicators was being checked:

- *Theatre utilisation rate* – it appeared that acute theatres were being counted 24/7;
- *Short notice postponements* – some of this may be due to scheduling churn being included in the data;
- *ESPI 2 and 5 120 day breaches* – the tail of breaches needed to be focused on, as it appeared some complex cases and postponements by patients were contributing to the breaches.

It was resolved:

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

D Cull/J O'Callaghan

10.0 ENVIRONMENTAL SUSTAINABILITY

The Executive Director People, Culture and Technology (EDPC&T) presented an update on Southern DHB's Green HealthCare strategy and action plan (tab 11). He advised that in 2017-18 the Minister of Health asked that environmental sustainability become a focus for DHBs and activity that would be concentrated on over the next twelve months would be included in the Southern DHB's Annual Plan.

The Executive Director Finance, Procurement and Facilities (EDFP&F) reported that her team were working with the Energy Efficiency and Conservation Authority (EECA) to undertake trials on conversion of Southern DHB's coal burning facilities to biomass. Discussions had been held with Pioneer regarding conversion of Boiler 2 in Dunedin and efforts were being made to get a trial in place for the Southland boiler.

The EDFP&F also reported that efforts were being made to minimise the use of disposable items and minimise waste.

During discussion, the Board:

- Requested a copy of Matt Jenks' report on Southern DHB's carbon footprint assessment 2016-17 and emissions reduction plan 2030;
- Suggested that staff collaborate with the University of Otago on environmental sustainability.

It was resolved:

"That the Board note the briefing paper and that progress on the strategy and action plan will be submitted quarterly to the Ministry of Health."

D Cull/T Potiki

The Executive Director People, Culture and Technology left the meeting at 12.10 pm.

11.0 POWER OF ATTORNEY – CHIEF EXECUTIVE

The Board considered a request to grant the Chief Executive Office power of attorney to enter into deeds of lease within his delegated authority (tab 12).

It was resolved:

"That the Board:

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

J O'Callaghan/L Soper

Mr Roger Jarrold, Crown Monitor, re-joined the meeting at 12.10 pm.

12.0 DUNEDIN HOSPITAL ESCALATION PLAN

The Chief Medical Officer presented an update on the development of an escalation plan to signal and respond to delays in patient flow through the hospital system (tab 13).

It was resolved:

"That the Board note and support the ongoing work."

D Cull/M Theodore

PUBLIC EXCLUDED SESSION

***At 12.15 pm it* was *resolved*:**

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

D Cull/J O'Callaghan

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 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	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.

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

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

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

The meeting closed at 2.55 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 25 September 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020	**Performance Dashboard** (Minute item 9.0)	▪ Caseweights per FTE to be added as a productivity indicator.	EDQCGS	▪ Included in last month's CEO report, will look to enhance into dashboard.	
Sept 2020	(Minute item 8.0)	▪ FSAs per medical staff FTE to be added to reporting.		▪ Suggest this is a deep dive outside of the organisational performance dashboard and not a new tile within.	
August 2020	(Minute item 9.0)	▪ Commentary to be added to explain breaches.	EDQCGS	▪ Actioned	Complete
		▪ All graphs to be labelled and "Staff Adverse Events" label to be checked.	EDQCGS	▪ Label is correct. It is a staff events graph, not a patient one.	
		▪ Data integrity issues to be checked, including: ○ Short Notice Postponements to be defined.	EDQCGS	▪ In progress.	
		○ Unplanned Readmissions graph to be checked.	EDQCGS	▪ Actioned.	Complete
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.	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 included in Committee and Board packs from November 2020	~~June 2020~~ November 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		▪ PHO performance indicators to be submitted to the Community & Public Health Advisory Committee.		These were included in the October CPHAC pack.	Complete
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	**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	An update on this initiative, as well as a full explanation in respect of funding is included in the CEO report this month.	~~September~~ October 2020
Sept 2020	**Continuation of COVID-19 Initiatives** (Minute item 7.0)	The following two programmes to be included in the draft District Strategic Plan and 2020/21 Annual Plan, with periodic reporting back on progress: 1. Exploration of seven-day hospital service provision, and	EDSP&C	Actioned. Will be reported to CPHAC and HAC respectively from November.	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		2. The comprehensive implementation of telehealth.			
Sept 2020	**Urology** (Minute item 8.0)	Update to be provided on urology performance.	EDSS	Attached.	Complete
Sept 2020	**Environmental Sustainability** (Minute item 10.0)	▪ Members to be provided with a copy of Matt Jenks' report on SDHB's carbon footprint assessment and remissions reduction plan.	BS	▪ Uploaded to the Diligent Resource Centre.	Complete
		▪ University of Otago to be approached re collaborating on environmental sustainability.	EDPC&T	▪ Contact has been made with the University and will work in partnership with them.	Complete

Urology update 18 September 2020

Provided as per the action, copied below:

Sept 2020	**Urology** (Minute item 8.0)	Update to be provided on urology performance.

15 September 2020 Waiting list status.

Outpatient Wait List

For outpatient appointments (first specialist appointment) the Urology service in Dunedin achieved ESPI 2 compliance (no patients waiting > 120 days) last year, using the Ministry's prioritisation tool to ensure that the referrals accepted into the service were in priority order and safely matched to the capacity within the service. The service has been compliant within 1 or 2 breaches ever since. The Southland service is also compliant within 1-2 breaches.

Inpatient Wait List

Dunedin surgical waiting list – 170 with 89 waiting longer than 4 months.

Southland surgical waiting list 42 with 6 waiting longer than 4 months.

Dunedin has 170 patients on the waitlist of which 89 have been waiting longer than 4 months, down from 218 total in July. Specific targeting of patients that have waited too long, additional private capacity and nursing case management of complex patients, has resulted in this reduction. There is additional funding via the Ministry of Health (MoH) Planned Care strategy which will see the number of patients reduce to zero in June 2021.

Southland has 42 patients on the waitlist of which 6 have been waiting longer than 4 months, this is down from 77 total in June. Surgical capacity in Southland is adequate to meet demand if augmented with some private capacity. Although this total capacity is lower than required for fluctuating demand, this is actively managed with use of flexible list allocation and outplacing in private.

For noting during the COVID period, the surgical teams on both sites continued to deliver cancer and urgent surgery to patients. The patients currently waiting for extended periods are not waiting for urgent cancer treatment.

The district team are to introduce a standardised Clinical Priority Assessment Criteria (CPAC) across both sites for access to theatres to help with prioritising urology demand. This will assist to sustainably manage the waiting lists. This is similar to other specialties where the MoH mandated use of a scoring tool many years ago. The expected MoH Urology CPAC tool is waiting to be released however the team have determined it is appropriate to introduce the tool now to ensure there is a balance in capacity and demand and the high priority patients get access to surgery.

Across district working for Urology has been strengthened with a district call introduced in 2020 and quarterly meetings held centrally (2018-2020). A Dunedin based SMO travels to Southland to service the on-call roster making it a 1:3 roster where it has been a 1:2 roster in the past. The visiting SMO also undertakes clinic and theatre to allow leave in Southland without a reduction in services. The service has had its first district meeting of the year in August where the SMO's, nurses and management of both sites met to move the service forward under the "one service, two sites" governance model.

FINANCE, AUDIT AND RISK COMMITTEE MEETING, 17 SEPTEMBER 2020

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

SOUTHERN DISTRICT HEALTH BOARD
FINANCE, AUDIT AND RISK COMMITTEE

17 September 2020

RECOMMENDATIONS TO BOARD:

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

Drug and Alcohol Policy

"That the Board approve the attached Drug and Alcohol Policy."

Colonoscopy Patient Review – Please see paper included in agenda.

Drug and alcohol policy

This policy outlines how Southern District Health Board will manage the risks posed by alcohol and other drugs, in order to maintain a positive safe and healthy environment for our patients and staff.

1. Scope

1.1 Applies to all Southern District Health Board ("Southern DHB") workplaces and workers.

2. Purpose

2.1 To protect the health and safety of persons to whom Southern DHB has a duty of care, including our patients, workers and other persons who may be present in our workplace.

2.2 To ensure a positive, safe and healthy workplace.

2.3 To ensure consistent, fair management of drug or alcohol-related incidents or issues.

3. Principles

3.1 Impaired workers pose a significantly higher safety risk to themselves and to other people

3.2 Abuse of alcohol or other drugs is a health-related matter; reasonable efforts will be made to support workers who voluntarily disclose a personal alcohol or drug problem.

3.3 All parties must act reasonably and proportionately; acting without prejudice and observing the principles of good faith, natural justice, privacy and confidentiality.

4. Policy statements

4.1 No person subject to this policy shall present for work under the influence of drugs or alcohol.

4.3 Every person is strictly prohibited from misappropriating, consuming, possessing, purchasing, selling, supplying, storing or transferring drugs in a Southern DHB workplace or during work.

4.4 Alcohol may only be consumed at Southern DHB workplaces and / or during work hours at a specific function or event, which must be authorised in writing by the Chief Executive.

4.5 Alcohol shall not be promoted or given as a gift to any other person or organisation.

4.6 Southern DHB will provide a rehabilitation and return to work plan for any employee who makes a voluntary disclosure of a personal drug or alcohol problem, assuming it is appropriate and safe to do so.

4.7 Making a voluntary disclosure is not in itself a breach of this policy; provided that the disclosure is made prior to Southern DHB having reasonable cause to suspect a breach of this policy.

4.8 Southern DHB may require contractors and suppliers to implement a drug and alcohol policy that meets or exceeds the requirements of this policy.

5. Southern DHB responsibilities

5.1 Southern DHB must take all reasonably practicable steps to protect workers and other people from risks to their safety or health that arise from our work or workplace.

5.2 Southern DHB is obliged to report the inability of a health practitioner to perform required functions due to mental or physical condition; including without limitation a condition or impairment caused by alcohol or drug abuse.

6. Individual responsibilities

6.1 Every person subject to this policy must:

a) Ensure they are fit for work, and not under the influence of drugs or alcohol;
b) Take responsibility for their own conduct, and ensure their behaviour is consistent with Southern DHB values;
c) Take reasonable care that personal use of alcohol or drugs does not adversely affect the health and safety of other persons;
d) Take action to manage the risk of alcohol or drug impairment in others, by reporting concerns, issues or incidents to their line manager;
e) Comply with any reasonable instruction given to achieve the purpose of this policy.

7. Compliance provisions

7.2 Southern DHB may undertake lawful searches and/or surveillance of its workplaces.

7.3 Southern DHB may commence investigations into potential breaches of this policy.

7.4 As part of an investigation, and having first established 'reasonable cause', Southern DHB may request any person subject to this policy to provide a specimen for drug and/or alcohol testing in accordance with New Zealand Standards and/or relevant Southern DHB procedures.

7.5 Southern DHB may give any reasonable instruction necessary to achieve the purposes of this policy, which might include temporarily postponing a worker's usual duties i.e. to 'stand-down' from duty while they remain at work.

8. Consequences of breach

8.1 Breach of this policy may constitute serious misconduct.

8.2 If an investigation concludes that this policy was breached, Southern DHB may take or require whatever actions are reasonable and appropriate in the circumstances.

8.3 Without limitation, actions could include any one or a combination of:

a) Rehabilitation and return to work,
b) Further education or training;
c) Restricted duties or re-deployment;
d) Removal of access permission and/or adverse contractual consequences (in the case of a contractor);
e) Removal of access permission and/or referral back to a tertiary institution (in the case of a student);
f) Disciplinary action in accordance with the Disciplinary Policy (in the case of an Employee).

9. Complaints

9.1 Any person subject to this policy may make a complaint about the application of this policy or associated processes.

9.2 Complaints should initially be directed to the General Manager Health, Safety and Welfare.

9.3 Complaints will be investigated within 20 working days.

10. Definitions

Term	Definition

Drug(s)	*Includes:* • Substances listed in schedules 1-4 of the Misuse of Drugs Act 1975 (including future amendments) and any substance analogous with those substances; • A psychoactive substance, as defined by the Psychoactive Substances Act 2013; • Any other synthetic or natural substance with psychoactive effects capable of inducing impairment, which the user knows, or ought to know, has such an effect. • For the avoidance of doubt: includes cannabis and cannabinoids. *Does not include:* Medicines as defined in the Medicines Act 1981 that are: • Used in accordance with medical directions and unlikely to cause significant impairment. • Legitimately being stored, transferred or supplied for healthcare purposes.
Impaired / impairment	The loss or abnormality of a body function [resulting from or influenced by personal use of drugs or alcohol] that may be anatomical physiological or psychological [cognitive or behavioural]. Note: not intended to include chronic impairment or disability that is unrelated to personal use of drugs or alcohol. Refer to Drug and Alcohol (Investigation and Testing) Procedure for indicators of impairment.
'Reasonable cause'	To have knowledge of facts which, although not amounting to direct knowledge, would cause a reasonable person, knowing the same facts, to come to the same conclusion. For the purpose of this policy, means having reasonable cause to suspect a breach of this policy. Without limitation, 'reasonable cause' may be established by any one or more of the following: • A patient makes a *bona-fide* formal complaint that their health care provider appeared to be impaired by drugs or alcohol; • There are observable indications or signs of drug or alcohol-related impairment; • There is evidence of theft or misuse of controlled drugs or medicines; • There is evidence that drugs were possessed, purchased, sold, supplied, stored or transferred during work time (including during breaks, whether on or off the workplace); or • An independently validated drug-detection dog indicates to its handler that a worker has recently used, been in contact with, or may be in possession of drugs. Notes: Reasonable cause applies to individual workers; not to a whole shift or whole workforce. Reasonable cause must be established at the time, or within a reasonable period, of a test being required. Reasonable cause must be established *before* commencing drug or alcohol testing.
'Stand-down'	May include temporarily modified or restricted duties; or any duties required to comply with other instructions to ensure health or safety and that are not the worker's usual duties, such being directed and accompanied to drug or alcohol testing facilities. Note: For the avoidance of doubt, stand-down is not suspension. Stand-down is paid work, carried out in a workplace.

'Under the influence'	A person is presumed to be under the influence of drugs or alcohol, and therefore to have breached the primary policy statement, if they: • Present for work whilst apparently impaired, with detectable drugs in their system; or • Present for work whilst apparently impaired, with detectable alcohol in their system; or • Present for work with a blood alcohol level in excess of the legal limit to drive (whichever threshold is lower); or • Refuse to provide a specimen for drug or alcohol testing, but exhibited signs or behaviours giving rise to 'reasonable cause' and for which an investigation concludes there is no other reasonable explanation.
Work	Includes paid or unpaid work carried out for or on behalf of Southern DHB by any person to whom this policy applies. For the avoidance of doubt, working from home, or being 'on-call' is work.
Worker	As defined in the Health and Safety at Work Act 2015. A worker is an individual who carries out work in any capacity for Southern DHB, whether paid or unpaid, employed or contracted. Employed workers are subject to this policy whilst at work. Contracted workers and students are subject to this policy whilst at work in a Southern DHB workplace. The management of an investigation or breach may differ depending on the employment relationship.

Associated Documents:

- Health safety and welfare policy
- Rehabilitation of staff policy
- Drug and Alcohol (Investigation and Testing) Procedure
- Code of conduct and integrity
- Disciplinary policy

Legislation

- Health and Safety at Work Act 2015
- Misuse of Drugs Act 1975
- Psychoactive Substances Act 2013
- Medicines Act 1981
- Health Practitioners Competency Assurance Act 2003

JOINT MEETING OF THE COMMUNITY AND PUBLIC HEALTH (CPHAC) AND DISABILITY SUPPORT ADVISORY COMMITTEES (DSAC), 5 OCTOBER 2020

- Verbal report from Moana Theodore, DSAC Chair, and Tuari Potiki, CPHAC Chair

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 7 September 2020, commencing at 1.30 pm in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr David Perez	Chair
	Mrs Jean O'Callaghan	Deputy Chair
	Ms Justine Camp	Committee Member
	Dr John Chambers	Committee Member
	Mr Dave Cull	Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member *(by zoom)*
	Dr Moana Theodore	Committee Member
In Attendance:	Ms Ilka Beekhuis	Board Member *(by zoom)*
	Mrs Kaye Crowther	Board Member *(by zoom)*
	Mr Terry King	Board Member
	Mr Andrew Connolly	Crown Monitor *(by zoom)*
	Mr Chris Fleming	Chief Executive Officer
	Mr Patrick Ng	Executive Director Specialist Services
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

The Chair welcomed everyone to the meeting and acknowledged Mrs Joanne Fannin as the minute taker for the Hospital Advisory Committee in her new role as Personal Assistant to the CEO's Office.

2.0 APOLOGIES

An apology for lateness was received from Ms Justine Camp (new appointment to the Committee from the Iwi Governance Committee) and an apology for early departure was received from Mr Dave Cull and Mr Gilbert Taurua.

3.0 DECLARATION OF INTERESTS

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

The Chair asked for any changes to the registers to be sent to the Minutes Secretary 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 6 July 2020 be approved and adopted as a true and correct record."

D Perez/J O'Callaghan

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 4).

Nitrous Oxide Usage

- The Executive Director Specialist Services (EDSS) advised that a report received has indicated a reduction in usage of 1301 tonnes since the reporting started. He asked that the action be carried over one more time due to concerns that there may be a reporting issue as there is no explanation for the reduction in usage.

Colonoscopy

- The standardised Colonoscopy intervention rate increased from 76 per 10,000 in 2015/16 to 100.2 in 2018/19. A request was made for a comparison to the national rates to be provided.

6.0 VALUING PATIENTS' TIME

Mrs Jane Wilson, Chief Nursing and Midwifery Officer and Dr Nigel Millar, Chief Medical Officer presented on the Patient Flow – a strategy to improve quality, performance and efficiency.

The Committee was informed on the following:

- The challenges since the last meeting with the resurgence of COVID-19 and getting data.
- Why VPT is critical in an integrated health system.
- The impact of 10 days in hospital on ageing in the muscles of people over 80.
- The pathway forward in joining up the whole system, connecting primary care initiatives to hospital patient journeys.
- The work being done with the patient cohort in the Emergency Department (ED) in Southland.
- The aligning metrics and dashboards will be provided to all staff in individual departments once they have been refined.
- The programmes of work underway, e.g. Fit to Sit in Dunedin, Generalism and Older People's Health.
- The five components of the safer patient flow bundle which is designed to expedite inpatient care and discharge.
- The importance of engagement with the Clinical Council, Clinical Directors and other Inter-professional Leads.

- Questions every patient and relative/carer should know the answer to and the senior review process.

Ms Justine Camp joined the meeting at 2.00pm.

- Rapid rounds and self-assessment. Members viewed a video clip with staff speaking on rapid rounds.

Management answered questions from members on the programme, including whether there are sufficient district nurses to support those being discharged, involvement of the Home Team and afternoon wrap-ups and evaluation.

The Hospital Advisory Committee thanked the team for their presentation and strongly endorsed the Safer Patient Flow concept and programme, whilst acknowledging that it is early days and they look forward to seeing the delivery in time.

Dr Jo Mitchell joined the meeting at 2.10pm.

The Chairman acknowledged and welcomed Ms Justine Camp and Dr Jo Mitchell to the meeting.

7.0 A JOURNEY TOWARDS INTEGRATION: A MODEL OF CARE FOR PATIENTS WITH RHEUMATOLOGICAL CONDITIONS

Dr Jo Mitchell, Rheumatologist, presented on a model of care for patients with rheumatological conditions which allows for many patients with stable rheumatological conditions to be largely managed in the community. The Committee was informed on the following:

- The journey of three years that is on-going.
- Integrated Care is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems.
- Rheumatology is a multi-disciplinary specialty with a high level of interaction within services.
- The Rheumatology Service is an outpatient based specialty, but does have in-patients.
- The wide range of conditions that fall under the Rheumatology specialty.
- The Rheumatology team and service vision.
- Patient involvement, building relationships and engaging with primary care and the re-design of models of care.
- Consumer engagement and the establishment of the Consumer Advisory Group (CAG) in 2019.
- Patient experience surveys, developed with the Health Quality and Safety Commission.
- Survey of Rheumatology patients by telephone between February and June 2020 and the need to follow up to understand why 23% of those surveyed indicated they would not want a telephone appointment again.
- Engagement with the Health Pathways Team.
- Primary care engagement and initiatives to achieve that.
- Vision focus and transforming thinking.
- Service redesign from the learnings and region and practice specific solutions.

- Telemedicine pilot in Wanaka and meeting with Wanaka GPs.

Dr Mitchell responded to questions from management and received feedback as follows:

- Locality Network members in Central Lakes spoke highly of the Rheumatology service and other services could be integrated in a similar way.
- Communication via e-mail is not always secure and the use of the Electronic Referral Management System (ERMS) is encouraged.
- The initiative has created more of a demand on Dr Mitchell's time, but it is believed that as the new model is embraced that will change.
- Ms Camp queried how the new integrated model would facilitate more whānau care in the area of Rheumatology. Consideration is being given to whānau going to their GP and having a telemedicine consultation, so they don't need to take time off work. Any feedback on that concept or other ideas are welcome.
- The "hands on" aspect of Rheumatology is addressed by having a GP in the room with the patient and the GP does the examination. The goal is to upskill primary care in the Rheumatology examination.
- To maximise efficiencies, a remote team is required.
- The EDSS advised on the proposed funding mechanism.

The Hospital Advisory Committee thanked Dr Mitchell for her presentation, noting that it is a prototype that will affect other services. The Committee acknowledged that it is still a work in progress and undertook to support the initiatives as much as possible.

Mr Gilbert Taurua left the meeting and Mr Simon Donlevy, Ms Emma Bell and Professor Patrick Manning joined the meeting at 2.40pm. Ms Miranda Buhler joined the meeting via zoom at 2.40pm.

8.0 TELEHEALTH FOR THE SOUTHERN HEALTH SYSTEM

Professor Patrick Manning, Specialist Endocrinology; Ms Miranda Buhler, Physiotherapist; Mr Simon Donlevy, General Manager Medicine, Women's and Children's Health and Ms Emma Bell, Programme Lead, presented on Telehealth for the Southern Health System (He Hautoka, he hauora). The Committee was informed on the following:

- As part of the process discussions have been held with Dr Jo Mitchell to ensure that the respective projects dovetail in with each other. Telehealth in Rheumatology is a long way ahead of other services.
- A recap on what telehealth is.
- The benefits of telehealth for both patients and the DHB.
- Telehealth models.
- Progress since COVID – a steering group and interest group have been established.
- Progress made by the Steering Group and the development of a toolkit for services contemplating using telehealth.
- Targets and evaluation – the challenges and the measures.
- The numbers using telehealth within Southern DHB. There has been a five-fold increase in services using Telehealth since April 2019.

- Overall Telehealth is good for our population and there is plenty of enthusiasm around it. Expansion into utilisation to increase communication between Primary and Secondary care has much potential and there is a need for only relatively modest additional resource to realise the full potential.

- How can the HAC support increased adoption of Telehealth?
- Professor Manning provided an update on the evolution of his use of Telehealth in his specialty of Endocrinology following COVID, citing the positive feedback from patients re the time saving and the increased productivity. He advised the need to educate people about the use of telehealth and reported on the increase in work involved for administration staff. Telehealth is time efficient for people living locally as well as those based rurally.
- Ms Buhler provided an update on the benefits of Telehealth for her as a Hand Therapist. She noted barriers in the past with availability of facilities with access to the technology and noted the benefits of being able to link directly into people's homes. The age of some devices can cause connection issues, but overall interactions have been successful remotely. Telehealth is worth the investment and allows less people to miss out on good quality care.

The team answered questions from members on Telehealth, including providing statistics on Did Not Attends (DNAs). Feedback was provided on the issue of risk and Medico-Legal considerations, with Professor Manning acknowledging risk and outlining mitigation strategies, noting that where there are concerns the patient would need to attend a meeting in person. Education in primary care and good quality cameras would assist in addressing some of the issues. There is currently no telehealth system that interfaces with the Inpatient Management System (IPM), which is causing the additional burden for administration. There is a booking function within Microsoft Teams, which is being developed and will make it easier for administration staff to book Telehealth appointments, but this is still an extra step. Canterbury DHB has managed to integrate Microsoft Teams with the South Island Patient Administration System. Professor Manning advised of enhancements being developed that will enable a field to be added to ERMS to indicate when a Telehealth appointment is acceptable to the patient.

Discussion was held on equity and the use of community hubs to increase cultural capacity within the DHB for whānau. Telehealth also provides a tool to reach back out in to the community, accommodating whānau support.

The team consider that Telehealth has now reached a stage where it can be considered a standard procedure. It was agreed that the public need to be educated on the benefits of Telehealth so they know it is an option available to them. The CEO has asked the Community Health Council to look at how they can engender a process where the community ask for it. Work is being done to roll Telehealth out in a measured way to ensure that Clinicians and other health professionals can cope with the demand created.

The Hospital Advisory Committee thanked the team for their presentation, noting that it is good to see Telehealth imbedded in the system and members look forward to receiving future updates.

Mr Simon Donlevy, Ms Emma Bell, Professor Patrick Manning, Dr Jo Mitchell and Ms Miranda Buhler left the meeting at 3.40pm.

9.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director Specialist Services' Report

The Executive Director Specialist Services (EDSS)' monthly report (tab 8.1) was taken as read and the EDSS drew the Committee's attention to the following items:

Surgical Case Weights

The EDSS advised that for the month of July 2020, 350 case weights more than plan were completed. Of this, 100 case weights were additional outsourcing due to initiating recovery of surgery early, leaving 250 case weights delivered more than plan. Most of the activity was due to a clear run with cardiothoracic cases and a catch up of cardiac activity following the closure of the Catheter Laboratory during the COVID lockdown earlier in the year. This was a positive result in terms of catching up with plan, but resulted in additional costs for clinical supplies. An expenditure problem has resulted and a special report on that is included as part of the financial section.

Outpatients performance

Good performance was recorded, with activity starting to recover to pre COVID levels of outpatient reaches and good initiatives driving improvement.

Prioritisation tool

The prioritisation tool is continuing to achieve good results for the services it has been rolled out to. An innovation funding request has been put in to the Ministry of Health (MoH). Resourcing would allow systematic delivery across all specialties.

Inpatient waitlist (patients waiting more than 120 days for surgery)

There are currently 1000 patients on the inpatient waitlist. Most services are in balance so what is being accepted on the inpatient waitlist on a weekly basis on average matches what is being taken off through surgical activity. COVID, strikes pre COVID and some history has caused a high accumulation of long waiting patients. It is expected that recovery money will assist in clearing 60% of the list over the next three years, but some action will need to be taken in the short term. One initiative has been to build dashboards so that management can see by specialty every patient waiting greater than 120 days. Every patient who has been waiting over two years will be looked at and a call will be made to discharge or fast track back through the outpatient process.

Medical Imaging

A lot of work has been put in to recover MRI and CT following two recent equipment failures in Dunedin, resulting in one machine being out of commission for two weeks and a second machine expected to be out of commission for one week. The supply of parts from overseas has been impacted by COVID.

Emergency Department (ED)

Management has undertaken a special analysis, with a view to understanding quantitatively what happened to ED volumes during COVID. Data was available showing every transaction over the past five years. An update was given on the percentage change in volumes for both Dunedin and Southland Hospitals. Of note was the difference in reduction of presentations between Māori and non-Māori on the Dunedin and Southland Hospital sites and the slight decrease in the time spent waiting for a clinician following triage on the Dunedin site, offset by a longer wait

before being discharged. In Southland there was a significant reduction in the time spent waiting for a clinician and the overall time spent waiting between triage and discharge. The work to review and treat patients more quickly in Southland appears to be producing results.

Oncology 31 Day Target (85%)

The new dashboard for Oncology is showing good results with the 85% target being exceeded. One of the determinants of the performance is Urology. Though their average is within a timeframe, the key reason for their wait is Computed Tomography (CT). If the urgency of Urology CT referrals can be better managed the Urology result can be improved and the overall 31-day cancer performance can also be improved.

Gastroenterology

Good progress is being made in getting back to MoH target timeframes for Gastroenterology. The 14-day target for Class A patients is being exceeded across the district and the 42-day target for Class B patients is now at 66% against the MoH target of 70%. A lot of focus has gone in to Gastroenterology and a modest investment was made to get Endoscopy Nurses to run additional Endoscopy Clinics. This will ensure recovery against the 42-day target in the coming months. The surveillance performance is 36% against a 70% target and it is expected that this will be fully recovered by February 2021. Reference was made to the table included on page 12 of the EDSS report and clarity was provided in relation to the header references, which have been changed to align to the Ministry of Health (MoH) reporting requirements, i.e. "A" is urgent two-week indicator; "B" is non-urgent six-week indicator and "C" is routine.

The Chair requested that colonoscopy rates for SDHB are included in the gastroenterology dashboard. This will allow comparison with national rates.

Management received feedback and answered questions from members on the EDSS report, which included the following:

- Concern was raised over the risk with patients with co-morbidities being on the waiting list for excessive amounts of time without being treated. Further concern was raised over the impact of this on ethnicity. The EDSS provided a further breakdown of those on the waiting list and advised that the issue had not been visible in the past. A request was made for the EDSS to include ethnicity in to future reports, with a focus on Māori and Pasifika in particular.
- The EDSS reported that the prioritisation tool is working well in Urology, but needs to be working well in all other specialties as well. There is a need to establish where the line should be drawn based on capacity and clarity is required around whether where the line is drawn is safe. Where a service cannot be managed safely, a request would need to be made for additional SMO resource through a business case. Members advised the need for them to be made aware of any unmet need in the community. The CEO advised the need to look at intervention rates as well. The use of Telehealth may add a volume advantage when following up, especially in some of the surgical disciplines.

Financial Performance Summary and Surgical Services

The EDSS presented the July 2020 financial results for Specialist Services (tab 8.2) and the special report on clinical supplies variances for Surgical Services and Radiology Directorate for July 2020 and drew the Committee's attention to the following:

- The financial variance of approximately $700K for the month is in the Clinical Supplies line. $400K of that amount relates to surgical services and radiology.
- Management has determined that the case weight delivery was 9% more than planned and clinical supplies expenditure was 14% higher than planned.
- Further investigation showed $81K related to an accrual issue where hips and knee costs from June weren't picked up and accrued for in June and the expenditure was incurred in July 2020. Secondly, the radiology expenditure in clinical supplies does not correlate to case weights; that ties in to Radiology delivery.
- In summary, more than 100% of elective case weight delivery target was achieved, but management only accrue to 100% of case weight activity being earned. If the additional case weights had been recognised, it would have more than offset the additional clinical supplies costs.
- Looking at the August 2020 results as stand alone, there has been less case weight activity delivered than planned due to bed block, etc. Clinical supplies are not reflecting the reduction they should and this is being investigated.

10.0 GENERAL

The Chairman requested feedback from members on the recommendation to go to the Board from the Committee in relation to Post COVID initiatives. Members provided feedback on the proposed recommendations as indicated below:

- Implementation of Telehealth (as represented in the presentation). The Board Chair advised that the learnings coming out of Telehealth need to be feeding in to the planning for the Information Technology component of the new Dunedin Hospital Build. The change is required to optimise the use of the new Hospital.
- Seven-day Hospital Services (primarily Allied Health component). It has been recommended that there is greater allied input to enable patients to be discharged faster and more allied input over the weekend when working towards generalism. More surgery could be done over the weekends – this is currently being done as part of the recovery work. Discussion was held on review and discharge processes over weekends. The EDSS is to review five years of data on hospital activity and this will enable trends to be identified. The CMO advised that waiting lists are created through variation in either demand or supply and if that can be remedied then the result will be less people waiting for surgery. A request was made for a report giving a stocktake of the seven-day Hospital Services proposal and identification of where the barriers are. The report is to include commentary on access to diagnostics, i.e. inflow, in the middle and outflow.
- Streamlining of Cancer Pathways (work in progress).
- Regular co-ordinating meetings across services (mainly Surgical).

***It was resolved**:*

"That the Hospital Advisory Committee recommends that the Board endorse in principle the inclusion of the following two programmes in the District Strategic Plan and 2020/21 Annual Plan, with periodic reporting back on progress:

1. Exploration of seven-day hospital service provision, and

2. The comprehensive implementation of telehealth."

D Perez/L Soper

***It was resolved**:*

"That the reports be noted."

Ms Lesley Soper left the meeting at 4.15pm.

CONFIDENTIAL SESSION

At 4.15pm it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Sterile Services Update	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
2. Executive Director of Specialist Services Report i. Surgical Performance case weights and discharges ii. Inpatient Performance (ESPI5) iii. Generalism iv. Planned Care Wait List Improvement	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.
3. Previous Public Excluded Meeting Minutes and Action Sheet	As set out in previous agenda.	As set out in previous agenda.
4. Dunedin Hospital Redevelopment	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

Confirmed as a true and correct record:

Chair: _____

Date: _____

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	6 October 2020

Summary:

Considered in this paper are:

- General information and emerging issues

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

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

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

Prepared by: Chris Fleming Chief Executive Officer **Date:** 28 September 2020	**Presented by:** Chris Fleming Chief Executive Officer

RECOMMENDATIONS:

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

CHIEF EXECUTIVE OFFICER'S REPORT

1. PURPOSE

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

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

2. ORGANISATIONAL PERFORMANCE

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

- Finance report
- High Level Volumes
- Performance Dashboard.

Financial performance for the month of August is a deficit of $0.1 million compared to a planned surplus of $0.2 million, and hence $0.3 million unfavourable to plan. YTD financial performance is a $1.95 million deficit against a planned deficit of $2.0 million, resulting in a small surplus of $0.05 million. As per last month's report, forecasting of year end performance will commence at the end of the first quarter.

From a volumes perspective, overall activity remains down over the measures of case weighted discharges, Emergency Department (ED) attendances and Mental Health bed days for both the month of August (when compared to last August) and year to date (when compared to the prior corresponding financial year). Acute medical admissions account for the reduction in case weighted discharges when comparing to the prior corresponding financial year, with a 11% reduction. General Medicine and Paediatric Medicine make up the bulk of this variance. ED presentations continue to higher in Southland (+3.3%) but lower in Dunedin (-3.5%) and Lakes (-7.7%).

3. MOVEMENT OF ACTIVITY FROM SECONDARY TO PRIMARY CARE

The majority of the detail has now been worked up and this programme is likely to begin from the next quarter. It is hoped that this programme will be a template for a repeatable model of how primary and secondary care can work effectively together to deliver care closer to home, and shift activity from secondary care that it is not considered to be acute care.

In respect specifically of the patient co-pay, as is the case already in primary care, if the person has a community services card then there is no expectation that there will be a co-pay for the service if it is delivered in primary care. If the person does not have a community services card, but the lesion meets the clinical criteria for treatment (against criteria that has been agreed in respect of the size and placement of the lesion), then there will be no co-pay for the treatment. The expectation is that the referring general practitioner (GP) would have had a discussion with the

patient about whether they have medical insurance, as this should be utilised if possible, before being placed on a public list.

4. NEW DUNEDIN HOSPITAL DETAILED BUSINESS CASE

The New Dunedin Hospital Detailed Business Case (DBC) has been signed off in principle, with final sign-off to occur in 2021. A refreshed Detailed Business Case is due in December 2020.

5. ONGOING CORONAVIRUS MANAGEMENT RESPONSE

There is currently (as of 24 September) no transmission of COVID-19 in the community. A significant amount of work continues in this area, which is outlined in the following sections.

Isolation Hotels

During August a large amount of energy was expended supporting national conversations to inform a decision about the suitability of our District to host Managed Isolation Facilities (MIFs).

During July a visit to Southern took place by Minister Megan Woods and Air Commodore Darryn Webb to review suitability for placement of a Managed Isolation facility for people returning from overseas. This was subsequently discounted due to a national decision to limit the placement of these facilities a small number of large cities.

Subsequently, in August there was a high level of interest in Queenstown as a potential site for a Sporting MIF, which was being sought by various sporting codes as a quarantine site upon entry into the country for international teams in advance of international tournaments. Despite the likelihood of this looking very probable at one point, a cabinet decision around quarantine requirements saw South African, New Zealand, Australian and Argentinian Rugby (SANZAAR) award the Rugby Championship hosting rights to Australia rather New Zealand, hence removing the need for quarantine facilities.

Most recently, a Ministry of Health / Ministry of Business Innovation and Employment (MBIE) led discussion has been instigated with several DHBs (those greater than 2.5 hours away from a border quarantine facility) to investigate what suitable accommodation would look like locally in the event that COVID-19 positive people are detected in the community in the future. These conversations are ongoing.

A focus on recovery – Queenstown

This group was established as part of the COVID response during the first wave, recognising the impact on COVID on wellbeing in the Central-Lakes area. Established by Southern Health Mental Health Network Leadership Group, and the Central Lakes Mental Health and Addictions Network working to national psychosocial response plan. The group has representation from Queenstown Lakes District Council, Southern DHB, WellSouth, Central Lakes Family Service, Central Lakes Mental Health and Addictions Network (chaired by Emily Nelson, has a wide representation), Central Lakes Locality Network (chaired by Helen Telford, established to ensure key agencies aware of each other’s activity, and wider initiatives in the community).

The group is purposed to maintain visibility of how mental health and wellbeing services in the community are managing, and identify areas where additional support is needed

Initially focused on urgent needs; the group is now preparing for ongoing role with COVID part of ongoing reality. The group is premised on the idea that this challenge requires a whole of community response, and we all have a part to play. The group monitors the demand on services in the district through our weekly updates.

The main highlights from the group reported for August are as follows:

- Mental health services continue to be busy, although waiting times for appointments have not increased.
- The impact of unemployment is becoming more apparent. Referrals in the community for children with anxiety symptoms seem to be increasing, and the services are dealing with issues arising out of parental separation and financial stress. The Central Lakes Family Service is looking to dedicate two staff to youth services, as a response to the rise in referrals. There has been an increase in referrals for Family Services in Dunstan, but not from Queenstown at this stage.
- There does appear to be an impact in respect of maternal and post-natal situations; it is thought this is compounded by absence of support traditionally that would have been in place (family members etc). The impact is seen as an increase in anxiety and panic, and there have been a higher than expected number of referrals this month (compared to the same time last year).
- There has been no change to the wait time for secondary/tertiary services; urgent patients can be seen immediately, and within 2-3 weeks for less acute situations.
- Secondary services are fully staffed.
- The WellSouth Brief Intervention Service have reported a 40% increase in referrals compared to last year at the same time. The month of August saw an 87% increase in referrals in the Central Otago Lakes District. Referrals from Alexandra and Wanaka show the largest increase. To date the wait times for the service have been consistent and maintained with those pre COVID.
- The 'Health Improvement Practitioners' (HIPS) are now in place at Queenstown Medical Centre, Wanaka and Aspiring Medical Centres. The increased accessibility of support and the impact will not be able to be reviewed for at least three months social worker available to see anyone of any age.
- Central Lakes Family Services (a non-government organisation (NGO)) has commenced a social worker in schools programme, with a social worker working across Queenstown's seven primary schools. This is making a real difference in supporting children.
- There was a waiting list with Thrive during a period of a staff vacancy, but this has now been filled.
- PACT have reported that their community support workers do have capacity for additional clients, and that additional workers might be available if the need is there.
- Reminder that free counselling is available 24/7 by calling or texting 1737.
- The message to share is that services are available for those who need to reach out for support.
- Reinforce the importance of resilience-building resources – All Right/Getting Thru Together, Mentemia, Just a Thought and GoodYarn.

Public Health Response

On 18 August 2020 the Ministry of Health advised that all Public Health Units (PHUs) should reprioritise their work and defer all non-essential activity over the following two weeks to ensure we have capacity available to respond to COVID-19. The requirement from the Ministry is that the service must be prepared to contact trace up to 24 cases a day with a surge capacity of up to 34 cases a day.

There have also been several requests from the Ministry of Health to provide assistance to the Auckland Regional Public Health Service Response. During August:

- We have provided a National Contact Tracing Solution (NCTS) super-user to provide on-site training in Auckland. NCTS is the national information system for COVID-19 cases and contacts. We have received extremely positive feedback about the staff member who went to Auckland and how helpful this was to the Auckland team.
- We have also agreed to manage cases in Managed Isolation Facilities in Auckland. This work is being shared with Community and Public Health (Canterbury) and will be reassessed after a two-week period.
- Teams have also been on standby to assist with follow up of symptomatic close contacts should the need arise.
- Alongside this work all protocols and documentation is being reviewed and updated to ensure that our Public Health Unit is prepared.

More recently we have responded to a request for additional Medical Officer of Health support for the Auckland Regional Public Health service, and have agreed that Dr Susan Jack will cover a two week period in November, subject to our own District remaining COVID free.

Locally a lot of work has been underway to ensure that there are the appropriate number of people within teams to be able to escalate quickly to cope with a second wave of cases. There continues to be extensive NCTS training across the Public Health Unit. Training is being progressed for 20 Public Health Nurses for case management and monitoring roles. Work is also underway with Human Resources (HR) and recruitment to identify other District Health Board staff who would be unavailable to work in a clinical setting and could be made available for training so they could assist with response work if required. This is ongoing, and is a challenge given the organisations competing demands with recovery of activity lost during the first wave.

Meetings have been held with the Māori Health Directorate and Pacific community providers to discuss how we can support each other in the event of further COVID-19 cases.

Maritime Border Response

There has been COVID-19 testing of maritime workers at South Port, Port Otago and Tiwai across August in line with advice from the Ministry, which continues to evolve. We hope to receive clear information about whether testing of border workers is mandatory, and what frequency of testing required as we attempt to incorporate these requirements into a more sustainable longer-term testing strategy.

Primary Care Response

Significant work continues to ensure we are prepared for new cases of COVID-19 in our district. For Primary Care, the focus is to work closely with general practice around operating a different model of care given the success of telemedicine during lockdown.

General Practice in all areas continue to provide assessment and testing as required, although the volumes in primary care continue to abate as less flu like symptoms present in the community. Access to swabbing, particularly outside of routine hours and weekends, continues to be problematic in Invercargill, and close monitoring around access is needing to be maintained to ensure we are compliant with the Minister's expectation that swabbing facilities are available seven days per week.

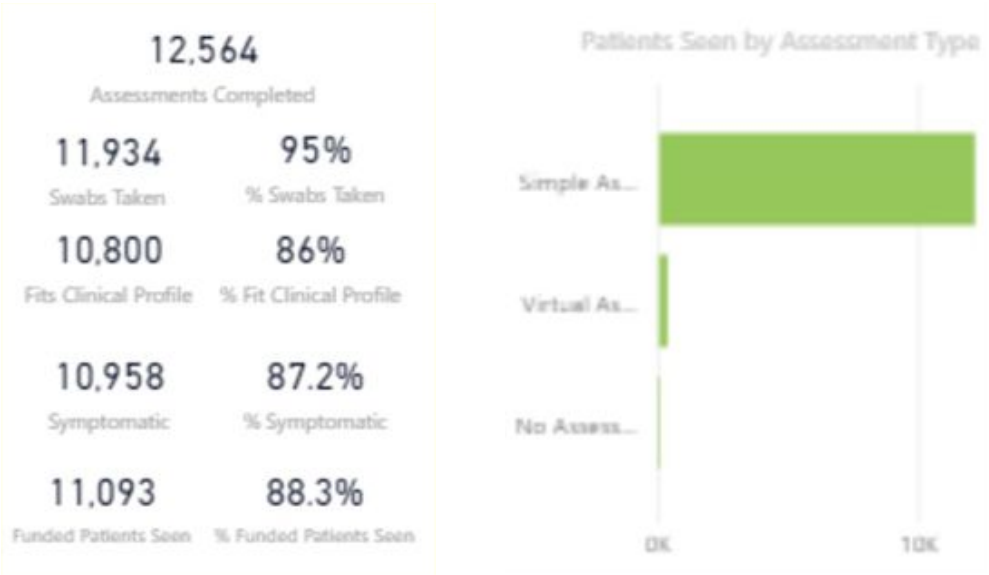
Plans are in place to be able to mobilise Community Based Assessment Centres (CBACs) in the future if required.

Swabbing

Current volumes of swabbing undertaken in primary care 1 July to 8 September include 18,264 simple, 583 virtual and 59 full assessments.

Latest data from General Practice COVID-19 activity as at 28 August 2020 is as below:

Level of activity through GP assessment for August



Testing trends over the month of August

Population Health

Resurgence planning has been the main focus of the service over the previous month. Within our core Public Health Nursing service - school and pre-school health services, there is the requirement to provide surge capacity to the local Public Health Unit in the event of an outbreak, whilst maintaining cover for urgent work such as Child Protection. The total full-time equivalents (FTE) for this component of the service across the whole district is 18.6 FTE. Following the community outbreak in Auckland, it has been identified that 20 FTE of clinical staff would be required as a minimum to case manage and monitor 24 cases per day. This level of provision without the region being in Alert Level 4 will have a significant impact on the Population Health Service ability to meet other contractual requirement and targets. Increasing risks of negative downstream effects on child and youth health outcomes. Staff continue training for future responses while management look at stand up planning and staff training involved with this.

Public Health Nursing

The longer-term impacts of the first COVID-19 outbreak are being seen, the team are receiving more complex referrals with some children experiencing separation anxiety post COVID-19 lockdown. Additionally, phone calls and emails for early childhood centres and schools requesting Public Health Nurse support has increased. With feedback being received from some Principals that they feel they have hardly seen their Public Health Nurse this year. This is likely to continue as nineteen Public Health Nurses have been required to cancel normal service delivery for a week, in order to prepare for a phase 1 public health response and train on the National Contact Tracing Solutions system.

Lakes District Hospital and the Rural Hospital Response

Lakes District Hospital has escalated its preparedness for new presentations of COVID-19. This includes:

- Screening all people presenting to the hospital
- Using the COVID QR codes
- Implementing security at the main hospital entrance
- Limiting visitors to one per patient
- Limiting support people in Emergency Department
- Facilitating one metre social distancing
- Reviewing the Resurgence Workforce Plan
- Screening outpatient attendees, with instructions to wait in their car until ready to be seen.

Rural Hospital Trusts

Gore Health, Clutha Health First, Waitaki District Health Services Ltd, Central Otago District Health Services Ltd and Maniototo Health Services Ltd have all their Alert Level 2 plans, screening all people presenting to the facilities, having QR codes available for scanning, limiting visiting numbers and hours, encouraging social distancing and screening all outpatient attendees prior to appointments.

All hospitals have developed workforce resurgence plans, to identify their vulnerable staff, and to plan for redeployment if required.

Aged Residential Care (ARC)

The ARC Steering Group continues to meet weekly as the conduit between the DHB and our 65 aged residential care facilities as we move up and down Alert Levels,

with the resulting challenges for their staff, residents, visitors and relationships with acute hospitals. There continues to be conflicting guidance to the sector from Ministry of Health and the Aged Care Association which we are working to mitigate on a local level through our Locality Groups, finding agreement where possible, respecting differences, but focussing on resident-centred principles. Differences between ARC facilities exist in visiting policies and the need for new or returning residents to isolate for fourteen days. The new Infection Prevention and Control (IPC) resource for ARC will make a significant difference to facilities negotiating these challenges.

The Influenza like Illness (ILI) Health Pathway has been finalised and used several times, as under the new definitions, three ARC facilities had ILI outbreaks this month. Another four had gastroenteritis outbreaks, all supported by Public Health South.

Aged Residential Care is embracing the Health Quality & Safety Commission's (HQSC's) Shared Goals of Care document, and, with the support of our Hospice Nurse Practitioners and Clinical Nurse Specialists who support ARC, implementing it widely as time allows. Staff are finding the Shared Goals of Care document well-suited to the aged residential care population, who are often too unwell or cognitively impaired to fully participate in the Advance Care Planning process. However, the Advance Care Planning training is excellent in giving staff the skills to have difficult conversations and translate them into clinically interpretable instructions. This work is ongoing. Southland Hospice developed a similar document, Clinical Order Articulating Scope of Treatment (COAST), two years ago, which is intended for all patients who are believed to be in their final year of life. There are synergies between the COAST, Shared Goals of Care and Advance Care Plan documentation, and all can be uploaded to the Acute Plan in Health Connect South.

All aged care facilities have been given the opportunity to 'onboard' one of their Registered Nurses to Health One/Health Connect South. Thirty of the 65 facilities are on their way to having access shared information about their residents. This will be a significant step towards integrated care.

Resurgence Planning continues with further efforts to identify staff required in the event of COVID-positive residents in ARC and the support and information required for replacement staff to work successfully.

All facilities have been asked to have a weeks' supply of Personal Protective Equipment (PPE) on hand. PPE that is not able to be sourced by the facility is provided by Southern DHB.

In an effort to bridge understanding between the hospital and ARC Sector, eight senior nurses spent a morning touring two aged residential care facilities, to gain a better understanding of the care and support long term aged care residents receive at different levels of care (Rest Home, Secure Dementia, Hospital and Psychogeriatric). The tour was very successful and will be repeated in Dunedin and organised in Southland when COVID Alert Levels allow.

Mental Health Addiction and Intellectual Disability (MHAID)

All teams responded promptly as Level 2 plans were well prepared. The weekly meetings with NGOs have reconvened and provide an opportunity for NGOs to identify issues and collectively and collaboratively share problem solving. All NGOs have Alert Level 2 plans in place and are ready to implement higher alert level plans should these be necessary.

The main topics of conversation with the NGO community have been the supply of PPE and in particular the use of masks. Consideration has included the possibilities of shared workforce across the sector and the establishment of a shared isolation facility for residential services, rather than each provider having to make provision for themselves.

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

The shortage of Rural Hospital senior medical cover persists within the Southern District. This is creating a financial burden for Rural Hospital Trusts in particular. Initial discussions to support the workforce, whilst exploring models of care that may enhance integrated community services and reduce the dependence on this scarce workforce have commenced.

7. RADIOLOGY

A project to explore the options available to provide a sustainable and accessible Radiology service across the District has been commenced. The terms of reference are under development, so timelines are yet to be agreed, however, the key issues have been identified.

8. 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.

9. INDEPENDENT REVIEW OF THE SOUTHERN MENTAL HEALTH AND ADDICTION SYSTEM CONTINUUM OF CARE

The Request for Proposal (RFP) to select a consultancy for the provider to undertake the review has now closed with a good number of viable and high-quality submissions received. We are currently finalising the local steering group, which will oversee the undertaking of the review, including the marking of submissions and selection of provider. Dr Clive Bensemann, a consultant Psychiatrist from Counties Manukau DHB, has agreed to be the Independent Chair and spokesperson for the steering group.

10. TRANSITION PLANS

This has been identified as a national priority for Mental Health services.

Compliance across our services continued to improve across August 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%.

Otago Specialist Teams have maintained gains in compliance although increased workloads have slowed progress towards the 95% compliance rate – work continues to achieve this.

Adult (Otago) services are also maintaining the compliance achieved although are down very slightly to 75% this month. As reported previously until the service resolves the single clinician model the Adult service will find it challenging to reach the 95% target.

Southland based services experienced a slight drop off and the team continues to maintain their focus on sustaining improvement, drilling down to individual teams and staff performance and identifying variables and opportunities for improvement.

11. STATEMENT OF SERVICE PERFORMANCE

The 2019/20 Statement of Service Performance (SSP), which is a key component of the DHB Annual Report has been drafted, with a working draft being submitted to Executive Leadership Team and the Board for review. The creation of the SSP for the 2019/20 year has been complicated by COVID-19 and the Strategy and Planning team worked with individual services to ensure that performance for the 'pre COVID-19', 'COVID-19' and 'post COVID-19' periods are reflected. During September the SSP will be refined and submitted for review to Audit NZ and the Ministry of Health before being submitted to the Board as part of the Annual Report.

The System Level Measures (SLM) Improvement Plan has been approved by the Alliance Leadership team. The SLM Improvement Plan will now be appended to the Annual Plan and the full DAP will be submitted to the Board for approval at the next Board meeting.

12. EMERGENCY DEPARTMENT (ED) – DUNEDIN AND SOUTHLAND

We have been reviewing ED performance in Southland on a fortnightly basis with the intention of implementing pragmatic initiatives that will lead to performance improvement against the Shorter Stays in ED target of 95% treated or admitted within six hours.

The Southland result since July has typically ranged from mid-80's (85% plus) to 90% performance on a weekly basis. An early win that has been identified within budgeted resources is to supply a healthcare assistant to manage a discharge lounge in Southland. The lounge was trialled as part of a Francis Health (valuing patients' time) initiative and was found to be very effective. The concept is to facilitate the discharge of circa six patients per day, freeing up the beds they would otherwise occupy for new admissions, e.g. post operatively. The improved flow and increased bed availability the positively impacts on ED performance as a bed becomes available faster for patients who would otherwise be waiting in the ED and also facilitates more surgery being completed (less cancellations due to lack of available beds).

As we stepped through the Southland ED data we have observed that a number of the long stay patients have been admitted into ED during the evening / early morning when our ability to assess patients and admit them onto the wards is greatly reduced (as there is considerably less senior medical officer (SMO) cover during this time). We need to think of effective solutions that would allow patients

to be admitted throughout the evening and which will then reduce some of the lengthier stays in the ED.

Another area of focus for us with the Southland ED is to develop a proposal that will lead to further capacity in the ED and will prevent overcrowding when we are at peak demand. A concept we are keen on is a short stay / medical assessment form of additional beds, which would allow patients to be pulled into the assessment unit (similar to what we have in mind for Dunedin ED) and allow rapid assessment and either discharge or admission for further care. We plan to work up a proposal that will be submitted into the budget bid process (for both operating cost and capital) for consideration alongside our other organisational priorities.

The ED in Dunedin has been under considerable pressure throughout the month of August. We know that the manner in which we roster and resource our ED is relatively consistent throughout the year. However, the demands on our ED peak during the winter months. ED presentations on a daily basis typically average in the region of 125 presentations per day in Dunedin. However, this lifts to circa 135 in the winter months and at peak we can have as many as 165-170 presentations. Our roster patterns / resourcing cannot vary to the same extent and we therefore need to consider how we can better flex resources to cope with winter pressures in the ED.

Our 'fit to sit' ED chairs, which will add much needed capacity, have been further delayed. However, we anticipate that these will become available in late November and will bring some much needed additional capacity to the ED.

The Dunedin ED performance has been more variable than Southland. Pre-July mid 80's performance was being achieved in some weeks. However, since July performance has been in the mid 70's. As well as the use of an escalation pathway which is being championed by the Chief Medical Officer (CMO), and consequential improved flow, we anticipate that the most significant opportunity to improve performance in the next two years will be the implementation of the medical assessment unit on the assumption that Generalism plus the Medical Assessment Unit is the chosen option for implementation.

13. GASTROENTEROLOGY

The 'live' performance (as at 13 September) is per the following table:

	Dunedin					**Southland**				
	NBSP	A (14)	B (42)	C	Surveillance (84)	NBSP	A (14)	B (42)	C	Surveillance (84)
Average	11.93	3.33	25.14	36.86	110	21.92	6.17	19.95	94.08	155
Shortest	2	2	2	2	1	3	2	2	2	1
Longest Wait	23	5	188	108	239	216	10	220	223	348
Patients	40	3	85	56	371	24	6	43	63	362

Performance against the Ministry targets is as noted below:

Colonoscopy August Performance (July figures in brackets)	
Urgent 85% (91%)	Meets target
Non-urgent 83% (66%)	Meets target
Surveillance 35% (36%)	Performance maintained but way below 70% target. Patients least at risk of delay in this group however will be next focus of recovery. High risk (1 year) surveillance patients prioritised.

As noted above, the performance against the 14 and 42 day targets has been recovered post COVID and the focus is now on improving the surveillance performance against the target. Funding has specifically been requested as part of the recovery funding to enable this to occur and we will fund nurses that will enable additional scoping to occur over the coming six months to also recover surveillance performance.

14. OUTPATIENT (ESPI 2)

Outpatient performance has been steadily improving since COVID and we appear to have dropped from circa 1,700 breaches immediately post COVID in the surgical specialities to circa 817 currently.

In surgery, the prioritisation tool has enabled us to bring the urology and orthopaedics services towards being in balance and we have now implemented the tool in General Surgery in Southland and are working through implementation in General Surgery in Dunedin, too.

One of the key initiatives that we have asked to be funded is the implementation of the prioritisation tool across our other surgical specialities and we will soon be starting conversations with the Ear, Nose and Throat (ENT) service in Dunedin (with a view to implementing the tool across Dunedin and Southland, enabling us to address vacancies and reduced capacity in Southland). We also believe that Obstetrics and Gynaecology is under resourced in Southland and want to implement the tool so that we can get a clear sense of what we would have to return to primary care in order to bring the service into balance and how this compares to an appropriate return rate.

The Medicine and Women's and Children's Health services have also seen an improvement since COVID, dropping from circa 270 breaches post COVID to currently only having 70 breaches (excluding Obstetrics and Gynaecology). For the Medicine and Women's and Children's Health services as we are close to overall compliance we are now focusing on booking all outpatient appointments that are over eight months old and we have developed a Power BI report with filters that allows us to focus on these. Once we have this addressed, we will then bring the tail in and focus on over six months and then over four months.

15. INPATIENT (ESPI 5)

Inpatient (waiting for surgery) is more challenging to address without additional theatre capacity and we are more reliant on gaining additional theatre capacity through recovery money. However, we are focusing on long wait patients with the goal of definitively sorting out all patients who have waited over 21 months for surgery. We have developed a Power BI report that enables us to review individual patients and we are now focused on this at our weekly ESPI meetings.

We have developed a pathway using Ministry guidelines that will allow patients who have not met the criteria for surgery (e.g. weight loss or no longer smoking) to be discharged back to the care of their GP, but to then have a rapid pathway back for surgery when they meet the criteria and can therefore be operated on. This is in the final stages of testing.

Overall patients who have been waiting a long time either need to complete the actions required to meet the criteria for surgery, need to be confirmed as still being

suitable for surgery and booked accordingly, or are errors and need to be corrected in the wait list.

As recovery money becomes available, we will be able to complete more surgery to move long waiting patients off the wait list. We will also be implementing initiatives that prevent the additional ESPI 2 outpatient appointments that are part of recovery from converting to inpatient surgery at the normal rate and therefore creating a challenge for surgical capacity.

Interestingly, we have noticed that surgical demand (booked onto the inpatient wait list) has increased in the months post COVID which we are attributing to post COVID demand. We will watch this pattern carefully to track its return to normal as the COVID bulge gradually works its way through.

16. CASE WEIGHT DISCHARGES (CWD)

We have now agreed our Production Plan with the Ministry and are in the process of phasing it. In the plan the Ministry initially stretched us by 250 case weights of unfunded activity (worth $1.4m of revenue), but we have negotiated out this stretch. When the rules changed for planned care last year, we were also stretched by 1,100 discharges as skin lesions and Avastin injections which previously counted for surgical discharges could no longer be counted. We have managed to lift surgical discharge performance to address half of this 1,100 stretch (by completing more low case weight high volume discharges in ophthalmology), and we have also managed to negotiate out a further 300 discharges with the Ministry. This leaves us with an underlying stretch of 300 discharges that we need to achieve which is a much more manageable increase to plan to for discharge activity.

We are still reconciling our phased plan with what has been delivered to date but we believe we are essentially on plan for case weight delivery on a year to date basis. We had good CWD performance in July, but this has then been unwound somewhat by having to cancel surgery due to a lack of available beds on a number of occasions during August and September. This is a winter problem, but as noted in the ED commentary, we need to get better at being able to flex nursing resources to cope with winter pressures and allow us to meet the medical, acute surgical and elective bed demands that happen at this time of year better.

17. COMPUTED TOMOGRAPHY (CT) (42 DAY TARGET)

CT performance has improved from circa 48% of the 42 day target post COVID to current performance which is 63% across the district, despite almost a week of lost productivity in Dunedin due to the loss of the CT machine in the radiology department and the need to order replacement parts from overseas. Pleasingly, the Medical Imaging Technologist (MIT) resources are now on board for the evening shift and the one day a week shift of the nuclear medicine CT. This will enable us to complete an additional 20 scans per week from now onwards which will systematically improve our monthly CT performance.

18. MAGNETIC RESONANCE IMAGING (MRI) (42 DAY TARGET)

MRI performance has improved from circa 29% performance post COVID to circa 52% performance against the 42 day target across the district. This is good performance when we consider that we have had the Southland MRI out for a six week period to implement the new MRI machine and when you consider that the Dunedin MRI machine had an unplanned outage of almost two weeks. However, we

are anticipating that a number of patients who weren't done in Dunedin during the outage will tip into over 42 days and the performance will deteriorate in the coming month. MRI is one of the focal areas for our recovery funding and we will be working hard to recover performance over the coming year.

19. ONCOLOGY (31 DAY TARGET)

Performance against the 31 day target (time from identification to first treatment) has generally been good and on average over the last two quarters we are slightly above the 85% target.

20. PROGRESS UPDATE – GENERALISM

The generalism case is now in its final phases before being brought back to the executive leadership team in final draft. The medical assessment unit has been designed at concept level and will be quantity surveyor costed soon. We have further differentiated the performance we believe will be possible for generalism versus generalism plus a medical assessment unit in order to finalise the financial case and we are now in the final phases of determining how the ward rounding and admission time spent by the sub-specialists will be re-directed once this is done as part of a generalist admitting model. We believe the majority of this effort will be able to be re-directed at providing the underlying capacity necessary to manage outpatient performance for these sub-specialties (including allowing for growth in these services over time) but there is more work to do to quantitatively determine this.

21. CLINICAL COUNCIL

- The first official meeting of the new Clinical Council members was held on 13 August.
- A Position Description for a 'Rising Star' member has been drafted and will be recruited for a one year term in the coming months.
- A community/Iwi representative will be recruited through the Community Health Council networks to be a member of the Clinical Council.
- The Chief Nursing and Midwifery Officer has drafted a Charter for Clinical Council members to agree to when they join the Council.
- The Communications Team are currently updating information on the website about Clinical Council members and a newsletter about clinical governance incorporating the newly reformed Clinical Council as well as the Clinical Practice Committee and Mortality Committee will be circulated in the next month.
- The Terms of Reference for the Clinical Council have been finalised and will be available on the website.
- The Chiefs will have input into further developing the workplan for the Council going forward.
- The next steps for the Clinical Council include:
  - The Service Level Accountability Pack will be presented at the September meeting to members.
  - Members will be updated on the new Quality Safety Marker around consumer engagement in September.
  - A risk management workshop is scheduled for October.

22. CARE CAPACITY DEMAND MANAGEMENT (CCDM)

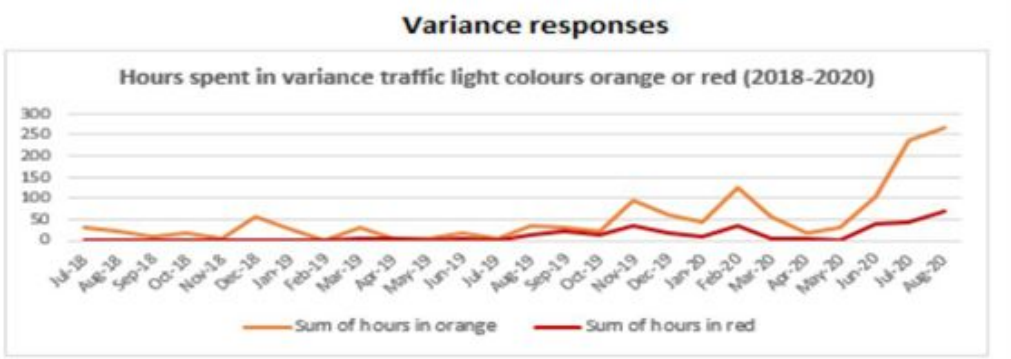
CCDM Programme Manager Summary

August has been a busy month for the TrendCare and CCDM team, including:

- Meetings have occurred with Safe Staffing Health Workplace Unit (SSHWU) to continue the journey to improving Maternity TrendCare data.
- The CCDM Standards Assessment was completed against the CCDM programme standards and was signed off by SSHWU.
- Planning continues for the TrendCare Inter-rater Reliability (IRR) education in October with meetings held with the TrendCare Vendor and the Southern DHB team.
- Meetings continue with the TrendCare Vendor to more deeply understand TrendCare data requirements for the Mental Health Addiction and Intellectual Disability Service (MHAIDS).
- Discussions continue as to whether TrendCare Patient Acuity Tool will be implemented at Lakes District Hospital.

Service Overview

- August has seen the CCDM team focusing on Variance Response Management (VRM) implementation and furthering progress on FTE.
- All 34 inpatient wards have a Local Data Council (LDC).
- An Acuity and Workforce Management steering group meeting was held, with the group noted the number of significant negative variances for July 2020 where the highest since August 2019.
- A theme from staff at LDC meetings has been the high patient acuity, churn of patients through wards and challenges with replacing staff due to sickness/ACC which is placing considerable pressure on staff. Number of missed actualisations for July (391) reduced compared to June (555).
- Core Data Set (CDS) – progress continues with the movement of 23 Core Data Set (CDS) measures onto a single electronic platform to meet CCDM implementation requirements. Meeting held with Reporting Analyst on 25 August. 17 of the 23 CDS measures are in place on Microsoft Power BI. 2 of the remaining measure are on hold, the remaining 4 are a work in progress. Close to production of this application.
- FTE Calculations – discussions have occurred with three Directors of Nursing (DoN) to discuss FTE calculations for their specific wards. Next steps will be for the CCDM team to discuss with Charge Nurse Managers (CNMs) and Associate Charge Nurse Managers (ACNMs) of the relevant wards. FTE report close to completion for Assessment Treatment and Rehabilitation, Southland.
- Variance Response Management – significant support continues with the 11 remaining wards to implement VRM; x8 MHAIDS wards, Critical Care Unit, Maternity and Medical Assessment Unit. Whilst several wards are utilising this tool well, several continue to require encouragement to use VRM regularly. Summary of hours in VRM as per the following tables, as at 31 August:



Improvement Plans

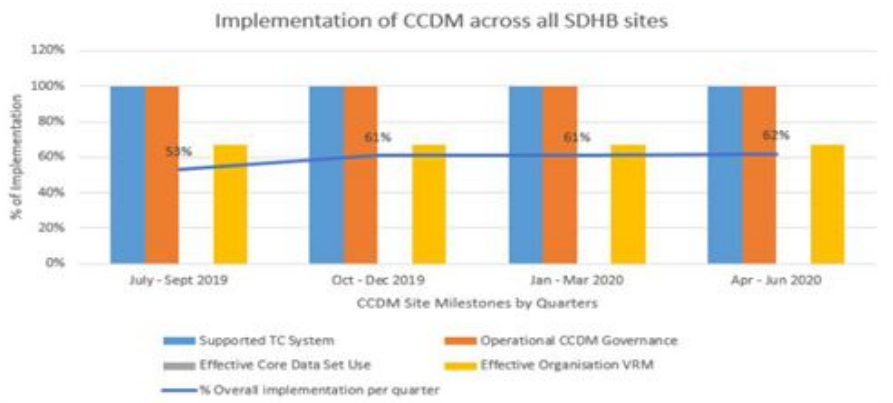
- Maternity
  - Actualisation/Categorisation data has significantly improved.
  - A review of the 90 day action plan highlights significant progress towards achieving the outstanding actions.
  - Of the remaining actions, of significance, Queen Mary need to undertake an action plan to ensure they achieve 100% IRR testing during the SDHB IRR testing month of November, workloads need to be allocated into TrendCare and utilisation of TrendCare at handover to become embedded in business as usual for Team Leaders when handing over to one another.
  - The ongoing series of meetings with SSHWU Maternity Programme Consultant and Patient Acuity Consultant will support resolution of actions. Combined with the planned IRR education delivered by the TrendCare Vendor in October the Maternity service should be well placed to complete the improvement plan and demonstrate data of high quality and integrity.
- Mental Health, Addiction and Intellectual Disability
  - Actualisation/Categorisation data has significantly improved.
  - A review of the 90 day action plan highlights significant progress towards achieving the outstanding actions.
  - Of the remaining actions, of significance, is for the MHAIDS to utilise TrendCare at handover, between the team leaders to assist with improvement of data, to ensure workloads are allocated and are fair in the distribution of patient workload amongst staff.
  - The planned IRR education to be delivered by the TrendCare Vendor in October plus the ongoing feedback from the CCDM/TrendCare team on TrendCare data, in conjunction with the TrendCare Vendor, should enable the MHAIDS to be well placed to complete the improvement plan and demonstrate data of high quality and integrity.

Performance

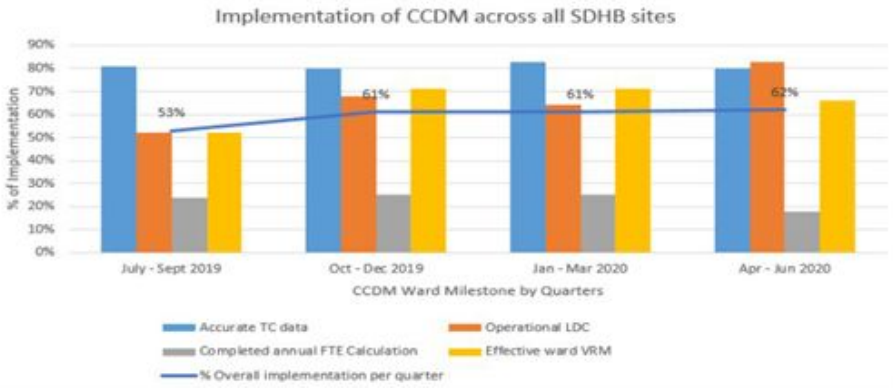
- Quarter 4 2019/2020 sees SDHB at 62% for CCDM implementation based on the Ministry of Health criteria.
- The national data report shows the overall implementation rate for DHBs is 54%, up 9% on last quarter.
- The highest Site Milestone for all DHBs is Operational CCDM Governance at 96% implementation, with SDHB at 100%, and the lowest is Effective CDS Use at 35% implementation, SDHB at 0%.

- Of the Ward Milestones for all DHBs the highest is Accurate TrendCare Data at 66% implementation, SDHB at 80%, and the lowest is Completed Annual FTE Calculation at 28% implementation, SDHB at 18%.
- See all the graphical representation of the four Site and four Ward Milestones for SDHB below:

Site Milestones



Ward Milestones



23. TE PŪTAHITANGA O TE WAIPOUNAMU

Southern DHB has followed up with Te Pūtahitanga o Te Waipounamu on a conversation back in October 2019 with the Commissioner regarding potentially developing a relationship with the South Island Whānau Ora commissioning agency. Te Pūtahitanga o Te Waipounamu was formed in March 2014 as a legal partnership of Ngā Iwi o Te Waipounamu, the nine iwi of the South Island mandated under Ngāi Tahu, Ngāti Apa ki te Rā Tō, Ngāti Tama, Ngāti Kuia, Ngāti Koata, Te Ati Awa, Ngāti Toa Rangatira, Rangitāne o Wairau and Ngāti Rarua.

Whānau Ora marks a philosophical shift in the social and health sectors. Whānau Ora commissioning has been resourcing the needs of whānau for their own personalised states of wellbeing and to date the DHB has not been actively involved in those providers funded through Te Pūtahitanga. From a health perspective there has been limited joined up activity and there is logic to frame up a pathway so that the Whānau Ora model can inform our developing model of care which includes the way we contract with our kaupapa Māori health providers. A meeting is being scheduled to be held in Christchurch shortly with the CEO and their Principal Advisor from Te Pūtahitanga o Te Waipounamu to further these discussions.

24. IWI GOVERNANCE COMMITTEE (IGC) PARTNERSHIP AGREEMENT

The updated IGC Partnership Agreement was endorsed by the Boards of the Southern DHB and WellSouth on 8 September. Section 12.1 is the only outstanding point of clarification and the DHB Chair will look to discuss this issue with the IGC Chair. We will look to a signing on a local marae in November where the Chairs of the seven Papatipu Runaka will be invited to come and celebrate the signing of this agreement. This marks a significant milestone in our relationship.

25. FIRST 1,000 DAYS

The Chief Māori Health Strategy and Improvement Officer (CMHSIO) is supporting the development of our *First 1,000 Days* work stream as part of the Alliance Leadership Team (ALT) work programme.

There is a growing body of evidence that experiences in the first 1,000 days, the period from conception until a child's second birthday, has far-reaching impact on health, education and social outcomes, and on health equity. Prevention and intervention strategies aimed at early childhood have been identified as good investment as the economic benefits are greater than the costs of the interventions. They impact on many aspects of life throughout the life course and also extend beyond the individual to the whānau, community and wider society.

Within the Southern district there is a lack of inter-sectoral planning, action and monitoring to support the best start in life for every child in our rohe. There is a need for a unifying approach to align and drive our efforts to improve health and wellbeing outcomes for the first 1,000 days of a child's life and a stronger equity focus may bring about significant advancements in Māori health gains.

26. COVID-19 COMMUNITY TESTING

The associate Māori health team have been supporting the WellSouth outreach community testing in Gore, Balclutha and Oamaru during September 2020. These clinics have included flu vaccination and the organisation of these clinics has been in collaboration with the WellSouth team, Māori health providers, Runaka, Māori and Pacific communities. It is important that this level of community COVID surveillance reaches out to communities potentially at risk of COVID-19 and in light of the recent South Auckland COVID wave we need to ensure we prioritise Māori and Pacific testing. The instruction for this testing comes from community and public health as directed by the Ministry of Health.

27. SOUTH ISLAND MĀORI PRIMARY HEALTH ORGANISATION (PHO) NETWORK

The Māori Health Directorate leadership team participated in a virtual meeting with all the Māori PHO staff across the South Island on 11 September. A future face-to-face meeting is being coordinated. The purpose of the meeting is to share work programmes with the view of learning from the collective and enhancing our collaboration. Already from our first meeting there are lots in common and a variety of projects that may have merit for the Southern region.

28. COVID-19 MĀORI COMMUNITIES OUTREACH AND SUPPORT – MĀORI HEALTH SUPPORT RFP

Southern DHB released an RFP on 25 August (closed on 11 September) 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 approval committee will meet on 15 September to consider these applications.

29. HARTI HAUORA PROGRAMME

The Harti Hauora Programme (ambulatory sensitive hospitalisations (ASH) project) funded by WellSouth will be launched on the Southland Hospital site in the Education Centre on 16 September. WellSouth 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 clinical nurse specialist, hospital staff and the registered nurse 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.

30. 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 team met with Kate Anson an ED Consultant from Middlemore Hospital on 6 September who is working with the DHB to advance this strategy. Our discussion to date is looking at developing a Māori name for our Emergency Department, signage and translations, introduction of our new education programme into the department and te reo Māori.

We are working with Emergency Departments to develop this plan in line with this strategy.

31. PATIENT/WHĀNAU CONTINUUM OF CARE – CARDIOLOGY SERVICES

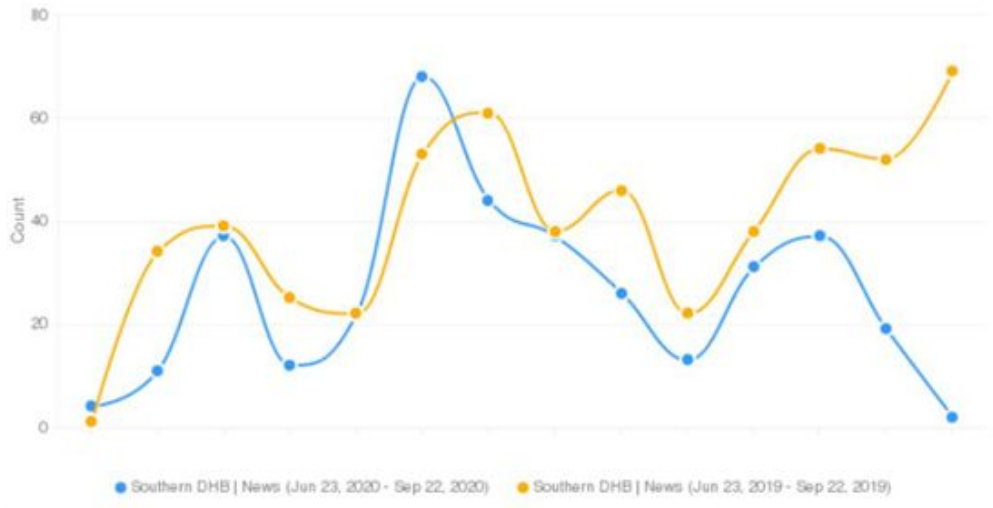
The Māori Health Directorate is working with WellSouth (outreach service) and Māori Health providers to better support the patient/whānau journey through the Southern health system. The aim is to ensure patients/whānau are well informed and supported in decision making and navigation of health through community, primary care and hospital services that results in reduced hospital admissions. The team 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 and 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.

32. SOUTHERN MEASLES IMMUNISATION CAMPAIGN

The Māori Health Directorate is involved in the Southern Measles Immunisation Campaign to equitably improve measles immunity across the Southern district. This campaign targets those 15-29 years of age with a focus on engaging Māori and Pacific youth while providing a whānau centred approach for other vaccinations and health services. The Māori Health Directorate is developing a Māori response plan for the campaign and will engage with Iwi, Rūnanga, Kohanga Reo, sports groups, workplaces, General Practice, Māori Health and Social Service providers and wider Māori communities for participation.

33. COMMUNICATIONS

Volumes of daily media mentions are broadly consistent with the same period last year. Areas of interest over the past month have included colonoscopy services, the possibility of managed isolation and quarantine facilities in the Southern district, progress on the primary maternity facilities in the Central Otago/Wanaka area, pop-up COVID testing around the district and responses to changing alert levels, mental well-being relating to the impact of COVID-19, a new diabetic foot clinic, repairs and replacement of our scanners, and the approval in principle of the detailed business case for the New Dunedin Hospital.



Collaborative work is being undertaken in the Central-Lakes area, focusing on efforts to support psychosocial well-being in this community. The group has been maintaining an overview of the services available in the community and is looking to strengthen communications with stakeholders through our networks.

Following staff feedback, the success of staff webinars during the COVID-19 crisis have now been developed into a regular series, covering a range of strategic priorities for Southern DHB.

This month the communications team has also supported national initiatives including Mental Health Awareness Week, Te Wiki o te Reo Māori, New Zealand Sign Language Week, Cervical Screening Awareness Month, Wound Awareness Week, as well as initiatives such as Wig Wednesday supporting Child Cancer NZ, and Pour Choices focusing on limiting alcohol intake.

Chris Fleming
Chief Executive Officer

28 September 2020

Southern DHB Financial Report

Financial Report for: 31 August 2020
Report Prepared by: Finance
Date: 11 September 2020

Report to Board

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

The net deficit for the period ending 31 August 2020 was $1.9m, being $0.05m favourable to budget.

During August 2020, Revenue was $2.6m favourable to budget, mainly due to $1.6m COVID-19 Surveillance and Testing 'pass-through' funding and $0.4m recognised for the Recovery Plan. Workforce costs were $0.7m unfavourable to budget. Outsourced Services were $0.6m unfavourable to budget and Clinical Supplies were $0.6m unfavourable to budget, reflecting the Recovery Plan activity for the month. Provider Payments were $1.1m unfavourable due to the COVID-19 Surveillance and Testing expenses for the Primary healthcare services.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 August 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						
99,114	96,349	2,765	F	Government & Crown Agency	197,319	192,733	4,586	F	1,089,019	1,155,951
758	877	(119)	U	Non-Government & Crown Agency	1,436	1,755	(319)	U	11,047	10,528
99,872	97,226	2,646	F	*Total Revenue*	198,755	194,488	4,267	F	1,100,066	1,166,479
				EXPENSES						
37,469	36,732	(737)	U	Workforce Costs	75,888	75,955	67	F	450,139	462,125
4,307	3,726	(581)	U	Outsourced Services	8,501	7,464	(1,037)	U	41,837	43,556
9,215	8,573	(642)	U	Clinical Supplies	18,702	17,138	(1,564)	U	99,345	96,871
4,982	5,138	156	F	Infrastructure & Non-Clinical Supplies	10,106	10,287	181	F	58,569	60,354
40,801	39,717	(1,084)	U	Provider Payments	81,166	79,401	(1,765)	U	466,737	474,021
3,183	3,138	(45)	U	Non-Operating Expenses	6,341	6,241	(100)	U	34,951	40,469
99,957	97,024	(2,933)	U	*Total Expenses*	200,704	196,486	(4,218)	U	1,151,578	1,177,396
(85)	202	(287)	U	**NET SURPLUS / (DEFICIT)**	(1,949)	(1,998)	49	F	(51,512)	(10,917)

During August 2020, two Dunedin Hospital scanning machines failed and critical components had to be imported from the US and Germany to resolve the equipment outages. Unfortunately, two days later the CT scanner also failed and required repair.

The planned replacement of the Southland Hospital MRI scanner began in August 2020. The project is progressing with the new MRI scanner expected to be operational in early October 2020.

Revenue (Year To Date)

Government and Crown Agency revenue includes additional funding for COVID-19 and Recovery Plans. These revenue streams have a direct connection to expenditure.

Expenditure (Year To Date)

Total Expenses year to date were $200.7m which is $4.2m unfavourable to budget.

Outsourced Services are $1.0m unfavourable year to date reflecting support for the delivery of the Recovery Plans.

Clinical Supplies are $1.6m unfavourable year to date as hospital clinical activity lifted to deliver the Recovery Plan. This included Treatment Disposables, Implants & Prostheses and Other Clinical Costs.

Provider Payments are $1.8m unfavourable year to date for payments to NGOs supporting COVID-19 activity, especially COVID-19 testing in the community.

Summary of Year to Date Results - MoH

The Financial Performance includes unbudgeted expenditure outside the normal Business as Usual (BAU). The year to date Financial Performance table below indicates the split of financial performance across each of BAU, COVID-19, Holidays Act 2003 and Dunedin Hospital Accelerated Depreciation.

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - MOH
For the period ending 31 August 2020

	YTD COVID-19 $000	YTD Holiday's Act $000	YTD ODH Accelerated Depn $000	YTD BAU $000	YTD Total $000
REVENUE					
Government & Crown Agency	2,302	-	-	195,017	197,319
Non-Government & Crown Agency	-		-	1,436	1,436
Total Revenue	2,302	-		196,453	198,755
EXPENSES					
Workforce Costs	1	-	-	75,887	75,888
Outsourced Services	(3)	-	-	8,504	8,501
Clinical Supplies	5	-	-	18,697	18,702
Infrastructure & Non-Clinical Supplies	17	-	-	10,089	10,106
Provider Payments	2,302	-	-	78,864	81,166
Non-Operating Expenses	-	-	-	6,341	6,341
Total Expenses	2,322	-	-	198,382	200,704
NET SURPLUS / (DEFICIT)	(20)	-	-	(1,929)	(1,949)

Financial Position Summary

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

Actual 30 Jun 2020 $000		Actual 31 Aug 2020 $000	Budget 31 Aug 2020 $000	Actual 31 Jul 2020 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	19,364	7,311	27,206	7
49,819	Trade & Other Receivables	58,690	57,935	50,960	48,830
6,095	Inventories	6,377	5,569	6,069	5,235
86,925	*Total Current Assets*	84,431	70,815	84,235	54,072
	NON-CURRENT ASSETS				
331,152	Property, Plant & Equipment	330,477	334,098	331,710	355,122
3,307	Intangible Assets	4,023	11,837	3,307	20,149
334,459	*Total Non-Current Assets*	334,500	345,935	335,017	375,271
421,384	**TOTAL ASSETS**	418,931	416,750	419,252	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	-	-	16,259
64,666	Payables & Deferred Revenue	65,009	61,830	68,895	64,494
962	Short Term Borrowings	815	1,226	964	955
129,920	Employee Entitlements	129,302	128,393	125,495	85,533
195,548	*Total Current Liabilities*	195,126	191,449	195,354	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	1,009	1,091	1,017	1,018
19,810	Employee Entitlements	19,810	19,810	19,810	19,810
20,901	*Total Non-Current Liabilities*	20,819	20,901	20,827	20,828
216,449	**TOTAL LIABILITIES**	215,945	212,350	216,181	188,069
204,935	**NET ASSETS**	202,986	204,400	203,071	241,274
	EQUITY				
485,956	Contributed Capital	485,956	485,956	485,956	531,750
108,500	Property Revaluation Reserves	108,500	108,502	108,500	108,502
(389,521)	Accumulated Surplus/(Deficit)	(391,470)	(390,058)	(391,385)	(398,978)
204,935	*Total Equity*	202,986	204,400	203,071	241,274
	Statement of Changes in Equity				
172,410	Opening Balance	204,935	206,398	204,935	206,398
(51,512)	Operating Surplus/(Deficit)	(1,949)	(1,998)	(1,864)	(10,917)
84,744	Crown Capital Contributions	-	-	-	46,500
(707)	Return of Capital	-	-	-	(707)
204,935	Closing Balance	202,986	204,400	203,071	241,274

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 August 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	189,863	187,756	2,107	1,156,983	176,642
Non-Government & Crown Agency Revenue	1,388	1,716	(328)	10,296	1,621
Interest Received	48	39	9	232	42
Cash was applied to:					
Payments to Suppliers	(122,915)	(117,909)	(5,006)	(675,364)	(110,238)
Payments to Employees	(75,240)	(76,513)	1,273	(499,568)	(72,644)
Capital Charge	-	-	-	(12,605)	-
Goods & Services Tax (net)	(257)	(92)	(165)	(486)	401
Net Cash Inflow / (Outflow) from Operations	(7,113)	(5,003)	(2,110)	(20,512)	(4,176)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	-	-	-		1
Cash was applied to:					
Capital Expenditure	(4,303)	(18,461)	14,158	(72,294)	(7,587)
Net Cash Inflow / (Outflow) from Investing Activity	(4,303)	(18,461)	14,158	(72,294)	(7,586)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions		-	-	45,763	
Cash was applied to:					
Repayment of Borrowings	(231)	(237)	6	(220)	(300)
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	(231)	(237)	6	45,543	(300)
Total Increase / (Decrease) in Cash	(11,647)	(23,701)	12,054	(47,263)	(12,062)
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	19,364	7,311	12,053	(16,252)	(21,950)

Cash flow from Operating Activities is unfavourable to budget by $2.1 million. The payments to Suppliers were $5.0 million higher than budget because of the COVID-19 NGO pass-through payments of $2.1m, other expenditure of circa $500k and a reduction in trade creditors from the previous month.

Cash flow from Investing Activities is favourable to budget by $14.2m. This continues to be driven by the timing of capital plan approval. The Capital Expenditure cash spend is $3.3m less than last year reflecting the both the Alert Level restrictions and timing of approvals.

Cash flow from Financing Activities is close to budget at $6k favourable.

Capital Expenditure Summary

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

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	FY19 YTD Actual $000
Land, Buildings & Plant	1,256	3,066	1,810	U	3,449
Clinical Equipment	1,742	2,888	1,146	U	3,086
Other Equipment	110	316	206	U	108
Information Technology	548	4,774	4,226	U	389
Motor Vehicles	0	0	(0)	-	-
Software	647	7,417	6,770	U	555
Total Expenditure	4,303	18,461	14,158	U	7,587

At 31 August 2020, our Financial Position on page 3 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $334.5m, which is $11.4m less than the budget of $345.9m.

Ongoing delays with projects including Dunedin Hospital ICU, Southland MRI, Queen Mary and Deferred Maintenance continue to contribute to the underspend in Property, Plant & Equipment. As projects progress the variance will diminish.

Information Technology and Software is a combined $11.0m underspent, including Radiology RIS, Cherwell Automation, Patientrack and South Island Patient Information Care System (SIPICS) projects.

To date only those projects that are urgently required to progress have commenced. For the most part, we are awaiting the approval of the 2021 Annual Plan by the Minister of Health which is expected during September 2020.

Aug-20				Aug-19	YEAR ON YEAR		YTD 2020/2021				YTD Aug-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,461	1,585	(124)	-8%	1,640	(178)	Acute	2,993	3,088	(94)	-3%	3,371	(377)
385	314	71	23%	376	9	Elective	720	565	155	27%	686	34
1,846	**1,899**	**(53)**	**-3%**	**2,016**	**(169)**	**Total Medical Caseweights**	**3,714**	**3,653**	**61**	**2%**	**4,058**	**(343)**
						Surgical Caseweights						
1,281	1,325	(44)	-3%	1,181	99	Acute	2,426	2,520	(94)	-4%	2,389	37
1,385	1,467	(82)	-6%	1,464	(79)	Elective	2,990	2,808	183	7%	2,924	67
2,665	**2,792**	**(126)**	**-5%**	**2,645**	**20**	**Total Surgical Caseweights**	**5,416**	**5,328**	**88**	**2%**	**5,313**	**103**
						Maternity Caseweights						
85	99	(14)	-14%	82	3	Acute	207	192	15	8%	211	(4)
336	389	(53)	-14%	399	(64)	Elective	759	760	(1)	-0%	787	(28)
421	**488**	**(67)**	**-14%**	**481**	**(60)**	**Total Maternity Caseweights**	**967**	**953**	**14**	**1%**	**998**	**(32)**
						TOTALS						
2,826	**3,008**	**(182)**	-6%	**2,903**	**(77)**	**Acute**	**5,627**	**5,801**	**(174)**	-3%	**5,972**	**(345)**
2,105	**2,170**	**(65)**	-3%	**2,239**	**(133)**	**Elective**	**4,470**	**4,133**	**337**	8%	**4,397**	**74**
4,932	**5,178**	**(246)**	**-5%**	**5,142**	**(209)**	**Total Caseweights**	**10,097**	**9,934**	**163**	**2%**	**10,369**	**(271)**

						TOTALS excl. Maternity						
2,742	**2,909**	**(168)**	-6%	**2,821**	**(79)**	**Acute**	**5,420**	**5,608**	**(189)**	-3%	**5,761**	**(340)**
1,769	**1,781**	**(11)**	-1%	**1,840**	**(69)**	**Elective**	**3,710**	**3,373**	**337**	10%	**3,610**	**101**
4,511	**4,690**	**(179)**	**-4%**	**4,661**	**(149)**	**Total Caseweights excl. Maternity**	**9,130**	**8,981**	**149**	**2%**	**9,371**	**(240)**

Aug-20				Aug-19	YEAR ON YEAR		YTD 2020/2021				YTD Aug-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,716	3,286	(570)	-17%	2,891	(175)	**Mental Health bed days**	5,378	6,572	(1,194)	-18%	5,642	(264)

Aug-20	Aug-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Aug-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,806	3,895	(89)	Dunedin	7,510	7,790	(280)
1,139	1,304	(165)	Lakes	2,386	2,585	(199)
3,322	3,200	122	Southland	6,410	6,204	206
8,267	8,399	(132)	**Total ED presentations**	16,306	16,579	(273)

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Performance Dashboard**
Report to:	Board
Date of Meeting:	6 October 2020

Summary:

Of note on this month's dashboard are:

- Figures from the dashboard are a month in lieu due to meeting timing
- Mortality title changed to death, as it is a number illustrated, not a rate.
- Short Notice Postponements made on or within 24 hours of surgery totalled 92 for the month, 152 were postponed over 48 hours ahead of planned surgery date/time. This is a key measure as the build-up and subsequent let down impact the patients experience. Better planning tools need to be deployed to minimise the volume of short notice postponements.
- Theatre utilisation - the percentage illustrated counts acute theatres and weekends. Reporting is being aligned to the Health Round Table so will change over the next few months. Currently elective theatre usage (Mon – Fri 8-4) is averaging around 80%.
- NB that for the report on restraint and seclusion, Wakari hospital data is included in Dunedin's.
- Staff events are only reported as total numbers currently, not broken down by hospital site.

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

Financial:	Case weight volumes are up.
Workforce:	Work pressure may negatively impact unplanned leave. Sickness & absence data measure under development for inclusion in the dashboard.
Equity:	Short Notice Cancellations provide an opportunity for inequity to increase.
Other:	n/a

Document previously submitted to:		**Date:**
Approved by Chief Executive Officer:		**Date:** 28 September 2020

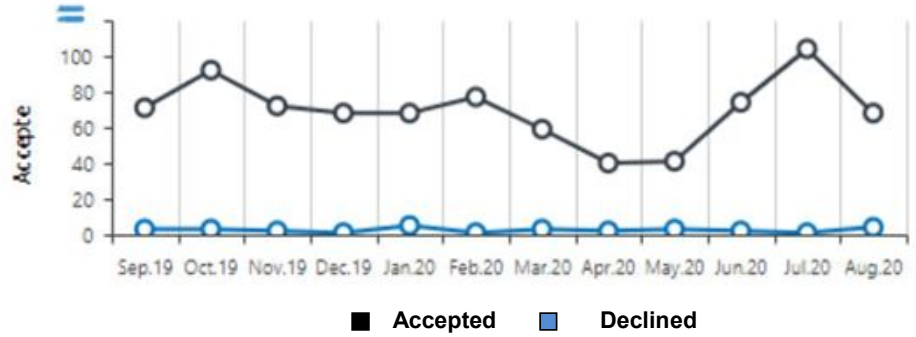
Prepared by: Gail Thomson Executive Director of Q&CGS 22 September 2020	**Presented by:** Chris Fleming Chief Executive Officer 6 October 2020

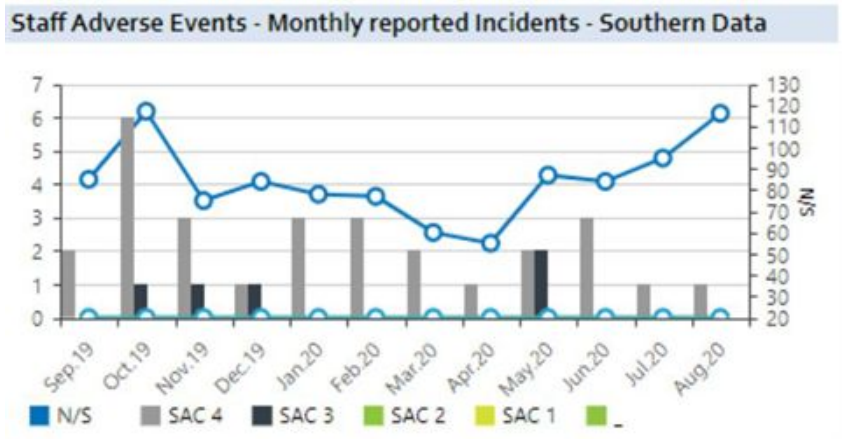
RECOMMENDATION:

That the Board note the Performance Dashboard

Performance Dashboard Tile Definitions (Southern)

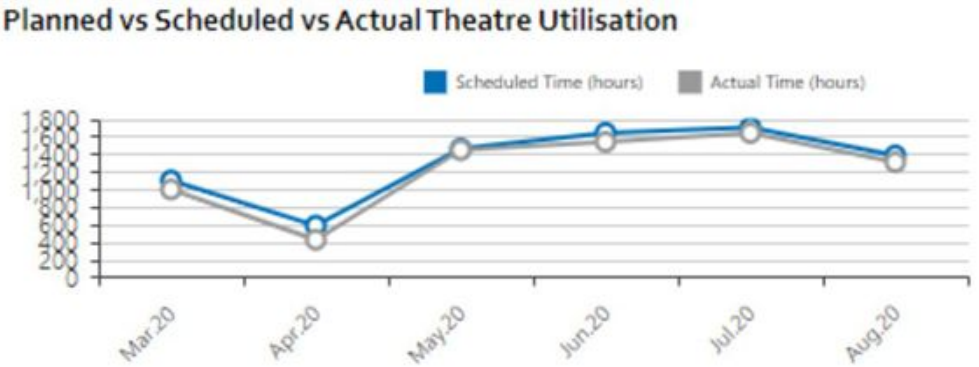
Tile Image	Tile Description
	Safety 1st data. *Complaints* The number of internal complaints (from website, phone, email, letter, health and disability, comment form, etc) per month. *Resolutions* The percentage of complaints that were resolved within 35 working days.
	*Restraints* Safety 1st data. The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

	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
Referrals Received & 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). Staff Adverse events are currently available as a total only.
	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.

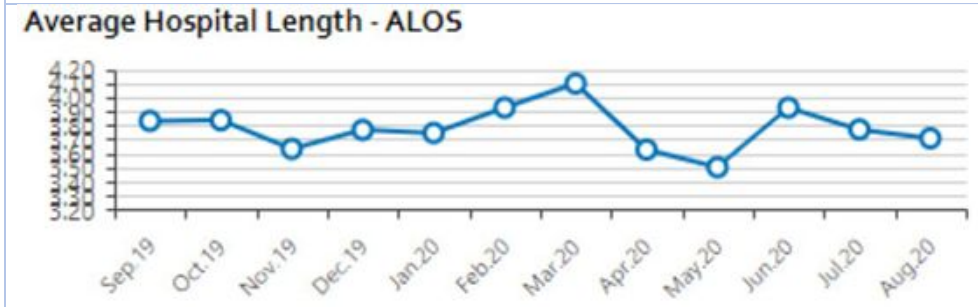
Both series display the theatre times for a subset of theatres. Dunedin tab: DNTH1 to DNTH9 inclusive
Invercargill tab: OR1 to OR4 inclusive
Southern tab: Dunedin tab theatres and Invercargill tab theatres

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

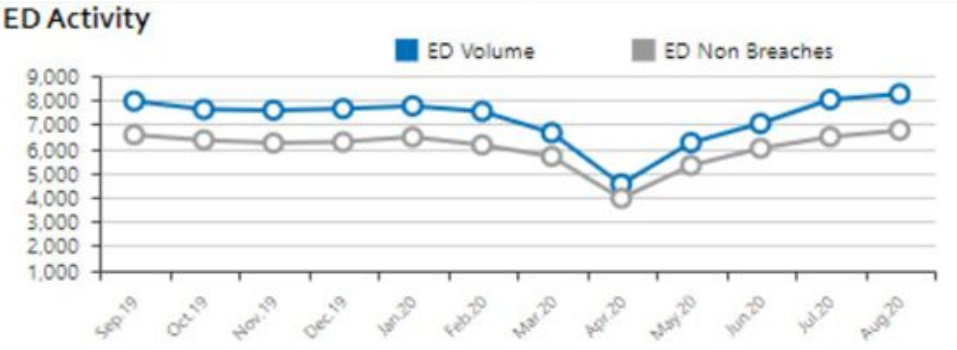
The monthly number of patients who have their procedure postponed after their surgery is scheduled.

1. All ACUTE procedures are excluded (so only short notice postponements for ELECTIVE procedures)
2. Identify the short notice postponements as those which have been recorded with "Cancellation Date" in IPM theatres
3. Based on the duration (in hrs) between the Cancellation Date/time and the Operation Proposed date/time classify the postponements in to 4 buckets:
    a. Made after Scheduled Surgery
    b. Made on or within 0 to 24 hours
    c. Made on or within 25 to 48 hours
    d. Made over 48 hours

This report shows the total postponements for all of the above category timelines.



The monthly average number of days that patients stayed in hospital.



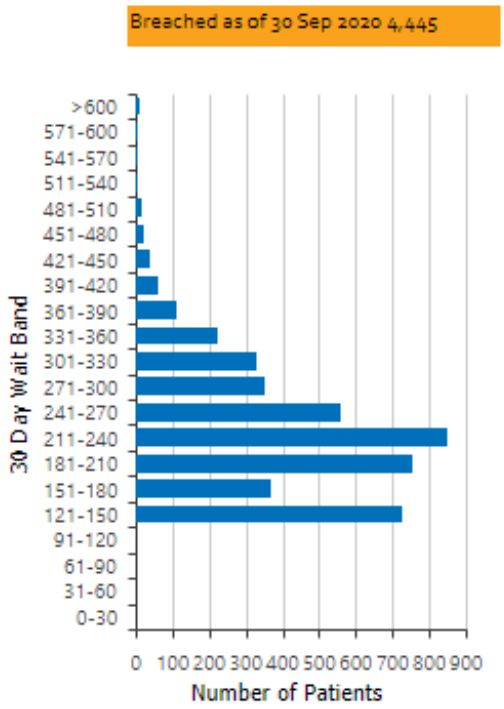
ED Volume

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.

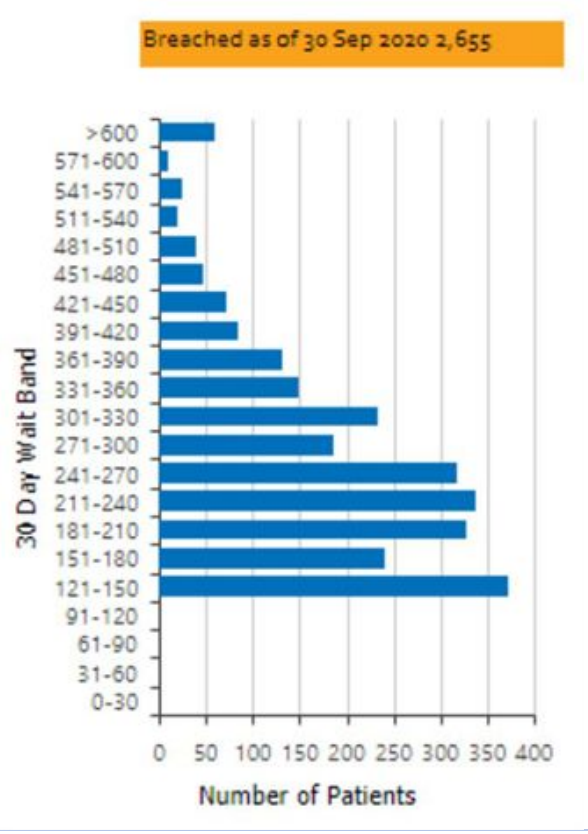
120 Day Breaches – ESPI 2



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.

120 Day Breaches – ESPI 5

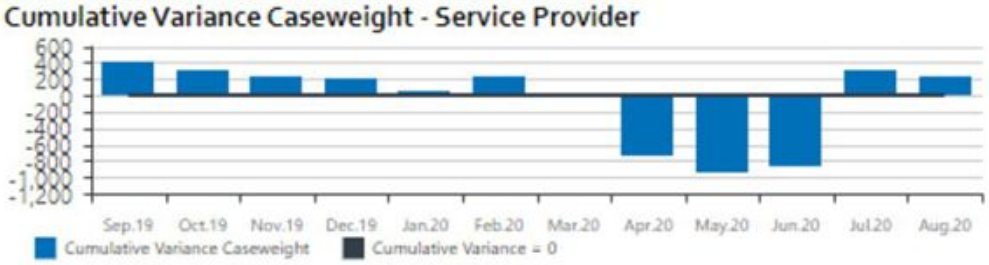


The number of patients whose wait for surgery will exceed a four month wait, and hence breach ESPI 5, by the end of the current financial month if no more surgeries are completed.

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

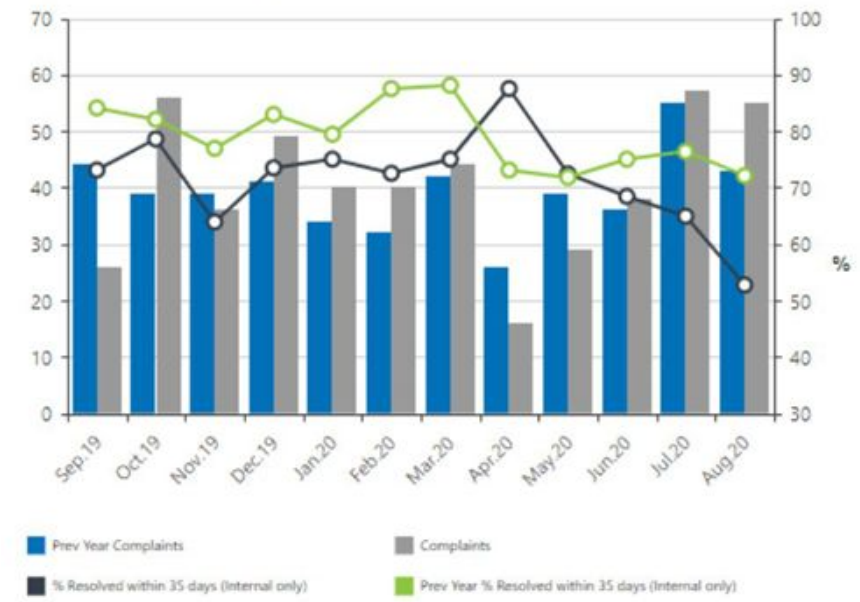
The case weight definition is as per MoH WIESNZ17.

	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 **MoH** – Acute: AC / AC, AA, WAA / AC / AC **PVS** – Elective: WN, 11 / WN, 11 / WN, 11, AA, WAA / WN, 11, AA, WAA **PVS** – 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*

Performance Dashboard Tiles October (Dunedin)

Tiles

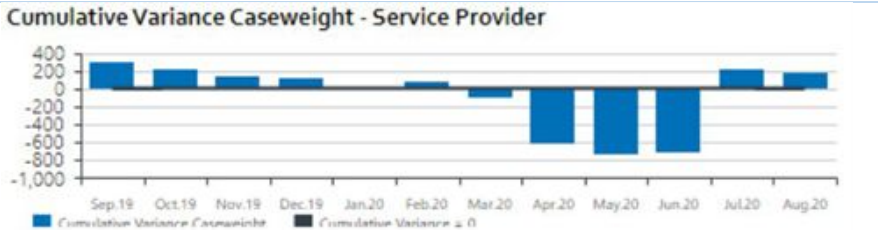
Complaint Rate and Resolution

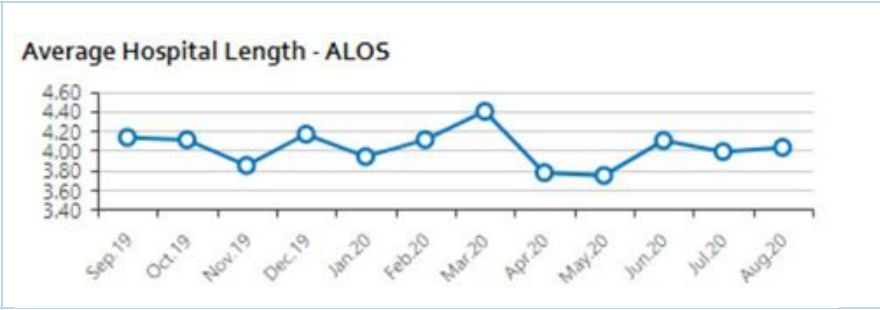


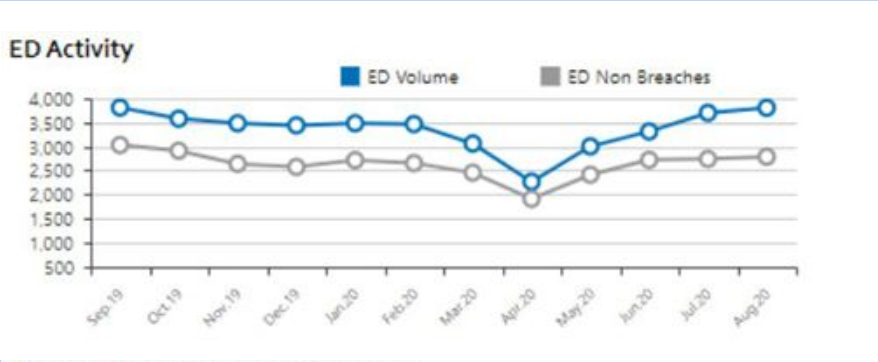
Planned vs Scheduled vs Actual Theatre Utilisation

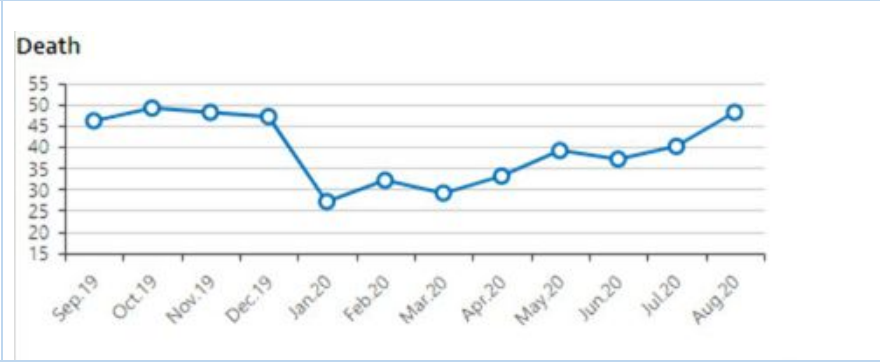
Restraint & Seclusion - Dunedin and Wakari Data

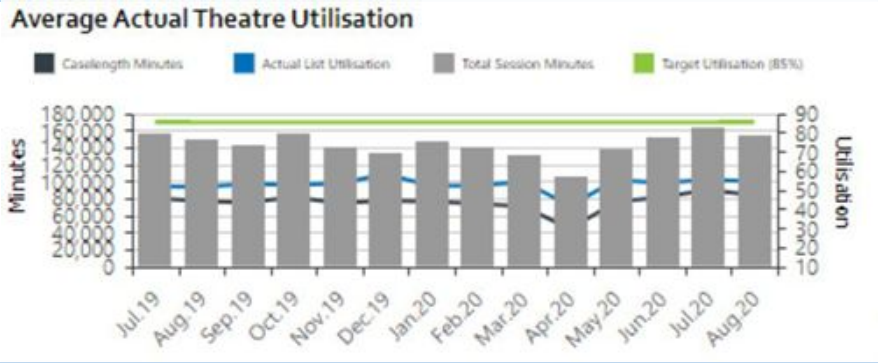
Short Notice Postponements


Cumulative Variance Caseweight - Service Provider
400
200
0
-200
-400
-600
-800
-1,000
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


Average Hospital Length - ALOS
4.60
4.40
4.20
4.00
3.80
3.60
3.40
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20

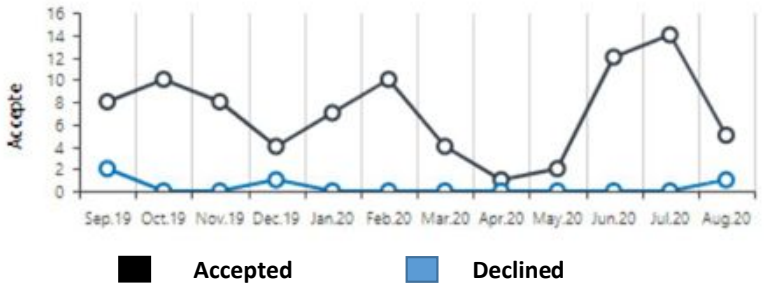

ED Activity
ED Volume
ED Non Breaches
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


Death
55
50
45
40
35
30
25
20
15
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20

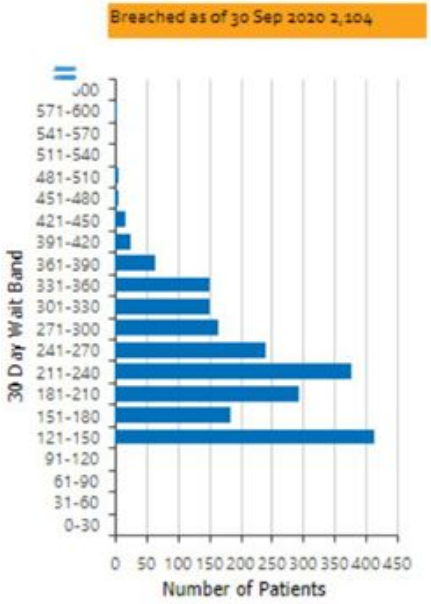

Average Actual Theatre Utilisation
Caselength Minutes
Actual List Utilisation
Total Session Minutes
Target Utilisation (85%)
Minutes
Utilisation
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
90
80
70
60
50
40
30
20
10
Jul.19
Aug.19
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


Unplanned Hospital Readmissions
Events
IP Days
Rates
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
10
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20

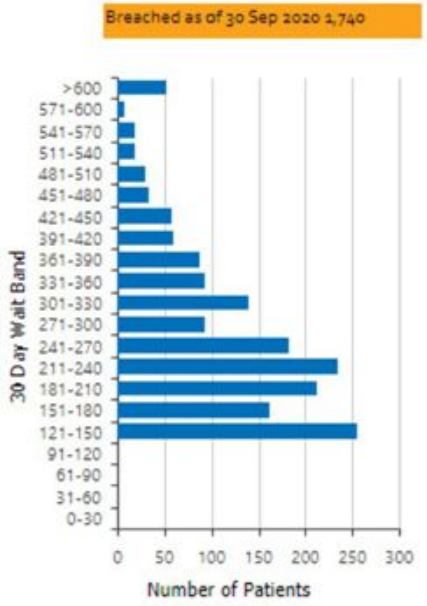
Referrals Received & Declined



ESPI 2



ESPI 5



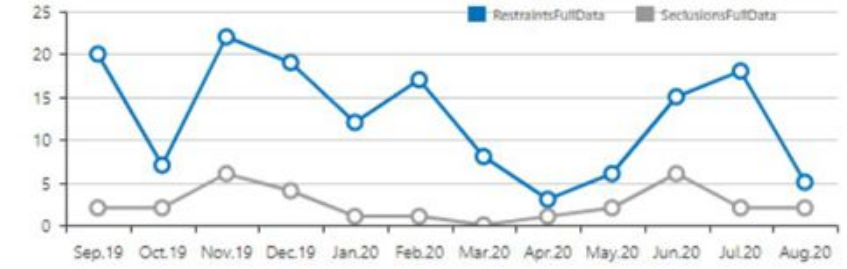
Performance Dashboard Tiles October (Invercargill)

Tiles

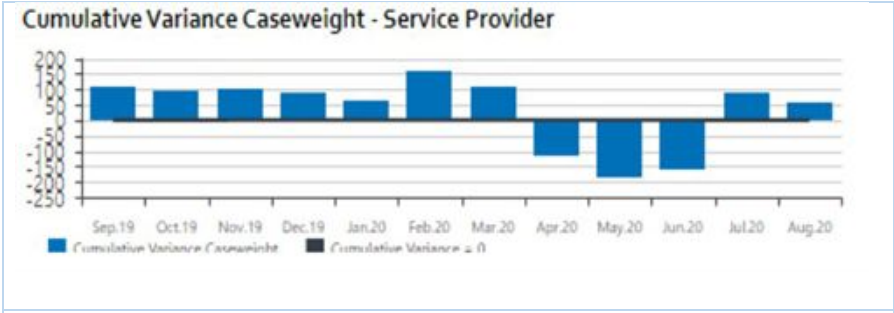
Complaint Rate and Resolution

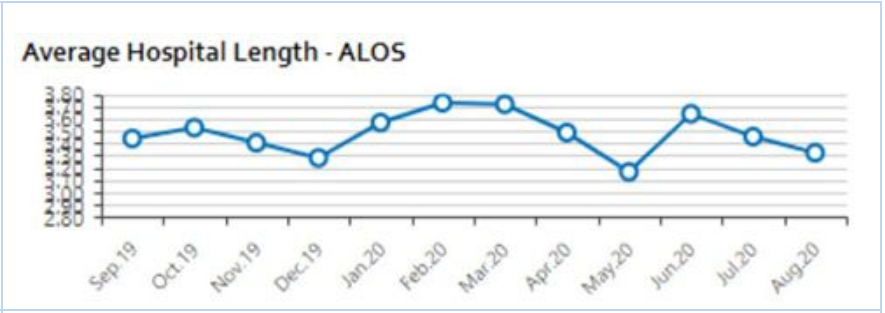
Planned vs Scheduled vs Actual Theatre Utilisation

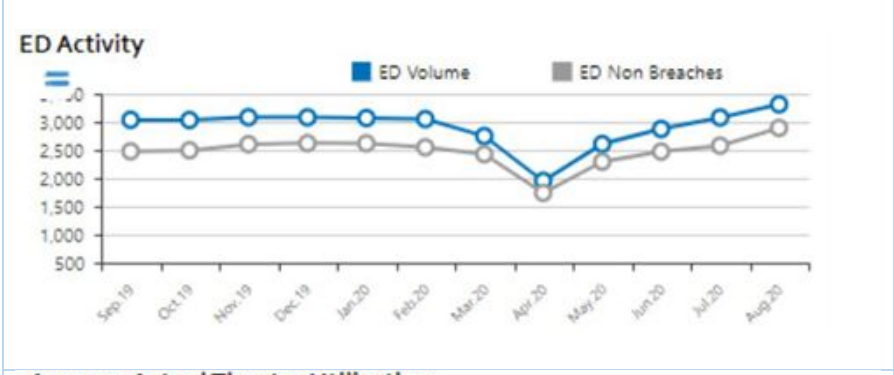
Restraint & Seclusion



Short Notice Postponements


Cumulative Variance Caseweight - Service Provider
200
150
100
50
0
-50
-100
-150
-200
-250
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20

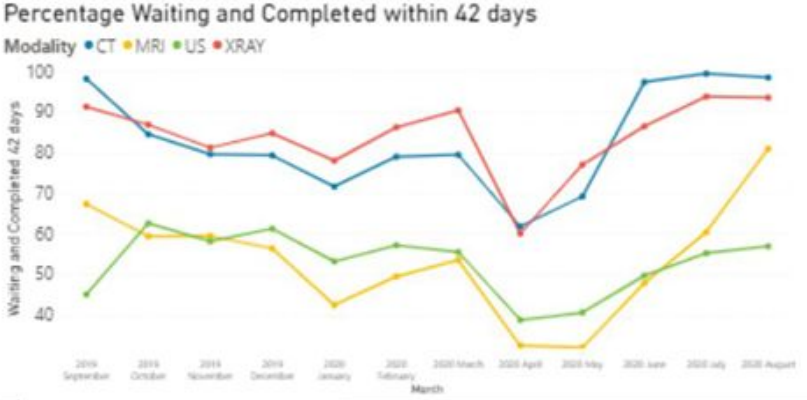

Average Hospital Length - ALOS
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


ED Activity
ED Volume
ED Non Breaches
3,000
2,500
2,000
1,500
1,000
500
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


Death
24
22
20
18
16
14
12
10
8
6
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


Average Actual Theatre Utilisation
Caselength Minutes
Actual List Utilisation
Total Session Minutes
Target Utilisation (85%)
Minutes
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Utilisation
90
80
70
60
50
40
30
20
Jul.19
Aug.19
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20


Unplanned Hospital Readmissions
Events
IP Days
Rates
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
10
Sep.19
Oct.19
Nov.19
Dec.19
Jan.20
Feb.20
Mar.20
Apr.20
May.20
Jun.20
Jul.20
Aug.20



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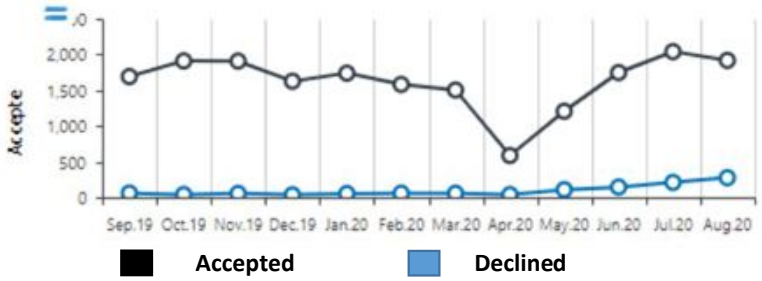
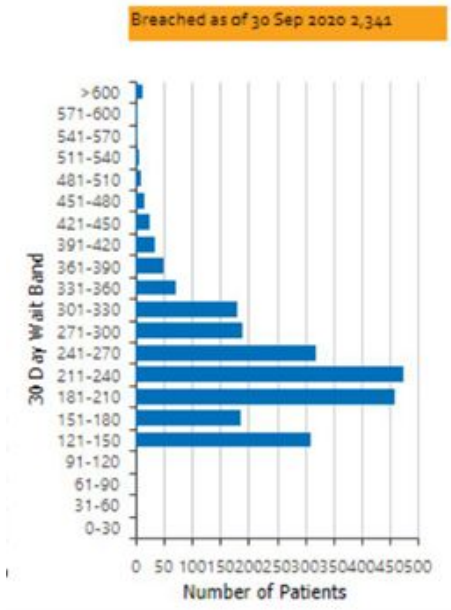
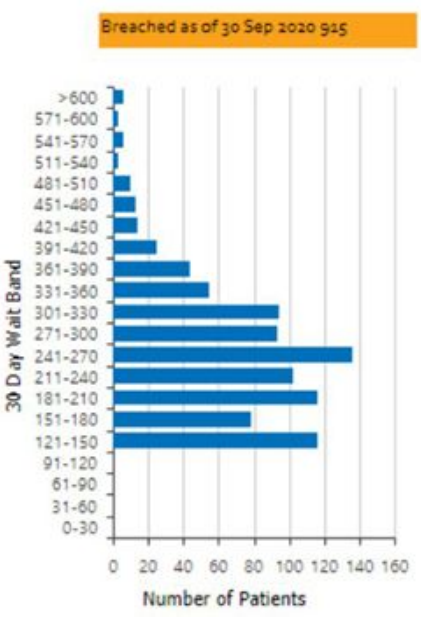


ESPI 2



ESPI 5



SOUTHERN DISTRICT HEALTH BOARD

Title:	**Colonoscopy Patient Review**
Report to:	Board
Date of Meeting:	06 October 2020

Summary:

- The attached review of Gastroenterology patients was commissioned by the Chief Executive Officer of Southern District Health Board. It follows the completion of a report in May 2019 on the 'Assessment of Diagnostic and Treatment Times for Endoscopic Cases' at Southern DHB (Review 1).
- Review 1 set out to audit all 102 files only 20 could be completed due to access to records and time constraints.
- The attached review set out to identify patients that might need urgent follow-up and address apparent short comings of the initial review.
- A total of 50 cases were audited which included a control group of 18.
- The reviewers made 6 recommendations regarding:
    - Improving management of referrals
    - Upgrade of the booking and recall system
    - Colonoscopy capacity
    - Application of direct access criteria
    - Inter-professional tensions
    - Process for all suspected cancer patients following colonoscopy
- To ensure that progress continues at pace we have decided to:
    - Reshape the Endoscopy User Group into two groups, one being the Endoscopy Oversite Group which will be chaired by Andrew Connolly who will have the responsibility to oversee the implementation of the actions and any outstanding agreed actions from previous reviews, and secondly the Clinical Referrers Group who will meet more regularly to address operational issues and to ensure any referral issues or concerns are addressed in a timely manner
    - Appoint a fixed term Project Manager for six months to be accountable tof ensuring that actions are addressed and work closely with the single responsible Executive member and the Chair of the Endoscopy Oversite Group.

- The single responsible Executive is the Executive Director Specialist Services, Patrick Ng, and progress reporting on activity will be through the Hospital Advisory Group
- A project action plan will be developed urgently on appointment of the project manager

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

Financial:	Maybe some system reconfiguration or implementation associated costs.
Workforce:	Interprofessional relationships highlighted as a recommendation, and clinical capacity.
Equity:	Addressing system issues to ensure equitable and timely access to colonoscopy.
Other:	

Document previously submitted to:	Executive Leadership Team Finance Audit and Risk	**Date:** 17/9/2020 **Date:** 17/09/20
Approved by Chief Executive Officer:	Received	**Date:** 9/9/2020

Review Report Prepared by: **Professor Ian Bissett**; Colorectal Surgeon Auckland DHB, Chair National Bowel Cancer Working Group **Kate Broome**, GM Rutherford Clinic (ex CNS Gastroenterology HVDHB) **Date:** 29 September 2020	**Presented by:** Patrick Ng Executive Director of Specialist Services Gail Thomson Executive Director Quality and Clinical Governance Support Chris Fleming Chief Executive

RECOMMENDATIONS:

That the Board

- **note the report and recommendations**
- **note the planned actions which are subject to Endoscopy Oversite Group ratification**
- **note the establishment of the Endoscopy Oversite Group and the appointment of Andrew Connolly to Chair the Group**
- **note progress will be reported through the Hospital Advisory Committee**

Colonoscopy Patient Review

Report for

Southern District Health Board

September 2020

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Executive Summary

This review of Gastroenterology patients was commissioned by the Chief Executive Officer of Southern District Health Board. It follows the completion of a report from Philip Bagshaw CNZM FRCS FRACS and Steven Ding MB CHB FRACP in May 2019 on the 'Assessment of Diagnostic and Treatment Times for Endoscopic Cases' at Southern DHB (Review 1). Review 1 set out to audit 102 case files of patients notified by surgeons in Southland as patients that were unnecessarily delayed in their access to colonoscopy due to internal processes and relationships. Although Review 1 set out to audit all 102 files only 20 could be completed due to access to records and time constraints. This review (Review 2) set out to complete the file review of the 102 cases, to identify patients that might need urgent follow up and to provide recommendations where shortcomings were apparent.

The initial approach to the file review was to start with patients identified as not previously audited in review 1 and not identified as deceased. The rationale for this approach was to ensure that patients who had not been investigated were identified so that they could be followed up urgently. The reviewers were also asked to include a control group of patients who had not been previously identified to ascertain whether there were similar shortcomings common to this group.

The audit of patient files has been problematic and has taken considerably longer than originally anticipated. A number of factors have contributed to this; auditor unfamiliarity with the SDHB systems, multiple systems used for a single patient episode (two electronic systems and a paper record) and the naming and storage of information within the SDHB systems. These factors have meant that the time taken to review each patient accurately has averaged more than an hour. The time available from appropriately skilled personnel has not been adequate to complete the task to date.

The nation's response to COVID-19 and lockdown further compounded the delays in the generation of this report, as has access to reliable and sound data on referral and declination rates. As highlighted by the reviewers within the report, systems for referral would benefit from improvement, notably digital. This would benefit the teams and organisations ability to track referral activity. This interim report has been written to provide feedback of the findings and the recommendations to date.

Gastroenterology Patient Review

Fifty patient records have been reviewed to date, 32 of the notified patients from the 18 controls. Among the 32 there were 11 cancer patients and two colitis patients who appear to have been managed appropriately. There were shortcomings in the other 19 patients' management. There were several reasons identified that resulted in referrals being declined or delayed. These included patients declined outright or delayed by referral through the First Specialist Assessment (FSA) route, patients being assessed against the direct access criteria when they were referred by other specialists, patients accepted for colonoscopy but having very long waits, the non-progression of two accepted patients on to the colonoscopy waiting list, inter-professional tensions impacting on patient and poor referrals that did not include required information.

The reviewers recommend

1. Improving management of referrals.

   The referral pathway needs to be strengthened to ensure that referrals received contain all the essential information to allow rapid, accurate triage. This would, at minimum, involve a mandatory template referral document, preferably digital, for all referrals. There are several possible examples already in use across New Zealand.

2. Upgrade of the booking and recall system.

   The booking and recall system in use for managing accepted referrals does not appear to be fit for purpose. There is no system for highlighting overdue investigations and there even appear to be patients that are lost after initial acceptance for colonoscopy.

3. Increase of colonoscopy capacity.

   The colonoscopy capacity appears to be constrained, placing undue pressure on those referring and those triaging patients. An increase in the colonoscopy resource provided by the DHB is strongly recommended.

4. Application of the Direct Access Criteria

   Although the Direct Access Criteria are provided for guidance there should always be the provision for clinical over-ride by those triaging or other gastrointestinal specialists.

5. Address inter-professional tensions.

   Correspondence associated with several of the patients highlighted that communication between professionals was at times strained and this affected the flow of patient management.

6. Process review for all suspected cancer patients following colonoscopy

   All colonoscopy findings with suspicion of colorectal cancer should be reported to the Clinical Nurse Manager (or another appropriate team member), who reviews referral pathway and time taken from referral to Colonoscopy. This allows for prompt review and will flag any issues in a timely manner. If the patient pathway deviates from that expected or they have waited longer than 6 months, review by the Endoscopy User Group is required.

1.0 Background

An external audit of the 'Assessment of Diagnostic and Treatment Times for Endoscopic Cases' was performed in early 2019, a draft report received 30 March 2019 and a final report completed 10 May 2019. The review was commissioned following concerns raised by the General Surgeons in Southland and was performed by Philip Bagshaw CNZM FRCS FRACS and Steven Ding MB CHB FRACP from Canterbury.

The Southland surgeons raised concerns that patients had delays in diagnosis because Direct Access Referral Criteria for Outpatient Colonoscopy or Colonography were being used, not only for referrals directly from general practitioners, but also for referrals from specialists. Further there were perceptions of compounded delays e.g. some general practitioners are sending patients to General Surgery outpatient clinics instead of consideration of direct access endoscopy thus further delaying diagnosis.

For a variety of reasons the audit only reviewed 20 of the 102 cases intended. It utilised information made available to them in electronic form to complete the review remotely. The review raised a number of concerns including; confirming that specialist override for referrals should be put in place, which has been subsequently addressed, and that in the 20 cases reviewed there were potentially significant delays in diagnosis.

SDHB was concerned that the case reviews did not necessarily utilise all information available nor liaise with clinicians regarding any findings. The review also limited itself to 20 cases when there were 102 cases identified by the General Surgeons.

The second review was commissioned to undertake an audit of the rest of the cases suspected as being 'subject to delay' in investigations by the SDHB gastro/GI teams. The review also aimed to look at a group of cases identified as not 'subject to delay' to identify factors that might be important to address in this setting.

Terms of reference were developed by SDHB's Executive Director Quality & Clinical Governance for the Chief Executive Officer. Reviewers were sought and the audit team commenced reviewing patient files in September 2019.

The patients highlighted were identified over the period (2013-2018) in the context of an overall demand and provision of colonoscopy as outlined in table 1. This table demonstrates that overall in

the last seven years 15% of referrals have been declined with similar decline rates for both Dunedin and Southland sites (14% and 16% respectively). 2013 data has been excluded from the calculation as the dataset was deemed incomplete.

Table 1: Number of referrals, complaints and incidents relating to colonoscopy in Southern DHB by site:

Referrals Accepted	2013	2014	2015	2016	2017	2018	2019	Total
Dunedin	1698	1584	1167	1097	1034	1008	1126	9101
Southland	91	235	748	675	659	601	628	3848
Total	1789	1819	1915	1772	1693	1609	1754	12949
Referrals Declined	2013	2014	2015	2016	2017	2018	2019	Total
Dunedin	444	415	171	146	134	129	201	1699
Southland	1	29	204	139	105	125	125	771
Total	445	444	375	285	239	254	326	2470
Incidents Reported	2013	2014	2015	2016	2017	2018		Total
Dunedin	n/a	n/a	1	2	2	2		7
Southland	n/a	n/a	2	0	8	3		13
Total	n/a	n/a	3	2	10	5		20
Complaints Received	2013	2014	2015	2016	2017	2018		Total
Dunedin	n/a*	n/a	4	3	4	3		14

Gastroenterology Patient Review

Southland	n/a	n/a	3	1	4	4		12
Total	n/a	n/a	7	4	8	7		26

*n/a = not available as paper based reporting only. From 2015 data is extracted from an electronic incident management and feedback system.

2.0 Methodology

The review undertook to audit the remainder of the 102 cases (sample) suspected by the SDHB gastro/GI teams as having an undue delay prior to colonoscopy. The objectives of the review were:

1. to identify any patients who required active follow-up as a matter of priority.
2. to establish whether there were any factors that contributed to the delays to colonoscopy that could be addressed to reduce these patient delays.

The audit team was established following recommendations from the office of the Chief Medical Officer, Ministry of Health and other national networks of well-known and credible clinicians. The team was finalised in September 2019. This part of the process took nearly 2 months to conclude as the topic at the time was highly sensitive, and all SDHB parties needed to be comfortable with the individuals selected.

The final team consisted of:

- Professor Ian Bissett; Colorectal Surgeon Auckland DHB, Chair National Bowel Cancer Working Group
- Kate Broome, GM Rutherford Clinic (Clinical Nurse Specialist (CNM) Gastroenterology at HVDHB prior to that)

The team agreed and finalised the Terms of Reference and approach to the second review. An audit tool was designed, tested and signed off by the review team. The review team was not provided with the previous report (Review 1) prior to their review at their own request so as to approach the cases that had been notified as 'at risk' with no preconceptions of likely outcome for the review.

2.1 In Scope:

Patient files were audited to establish the referral/assessment/intervention/outcome pathways for each of the patients concerned. The audit looked at the potential impact of the system on patient outcomes:

a) Referrer (GP, specialist)

b) Condition on first appointment – e.g. early/late presentation

c) Timeliness of referrals

d) Application of local guidelines including onward referral/declinations & reasons why

e) Delays in the system for appointments/diagnostics/intervention

f) Patient outcomes – successful treatment/no treatment/disease progression

g) Patient experience – complaints/incidents

2.2 Out of Scope:

- The audit was not a service review
- It was not a review of clinical competence or peer review of individuals practice

2.3 The audit process

A two day on site review of files took place in Invercargill during September. The CNM led the two-day review supported by her personal assistant, the personal assistant to Executive Director of Quality and Clinical Governance and the medical records staff at Southland.

Data from individual patients were recorded on a spreadsheet that included demographic details, route of referral, timeliness of triage, outcome of triage, causes of delay to investigation, outcome and an assessment of the degree of impact caused by any delays categorized as minimal, considerable and extensive.

For expediency the following approach was taken:

- Exclude cases identified as being duplicates or false patients which totalled 6. This immediately reduced the total files requiring review from 102 to 96.
- Prioritise patients who were still alive and had not been assessed by the first review team (20 cases were previously reviewed and 27 had subsequently died)
- Include a control group of 18 cases to identify any significant factors common to the delayed group that were not present in the control group.

The total potential files to review for at risk patients requiring urgent follow up was reduced to 49 plus the control group once those deceased and previously reviewed were excluded.

Gastroenterology Patient Review

Patient files were retrieved and provided for the review, including those for the control group. The team worked together to identify and capture timelines and events for each case reviewed. Any requiring a second or expert opinion were highlighted during the process.

A subsequent on site review (including Prof Ian Bissett) took place on 24 October, 2019. The focus was on expert review of cases that had been highlighted during the initial CNM review. Following this the pertinent data regarding further patients were summarised by the CNM and reviewed in thirteen videoconferences including Prof Ian Bissett, CNM Kate Broome and Executive Director of Quality and Clinical Governance of SDHB.

Although the initial patients reviewed were still alive the reviewers decided that some of the deceased patients should also be reviewed. The 50 reviewed cases included eight who had died.

3.0 Findings

A total of 50 cases have been audited to date, 32 of the deemed 'at risk' group and 18 in the control group. The findings of the review group are summarised in Table 2.

3.1 Patients requiring active follow Up

Initially patients were assessed to determine if there were any that had investigations that were still outstanding. Within the 'at risk' group there were none identified in this category but one of the control group of patients had not been investigated despite being accepted for colonoscopy. This patient has been now been contacted by the Service Manager and Clinical Leader Gastroenterology and it was determined that this patient had requested to be removed from the waitlist. The patient is being followed up again as a result of this review.

3.2 Timeliness of referral triage

There was efficient review of the referrals received with referrals graded a median of 3 days (range 0-30 days) after they were received. With only 3 referrals taking longer than 2 weeks to be triaged.

Twenty six complaints were received between 2015 and 2018 inclusive in regards the colonoscopy service. These were evenly split across Dunedin and Southland Hospitals, and almost exclusively relate to the referral process, ambiguity of letters, doctors manner or delays in access to a specialist or diagnostics (colonoscopy). Almost all complaints were from patients or their close family.

Twenty incidents were lodged in the DHB incident management system during the same time period (2015 – 2018) with Southland proportionately over represented in 2017.

Nine of the 20 incidents (7 Southland, 2 Dunedin) were about delays in access to colonoscopy due to a combination of factors; declined at initial triage, referrals getting lost in the system and dispute amongst medical staff regarding the appropriateness of the referral. The severity of impact of the delays ranged from near miss to severe, severe being 2 with end stage inoperable disease.

3.3 Factors involved in delay to colonoscopy

In the 32 'at risk group reviewed there were two patients with Inflammatory Bowel Disease that were managed satisfactorily. There were another 11 patients in that group who appeared to be appropriately triaged and did not suffer any delay in their management.

The other 19 patients are summarised in table 2. For some of these patients more than one criterium was present but each patient was only entered into the most appropriate category. Six patients in the 32 'at risk' group that appeared to meet the criteria for acceptance for direct colonoscopy were declined and either sent for First Specialist Appointment (FSA), a CT scan or returned to the GP. This resulted in an extended delay to final colonoscopy in all of them. One example was a 65 year old man who was referred with a change of bowel habit and then waited five months for a FSA assessment then another 5 months before his colonoscopy was performed a total wait of 10 months. At diagnosis he had an almost obstructing sigmoid colon cancer. He survived his cancer treatment but has subsequently died of other causes.

A second was a 49 year old man with PR bleeding and a change in bowel habit (not defined) who was referred from one of the specialists but was declined as he had not undergone a sigmoidoscopy. The colonoscopy subsequent to the sigmoidoscopy was normal. It appears that this patient was assessed on the criteria pertaining to direct access from a primary care doctor rather than as a referral from another specialist.

A further three patients were referred and accepted for colonoscopy but subsequently had prolonged delays before they had their colonoscopy varying from 8 to 24 months from the time of referral. One of these, a 74 year old woman was referred with rectal bleeding and accepted for colonoscopy. It is not clear from the information available to the reviewers why she waited 12 months before her colonoscopy but this identified an advanced colon cancer which she subsequently had successfully treated.

The nine patients in the previous two categories whose colonoscopies were delayed unacceptably long periods suggest a service that is struggling to provide the colonoscopy volumes that are required to meet the population needs. This is also demonstrated in Table 1, where there has been

no increase in colonoscopy provision between 2013 and 2019 in the SDHB, whereas the national colonoscopy provision has increased by 45% during the same time period. [1]

Data released last year comparing colonoscopy intervention rates by population for the years 2014-2018 indicated that the SDHB colonoscopy intervention rate was in the lowest 25% of DHBs (Appendix 3). When this is combined with the fact that the DHB also has one of the highest incidences of colorectal cancer it is hard to deny that there has been an under-provision of colonoscopy during this period.[2] A possible scarcity of colonoscopy may also have had an impact on the relationships between referrers and providers.

We identified three patients whose treatment appears to have been hampered by poor inter-team communication with letters written that were less than collegial in tone. One such patient was an 85 year old man who had a previously diagnosed rectal cancer and had known metastatic disease but presented with further rectal bleeding. There were conflicting opinions and the GP was copied in to this without any clear advice. The patient does not appear to have been discussed in a multidisciplinary team meeting and communication between the specialist referrer and the referral triaging doctor indicated that there was no common understanding of the indication for the colonoscopy.

There were two patients who appeared to have been accepted for colonoscopy and entered as accepted in the chart but did not proceed to invitation. It is not clear to the reviewers why this occurred and may represent a significant process/systems error that needs to be further investigated. One of these was a 65 year old man who had iron deficiency anaemia and a polyp seen in the rectum at the clinic. He was accepted for colonoscopy but does not appear to have progressed onto the actual waiting list. He only had his colonoscopy after a further GP referral seven months later enquiring about the timing of the procedure.

Finally, there were five patients whose referrals did not contain enough information to adequately triage them patients for referral. For each of them there was a delay in progression resulting from return to the referrer and to provision of the additional information.

Review of the control group did not identify any of the above factors at play in their management.

[1] https://www.rnz.co.nz/news/national/366774/patients-waiting-too-long-for-bowel-cancer-diagnosis
[2] https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/Atlas/BowelCancerSF/atlas.html

Table 2: Analysis of causes of delay to treatment in the 50 reviewed patients.

18	Controls – No further follow up required
2	IBD patients
11	Reviewed but no issue identified
6	Met criteria but were declined – either returned to GP or referred for FSA which created a delay
3	Had unacceptable delay of 8-24 months
3	Poor inter – team communication resulting in poor pathway through system
2	Referral lost in system
5	Referrals poor (not enough information to triage)
50	

3.4 Patient impact

The reviewers considered that nine of the 32 notified patients had delays in the pathway that had an extensive impact on them. One such patients was a 70 year old woman who was referred with a high suspicion of cancer by her general practitioner with a two month history of rectal bleeding, change in bowel habit and tenesmus. She was declined direct colonoscopy and advised for referral for sigmoidoscopy at a surgical clinic. She was referred for private colonoscopy two months later and a rectal cancer was identified. She then underwent an anterior resection in the DHB a month later. Several others of these have already been described in the previous sections.

4.0 Summary and recommendations

In the group that were identified as needing investigation by the clinicians we found about a third had been assessed and appear to have had appropriate management. In the other 19 patients there were several reasons identified that resulted in referrals being declined or delayed. These included patients who appeared to meet acceptance criteria being declined or being delayed through the FSA route, patients being assessed against the direct access criteria when they were referred by other specialists, patients accepted but having very long waits, the non-progression of two patients on to the colonoscopy waiting list, and poor referrals that did not include the required information.

In the convenience sample of 18 patient who were assessed as controls we did not identify any of the issues that have been described above. However, there was a single person who requested removal from the list and therefore had not had a colonoscopy.

4.1 Major findings

The reviewers have summarised their findings into four major groups

1. The referral process is poor. Many referrals have inadequate information for triage and obtaining clarifications for omitted data creates an increase in patient waits. This issue would be address by introduction of a referral form (preferably digital) that required inclusion of all the relevant information at the time of referral.

2. The system of managing the patient journey was almost impossible to audit, involving two different databases and also notes on paper. This makes tracking an individual patient's journey through the system very difficult. The reviewers were concerned that two patients had been triaged as accepted for colonoscopy but did not appear to have been added to the colonoscopy waiting list.

3. Colonoscopy numbers have not increased over the last seven years despite a marked increase in provision nationally. We identified several patients whose colonoscopies were significantly delayed. We also noted that the Southern DHB has one of the lowest colonoscopy intervention rates along with one of the highest bowel cancer rates in the country. These findings suggest that colonoscopy capacity is inadequate for the population served.

4. There were instances where the direct access criteria were applied not just to patients referred directly from primary care but also referrals from other specialists.
5. Correspondence reviewed demonstrated there are significant professional tensions between the different service providers which is likely to have impacted on patient management.

4.2 Recommendations

1. Improving management of referrals.

   The referral pathway needs to be strengthened to ensure that referrals received contain all the essential information to allow rapid, accurate triage. This would, at minimum, involve a mandatory template referral document, preferably digital, for all referrals. There are several possible examples already in use across New Zealand.

2. Upgrade of the booking and recall system.

   The booking and recall system in use for managing accepted referrals does not appear to be fit for purpose. There is no system for highlighting overdue investigations and there even appear to be patients that are lost after initial acceptance for colonoscopy.

3. Increase of colonoscopy capacity.

   The colonoscopy capacity appears to be constrained, placing undue pressure on those referring and those triaging patients. An increase in the colonoscopy resource provided by the DHB is strongly recommended.

4. Application of the Direct Access Criteria

   Although the Direct Access Criteria are provided for guidance there should always be the provision for clinical over-ride by those triaging or other gastrointestinal specialists.

5. Address inter-professional tensions.

   Correspondence associated with several of the patients highlighted that communication between professionals was at times strained and this affected the flow of patient management.

6. Process review for all suspected cancer patients following colonoscopy

All colonoscopy findings with suspicion of colorectal cancer should be reported to the Clinical Nurse Manager (or another appropriate team member), who reviews referral pathway and time taken from referral to Colonoscopy. This allows for prompt review and will flag any issues in a timely manner. If the patient pathway deviates from that expected or they have waited longer than 6 months, review by the Endoscopy User Group is required.

4.3 Limitations

The reviewers recognise that there are several limitations that need to be acknowledged in the production of this report. First, the hospital records were very difficult to navigate and it is possible that some documents that would have shed further light on individual patient journeys may have been omitted. These potentially could have altered the conclusions for some of those reviewed. Second, the reviewers were judging the patient journeys with the benefit of hindsight which may have coloured the understanding of patient risk. There was a genuine attempt by the reviewers not to allow the final outcome to prejudice the interpretation of the initial symptoms and referral details but some unconscious bias may have played a part. Finally, the reviewers have not completed the entire number of patients notified to the DHB as being at risk of delay to treatment. The reviewers, however, consider that the completion of the remaining patients on the list is unlikely to make a major difference to the recommendations and the complexity of the record system is such that completing the task would require considerably greater resource than they can provide.

5.0 Appendices

Terms of Reference Gastro Patient Review

Southern District Health Board Internal Review	
Review	**Gastroenterology**
Sponsor	Chief Executive Officer
Responsible Manager	Gail Thomson – Executive Director Quality & Clinical Governance
Background	An external audit of the 'Assessment of Diagnostic and Treatment Times for Endoscopic Cases' was performed in early 2019 and a draft report received 30 March 2019. The review was commissioned following concerns raised by the General Surgeons in Southland. The surgeons purported that patients had delays in diagnosis due to the use of the Referral Criteria for Direct Access Outpatient Colonoscopy or Colonography, without the ability of the specialist to over-ride the criteria. Further there was perceptions of compounded delays e.g. some general practitioners are sending patients to General Surgery outpatient clinics instead of consideration of direct access endoscopy thus further delaying diagnosis. Unfortunately for a variety of reasons the audit only reviewed 20 cases, and then only utilised information which was available in paper form to be sent to the reviewers who were completing their review remotely. The review indeed raised a number of concerns including confirming that specialist override for referrals should be put in place, which has been subsequently addressed, and that in the 20 cases reviewed there were potentially significant delays in diagnosis, as well as raising further significant concerns. SDHB is however concerned that the case reviews did not necessarily utilise all information available nor liaise with clinicians regarding any findings. The review also limited itself to 20 cases when there were 102 cases identified by the General Surgeons. The purpose of this review is to undertake an audit of cases suspected as being at risk by the SDHB gastro/GI teams. The review will also look at a group of cases identified as not a risk to establish if any underling factors were common and therefore not attributable to the outcomes. This terms of reference has been developed with SDHB's Executive Director Quality & Clinical Governance. The final report will be provided to the Chief Executive.
Base Method	The purpose of this review is to undertake an audit of 102 cases (sample) suspected as being of risk by the SDHB gastro/GI teams. The review will also look at a control group of 20-25 cases initially to establish if any significant factors found in the sample were present in both groups. The primary objective is to establish if there are any patients that require active follow-up as a matter of priority. The secondary objective is to establish what factors helped prevent the patients in the control group from getting lost. These finding can be used to improve the system for all. **In Scope:** Patient files will be audited to establish the referral/assessment/intervention/outcome pathways for each of the 102 patients concerned. The audit will determine the impact of the system on patient outcomes: a) Referrer (GP, Self) b) Condition on first appointment – e.g. early/late presentation c) Timeliness of referrals d) Application of local guidelines including onward referral/declinations & reasons why e) Delays in the system for appointments/diagnostics/intervention f) Patient outcomes – successful treatment/no treatment/disease progression g) Patient experience – complaints/incidents

Gastroenterology Patient Review

	Out of Scope: • It is not a service review It is not a review of clinical competence
Deliverables	The audit will determine the impact of the 'system' on patient outcomes and experience, where attributable. It should also identify whether any of the cases reviewed indicate that direct patient follow up should occur. It will also discount factors that exist in both cases that went well and not so well to remove false positives from the review. The report will outline our findings and will contain suggestions for improvement or further review where appropriate. A draft report will be provided to all engaged in the review with the ability for feedback to be provided to the reviewers for consideration before producing the final report. The final report will be provided directly to the Chief Executive Officer.
Professional Standards	As registered health professionals and members of specialist professional bodies and associations, the review team will act professionally, impartially and ethically throughout the review. Reviewers will display independence, abide by the SDHB codes of conduct and confidentiality and agree to the terms of engagement. Any identified risks will be escalated upon discovery if appropriate. The reviewers will not release the report or comment publicly on the review unless approved by the Chief Executive or delegate.
Review team	Professor Ian Bissett; Colorectal Surgeon Auckland DHB, Chair National Bowel Cancer Working Group Kate Broome, GM Rutherford Clinic (ex CNS Gastroenterology HVDHB)
Timing	Fieldwork to commence August 2019, complete December 2019

Gastroenterology Patient Review

Audit Tool Questions

1.	NHI
2.	Deceased Patient
3.	Previously audited
4.	Case
5.	Age (at date of referral)
6.	Male /Female
7.	Ethnicity
8.	Domicile
9.	Referrer
10.	Date referral completed
11.	Date referral received by DHB
12.	Date referral triaged
13.	Triager A B C
14.	Time to triage (Days)
15.	Reason for Delay in Triage (i.e lack of info in referral etc)
16.	Indications requested for Colonoscopy
17.	Triage category
18.	Did referral meet the Direct Access Criteria - Yes/No
19.	What Investigations were provided by referrer (FBC, Ferritin)
20.	If met criteria did patient get referred for Colonoscopy /CTC / FSA or Declined
21.	Is patient late stage presentation
22.	If declined - Reason for decline
23.	If declined - did patient receive any follow up
24.	If re-referred to service next outcome
25.	Time from accepted referral until Colonoscopy/CTC or FSA- 3 months/3-6 months/6-9 months/> 9 months
26.	Outcome Colonoscopy- Early /Late Presentation/Unknown
27.	Outcome FSA - Discharged / Triaged / Follow up FSA / Referred to another service.
28.	FSA Triage Category < or > or same than original triage
29.	If High Suspicion of Ca. Next date of intervention (CT/MRI)
30.	Other delays in the system? appointment-diagnostics diagnostics-intervention
31.	Patient Outcomes (if known)in remission active treatment palliative

Gastroenterology Patient Review

32.	Reported incidents- /N If Y, theme: delay communication other
33.	Reported Complaints-Y/N If Y, theme: delay
34.	Comments
35.	Patient Impact - Minimal / Considerable /Extensive
36.	Key Themes
37.	**Outcome of Audit**

Response to Recommendations from the Colonoscopy Patient Review, September 2020

1. Background

Southern DHB has now received a detailed report about colonoscopy services at Southern DHB. At the outset we want to acknowledge there have been many issues raised over time that have needed to be addressed. We have taken many steps to move forward and to improve the service, but there is more to be done.

The *Colonoscopy Patient Review* was commissioned from Professor Ian Bissett as a follow up report following the review undertaken by Mr Bagshaw and Dr Ding into referrals into the gastroenterology service released in mid-2019. The Bagshaw/Ding report only reviewed 20 of the 102 cases identified by the DHB and the follow up report was commissioned to:

- Determine if there were further cases of concern and patients who needed to be recalled for care.
- Identify any process issues potentially placing patients at the risk of harm.

While this report was being completed, the DHB has continued to implement the recommendations from the Bagshaw/Ding report, as well as recommendations made by Mr Andrew Connolly following his engagement with the services. A number of the themes of this subsequent report echo these previous reports and affirm the actions taken to date. These fall into the three key workstreams, as follows:

- Enabling gastroenterologists and GI surgeons to refer directly into the service. This has now been in place since May 2019, however there remained an issue of the prioritisation of each referral which has now been addressed.
- Strengthening the team dynamics. This has been an ongoing process and remains a priority.

Further examining our processes and identifying areas for improvement, with an action plan overseen by the Endoscopy Users Group. The group was reformed and a number of the identified actions have been carried out. Professor Bissett's report has also identified further areas to be addressed.

It identified challenges in the multiple processes that make up the patient journey. These not only related to the issue of whether referrals were accepted or declined, but other aspects of care, including the quality of the initial referrals, IT systems, delays to be seen in a specialist appointment and waiting times for a colonoscopy.

It has also identified that further process improvements are needed, particularly in our administration systems.

We accept the recommendations of the review and have determined that we need to go further to ensure that the improvements to the service receive the oversight and focus which they require.

In this paper we provide a review of the recommendations in the context of the service that is provided today.

We also propose strengthening the governance framework for endoscopy services to:

- Provide greater oversight of the entire patient journey through the service, beyond the single measure of whether a referral has been accepted or declined.
- Support the establishment and delivery of a single project with clear accountability for the review and implementation of recommendations including identification of any further resources which may need to be prioritised through the DHB planning cycles.
- Improve the separation of operational and strategic issues.

A decision has been made to have two separate groups:

- An Endoscopy Oversight Group – This group will now be chaired by Andrew Connolly and will have representatives from the Referrers' Group (see below). It will also be the place for consumer participation. The Oversight Group will have the responsibility for ensuring that the actions are fully implemented, and the Clinical Referrers' Group will be expected to action any decisions made by the Oversight Group. The Endoscopy Oversight Group will be supported by a fixed term project manager who will be appointed for a six month period. The Oversight Group will report directly to the Executive Director Specialist Services who will hold Executive responsibility for ensuring all actions are addressed. The Oversight Group Chair will also have a direct line to the Chief Executive and the Board for escalation as needed. The Oversight Group will meet on a monthly basis to ensure progress continues at an appropriate rate.
- A Clinical Referrers' Group – This group will meet weekly to ensure referral processes are being adhered to and any issues raised are resolved in a timely manner. The Clinical Referrers' Group will periodically get direction from the Oversight Group to which it will be required to respond in a timely manner.

We do need to ensure we apply some context to the issues that have been identified. The issues that have been raised in both the Bagshaw/Ding and Bissett reports related to a proportion of the patients who were selected because of concerns about their cases. This more recent (Bissett) report looked at a selection of cases where no concerns had been raised (a control group) to assess whether the issues found were universal. The issues did not appear in the control group. This suggests that while there are issues that need to be addressed, they are not universal to all cases. We note that since 2014 there have been some 13,000 colonoscopies undertaken. Although the problems identified relate to a very small proportion of these 13,000 colonoscopies, we are still determined that we will improve our systems based on the recommendations of the report.

It should also be noted that waiting times for the service compare reasonably well with those of other DHBs. This is positive, but we do recognise that if referrals have been suppressed in any manner then this may be artificial. Careful monitoring of waiting lists is therefore essential. Whilst context is important, the issues identified nevertheless have the potential to impact on patient care. We must work to address them and to continually improve the delivery of our services.

We have a higher rate of bowel cancer in our district than elsewhere in New Zealand, and appear to have a relatively low rate of colonoscopies. This suggests we must also do more to raise awareness of bowel cancer and the symptoms that may indicate a problem, so that the community are aware of the need to seek the assistance of their GP. We will work to ensure that the whole process is improved so that people who have symptoms that indicate bowel cancer know where to go for help and that, where indicated, there is prompt and easy access to a colonoscopy. The bowel screening programme remains a significant intervention to ensure we find cancers at an earlier stage, and we expect the high uptake in this programme will be seen in the rate of cancers in our district in the years to come.

2. Response to the Bissett Report Recommendations

The following sets out the recommendations coming from the Bissett report, management's response and the proposed actions. It should be noted that these actions were presented at the Endoscopy User Group meeting on 25 September and further discussion was requested. The actions are therefore presented as draft actions to be further refined and endorsed by the reshaped Endoscopy Oversight Group.

Recommendation #1: Improving Management of Referrals

'The referral pathway needs to be strengthened to ensure that referrals received contain all the essential information to allow rapid, accurate triage. This would, at minimum, involve a mandatory template referral document, preferably digital, for all referrals. There are several possible examples across New Zealand.'

Management Response

We believe that for *external referrals*, the colorectal/colonoscopy specific electronic referral form introduced into our Electronic Referral Management System (ERMS) in July 2018 is a robust referral template. (Refer to Appendix C). ERMS allows us to receive referrals electronically into our clinical portal, Health Connect South. We have included the ERMS referral template in the appendices for reference. However, for our *internal referrals*, we acknowledge there are opportunities to improve the referral template. Internal referrals can currently be made either using a manual form, or as a 'Consult Request' in our in-house internal referral system which is not specific to endoscopy/ colonoscopy referral types. (Refer to Appendix D). We believe that for our internal referrals, the creation of a specific internal digital referral form which required the population of information specific to an endoscopy/colonoscopy would assist in the triaging of referrals.

Proposed Action

Seek support from our Information Technology team to urgently develop an improved internal referral template which can be utilised appropriately. This may be specifically for internal referrals which are endoscopy/colonoscopy related, or for internal referrals more generally. The improvement actions will need to occur in a timely manner. The relevant General Manager (who was formally the Service Manager for the service), the Clinical Leader and the relevant Executive Director will work with the relevant IT resource (once assigned) to design and implement an enhanced electronic internal referral template.

Recommendation #2: Update of the Booking and Recall System

'The booking and recall system in use for managing accepted referrals does not appear to be fit for purpose. There is no system for highlighting overdue investigations and there even appear to be patients that are lost after initial acceptance for colonoscopy.'

Management Response

We are keen to discuss this finding with the reviewers to gain further clarity. Our IPM patient administration system is used to manage patients who are on recall (for surveillance) and symptomatic patients who, once accepted at the point of triaging, are placed onto an appropriate waiting list in IPM. Once patients are loaded for surveillance or onto a wait list and are therefore in our IPM system, they can then be tracked via our waiting lists and the amount of time they have spent waiting on our waiting lists can also be tracked. We do, however, believe that system improvements could be made for the capture of triage decisions.

Proposed Action

Seek further clarity from the review team about the nature of their concerns with respect to recommendation #2. We can then either confirm that our IPM patient administration system does in fact address the concerns or investigate any shortcomings further. We also need to confirm that the replacement patient administration system which will be rolled out in the next 18 months (PICS), will have meet all of the requirements related to the booking of colonoscopy/endoscopy patients. We will also seek IT support to investigate options to improve the capture of triaging decisions electronically.

Recommendation # 3: Increase in Colonoscopy Capacity

"The colonoscopy capacity appears to be constrained, placing undue pressure on those referring and those triaging patients. An increase in colonoscopy resource provided by the DHB is strongly recommended."

Management Response

This recommendation appears to link with the observations made about the low intervention rates in Southern when compared to North Island DHBs and the overall mean intervention rate nationally. Our GM (formerly the Service Manager for this service) has contacted the Ministry of Health as he is uncertain about the intervention rate information previously published and wants to be sure that the information is being reported correctly (particularly with regard to whether flexible sigmoidoscopies are being included in the colonoscopy count or not). Once we have clarity about our intervention rates and how they compare nationally we can then make a case to increase resources as appropriate to address any shortfall. With the changes that have been made to the management of referrals received from specialists close attention now needs to be placed on waiting times. If accepted referral numbers increase in excess of our available capacity this will manifest itself in increasing waiting times which will be a further catalyst to make a case for investing in additional resources.

Proposed Action

Confirm that what is being reported is correct. Clarify Southern DHB's current intervention rate for colonoscopy and how this compares to the national mean. Develop a case around increasing resources to enable more scoping to be done to increase our intervention rates as appropriate. It should be noted that on the assumption that we are applying the Ministry criteria for colonoscopy accurately and appropriately, a broader work programme may be required to increase intervention rates, such as appropriately encouraging higher referral rates from primary care into secondary care. We will also actively monitor waiting times.

Recommendation # 4. Application of Direct Access Criteria

"Although the direct access criteria are provided for guidance there should always be the provision for clinical over-ride by those triaging or other gastrointestinal specialists."

Management Response

We agree with this recommendation. While historically there has been the ability for GI Specialists to review and override cases which did not meet the criteria but for whom they determined access was required, the Southland surgeons did not engage with this process. In 2019 a process to allow the GI Surgeons to override referrals was put in place, however following feedback this has now been modified to allow referrals to be directly added to the waiting list with the relevant urgency. Where there are questions of urgency of a referral, the requirement is for collegial conversations to take place rather than unilaterally changed. This will be monitored by the Endoscopy Oversight Group.

Recommendation # 5. Address Interpersonal Tensions

"Correspondence associated with several of the patients highlighted that communication between professionals was at times strained and this affected the flow of patient management."

Management Response

We acknowledge that relationships have been a key issue. Actions identified by the Bagshaw report are ongoing in respect of this.

Recommendation # 6. Process review for all suspected cancer patients following colonoscopy.

"All colonoscopy findings with suspicion of colorectal cancer should be reported to the Clinical Nurse Manager (or another appropriate team member), who reviews the referral pathway and the time taken from referral to colonoscopy. This allows for prompt review and will flag any issues in a timely manner. If the patient pathway deviates from that expected or they have waited longer than 6 months, review by the Endoscopy User Group is required."

Management Response

We acknowledge that this is a good quality initiative that if implemented would provide further oversight for patients who are at risk of adverse outcomes if not attended to promptly.

Proposed Action

Processes will be put in place to ensure this additional level of oversight is able to be achieved. There may be a a requirement for additional resources. We will determine this as the process is developed and we will seek resources through our organisation's prioritisation processes as required.

Summary of the Actions to be Taken

We propose to strengthen the governance of colonoscopy services to provide greater oversight of the entire patient journey through the service, beyond the single measure of whether a referral has been accepted or declined. We also propose the following actions:

- Supporting the establishment and delivery of a single project with clear accountability for the review and implementation of recommendations including identification of any further resources which may need to be prioritised through the DHB planning cycles.

Improving the separation of operational issues from maintaining oversight of the strategic issues.

This would be undertaken through the splitting of the roles of the Endoscopy User Group into:

1. An Endoscopy Oversight Group. This group would be chaired by Andrew Connolly and would have oversight to ensure that all of the recommendations are actively addressed. This group is likely to meet on a monthly basis.

2. An Endoscopy Clinical Referrers' Group. This group would address issues impacting on the management and triaging of referrals to ensure that they all occur in a timely manner and that any operational conflicts between referrers are addressed promptly. This group is likely to meet on a weekly basis to ensure the timely management of referrals.

To support these changes a fixed term Project Manager reporting to the relevant General Manager will be appointed for a period of six months to ensure that both groups are supported adequately and that the required actions are taken. It is expected that within six months good progress on the actions will have been made and the responsibility for progress on an ongoing basis should then revert to the relevant Service Managers and Clinical Leaders.

3. Conclusion

We believe that this review has identified a number of improvement opportunities which reinforce and build upon the previous reviews and work that has been undertaken in the service in recent years. As indicated in the proposed actions noted above, a combination of immediate action, further investigation and the development of proposals for additional resources or investment may be required to respond to the impact of some of the actions being taken. We are in the process of appointing a project manager to assist in the delivery of the proposed actions. We also propose to implement an Endoscopy Oversight Group that will enable us to improve the governance of both the more immediate actions and the strategic direction, supported by an Endoscopy Clinical Referrals Group which will manage the more operational issues. Once the Project Manager has been appointed, they will work with the relevant General Manager as well as the Chair of the Endoscopy Oversight Group to ensure the action plan is further refined with specific and measurable actions, dates and deliverables.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**New Dunedin Hospital Multi-Faith Centre – seeking SDHB Board's direction to help inform design**
Report to:	Board
Date of Meeting:	6 October 2020

Summary:

The issues considered in this paper are:

- In August 2020, the SDHB Executive Leadership Team (ELT) endorsed the position where a Multi-Faith (Spiritual) Centre – rather than both a Christian Chapel and/or a Multi-Faith Centre – would be designed in the New Dunedin Hospital. ELT also directed that the SDHB Board should be appraised of this discussion and be asked to endorse this position.
- Feedback received from a number of channels indicates that there is a view amongst some in our community that the New Dunedin Hospital should include a Christian Chapel as well as a Multi-Faith Centre.
- Given the Multi-Faith Centre space currently scheduled isn't as large as the current Chapel at Dunedin Hospital (~150m2), it is acknowledged that it will be difficult to accommodate both a Christian Chapel and a Multi-Faith Centre to a degree which is uniformly satisfactory.
- The SDHB Board is asked to endorse ELT's position that a Multi-Faith Centre should be planned for in the New Dunedin Hospital, rather than accommodating both a Christian Chapel and a Multi-Faith Centre or a Christian Chapel only. If the Board endorses this position, it will then be communicated to the Design Team to help inform Preliminary Design planning.

Specific implications for consideration (financial/workforce/risk/legal etc):	
Financial:	None expected.
Workforce:	Consideration about the composition of future pastoral care resources in the New Dunedin Hospital will be required.
Equity:	Considerations about how the Multi-Faith Centre will align to the Front of House spaces (and wider cultural narrative) will need to be incorporated into future design.
Other:	Further discussion and dialogue with any and all who have an interest in the ongoing development of this space should be planned as part of the project's wider communications plan.

Document previously submitted to:	ELT	**Date:** August 2020
Approved by Chief Executive Officer:	Pending	**Date:** dd/mm/yy

Prepared by:	**Presented by:**
New Dunedin Hospital Programme Management Office **Date:** September 2020	Hamish Brown, Programme Director

RECOMMENDATIONS:

The Board is asked to:

note the background to requiring a SDHB position about the use of the New Dunedin Hospital's Multi-Faith Centre space;

note that SDHB's ELT endorsed a position that a Multi-Faith Centre should be provided in the New Dunedin Hospital, a position that was reached whilst being cognisant – and respectful – of differing views about how to best use this space, albeit with a shared view about the importance of a spiritual dimension being catered for in the New Dunedin Hospital;

note that ELT's position was based upon contemporary health planning examples elsewhere and a changing demographic within the Southern District; and

endorse ELT's position that a Multi-Faith Centre be provided in the New Dunedin Hospital, which will then be communicated to the Design Team to help inform Preliminary Design planning

To: SDHB's Board

From: Hamish Brown (Programme Director, Hospital Development and Transformation Support)

Date: 6 October 2020

Copy to: New Dunedin Hospital PMO

New Dunedin Hospital Multi-Faith Centre – seeking SDHB Board's direction to help inform design

Issue

1. Dunedin Hospital currently includes a Christian Chapel. In August 2020, the SDHB Executive Leadership Team (ELT) endorsed the position where a Multi-Faith (Spiritual) Centre – rather than both a Christian Chapel and/or a Multi-Faith Centre – would be designed in the New Dunedin Hospital. ELT's position was based on their agreed view about the importance of providing a holistic, spiritual space that is reflective of a growing diversity of population and spiritual needs amongst patients, their whānau and our staff. ELT also directed that the SDHB Board should be appraised of this discussion and be asked to endorse this position.

2. Feedback received from a number of channels indicates that there is a view amongst some in our community that the New Dunedin Hospital should include a Christian Chapel as well as a Multi-Faith Centre.

3. Given the Multi-Faith Centre space currently scheduled isn't as large as the current Chapel at Dunedin Hospital (~150m2), it is acknowledged that it will be difficult to accommodate both a Christian Chapel and a Multi-Faith Centre to a degree which is uniformly satisfactory. This is based on discussions throughout the engagement process (see paragraphs 18—22) that were initially centred around providing both a Christian Chapel and a Multi-Faith Centre with acoustic treatments – such as a moveable partition – between the two spaces to offer flexibility of usage. A potential drawback of this approach could be that such a provision would create two small spaces that are not optimally designed and might be difficult to orientate.

4. It has also been mooted that there is a risk that the provision of a specific space for a discrete faith might create the perception of an inequity that could clash with a key design principle (equity) that underpins the New Dunedin Hospital build process.

5. The SDHB Board is asked to endorse ELT's position that a Multi-Faith Centre should be planned for in the New Dunedin Hospital, rather than accommodating both a Christian Chapel and a Multi-Faith Centre or a Christian Chapel only. If the Board endorses this position, it will then be communicated to the Design Team to help inform Preliminary Design planning.

6. This paper briefly explains the context of this discussion within the design and engagement process for the New Dunedin Hospital; a sense of differing views about how to best proceed; and seeks the Board's endorsement of ELT's position on how to proceed to help inform Preliminary Design for the New Dunedin Hospital.

Current context of demographic change

7. Planning for the New Dunedin Hospital is coinciding with a changing population demographic across the Southern district. Within that context, religious affiliation for people in the Otago region has shown a number of changes over recent times.

8. Table 1, below, outlines a snapshot of change of religious affiliation in the Otago Region between the 2006, 2013 and 2018 Censuses.

Table 1. Religious affiliation for people in Otago Region, 2006—18 Censuses[1]

Category	2006 (%)	2013 (%)	2018 (%)
No religion	38.8	48.3	55.8
Buddhism	1	1	0.7
Christian	54.1	46	33.4
Hinduism	0.4	0.7	0.8
Islam	0.4	0.6	0.7
Judaism	0.1	0.2	0.1
Māori religions, beliefs, and philosophies	0.3	0.3	0.2
Spiritualism and New Age religions	0.6	0.5	0.5
Other religions, beliefs, and philosophies	0.3	0.3	1.5
Object to answering	6.1	4.1	6.4

Planning continues to ensure clinical capacity is optimised

9. We are planning for a New Dunedin Hospital that will be 89,000m2 in total. Space for clinical capacity – such as numbers of Operating Theatres and Intensive Care Unit bed spaces – have been determined based on population growth and service provision. This has required some prioritisation of clinical resource across the facility, wherever possible and appropriate.

10. SDHB's Clinical Leadership Group are taking a leading role in helping to determine prioritisation of space within the New Dunedin Hospital whenever competing demands arise. Given space and budget constraints, we anticipate that any increases in size in one service will require an

[1] Sourced from Statistics NZ (https://www.stats.govt.nz/tools/2018-census-place-summaries/otago-region)

equivalent reduction elsewhere. Such prioritisation decisions will continue throughout the design process.

Proposal for the Multi Faith Centre in current planning

11. Each of the services within the New Dunedin Hospital has recently agreed a Functional Design Brief, which describes aspects of the spaces that are unique to their department/service and will help inform subsequent planning and design.

12. There is an acknowledged discrepancy in the Multi-Faith Centre Functional Design Brief in that it describes both provision of a Christian Chapel and a Multi-Faith Centre. Notwithstanding, the Multi Faith Centre's Functional Design Brief describes the following:

    - support for the needs of Dunedin Hospital patients and their family and whānau members during times of trauma, illness and loss;
    - support the needs of staff working at the Dunedin Hospital;
    - provide a place of meeting and celebration, with flexibility to support quiet reflection and individual prayer;
    - furnished as a space that has the ability to meet the requirements of all faith denominations and those who do not identify with a faith; and
    - to be flexible and able to cater for a number of different users' various needs, including a quiet space for reflection.

13. Australasian Health Facilities Guidelines (AHFG) were used as the basis for New Dunedin Hospital planning. Current provision for the Multi-Faith Centre in the new facility is at 75m2, comprising a 45m2 Multi Faith Centre, a 30m2 interfaith Prayer Room and a 4m2 wash room for religious ablutions.

14. The Multi-Faith Centre will also include a bookable interview room (14m2), shared office (15m2) for pastoral care workers and a general store (9m2). A small number of patients in beds would be able to participate in services, although other options – such as live-streaming services to a patient's bedside – will also be explored as part of the digital strategy, as proved successful by others during the recent COVID-19 lockdown period.

15. We are currently working with the Design Team around options for future flexibility for this space.

16. The agreed project direction is that most workspace provided will be collaborative.

17. As a consequence, the way that pastoral care, counselling and prayer – currently administered in some part from individual offices at Dunedin Hospital – will need to evolve in the new facility. About three-quarters of beds in the new hospital will be in private single rooms, so it is likely that support will be delivered either at a patient's bedside or within bookable meeting rooms on wards.

A User Group has met to help determine future usage

18. The Multi-Faith Centre Facilities in Transition (FiT) Group has met since early 2017 to discuss the future model of care, form and function of the Multi-Faith Centre in the New Dunedin Hospital.

19. The group is comprised of community representatives (from Buddhist, Baha'i and Christian perspectives), clinicians, a Hospital Chaplain, a representative of management and representatives from the Māori Health Directorate. Further representation, including from the Muslim faith, is being sought for the Preliminary Design engagement phase.

20. During FiT Group meetings held to date, a number of in-depth discussions have been held about how the Multi-Faith Centre should be designed. While there is universal agreement about the need for the development of a welcoming, spiritual space, opinions were split within the group about whether there should be a Multi-Faith Centre alone or a Christian Chapel alongside a Multi-Faith Centre.

21. A divergence of views were noted relating to the role of faith in health/healing; the role of the Chapel in Christian identity (further explored in Appendix 1); and the needs of the wider, increasing cohort of patients and whānau who do not identify with any particular religion but who might make use of a spiritual space for solace and reflection.

22. While discussions in the Multi-Faith Centre FiT Group have been consistently respectful and thoughtful, it is unlikely there will be consensus reached within the group about how to proceed.

23. The Ministry of Health currently do not have a position or policy upon which this decision could be based for new health infrastructure.

24. The trend across Australasia in health infrastructure builds is towards Multifaith centre.

Importance of a positive cultural narrative and recognition of Māori health perspectives

25. A spiritual dimension of this space – achieved through good design that involves a range of voices – will be critical to it realising its purpose, as described in paragraph 12, and ensuring it is culturally appropriate. It is recognised that for many Māori, modern health services lack recognition of taha wairua (the spiritual dimension). In a traditional Māori approach, the inclusion of the wairua, the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the physical manifestations of illness.

26. Spirituality, in its broadest sense, will need to be a cornerstone of design for this space. Adoption of Taha Wairua (spiritual health) as one of the four cornerstones (or sides) of Māori health, would provide a positive foundation for further review and reflection in design. Further discussions will follow in Preliminary Design, with support and guidance continuing to be sought from Māori Health Directorate colleagues.

Given its complexity and importance, wider views have been sought to help inform planning

27. In order to elicit wider views about how to best progress with planning, PMO – and key members of the FiT Group – met with the Dunedin Interfaith Council in July 2020. The Dunedin Interfaith Council is a voluntary association of people who act in an advisory and consultative capacity in representing a diversity of religions and faiths.

28. Key items to note in terms of the Dunedin Interfaith Council's position were as follows:

- The space provided, in their view, should be an interfaith/Multifaith "Chapel" that is accessible for all faiths (and for those who do not identify with a particular faith or spirituality/perspective). The Council believed we should not be providing space for particular faiths.
- The space provided should be known as a Chapel, but in an all-encompassing (rather than specifically Christian) sense. (Although chapels frequently refer to Christian places of worship, they are also commonly found in Jewish synagogues and do not necessarily denote a specific denomination). Non-denominational chapels are commonly encountered as part of non-religious institutions such as airports, universities or prisons.
- What is provided needs appropriate design treatment to ensure that there is an element of spirituality retained and the Chapel is not a neutral/bland, uninviting space. The Dunedin Interfaith Council provided examples of successful interfaith spaces such as North Shore Hospital and Griffith University in Brisbane. Other recent hospital developments in Australasia – e.g. Te Nikau (Greymouth), and Hagley (Christchurch) Hospital – have included Multi-Faith Centres.
- Consideration should be given to provision of Multifaith chaplaincy services in recognition of the changing faith-based demographics of Dunedin. While it is acknowledged that this workforce issue is beyond the scope of the project, it should be considered as part of future SDHB workforce planning.

Petition received in August 2020 calling for a Christian Chapel to be maintained

29. Alternative views about how to best design this space have also been received that differ from those expressed by the Interfaith Council.

30. A petition, signed by 52 people who are largely leaders of Christian congregations across the Southern region, was received in August 2020. It requested assurance that a Christian Chapel and an office for chaplains be given priority for the New Dunedin Hospital. This petition is included in Appendix 1 and 2 to this paper for the Board's review.

31. There is some nuance is views being received, including from others who identify with the Christian faith. Subsequent correspondence that offers a different suggested approach for planning is included in Appendix 3.

Determining a way forward: seeking SDHB's Board direction to inform planning

32. This paper has outlined both the importance of the Multi-Faith Centre space for spiritual health and described discussions held to date to try to agree a pathway forward. Provision of a spiritual centre that is appropriate for a wide variety of need will be critical.

33. We are now seeking Board endorsement of ELT's position to proceed with a Multi Faith Centre to help inform Preliminary Design.

34. SDHB's Board should note that, regardless of the direction given following their discussion, there will be disappointment among those who advocate for an alternative use of this space.

35. To help mitigate such concerns, further discussion and dialogue with any and all who have an interest in the ongoing development of this space should be planned as part of the project's wider communications plan.

36. Once Board endorsement about how to proceed is provided, design and FiT Group discussion will progress to consider the usage, size and flexibility of the Multi-Faith Centre's space(s). We will need to work collectively to ensure that a welcoming ambience is maintained and that the space(s) remain accessible and appropriate for all.

Requested actions

37. SDHB's Board is asked to:

    note the background to requiring a SDHB position about the use of the New Dunedin Hospital's Multi-Faith Centre space;

    note that SDHB's ELT endorsed a position that a Multi-Faith Centre should be provided in the New Dunedin Hospital, a position that was reached whilst being cognisant – and respectful – of differing views about how to best use this space, albeit with a shared view about the importance of a spiritual dimension being catered for in the New Dunedin Hospital;

    note that ELT's position was based upon contemporary health planning examples elsewhere and a changing demographic within the Southern District; and

    endorse ELT's position that a Multi-Faith Centre be provided in the New Dunedin Hospital, which will then be communicated to the Design Team to help inform Preliminary Design planning

Hamish Brown
Project Director for the New Dunedin Hospital development.

Dear Sir,

We the undersigned write to you on a matter of some urgency in regard to the design of the new hospital in Dunedin.

As leaders of the Church in Dunedin and Otago we understand that the steering committee convened by yourself is favouring a hospital without a chapel or any discernable Christian presence. This despite the fact that the present chapel is used every day by both staff and chaplains, as well as patients and their family members; and certainly, every Sunday. Many people find the chapel to be the only place of beauty and serenity in the whole hospital complex, necessary for processing significant life and death challenges. Furthermore, hospital chaplains have served the health community in this country since hospitals were first built, consistently providing to people of all faiths and those of no faith the support they have needed in a sensitive and impartial manner. Ecumenical (inclusive of all people) hospital chaplains are here to nurture the spiritual wellbeing of all people, regardless of their faith/religious identity.

Hospitals and the health systems in which they operate can largely be said to be an invention of the Church and they certainly rely on values espoused by the Church throughout its 2000-year history. We attach an appendix which provides significant evidence for this. In our current context it is increasingly recognized that health and wellbeing – *hauora* – involves a spiritual component. The concept of *'te whare tapa whā'* – the four cornerstones of Māori health, includes *Taha wairua* (spiritual health), and we are concerned this is being neglected.

More than this, however, is the concern that the Christian faith will not be primarily represented within a city founded on Christian principles and a country in which, still, the largest group of people claiming religious adherence are Christian.

The Chapel, which was a gift from the nurses initially and which was rebuilt into the new hospital along with the present clinical services block remains the cornerstone of spirituality in the hospital services as it is serviced by the hospital chaplains. These chaplains have consistently provided access to people of all faiths to the support they have needed in both a sensitive and impartial manner at little or no cost to the health system.

Given the centrality of these issues we are deeply concerned at the apparent lack of robust consultation in planning to provide for them. Some of us are involved with the Dunedin Interfaith Group, but it is a purely voluntary association of interested individuals, which can in no way be said to represent the various religious or spiritual communities of the city.
There appears to have been no consultation with the Maori representatives of the Christian tradition or with the faith leaders of Pacific people in this area, nor with the wider Christian constituency which still represents the largest group claiming religious adherence. We have no objection to a Muslim prayer room but ask that the faith tradition upon which both this nation and this city have relied on to guide them in forming an holistic health system be duly recognised.

We would therefore ask for an assurance that a chapel and an office for chaplains be a priority for the new build.

Sincerely,

Rev Richard Dawson (Leith Valley Presbyterian Church, Dunedin)

And the clergy below

Rev Tau Ben Unu
Mataura Presbyterian Church

Pastor Mark Billings
Dunedin New Life Church

Rev Doug Bradley
Cromwell Presbyterian Church

Pastor Linda Brewster
Dunedin Nations Church

Rev Peter Cheyne
Mornington Presbyterian Church

Rev Peter Cheyne
Mornington Presbyerian Church

Rev Stu Crosson
Hope Church Dunedin

Rev John Daniel
Presbyterian Church

Rev Richard Dawson
Leith Valley Presbyterian Church

Dr Adam Dodds
Dunedin Elim Church

Chaplain Steve Downey
Otago Polytech Chaplain

Pastor Kel Fowler
Dunedin Vineyard

Pastor Sharon Fowler
Dunedin Vineyard

Pastor Roland Green
Cornerstone International Bible Church

Rev Ian Guy
Wakatipu Community Presbyterian Church

Rev Andrew Harrex
Lawrence/Waitahuna Presbyterian Church

Rev Ian Hyslop
Upper Clutha Presbyerian Church

Rev Aaron Johnstone
Upper Clutha Presbyerian Church

Rev Alan Judge
Mosgiel Presbyterian Church

Rev Rachel Judge
Mosgiel Presbyterian Church

Rev Lee Kearon
Kurow Presbyerian Church

Pastor Levi Kelly
ARC Church Dunedin

Rev Eric Kyte
Roslyn Anglican Parish

Title First Name Last Name
Church
E-mail Address

Rev Hayden Luke
BATCH Presbyterian

Rev Rose Luxford
St Pauls Presbyterian Church Oamaru

Rev Martin Macaulay
East Taieri Presbyterian Church

Rev Martin Macauley
East Taieri Presbyterian Church

Rev Ed Masters
First Church Dunedin

Rev Ed Masters
First Church Dunedin

Rev Tom Mepham
StudentSoul Church

Rev Rob Pendreigh
Balclutha Presbyterian Church

Rev Rainier Raath
Wakatipu Community Presbyterian Church

Rev Dr Murray Rae
Professor Systematic Theology, Otago University

Rev Dr Jono Ryan
Dunedin Seedling Church

Rev Cameron Sinclair
Hospital Chaplain

Rev Geoff Skilton
Highgate Presbyterian Church

Rev Erik Stolte
Dunedin Reformed Church

Pastor Peter Tate
Dunedin Nations Church

Pastor Foliaki Tauofa
Riversdale Waikaia Presbyterian Church

Rev Dr Wayne Tekawa
Pinehill Presbyterian Church

Rev Dr Kevin Ward
Maungatua Presbyterian Church

Pastor John Watson
Abundant Life Centre Dunedin

Rev Ken Williams
Calvin Presbyterian Church

Rev Dr Selwyn Yeoman
Leith Valley Presbyterian Church

Rev Russell Thew
Minister Emeritus

Rev Carol Grant
Minister Emeritus

Pastor Bruce Elder
DCDC Baptist

Rev Dr Maurice Andrew
Professor Emeritus of the Theological Hall, Knox College.

Session ClerkPatricia Pat Kerr
Teviot Union Parish

Rev Andrew Howley
Alexandra / Clyde / Lauder Union Church

The Right Reverend Stephen Benford
Anglican Bishop of Dunedin

Rev Brendan McRae
Flagstaff Community Church

Appendix 2

Indeed, even a cursory examination of the history of hospitals will reveal that the Church was largely responsible for turning what were military hospitals in Ancient Greece and Rome into the civilian hospitals we are more familiar with today. The modern nursing movement was birthed by Florence Nightingale a deeply Christian woman and, indeed, the whole of medical science can be said to have its origins on the demythologizing work of the Early Church as it sought to understand the natural world as something created and orderly rather than something malignant and capricious. In the words of the evolutionary anthropologist and science writer Loren Eiseley:

> **'The philosophy of experimental science … began its discoveries and made use of its methods in the faith, not the knowledge, that it was dealing with a rational universe controlled by a creator who did not act upon whim nor interfere with the forces He had set in operation… It is surely one of the curious paradoxes of history that science, which professionally has little to do with faith, owes its origins to an act of faith that the universe can be rationally interpreted, and that science today is sustained by that assumption.'[1]**

The Reformation turned out to have a huge positive impact on the development of modern science according to Peter Harrison, a professor of history and philosophy at Bond University in Queensland, Australia (and one-time Andreas Idreos Professor of Science and Religion at the University of Oxford):

> **"It is commonly supposed that when in the early modern period individuals began to look at the world in a different way, they could no longer believe what they read in the Bible. I shall suggest that the reverse is the case: that when in the sixteenth century people began to read the Bible in a different way, they found themselves forced to jettison traditional conceptions of the world."[2]**

Stephen Snobelen, Assistant Professor of History of Science and Technology, University of King's College, Halifax, Canada, writes,

> **"It was, in part, when this method was transferred to science [the sophisticated literal-historical hermeneutics that Martin Luther and others (including Newton) championed.]**
> **, when students of nature moved on from studying nature as symbols, allegories and metaphors to observing nature directly in an inductive and empirical way, that modern science was born. In this, Newton also played**

[1] Eiseley, L., *Darwin's Century: Evolution and the Men who Discovered It*, Doubleday, Anchor, New York, 1961.

[2] Harrison, P., *The Bible, Protestantism and the rise of natural science*, Cambridge University Press, 2001; see review by Weinberger, L., Reading the Bible and understanding nature, *J. Creation* **23**(3):21–24, 2009

> **a pivotal role. As strange as it may sound, science will forever be in the debt of millenarians and biblical literalists."[3]**

Harrison will further argue that… **"The experimental approach… was deeply indebted to Augustinian views about the limitations of human knowledge in the wake of the Fall, and thus inductive experimentalism can also lay claim to a filial relationship with the tradition of Augustinianism."[4]**

And all of this has its origins not in some dusty academic study but in the structure of the Christian faith defined as it is by the love of Christ and His injunction to love neighbour as one loves self. This foundational belief is what is enacted daily in hospitals all over the world now.

The foundation of the modern hospital and health system would not exist without the Christian faith and the spiritual aspect of healing has been offered to patients in those hospitals since their inception. We believe that this must continue to be offered through the presence of a Christian space – a chapel, within the hospital building.

[33] Snobelen, S., Isaac Newton and Apocalypse Now: a response to Tom Harpur's "Newton's strange bedfellows"; A longer version of the letter published in the *Toronto Star*, 26 February 2004; isaacnewton.ca/media/Reply_to_Tom_Harpur-Feb_26.pdf.

[4] Harrison, P., *The Fall of Man and the Foundations of Science*, Cambridge University Press, 2007, introduction.

KNOX CHURCH
449 George Street
Dunedin
New Zealand
Ph. (03) 477 0229
www.knoxchurch.net

28 August 2020

Mr Hamish Brown
Project Director
New Dunedin Hospital Build
c/- Hamish.Brown@southerndhb.govt.nz

Dear Mr Brown

Knox Church is a neighbour to the present hospital and has been supportive of the care offered there since the hospital was built. Knox has many members who work there and the chair of the Chaplaincy Committee is one of our members. Our church building is often used for prayer and meditation by people whose friends or family members are in the hospital. Our congregation supports chaplaincy financially and assists in helping patients to attend services in the chapel.

We have a vital interest in the development of the new hospital. We were made aware of a letter coming from other churches regarding the provision of a chapel and space for chaplaincy and wished to make our own submission based on our particular approach.

We support the approach taken by Sir Mason Durie, Te Whare Tapa Wha, and the importance it gives to spiritual health. We see the provision of care as needing to embrace and express Taha Wairua. We strongly encourage the recognition of this dimension of human existence in the design, planning and aesthetic of the new hospital.

In the light of our faith and of Professor Durie's approach, we affirm the contribution of the chaplains and the importance of a special place for worship, prayer, reflection and meditation in a context where people often face challenging questions and issues.

We feel it is important to provide a suitable chapel and appropriate space for chaplaincy in the new building. We affirm what we have been told is a collaborative approach being taken in the development of plans, involving the Chaplaincy Committee.

We are confident that you will make sufficient and suitable space available for a chapel and chaplaincy services.

Warm regards

Alison Tait
Council Clerk

cc Stephen Packer, Chair Chaplaincy Committee

SOUTHERN DISTRICT HEALTH BOARD

Title:	**SOUTHERN DHB STRATEGIC REFRESH – TERMS OF REFERENCE**
Report to:	Board
Date of Meeting:	6 October 2020

A meeting of the Board and Committee Chairs along with the relevant Executive lead took place in early September. The purpose of that meeting was primarily to align work plans for each of the Committees, however the opportunity was taken to discuss the upcoming refresh of the Southern District Health Board's Strategic Plan and accompanying actions.

The Terms of Reference attached provides the background and proposed approach. The Board will be actively involved in the process, the Terms of Reference suggests a methodology however this will be affirmed once the consultants that we bring in to support our process are selected. The RFP process may identify innovative approaches we have not contemplated.

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

Financial:	Consultancy fees as a result of moving forward with this piece of work.
Workforce:	Targeted engagement that will occur with various parts of the workforce
Equity:	Has this ToR captured our desire around increased equity as fully as need be?
Other:	

Document previously submitted to:	Executive Leadership Team and Board Committee Chairs meeting	Date: 02/09/2020 and 07/09/2020
Approved by Chief Executive Officer:		Date 28/09/2020

Prepared by: Greer Harper, Principal Advisor to the CEO **Date:** 23/09/2020	**Presented by:** Chris Fleming Chief Executive Officer

RECOMMENDATIONS:

That the Board:

- **Endorse** the Strategic Refresh Terms of Reference
- **Approve** seeking proposals from the select group of identified consultants.

Terms of Reference

For the Southern DHB Strategic Refresh

DRAFT

September 2020

1. Overview

In recent years, Southern DHB has been on a journey of transformation, as we have worked to build the stronger, more equitable health system our communities have asked for.

The need to develop a high quality, future-focused and coherent health care system, has long been recognised, and is at the heart of the Southern Strategic Health Plan 2015.

In 2016, we embarked on Southern Future, a foundational programme of work where we asked our staff and community about their priorities in the health system. They told us they wanted care that was better coordinated across providers, with less wasted time and delivered closer to home; that communications make sense and are respectful; that they would have a calm, compassionate and dignified experience and that health services are high quality and equitable. To achieve this, our staff also told us about the importance of a stronger, more collaborative, values-based culture.

This has led to the development of important programmes of work that have provided a roadmap to build this health system.

This includes our Primary and Community Care Strategy and Action Plan developed in partnership with WellSouth PHO, and the significant impetus provided by the planning for the new Dunedin Hospital. In addition, we have developed our digital strategy, workforce strategy, and taken important steps towards model of care changes through patient flow initiatives, commencing a review of mental health and addictions services, and now a new business case for a generalist model of care in Dunedin hospital.

We have made a lot of progress and have much to build on.

Now, as we continue this journey, we are ready to take stock, pull the threads of this work together, and further galvanise our Southern Health community.

2. Purpose of the refresh

The purpose of the refresh is to inclusively examine the current Southern DHB strategic plan landscape and coordinate a process of wide engagement and facilitation that will enable us to identify a re-focussed strategic direction through to 2030. The refresh will:

- Apply a forward-looking lens, culminating in a clear succinct strategic plan.
- Be driven by an open and collaborative stakeholder engagement (co-design) process and alignment with our current suite of strategic documents & additional planning activity (appendix 1).
- Strengthen the equity lens so that better outcomes for our Māori, Pacifica, rural, remote and refugee populations are a driving force underpinned by a strong commitment to

understanding the needs and actions required to improve the experience of tangata whaiora, Māori and whānau in the Southern region.

- Undertake an engagement that is cognisant of and underpinned by our organisational values of Kind, Manaakitanga, Open, Pono, Positive, Whaiwhakaaro, and Community, Whanaungatanga, and building on all the work we've done in creating a more positive culture.

3. Focus of the Refresh

This refresh will focus on the current context and future direction for Southern Health - as per our (DHB's) key strategic documents (see appendix one). Further, our commitment to delivering on our obligations under Te Tiriti o Waitangi (the Treaty of Waitangi) will be a core facet of this review.

The focus will be on all health and disability services that are currently funded by the Southern District Health Board, but also stimulating enquiry into conceptualising pockets of unmet need, where funding might need to be reprioritised and potentially reallocated. Alternative scenarios should be considered to realise how our changing population is shifting need whilst also keeping our 'why' at the centre of it all.

4. Background

The Southern District Health Board developed its "Southern Strategic Health Plan – Piki te Ora" which was published on 9 February 2015. The plan encapsulated the years 2015 to 2025. The Strategic Plan had six priorities within it, which included:

- Develop a coherent Southern system of care
- Build the system on a foundation of population health, and primary and community care
- Secure sustainable access to specialised services

- Strengthen clinical leadership, engagement and quality improvement
- Enhance system capability and capacity
- Live within our means.

This document is still very relevant and much achievement has been made against this; more granularity and increased meaningfulness is the next step. Shortly after the completion of the Strategic Plan the Board was dismissed and the Commissioner Team was put in place. The Commissioner team embedded the Strategic Health Plan Priorities but then developed their "Strategy on a Page" called "Owning Our Future". This, along with the Southern Future work by default became the Strategic Plan for the organisation. The more formalised Strategic Plan then started to drift into the background.

Subsequent to this, there has also been a significant amount of planning activities, many centred around the Dunedin Hospital project and these include:

- Strategic Services Plan June 2016
- Strategic Assessment: Investment in Infrastructure to support ongoing provision of hospital services in Dunedin July 2016
- Detailed Services Plans for Dunedin Hospital Campus
- Indicative & Detailed (In principle) Business Case for Dunedin Hospital 2017

Further, there have been some companion strategies that have been developed which include:

- Primary and Community Strategy and Action Plan 2018
- Workforce Strategy and Action Plan 2019
- Digital Strategy and Action Plan 2019
- He Korowai Oranga: Māori Health Strategy 2014
- Southern DHB Disability Strategy (*Draft*) 2020
- Raise Hope - Hāpai te Tūmanako Strategy 2019-2023

The Strategic Plan should be the umbrella document and portray the overall direction of travel that the Southern DHB needs to go. It will be a plan that encapsulates what our Southern Health landscape might look like in the long and then short term.

This document should contain actions in three year phases with:

- Phase 1 covers 2027 to 2030 These actions should be quite loose, future looking incorporating 'blue-sky' visionary thinking.
- Phase 2 covers 2024 to 2026 – These actions should be more general and require a little greater interpretation before being able to specifically action.
- Phase 3 covers 2021 to 2024 –These actions should be relatively granular and measurable.

Biannually the Action Plan will be reviewed predominantly to update and realign actions with progress as well as reflecting any sector changes or policy settings which may occur over time. Every five years the Strategy and the Action Plan should then have a broader refresh to ensure that it maintains currency, reflects changes across the system and stays aligned to our Annual plans and service plans.

This process will also address an unresolved challenge that the Ministry of Health and the NDN Governance groups are pushing for – our Change Management Plan linked with the New Dunedin Hospital Programme. Our Change Management Plan would be our Strategy and Action Plan with the current manifestation of actions being in the Annual Plan. This will avoid misunderstanding and confusion in terms of different audiences wanting different deliverables.

We have identified partnering with external expertise is prudent to provide fresh thinking and innovation to the process. We envision a document that captures our plan visually supported with appropriate narrative that ensures it represents the hearts and minds of the Southern DHB.

5. What will the Refresh identify and what is in it for all of us?

It will identify the great work to date, not to be undone. We anticipate the refresh of our strategic plan will recognise this and build further, assist with clarity and crystallisation of our future. It will also take into account the changes that our system have undergone over recent years, the wider regional health context, whilst supporting our people to continue to do their best work. Further a pathway to providing the best health system we can for our community in the years to come.

The refresh will build on the excellent foundation we already have:

1. The conditions that support current pockets of innovative and/or excellent practice.
2. Valuing our patients' and our staff's time
3. A vision of what the Southern Health community wants our health system to be.
4. A future view of how our region's structure and mix/configuration of resources and services might look like.

6. Key principles underpinning the Refresh

This refresh will be underpinned by the key principles set out in the 2015 Southern Strategic Health Plan Piki te Ora:

- Develop a coherent Southern system of care
- Build the system on a foundation of population health, and the integration of secondary care into primary & community care.
- Secure sustainable access to specialised services

- Strengthen clinical leadership, engagement and quality improvement
- Enhance system capability and capacity
- Live within our means.

Southern DHB also acknowledges that the Māori experience of health services in the Southern region is inequitable. He Korowai Oranga is New Zealand's Māori Health Strategy, setting the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Its overall aim is Pae Ora, 'healthy futures for Māori', recognising the multifaceted needs of Māori through a holistic approach and three interconnected elements: mauri ora (healthy individuals), whānau ora (healthy families), and wai ora (healthy environments).

The approach reinforces the need to ensure that Māori are involved in both decision-making and service design. Pae Ora must guide our thinking on how the strategy needs to address the needs of Māori in Southern.

7. Methodology

The refresh will be sponsored by the CEO of the DHB, with the Executive Director, Strategy, Primary and Community acting as the key conduit for day to day management of the programme, accountable to the Steering Group chaired by the Chief Executive.

We would like to work alongside a chosen partner to develop what the methodology might look like as we are committed to utilising the fresh thinking that external partnerships bring, however we envisage that the refresh process might look as follows (but not limited too):

- A familiarization with our suite of current strategic documents as outlined in appendix 1.
- Collaborative development of inclusive stakeholder engagement plan.
- A series of facilitated workshops/focus groups with the combined Board, Iwi Governance Committee and the Executive Leadership Team will occur throughout the process at a minimum will include:
    - An initial workshop to set the scene reflect on the existing documents and propose a pathway for development and stakeholder engagement
    - A mid stream workshop to present progress, identify themes coming through and to identify further information required, stakeholder engagements etc
    - A end of project workshop to present the plan to seek endorsement ready for community engagement

The responsibility for engaging with the community and then finalizing the strategy will remain with the Board, IGC and Executive Leadership Team.

It is expected that stakeholders engaged will be broad including our staff, significant partners in the planning and provision of health and disability services, inter sectoral stakeholders, consumer / family / whanau representatives, educational institutions etc.

Throughout the process, it would be expected that other conversations, interviews or focus groups will take place as needed and identified and agreed upon. There should be a clear pathway for all staff to be able to contribute their ideas and thoughts during this process. Likewise, a method for incorporating our community's voice will be needed.

Appendix One – Key strategic documents

1. He Korowai Oranga: Māori Health Strategy 2014

He Korowai Oranga: Māori Health Strategy sets the overarching framework that guides the provision and delivery of Maori health care and support services in New Zealand and within the Southern DHB, to achieve the best health outcomes for Māori.

2. Whakamaua: Māori Health Action Plan 2020-2025

Whakamaua: Māori Health Action Plan 2020–2025 (Whakamaua) provides a roadmap of tangible actions that contribute to achieving the vision of pae ora for Māori. The release of Whakamaua, which will guide the implementation of He Korowai Oranga, bridges a gap that has existed since the completion of Whakatātaka Tuarua 2006–2011, the Ministry's previous Māori health action plan.

3. Primary and Community Care Strategy and Action Plan 2018

In 2017 the DHB released its Primary and Community Care Strategy and Action Plan that sets out a very clear articulation of the future strategic directions and programmes of work that are required to transform the way in which services are delivered across the health system. Mental Health is very much at the forefront of this future strategic direction, and we envisage that in the future a significant portion of our Mental Health services will be delivered in a more integrated way with our Primary Care and NGO partners.

A new delivery system, as outlined in the Primary and Community Strategy will enable the effective colocation of community health services, both mobile and in-clinic services (e.g. rehabilitation), hospital specialist care, onsite pharmacy and diagnostics, enhanced urgent care and minor procedures. Community Health Hubs will be developed through either existing infrastructure or new sites. In rural areas, rural hospitals may act as a hub but with the explicit expectation that this includes primary care delivering the HCH model of care. The DHB have been progressing the design of the Community Health Hubs. The Community Health (Care) Hubs Strategic Brief and the plan for Phase 1 of the start-up of Community Health Hubs (30 October 2019) states that "Community Health Hubs will be developed sequentially and incrementally across the Southern district". The plan outlines a two phased approach as follows:

- Phase one will focus on new models of care for child health, mental health and health of older people. This phase will also gather information for infrastructure development as well as interest from potential providers of services.

- Phase two is yet to be designed. It is likely to include development of new models of care for other health areas or services, as well as to further explore and develop (in partnership with key stakeholders) the Community Health Hub infrastructure.

4. Workforce Strategy and Action Plan 2019

The Southern Health Workforce Strategy describes our vision and goals for transforming our workforce, creating a sustainable and contemporary workforce by developing workforce capacity and capabilities, as well as improving workplace culture. Further this document describes the strategic drivers, and actions for building a sustainable and contemporary workforce. Written for Southern Health, rather than SDHB, it recognises that in a changing health environment, long-term planning for the health workforce needs to outlive any changes in organisational structure, service delivery or delivery location. The action plan reflects the need to take clear steps forward while managing current funding limitations and changes in care delivery models by identifying resources required, and prioritising actions.

5. Digital Strategy and Action Plan 2019

The Southern Health Digital Strategy describes the vision and goals for transforming our digital capabilities, within the context of the overall Southern Health System. Transforming healthcare delivery across the Southern Health System by providing modern sustainable solutions built on resilient environments that can share insights with our community is the ultimate goal. The Southern Health Digital Strategy and Action Plan (the Digital Plan) describes the strategic drivers, objectives, and actions that support our digital transformation.

6. Health and Disability System Review Report 2020

The review will also need to be cognisant of the issues raised in the *Health and Disability System Review Report* published in June 2020. Link to final report: https://systemreview.health.govt.nz/final-report/

7. Ministry of Health: Healthy Ageing Strategy

8. The UN Convention on the Rights of Persons with Disabilities (CRPD)

9. Ministry of Health: Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025

10. Strategic Services Plan June 2016

11. Strategic Assessment: Investment in Infrastructure to support ongoing provision of hospital services in Dunedin July 2016

12. Detailed Services Plans for Dunedin Hospital Campus

13. Detailed Business Case for Dunedin Hospital (in principle) 2020

SOUTHERN DISTRICT HEALTH BOARD

Title:	**2021 MEETING DATES**
Report to:	Board
Date of Meeting:	6 October 2020

Summary:

Draft meeting schedule for 2021 attached for the Board's consideration and adoption.

Note: the Iwi Governance Committee will be considering their meeting dates on 5 October 2020.

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

Financial:	n/a
Workforce:	n/a
Equity:	It is proposed that two joint planning workshops be held (highlighted in blue).
Other:	

Approved by Chief Executive Officer:		**Date:** 28/10/2020

Prepared by: CEO Office **Date:** 24/10/2020	**Presented by:** Chris Fleming Chief Executive Officer

RECOMMENDATION:

1. That the Board adopt the attached meeting schedule for 2021.

SOUTHERN DISTRICT HEALTH BOARD
MEETING SCHEDULE 2021

	JAN	FEB (Dunedin)	MARCH (In'gill)	APRIL (Dunedin)	MAY (In'gill)	JUNE (Dunedin)	JULY (Dunedin)	AUG (In'gill)	SEPT (Dunedin)	OCT (Dunedin)	NOV (In'gill)	DEC (Dunedin)
Hospital Advisory Committee 1.30 pm	No meeting		Monday 1		Monday 3		Monday 5		Monday 6		Monday 1	
DSAC/CPHAC* 1.30 pm	No meeting	Monday 1	***Monday 15*	Wednesday 7		Tuesday 1		Monday 2		Monday 4	***Thursday 11*	Monday 6
Board Meeting 9.30 am	No meeting	Tuesday 2	Tuesday 2	Thursday 8	Tuesday 4	Wednesday 2	Tuesday 6	Tuesday 3	Tuesday 7	Tuesday 5	Tuesday 2	Tuesday 7

*DSAC/CPHAC = Joint meeting of Disability Support Advisory Committee and Community & Public Health Advisory Committee

MONTH	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Iwi Governance Committee 10.00 am	No meeting	Monday 1	***Monday 15*	Wednesday 7		Tuesday 1		Monday 2		Monday 4	***Thursday 11*	Monday 6

***Proposed joint workshops between the Iwi Governance Committee and Board/Disability Support Advisory Committee and Community & Public Health Advisory Committee (Time TBC)*

MONTH	JAN (Dunedin)	FEB (Dunedin)	MARCH (Dunedin)	APRIL (Dunedin)	MAY (Dunedin)	JUNE (Dunedin)	JULY (Dunedin)	AUG (Dunedin)	SEPT (Dunedin)	OCT (Dunedin)	NOV (Dunedin)	Dec (Dunedin)
Finance, Audit and Risk Committee 12.30 pm	Thursday 28	Thursday 25	Thursday 25	Thursday 22	Thursday 20	Thursday 24	Thursday 22	Thursday 26	Thursday 23	Thursday 21	Tuesday 23	Thursday 16

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 ▪ 17 September 2020 Minutes b) Hospital Advisory Committee ▪ 7 September 2020 Minutes c) Iwi Governance Committee ▪ 5 October 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.
CEO's Report - Public Excluded Business ▪ Staffing Concerns ▪ Wanaka After Hours Primary Care ▪ Invercargill Primary Care ▪ Gastroenterology ▪ Suicide Prevention	To allow and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.
Contract/Lease Approvals ▪ Strategy, Primary and Community ▪ Air Transport – Patient and Staff Transfers ▪ Polaris Infrastructure as a Service (IaaS) Contract ▪ Mainland Cardiothoracic Contract ▪ Mercy 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.
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.
Annual Report 2020	Annual Report is not public until tabled in Parliament	Section 9(2)(f)(ii) of the Official Information Act.
SDHB Performance Report	Advice provided in confidence	Section 9(2)(f)(iv) of the Official Information Act.

*S 32(a), Schedule 3, of the NZ Public Health and Disability Act 2000, allows the Board to exclude the public if the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.

The Board may also exclude the public if disclosure of information is contrary to a specified enactment or constitute contempt of court or the House of Representatives, is to consider a recommendation from an Ombudsman, communication from the Privacy Commissioner, or to enable the Board to deliberate in private on whether any of the above grounds are established.