Southern DHB Board Meeting

Board Room, Community Services Building,
Southland Hospital Campus, Invercargill

03/11/2020 09:30 AM - 12:30 PM

Agenda Topic				Presenter	Time	Page
Opening Karakia						
Public Forum						3
	Dialysis South			Sally Tily	09:30 AM-09:40 AM	3
1.	Apologies					4
2.	Declarations of Interest					5
3.	Minutes of Previous Meeting					12
4.	Matters Arising					
5.	Review of Action Sheet					22
6.	Advisory Committee Reports					28
	6.1	Finance, Audit & Risk Committee				28
		6.1.1	Verbal report of 22 October 2020 meeting	Jean O'Callaghan		28
	6.2	Community & Public Health and Disability Support Advisory Committees				29
		6.2.1	Unconfirmed minutes of 5 October 2020 meeting	Tuari Potiki/Moana Theodore		29
	6.3	Hospital Advisory Committee				40
		6.3.1	Verbal report of 2 November 2020 meeting	David Perez		40
7.	CEO's Report			CEO		41
8.	Finance and Performance			CEO		72
	8.1	Financial				72

	8.2 Volumes		77
	8.3 Performance		78
9.	Performance Reporting	EDSS	97
10.	Digital Programme Business Case	EDPC&T (by Zoom)	206
11.	Primary Maternity Facilities – Central Otago/Wanaka	EDSP&C	211
12.	Resolution to Exclude the Public		278

Submission From Dialysis South

- Sally Tily, submitter, and Mike Blair, dialysis patient

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:	4 November 2020

Summary:

Board, Committee and Executive Team members are required to declare any potential conflicts (pecuniary or non-pecuniary) and agree how these will be managed. A member who makes a disclosure must not take part in any decision relating to their declared interest.

Interest declarations, and how they are to be managed, are required to be recorded in the minutes and separate interests register (s36, Schedule 3, NZ Public Health and Disability Act 2000).

Additions to Interests Registers over the last month:

- Andrew Connolly and Kaye Crowther's entries updated.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 27/10/2020

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
David Perez (Acting Board 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		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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 Otākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	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	
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
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, 6 October 2020, 9.40 am
Board Room, Wakari Hospital Campus, Dunedin

Unconfirmed

Present:	Dr David Perez	Deputy Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	*(by Zoom)*
	Dr Lyndell Kelly	
	Mr Terry King	*(until 3.00 pm)*
	Mrs Jean O'Callaghan	*(until 3.00 pm)*
	Mr Tuari Potiki	*(until 3.00 pm)*
	Miss Lesley Soper	*(by Zoom until 2.45 pm)*
	Dr Moana Theodore	*(until 3.00 pm)*
In Attendance:	Mr Andrew Connolly	Crown Monitor
	Mr Roger Jarrold	Crown Monitor
	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 *(by Zoom)*
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement and Facilities
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality and Clinical Governance Solutions *(until 1.20 pm)*
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone to the meeting.

2.0 PUBLIC FORUM

Home and Community Support Services

Mrs Jo Millar, President, Grey Power Otago, and Zone 7 representative, Grey Power Federation Board, speaking on behalf of the associations throughout the Southern District, addressed the Board on concerns about Home Help services.

Mrs Millar advised that she was concerned and upset that the Home Help contract had been rolled over for another two years and outlined the following issues.

- Providers appeared to be taking a one size fits all approach, when restorative care was required.
- Some clients in their 90s were having their home care cut to half an hour a fortnight by providers, when they had been assessed under InterRAI as needing an hour's Home Help per week.

- Clients were not being informed they were being assessed and were not being given the opportunity to have a support person present.
- Client care had been cut after the COVID-19 lockdown on the assumption that clients had managed on their own during that time.
- The travel time allocated to carers was ludicrous.

Mrs Millar requested that the contract be managed and advised that she was happy to provide further information.

The Executive Director Strategy, Primary and Community (EDSP&C) acknowledged the concerns about the provision of home care, noting however that it was a large volume contract and providers interacted with many people across the district. She advised that the contract had been extended for two years because of the significant change required by the Primary and Community Strategy, a key part of which was domiciliary and care closer to people's homes. In the interim, services would continue to be monitored and the EDSP&C welcomed Mrs Millar's input to holding providers to account.

It was agreed that the EDSP&C would report back on how the Home and Community Support Services contract was monitored.

Access to Carpal Tunnel Surgery and Nerve Conduction Testing

Due to the absence of the submitter, this item was not considered.

3.0 APOLOGIES

An apology was received from Mr Dave Cull, Board Chair.

4.0 DECLARATION OF INTERESTS

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

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

5.0 PREVIOUS MINUTES

Performance Monitoring

It was noted that the CEO was to circulate information clarifying reporting responsibilities to the statutory advisory committees, which were agreed at a meeting of the Advisory Committee Chairs and lead executives.

Hospital Advisory Committee – Continuation of COVID-19 Initiatives

The Executive Director Specialist Services (EDSS) agreed to report back on how the concept of seven-day hospital service provision could be progressed in the lead up to the new hospital.

Unconfirmed

It was resolved:

> **"That the minutes of the Board meeting held on 8 September 2020 be approved and adopted as a true and correct record."**

6.0 ACTION SHEET

The Board reviewed the Action Sheet (tab 5).

CT Capacity

The EDSS reported that work was under way to determine the best location for the additional CT machine and a recommendation would be made to Board.

Urology

The Board noted the update on Urology waiting times appended to the action sheet.

The EDSS reported that:

- There were no Urology outpatients waiting greater than 120 days;
- Some of the Planned Care Strategy funding from the Ministry of Health would be used to reduce the Urology surgical waiting list to zero by June 2021.

It was suggested that components of Urology should be moving towards a district wide service.

7.0 COLONOSCOPY REVIEW RESPONSE UPDATE

A report on an audit of case files of patients notified by surgeons in Southland as having unnecessary delays accessing a colonoscopy, together with a report from management on the implementation of the recommendations made by Professor Bissett and Kate Broome, and earlier recommendations by Drs Bagshaw and Ding, and Connolly, were circulated with the agenda (tab 9).

The Deputy Chair informed the meeting that Dave Cull, Board Chair, had put a lot of work into this issue and was very disappointed he could not be present for its consideration.

The Deputy Chair acknowledged the three recent reviews and reports on Southern DHB's colonoscopy services by Dr Bagshaw et al, Andrew Connolly, and the Bissett report, which clarified some of the issues raised in the Bagshaw report, and made six recommendations. He then made the following observations.

- Since the reports had been received there had been a lot of work and improvements made behind the scenes, but there had been some frustrations, and a lot still needed to be achieved.
- To date, there had been a lack of clarity and concerted management. Clear objectives, goals and timelines had not been set to report against, which was a weakness in the process, and the Board accepted responsibility for that.

On behalf of the Board, the Deputy Chair apologised for the lack of clarity and momentum, and any delays and harm that patients may have suffered as a consequence. He also apologised for the frustration felt by staff as a result of not seeing visible progress.

Unconfirmed

The Deputy Chair advised that, as a consequence, the Board needed to urgently address structures and processes to make its goals and objectives clearer, along with reporting systems and implementation timelines. The Board Chair would be putting out a press release later that day setting out his, and the Board's, thinking on these matters.

The Chief Executive Officer (CEO) advised that management and clinicians needed to take accountability also, then outlined the background to commissioning the Bissett report.

In addressing the Board, Mr Andrew Connolly acknowledged the strain on staff and advised that working collaboratively was the way forward. A number of quick wins could be made from implementing some of the recommendations in the Bissett report, however others would require strategic thinking and, potentially, investment. Mr Connolly highlighted that at no time had there been any question about the clinical quality delivered by any of the endoscopy staff. There had been progress in some areas since the Bagshaw report, however there was still a lot to be done, eg around categorisation of patients to determine the ideal timeframe for their colonoscopy and establishing one data source.

Mr Connolly informed the Board that the Director-General of Health did not consider there would be a conflict of interest if the CEO wished to appointment him to chair the Endoscopy Oversite Group.

The Board then considered the recommendations of the Bissett report (page 17). During discussion, the following points were noted.

- Southern DHB's colonoscopy intervention rate was in the lowest 25% of DHBs, yet it had one of the highest incidences of colorectal cancer, and late acute presentations. This needed to be addressed.
- Southern DHB had a high decline rate for referrals (15%), which raised questions about the appropriateness of referrals and capacity.
- The Ministry of Health published a document in 2019 setting out a reporting matrix and parameters.
- The timeframe of six months for a fixed term Project Manager was considered insufficient.
- Taking responsibility for the problems was also taking responsibility for the solutions.

It was resolved:

> **"That the Board directs the setting up of an Endoscopy Oversite Group, chaired by a senior external clinician, to draw together the recommendations from the three recent reviews and reports, then monitor progress against those over a defined period, to report to the public Hospital Advisory Committee and Board meetings, and the Executive Leadership Team."**

D Perez/L Soper

> **"That the Board directs the establishment of a Clinical Referral Group to oversee referral processes and report to the Executive Director Specialist Services and the Endoscopy Oversight Group."**

D Perez/T Potiki

Unconfirmed

The Board noted its expectations that:

- The Endoscopy Oversite Group will be supported to achieve its objectives;
- Reporting from the Executive Director Specialist Services (EDSS) will be submitted to the public Hospital Advisory Committee and Board meetings, and the Executive Leadership Team. Terms of reference encapsulating this will be developed with urgency;
- A project manager will be appointed for a term of 12 months to support the Endoscopy and Referral Groups, and to progress implementation;
- An action plan, with SMART deliverables, will be developed;
- Patient categorisation and reporting will be in accordance with Ministry of Health mandated requirements;
- These directions will be communicated to the wider community.

Speaking from the public gallery, Dr Gil Barbezat, Emeritus Professor of Medicine and former Consultant Gastroenterologist, thanked the Board and:

- Applauded its move forward and not enter a blame game;
- Suggested that a "truth and reconciliation" process be held to address the staff division.

Dr Barbezat agreed to send the proposal for a gastroenterology unit, put forward in 2013, to the Deputy Chair for circulation to the Board.

Associate Professor Brian Cox, Specialist in Public Health Medicine, with expertise in cancer screening, advised the Board that it was fundamental that the evaluation of positive tests are run through a completely separate clinic to ordinary symptomatic patients in cancer screening programmes.

8.0 NEW DUNEDIN HOSPITAL MULTI-FAITH CENTRE

Mr Hamish Brown, Programme Director, New Dunedin Hospital, joined the meeting for this item.

The Board considered a report recommending that a multi-faith centre be planned for the new Dunedin Hospital, rather than accommodating both a Christian chapel and multi-faith centre, or a Christian chapel only (tab 10).

It was resolved:

"That the Board:

- **Note the background to requiring a Southern DHB position about the use of the New Dunedin Hospital's multi-faith centre space;**
- **Note that Southern DHB's Executive Leadership Team (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 the ELT's position was based upon contemporary health planning examples elsewhere and a changing demographic within the Southern District; and**

Unconfirmed

- **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."**

T Potiki/I Beekhuis

9.0 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 17 September 2020, during which she highlighted the following items.

- The Executive Director Finance, Procurement and Facilities (EDFP&F) presented the consolidated financial summary for August 2020, noting that the leave revaluation phasing for nursing and management/admin made the position appear more favourable than it was.
- Management responded to questions on the financial statements and concerns about the increase in leave liability and decreased caseweights.
- The Committee reviewed the top 100 suppliers and the Chair requested additional information on each supplier.
- The Committee received a timetable for the preparation and approval of the annual financial statements.
- Benefit targets and savings plans were reviewed and achievement against them would be monitored.
- Mr Mackey, Audit New Zealand, joined the meeting and advised of delays at a national level on the adoption of annual financial statements, which would have a flow-on effect to completing local reports. He hoped to be able to give verbal clearance on 22 October.

  Mr Mackey commended the EDFP&F and her team for the support they had provided in a really challenging year.
- A report on inter-district flows was noted.
- Updates were provided on key capital projects, particularly the Intensive Care Unit (ICU) and Southland MRI.
- An update was received on the Finance and Procurement Information Management (FPIM) system.
- The Internal Auditors joined the meeting and discussed their report.
- The quality and risk reports were considered and further updates requested on MRSA and clostridium difficile (c.diff).
- The Committee expressed its expectation that discharge initiatives be taken up across all areas.
- The Committee discussed the Colonoscopy Patient Review and, given its prominence, requested the report go to the full Board and the Executive come up with a measurable plan of action.
- Key issues in the Health, Safety and Welfare Report were discussed.
- The Committee considered the revised draft Drug and Alcohol Policy and recommended that it be approved by the Board.

Unconfirmed

It was resolved:

> **"That the Board receive and note the verbal report on the FAR Committee meeting held on 17 September 2020."**
>
> J O'Callaghan/L Kelly

Drug and Alcohol Policy

It was suggested that a general reference to the requirement to report impairment to the appropriate professional regulatory body be added to the Policy.

It was resolved:

> **"That the Board approve the Drug and Alcohol Policy with the addition of a statement about referral to the appropriate professional bodies, with the wording to be approved by the CEO and Chief Medical Officer."**
>
> T Potiki/J O'Callaghan

Unconfirmed

Community and Public Health and Disability Support Advisory Committees

The Board received a verbal report from Dr Theodore on the joint meeting of the Community and Public Health and Disability Support Advisory Committees held on 5 October 2020, during which the following items were highlighted.

- The Committee received a snapshot of disability services at Southern DHB, which provided an overview of initiatives under way, including data for decision making, employment opportunities, information on disability confidence, disability awareness training, and a timeline for implementing the Disability Strategy. The Committee recommended that the paper be shared with the entire Board.
- An update was received from the Chair of the Community Health Council, noting the impact COVID-19 level changes have had.
- A presentation was received from the Portfolio Manager, Disability Directorate, Ministry of Health, on the services the Ministry provides, mostly for people under the age of 65, the current growth in people seeking disability support, their annual funding, and strategic direction.
- A presentation was received on the Health Needs Assessment (HNA), which would provide an up-to-date and comprehensive picture of the health needs of the Southern population. The findings of the HNA would be made public in a web-based format.
- A verbal update was received on Māori Health from the Chief Māori Health Strategy and Improvement Officer, with a focus on kaupapa Māori services.
- A verbal update was received from the WellSouth CEO, along with a draft performance dashboard.
- An update on Central Otago/Wanaka primary maternity services consultation was received from the Executive Director Strategy Primary and Community (EDSP&C). The Committee noted that that the Central Lakes Locality Network and DHB project team would be making a joint recommendation to the Board in November 2020.
- Reports on Strategy, Primary and Community and the Funder Financial position were considered.
- The Committee received a report on aged residential care COVID-19 preparedness.

It was resolved:

> **"That the Board receive and note the verbal report of the CPHAC/DSAC meeting held on 5 October 2020."**
>
> M Theodore/T King

Hospital Advisory Committee

The unconfirmed minutes of the Hospital Advisory Committee (HAC) meeting held on 7 September 2020 were circulated with the agenda (tab 6.3) and taken as read. The HAC Chair drew members' attention to the following items.

- The presentation on Valuing Patient Time (VPT), which was designed to get patients flowing more efficiently through the system. The HAC Chair suggested that an update on VPT be provided to every second HAC meeting;
- The recommendations resulting from the review of COVID-19 adaptive changes, including a seven-day hospital service;
- The implementation of telehealth.

It was resolved:

> **"That the Board receive and note the unconfirmed minutes of the Hospital Advisory Committee meeting held on 7 September 2020."**
>
> D Perez/I Beekhuis

The meeting was adjourned at 12.15 pm for sampling of Meals on Wheels.

The meeting resumed at 12.35 pm.

10.0 CHIEF EXECUTIVE OFFICER'S REPORT

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

- *Organisational Performance* – year to date financial performance was on plan but some volumes were down compared to the same time last year.
- *Movement of Activity from Secondary to Primary Care: Skin Lesions* – There was ongoing discussion with the PHO regarding this programme.
- *COVID-19* – Resurgence preparedness was continuing, particularly around ensuring there is appropriate access to primary care testing, ramping up the Public Health response to be able to deal with 34 new cases per day, and supporting aged residential care in the event of residents testing COVID-19 positive.
- *Elective Service Performance Indicators (ESPI)* – Good progress had been made in ESPI 2 compliance but ESPI 5 compliance was a challenge.
- *Generalism* – The draft Generalism Business Case was now in its final phases.
- *Independent Review of the Southern Mental Health and Addiction System Continuum of Care* – the request for proposal for a consultant to undertake the review had closed and a number of high quality submissions had been received.
- *Iwi Partnership Agreement* – The partnership agreement had been agreed between Southern DHB, the PHO and Iwi Governance Committee.

Unconfirmed

Management then responded to questions on the community skin lesion programme, radiology project, maternal and post-natal mental health capacity, concerns about the impact of COVID-19 on school and pre-school health services, gastroenterology, COVID-19 testing, and the Mental Health single clinician model.

During discussion it was agreed that:

- The EDSP&C would provide an interim update to the next meeting on the Public Health activity lost due to the focus on COVID-19 management, particularly school and pre-school health services, and the plans to catch these up;
- The EDSS would provide further information on the use of MRI for breast screening in Southland.

11.0 FINANCE AND PERFORMANCE

The finance, volumes and performance reports to 31 August 2020 (tab 8) were taken as read.

During discussion, it was noted that:

- There were some significant financial risks over the remainder of the financial year and the Executive Leadership Team (ELT) were working to address those;
- The caseweight volumes did not reflect the reported workforce pressure.

The EDSS advised that he would provide a clearer report on theatre utilisation.

It was resolved:

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

12.0 STRATEGIC PLAN REFRESH – TERMS OF REFERENCE

The CEO presented proposed terms of reference for a refresh of Southern District Health Board's Strategic Plan (tab 11) for members' information and feedback.

The Board requested that:

- The Green Healthcare Strategy be listed as a companion strategy;
- That the outcomes required of a chosen partner be made explicit, eg they are to draft the document, as well as conduct the process.

The Executive Director Quality and Clinical Governance Solutions left the meeting at 1.20 pm.

13.0 2021 MEETING DATES

The Board and advisory committee meeting dates for 2021 were circulated with the agenda (tab 12) for members' reference.

Unconfirmed

PUBLIC EXCLUDED SESSION

***At 1.35 pm it* was *resolved*:**

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

General subject:	***Reason for passing this resolution:***	***Grounds for passing the resolution:***
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee ▪ 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 activities 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.

D Perez/T King

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

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

The meeting closed at 5.00 pm.

Confirmed as a true and correct record:

Chairman: ________________________________ Date: __________________

Unconfirmed

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 27 October 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020 Sept 2020 August 2020	**Performance Dashboard** (Minute item 9.0) (Minute item 8.0) (Minute item 9.0)	▪ Caseweights per FTE to be added as a productivity indicator. ▪ FSAs per medical staff FTE to be added to reporting. ▪ Data integrity issues to be checked, including: o Short Notice Postponements to be defined.	EDQCGS EDQCGS	▪ Included in last month's CEO report, will look to enhance into dashboard. ▪ Suggest this is a deep dive outside of the organisational performance dashboard and not a new tile within. ▪ In progress.	
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
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

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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. 13/10/20 The procurement process for both the replacement radiology CT plus the additional fourth unit is under way. 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. An options paper is being put together for the Board proposing a preferred location for the new machine. We propose to table the options paper at either the December or January Board meeting.	December 2020 January 2021
Sept 2020 Oct 2020	**Continuation of COVID-19 Initiatives** (Minute item 7.0) (Minute item 5.0)	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 2. The comprehensive implementation of telehealth. Consideration to be given to how the concept of seven-day hospital service provision could be progressed in the lead up to the new hospital.	EDSP&C EDSS	Will be reported to CPHAC and HAC respectively from November. The concept of a 7 day hospital service represents a significant change and needs to be incorporated into the change programme that accompanies the new hospital build. The team associated with the new hospital business case are well	Early 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				aware of the requirements in respect of this, as it is an essential part of enabling the overall services (including future growth) to be delivered from the new buildings. In the meantime, we are undertaking practical changes to provide more services outside of regular hours. This includes weekend theatre list work and the generalism business case proposes weekend Allied Health cover to ensure the right level of input to support timely discharge. We will collectively advocate for the need to move our services towards a 7 day model in the lead up to the new hospital. This is a logical part of the change programme that will be necessary and some of the challenges will be complex – e.g. agreeing 7 day cover for Allied Health and Medical workforces who are accustomated to working on a Monday to Friday roster pattern.	
Oct 2020	**Home and Community Support Services** (Minute item 2.0)	Report to be provided on how the contract is monitored.	EDSP&C		December 2020
Oct 2020	**Performance Monitoring** (Minute item 5.0)	Information clarifying reporting responsibilities to the statutory advisory committees to be circulated to the Board.	CEO		Completed
Oct 2020	**Urology** (Minute item 6.0)	Consideration to be given to moving components of Urology to a district wide service.	EDSS	Urology has now taken more of a district wide approach. This is due to a Southland Urologist who has been managing both Invercargill and Dunedin Laparoscopic Nephrectomies. He has attended theatre in Dunedin and has brought Dunedin	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				patients to Southland. Cystectomy patients are managed by a Dunedin Urologist for both Southland and Otago. A Dunedin Urology registrar is assisting with 1 in 3 on call for urology Southland. The service managers have worked hard to get the two hospital services working together.	
Oct 2020	**Colonoscopy Review** (Minute item 7.0)	▪ Endoscopy Oversite Governance Group to be set up and report to public HAC and Board meetings. ▪ Clinical Referral Group to be established and report to the EDSS and Endoscopy Oversite Governance Group. ▪ Project Manager to be appointed for 12 month term. ▪ Action plan, with SMART deliverables, to be developed. ▪ MoH patient categorisation and reporting requirements to be used.	EDSS	The first meeting of the new group / last meeting of the old group is scheduled to occur on the 23rd of October and a Terms of Reference has been drafted with the Group Chair for discussion in the first meeting. A Clinical Referrals' Group terms of reference is being developed with input from the Oversight Group chair and will be formed in the coming weeks. A project manager has been appointed for a 12 month term. Proposed patient categorisations has been put on the agenda for the 23rd of October meeting and will be actioned according to the feedback provided.	
Oct 2020	**Drug and Alcohol Policy** (Minute item 9.0)	Statement re requirement to report impairment to the appropriate regulatory body to be added – wording to be approved by CEO and CMO.	GMHSW	Work in progress.	
Oct 2020	**Public Health** (Minute item 10.0)	Interim update to be provided to the November meeting on community activity lost due to COVID-19, particularly school and pre-school	EDSP&C	Update included in CEO's report.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		health services, and plans to catch these up.			
Oct 2020	**Southland MRI** (Minute item 10.0)	Further information to be provided on the use of MRI for breast screening in Southland.	EDSS	Southland MRI does not have software or hardware packages necessary to undertake Breast MRI examinations. There were 215 breast MRI examinations in the past twelve months, 31% (67 total) of patients examined were domiciled in either Gore, Invercargill, Southland or Queenstown-Lakes Territorial Local Authority • The cost of a breast coil is estimated at c. $45,000 therefore it would represent value for money when offset against the costs of outsourcing these examinations (Invercargill, Gore and some Southland patients are currently sent to Pacific Radiology at Invercargill, Queenstown-Lakes and remaining Southland patients are sent to Pacific Radiology at Frankton). However, the decision not to proceed with purchasing Breast MRI capability was made on the basis of there being inadequate capacity and capability to report these examinations appropriately: • There is no Radiologist at Southland Hospital trained to report Breast MRI examinations and the sole Radiologist within Southern DHB able to do so on our behalf is at retirement age. • Breast scanning and then outsourcing the Breast MRI is not currently practical as imaging requires post processing on a separate piece of	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				software which may not readily be exportable to another PACS system (for example at Dunedin, outsourced reporting of Breast MRI is not feasible for this reason). • Breast Radiologists state that it is not consistent with best practice to simply report the images obtained by the MRI scanner without post processing - these need to be post processed for comprehensive reporting. • Should we recruit a Radiologist qualified to examine breast images in the future we will re-evaluate the feasibility of purchasing the hardware which would enable breast scanning to occur on the Southland MRI machine.	
Oct 2020	**Theatre Utilisation** (Minute item 11.0)	Clear report to be provided.	EDSS	This action has been assigned to the Quality and Clinical Governance team, but we will validate the reporting they produce to ensure that the data definitions align to the manner in which the theatres are resourced and used.	
Oct 2020	**Strategic Plan Refresh – Terms of Reference**	▪ Green Healthcare Strategy to be listed as a companion strategy; ▪ Outcomes required of a chosen partner to be made explicit, eg they are to draft the document, as well as conduct the process.	CEO		Completed

FINANCE, AUDIT AND RISK COMMITTEE MEETING, 22 OCTOBER 2020

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

Southern District Health Board

Minutes of the Joint Meeting of the Community & Public Health Advisory Committee and Disability Support Advisory Committee held on Monday, 5 October 2020, commencing at 1.30 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Unconfirmed

Present:	Dr Moana Theodore	Chair, Disability Support Advisory Committee (DSAC) *(Meeting Chair)*
	Mr Tuari Potiki	Chair, Community & Public Health Advisory Committee (CPHAC)
	Ms Ilka Beekhuis	Deputy Chair, CPHAC
	Mrs Kaye Crowther	Deputy Chair, DSAC (*by Zoom*)
	Dr John Chambers	Member, DSAC
	Mr Terry King	Member, CPHAC
	Dr Lyndell Kelly	Member, CPHAC
	Ms Odele Stehlin	Member, DSAC and CPHAC
	Ms Paula Waby	Member, DSAC
In Attendance:	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer *(by Zoom)*
	Dr Nicola Mutch	Executive Director Communications
	Mr David Perez	Board Member, Southern DHB
	Mr Andrew Swanson-Dobbs	Chief Executive Officer, WellSouth Primary Health Network
	Ms Lesley Soper	Board Member, Southern DHB *(by Zoom)*
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality & Clinical Governance Solutions
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mrs Joanne Fannin	Personal Assistant (Minute Taker)

1.0 WELCOME AND KARAKIA

The Chair welcomed everyone and the meeting was then opened by Mr Gilbert Taurua with a karakia. A warm welcome was extended to new Committee member, Odele Stehlin, Iwi Governance Committee (IGC) Chair and the IGC representative on the DSAC/CPHAC.

2.0 APOLOGIES

Apologies were received from Mr Kiringāua Cassidy, Mr Dave Cull and Dr Kim Ma'ia'i.

It was resolved:

"That the apologies be accepted."

M Theodore/L Kelly

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

It was resolved:

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

M Theodore/T Potiki

5.0 CHAIRS' UPDATE

Disability Support Advisory Committee (DSAC)

Dr Moana Theodore, DSAC Chair, provided a brief report, noting the presentations that will be made during the meeting and inviting DSAC members to contact her if they have any queries relating to the meeting or any matters they would like raised at a future meeting.

Community and Public Health Advisory Committee (CPHAC)

Mr Tuari Potiki, CPHAC Chair, advised that he had nothing further to add in relation to CPHAC and noted the discussion points that would take place later in the meeting.

6.0 MATTERS ARISING FROM THE PREVIOUS MINUTES

There were no matters arising that were not already covered by the action sheet.

7.0 REVIEW OF ACTION SHEET

The Committees received the action sheet updates (tab 7). The Executive Director Strategy Primary and Community (EDSPC), Mrs Lisa Gestro, reported that:

- Pēhea Tou Kainga? How is your home? Central Otago Housing: The Human Story – work is ongoing and the EDSPC will provide a completion date for the report.
- The reporting template, informed by the new DAP will be presented to the December 2020 DSAC/CPHAC meeting.
- Invercargill Primary Care Access – some progress has been made, a consultant has been contracted and the next step is for an options paper to be provided.
- B4 School Checks Programme – a catch-up plan is in progress. The Programme remains at risk due to the demands on staff in this area due to the COVID-19 pandemic. A testing strategy is being developed to ensure that ongoing testing obligations are met and business as usual continues in all areas of health, alongside COVID-19 planning and response. The EDSPC responded to concerns raised by Mrs Kaye Crowther in relation to the B4 School Checks Programme and acknowledged by the Chair. Southern DHB has pro-actively reached out to parents in terms of re-engagement. The EDSPC is to provide data for the B4 School Checks Programme and other services impacted by the COVID-19

Unconfirmed

response over the course of the next two meetings to show how Southern DHB is tracking and to monitor to ensure inequity is not created as a result.
- The items marked as completed were taken as read and will be removed from the action sheet.

Mr Dave Keen from DPA, Dunedin, joined the meeting at 1.42pm.

- Oral Health - the EDSPC responded to a query related to the monitoring of preventive treatment for caries and advised that she would refer back to the District Annual Plan (DAP) and provide an update on the deliverables. Southern DHB relied heavily on Dental Therapists to support the COVID-19 response. The Chair noted her interest and advised that a previous audit of the Dental School had highlighted inequity of access, including preventive treatments, for Māori, Pasifika and lower socio economic people. A request was made for an update on what parts of the Southern District have fluoridated water.

It was resolved:

"That the Action Sheet be received and noted."

M Theodore/I Beekhuis

8.0 SNAPSHOT OF DISABILITY SERVICES

The Executive Director Quality and Clinical Governance Solutions (EDQ&CGS), Gail Thomson, presented a report outlining disability initiatives under way at Southern DHB and future plans for the coming year to achieve the goals of the Disability Strategy (tab 8). The report was taken as read and additional comments were noted as follows:

- The report is a snapshot of where Southern DHB is with Disability Services.
- The snapshot is timely with the recent approval of the Disability Strategy, which has highlighted there is a lot of work to be done.
- Data to inform decision making and the work being done nationally that will shape the work done within Southern DHB. The collective national thought is about having an alerts solution attached to the National Health Index (NHI) so that it goes beyond DHBs into the wider health arena.
- Employment – for just over a year staff have been asked to record if they have a disability. This should result in Southern DHB having a better picture going forward. The wishes of staff who don't want to be identified as disabled must be respected.
- Disability Confident Organisations – outlined in Table 1 on page 2 of the report.
- Equal Employment Opportunities – a policy is in place, but there is a concern relating to access to a number of older buildings.
- Staff awareness, education and training – a disability awareness training module was included with the staff mandatory induction training package in 2019. Further work will be done to ensure that the training is mandated to staff who have been working for Southern DHB for a number of years.
- Concern was raised around the difficulty in getting information from Southern DHB staff related to travel and assistance support which is funded by the MoH. The EDQCGS is to look into this and report back to members.
- Feedback was provided on the work being done on the content of patient letters, the language being used and the Community Health Council have been engaged in that work. There is a need to ask disabled persons what works for them and the section on how patients want to be communicated with was highlighted.
- The high level timeline of what needs to happen to implement the Disability Strategy. A number of the actions required are being actioned concurrently.

Unconfirmed

The timeline could be used as a guide for what the Committee is updated on at future meetings.

- A Steering Group is to be established to develop the actions and implement the key points from the Disability Strategy.
- Appendix 1 outlines a summary of the Southern District, taken from the 2013 census and highlights selected measures of disability for people in private households. The total numbers relate to people with more than one disability.
- Southern DHB does not currently have a Disability Advocate/Facilitator, but that will be considered as work progresses to establish what resource is required. The Community Health Council does a lot of advocacy in this area.
- Ms Paula Waby confirmed she had input some time ago into the Disability Training and she noted the feedback was in the form of a tick box that was very light. The EDQCGS confirmed alternatives are being considered to provide something more substantive.
- The Chair requested that a workshop be held for the DSAC to move the work on the Disability Strategy forward and to feed in to the District Annual Plan.

It was resolved:

> **"That the snapshot of disability services at Southern DHB be noted and shared with the entire Board."**

I Beekhuis/L Kelly

Ms Karen Browne joined the meeting at 2.08pm.

9.0 COMMUNITY HEALTH COUNCIL QUARTERLY REPORT

Ms Karen Browne, Chair of the Community Health Council (CHC) presented the CHC's quarterly report (tab 9) and responded to questions. Key areas highlighted included:

- The CHC Planning Session held in August 2020 where the draft Annual Plan and draft Work Plan (tab 9, appendix 1) for the year were decided.
- The update for the quarter with Rheumatology highlighted as a key service that the CHC were actively involved with.
- The CHC involvement with COVID-19 and testing in the community. Letters of appreciation from the CHC were sent to the CEO, the CE and the Public Health Service for the manner in which they handled COVID-19 across the district.
- Business as usual for the CHC is the work outlined in the Action Plan and the round table sessions where members provide comment from their respective communities and decide in discussion where further action is required.
- The CEO commended the CHC on their work and noted they have become self-perpetuating and compared favourably to other DHBs nationally.
- An update was provided on how the CHC will reach out to the Māori and Pasifika communities, given the limited feedback from them on the Disability Strategy. IGC Chair and Committee member, Odele Stehlin, confirmed that IGC will be appointing a member to the CHC.
- WellSouth CE, Mr Andrew Swanson-Dodds, provided a vote of thanks and appreciation to the CHC and in particular, Hana Halalele, who assisted with the testing strategy to increase the number of Pasifika people tested in the community in Oamaru. 20.5% of the population tested on the day were Pasifika. In partnership with Public Health and doing influenza vaccinations on the day, many people not enrolled with a General Practice showed up and are now enrolled and engaged with the WellSouth system.
- Discussion was held on the need for the CHC to have more of an input into Children's Health.
- The Chair thanked Ms Browne for her presentation.

Unconfirmed

Ms Karen Browne left the meeting at 2.20pm.

Mr Doug Funnell joined the meeting at 2.21pm.

10.0 PRESENTATION: MINISTRY OF HEALTH FUNDER

The Committee received a presentation from Mr Doug Funnell, Portfolio Manager, Disability Directorate, Ministry of Health (MoH), on the disability services funded by the Ministry of Health. Mr Funnell spoke to his presentation and responded to questions:

- Mr Funnell is responsible for the disability services funded contracts across Otago and Southland and does some work across NZ with Needs Assessment Service Co-ordination services.
- The slide presentation covered the following:
  - The MoH population group.
  - Statistics showing annual funding and numbers supported. There is an increase in the number of people seeking funding support.
  - Disability Supports – national framework.
  - Enabling Good Lives – a principle based approach. A joined up funding approach between the MoH and the Ministry of Social Development (MSD). New roles have been introduced, e.g. a connector role, assisting families and individuals plan for a better future.
  - Strategic Direction.
  - Success and what it looks like.
  - Family – enabling good lives. A patient story – Baker – Hungry Hamish.
  - Further information is available at https://www.health.govt.nz/our-work/disability-services
  - A hearing aid subsidy is available.
  - Service gaps were identified as follow:
    - High and complex needs that fall between Disability and Mental Health.
    - Disabled people accessing Mental Health services – there is a disconnect between service providers.
    - Disabled people with chronic health needs. A pool of funding has been set up and devolved to DHBs, which is assisting.
    - Ongoing support services for people with Autism is a growth area.
    - Support for people with Foetal Alcohol Syndrome Disorder (FASD). Only those diagnosed with an intellectual disability as well as FASD are entitled to assistance. FASD currently sits with Corrections.
  - Referrals are accepted from anybody – there is not a clinical based approach. Those referring in would have proof of diagnosis.
  - There is no direct relationship with Primary Care and referrals are received from Primary and Secondary Care services.
  - Disabled should not be excluded from anything and they should be able to access any mainstream service that is available.
  - There is limited overlap of services, but not often due to limited funding.
  - The service does not work directly with employers.
  - It is believed that COVID-19 has disproportionately affected disabled people, especially in the area of employment, but there are no statistics available to prove that at the current time.
- The Chair thanked Mr Funnell for his presentation.

Mr Doug Funnell left the meeting at 2.50pm.

Dr Katherine Graham and Mr Rory Dowding joined the meeting at 3.00pm.

Unconfirmed

11.0 PRESENTATION: SOUTHERN HEALTH NEEDS ASSESSMENT

The Committee received a presentation from Dr Katherine Graham, Public Health Registrar, overviewing the Southern Health Needs Assessment project (tab 11). Dr Graham spoke to her presentation and responded to questions and additional comments were noted as follows:

- Dr Graham is a Medical Director in training in Public Health Medicine. She was accompanied by Mr Rory Dowding, Strategy and Planning Manager and disclosed that she was being assessed on her presentation, as part of her training, by Dr Mavis Duncanson and Professor Brian Cox.
- The slide presentation covered the following:
  - Overview.
  - Background – what is a Health Needs Assessments (HNA). The last HNA was undertaken in 2013.
  - The Southern HNA is being led by Southern DHB, in partnership with WellSouth PHN and oversight by Alliance South.
  - Purpose – to bring information together on one site to inform and provide direction, highlight and improve health equity and outcomes. The intent is to have a web-based living document that will be constantly updated.
  - Scope – district wide at a population level.
  - Indicators – there are over 70 indicators in four main groups – Demography, Health Status, Health Drivers and Health Services.
  - Process – acquiring and analysing data, interpreting and writing the story. Engagement with stakeholders along the way is key.
  - Challenges – data, COVID-19 and expectations.
  - Presentation and narrative – explaining in a way that people understand and being descriptive, but not judgmental.
  - Proof of Concept – video presentation giving an example through Power BI – Southern population demographics.
  - Acknowledgements and thanks.
  - The work done has been based on work done in Northland, but has been expanded to take a wider view and more interactive technology is being used.
  - Data is being accessed from a number of external and internal sources.
  - Ultimately the tool will have a twofold purpose – public facing work where the narrative is continually updated and internally for Southern DHB staff to use as a Business Intelligence Tool.
  - Ambulatory Sensitive Hospitalisation (ASH) rates and the importance of awareness and working to keep people out of hospital. An update was provided on the process for data collection.
  - The CMO, Dr Nigel Millar, advised that statistically there should be less admissions if the determinants of health were optimised (e.g. smoking, housing, etc.) and you have good primary healthcare and preventative services.
  - Data is being obtained from both internal and external sources.
  - It is intended to update the HNA on an annual basis.
  - Mr Dowding noted the request for the historic data to be archived as the HNA is updated and undertook to put a process in place.
  - Dr Graham advised that obtaining data in relation to disability has been challenging and consultation is on-going to obtain the best and most

Unconfirmed

recent information available. She sought assistance from the Committee in terms of how best to access disability information. The Chair confirmed that the DSAC will have on-going discussions in terms of how the tool can be used.

- The Chair thanked Dr Graham, Mr Dowding and the assessors.

Dr Katherine Graham, Mr Rory Dowding and assessors left the meeting at 3.26pm.

12.0 MĀORI HEALTH

The Committee received a verbal update from the Chief Māori Health Strategy and Improvement Officer (CMHS&IO). Mr Gilbert Taurua reported:

- That there are currently 10 contracted Māori Health Providers across the district, plus WellSouth is funded for the reducing inequalities voucher programme.
- That the total Māori Health spend is $3.757M and when the Provider Arm is included (covering Mental and General Health across Southland and Dunedin Hospitals), the total Māori Health spend is $5.35M.
- That there is no annual review of the Māori Health Provider contracts and appears to be no correlation between what the Māori Health Providers are contracted for against the health priorities Southern DHB is required to report on.
- That Te Kaika has recently achieved Kaupapa Māori authority, but Southern DHB does not contract with them because of their very low cost access service funding.
- That Southern DHB relies heavily on Kaupapa Māori Health Providers to support the more vulnerable Māori Health communities.
- There is some consistency in contracting of services across the district with two providers contracted to provide Well Child Tamariki Ora services and two providers contracted to provide Te Kākano Nurse Led Clinics.
- On the nature and scope of the Te Kākano Nurse Led Clinics and the Māori Health Providers.
- On the need to review the nature and scope of the services to ensure that Southern DHB's priorities are aligned to what is at the forefront of services for the Māori Health Providers.
- On the need to invest additional equity resource into the contracts with Māori Health Providers.
- That work is underway and should continue to more closely link Māori Health Providers to secondary and tertiary health services.
- On the District Annual Plan (DAP) guidance looking to expand and extend contracts provided in the community based on Tiriti o Waitangi and feedback out of the Wai 2575 process.
- Māori Health Providers are audited on a regular basis, but the way they currently report does not necessarily meet Southern DHB's strategic goal requirements.
- That it would be useful to have a couple of the Māori Health Providers present to DSAC/CPHAC on the nature and scope of the services they provide.
- On the benefit of "Māori for Māori" services.
- On the essential work undertaken by Māori Health Providers in response to COVID-19.
- That there is a gap in Kaupapa Māori services in the Central Otago area.

Unconfirmed

Mr Tuari Potiki advised the need to understand the current investment and for adequate resourcing to be provided to address inequity and the priority areas identified for Māori. How does the funding provided support the Māori Health goals identified locally across Southern DHB? Accurate reporting is essential to investing in the right areas to improve Māori Health outcomes.

Mrs Kaye Crowther noted the strategic planning and the first 1000 days' initiative referred to in the Board papers and advised the need for Māori and Pasifika to be included in that. She advised the importance of looking at not just Māori Provider services, but all services being provided to Māori families for tamariki. Mr Tuari Potiki responded that non-Maori services have been providing services to Māori for decades and that has created disparity. He advised the need to strengthen Kaupapa Māori Health services and ensure that all other services who see Māori as a part of their generic services are held to account. The CMHS&IO advised on the disparity with funding for Tamariki, especially in Southland, noting that the Māori Health Providers are dealing with both rurality issues and the most vulnerable families and the funding needs to reflect that.

Committee member and Iwi Governance Committee (IGC) Chair, Odele Stehlin, acknowledged the report from the CMHS&IO and looks forward to a more detailed discussion at the next IGC meeting. At the IGC meeting on 5 October 2020 discussion was held on aligning the priorities to the District Annual Plan (DAP) and the recently released Māori Health Action Plan (MHAP). She acknowledged the kōrero around the table and the importance of that.

The CEO advised the challenges with prioritisation and the need for the Board to provide direction noting the conflicting priorities between investment in initiatives such as 1000 days and an increase in elective surgery.

The Chair advised the need for further discussion to be held on equity, short term versus long term priorities and models of care for the longer term as we move into the strategic review process.

13.0 WELLSOUTH PHO

A verbal update was provided by the CE WellSouth. Mr Andrew Swanson-Dobbs reported:

- On the on-going work with Public Health on the COVID-19 response and ensuring that expectations are met in terms of surveillance and the testing strategy.
- On the Integrated Mental Health contract and the new roles of Health Improvement Practitioners (HIPS) and Health Coaches. It is a significant opportunity within Southern to introduce new roles within General Practice to support the whole system. An update is to be provided to a future CPHAC meeting to highlight what the new roles are achieving. The greatest impact from the new roles is changing the narrative within the practice and a position of "any client is the right client". The roles within the General Practices are assisting GPs and nurses to support the person within the Practice so they are less likely to have to refer out. The service is free.
- Tranche 3 of the Health Care Homes is being rolled out, targeting a lot of General Practices with significant high need populations.

Unconfirmed

14.0 PRIMARY MATERNITY UPDATE

The Committee received a report on the second phase of consultation on possible options for the location of a new primary maternity facility in the Central Otago/Wanaka area (tab 14).

The Executive Director Strategy, Primary and Community referred to the written report and advised on the status of the consultation and feedback. The team are on track to provide a recommendation paper to the November 2020 Board meeting for consideration and ratification.

Management advised that the one-month slippage is due to the impact of the COVID-19 response on staff time. Additional consultation with a sub-group in the area was also undertaken due to the significant level of interest from the Wanaka/Lake Hawea area.

It was resolved:

"That the Committees:

- **Note the completion of the second round of public consultation on the question: *Where should we locate primary maternity facilities in Central Otago/Wanaka?***
- **Note that the Central Lakes Locality Network and the DHB Project Team will make a joint recommendation, taking into account public feedback, on the best option in November 2020."**

M Theodore/I Beekhuis

15.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 15.1) and attachments (15.1.1 – Alliance Leadership Team Minutes and 15.1.2 – WellSouth Performance Dashboard) were taken as read and the EDSP&C took questions. The following items were highlighted during discussion.

- The CE WellSouth provided an update on progress with Power BI and the dashboards. The COVID and Health Care Homes dashboards are already live and the remaining dashboards will be operationalised within the next two weeks. The dashboards in the report are an example only and the information portrayed on them is not accurate.
- Southern DHB has requested that a dashboard for smoking cessation improvement be included in the suite of dashboards and the WellSouth CE acknowledged that the results have deteriorated, due to some extent on the need to focus on the COVID-19 response. The WellSouth team has a plan to progress an improvement in the results.
- Management responded to concerns raised regarding a perceived gap in dental services in Dunedin, acknowledging that work is required and noting that a review of the service has been commissioned by the new Dean of the Dental School in Dunedin and the commitment by the University to look at the issue in an open and transparent way. A request was made for a report to be provided on District Oral Health Services.
- The CE WellSouth responded to concerns raised in relation to the Primary Care/Health Care Home reconfiguration and the perceived lack of understanding by the public on the model. He advised on a change to the model being done at a national level and noted that the next tranche of General Practices will be greater and is due to go live on 1 November 2020.

Unconfirmed

He also responded to concerns related to Care Plus and Client Led Integrated Care (CLIC) and advised on the review undertaken pre-COVID and the proposed pathway forward.

- Management concurred with concerns raised that representation of DHB Clinicians on the Alliance Leadership Team is light and the CE WellSouth responded to concerns regarding overnight GP coverage in Wanaka, noting the challenge is across the board with workforce depletion and younger GPs not wanting to work 24/7.

It was resolved:

"That the report and attachments be received."

M Theodore/T Potiki

16.0 FINANCIAL REPORT

In presenting the Strategy, Primary and Community (SP&C) financial results for August 2020 (tab 15), the EDSP&C advised:

- That the result for SP&C for the month of August 2020 and year-to-date is favourable.
- That the "comments for discussion" section is the most important section of the report.
- That the key areas of risk in the report are Pharmaceuticals, Aged Care and Mental Health.
- On the change strategy initiatives embedded in the day to day work programmes, promoting significant lines of quality improvement in an effort to run in the most efficient way possible.

It was resolved:

"That the report be accepted."

M Theodore/I Beekhuis

17.0 AGED RESIDENTIAL CARE FACILITIES – COVID-19 PREPAREDNESS

The EDSP&C presented the results of Aged Residential Care (ARC) facilities' COVID-19 preparedness assessments (tab 15) and advised on the work done to prepare in case of future outbreaks. Members noted comments from the CMO highlighting that the COVID issues in the Aged Residential Care sector were equally as complex as those in the Hospitals and health professionals in both sectors were equally important. Management responded to concerns raised around those in care requiring support and supply of PPE. Committee member and IGC Chair, Odele Stehlin, commended management on the paper, but noted concern that equity was not considered to be a driver as noted on the cover sheet. Management acknowledged the concern and agreed with the need for evidence that consideration has been given to equity.

It was resolved:

"That the report be noted."

M Theodore/L Kelly

The Chair thanked management and members for their input and noted that a workshop is to be held prior to the next meeting.

Unconfirmed

A closing karakia was provided by the CMHS&IO, Mr Gilbert Taurua and the meeting closed at 4.25 pm.

The next meeting is to be held on 7 December 2020 commencing at 1.30pm.

Confirmed as a true and correct record:

Chair: ______________________________

Date: ___________________

Unconfirmed

HOSPITAL ADVISORY COMMITTEE MEETING,
2 NOVEMBER 2020

6.3

- Verbal report from David Perez, Committee Chair

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	3 November 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:	**Presented by:**
Chris Fleming Chief Executive Officer **Date:** 27 October 2020	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 September is a deficit of $2.2 million compared to a planned deficit of $1.1 million, and hence $1.1 million unfavourable to plan. YTD financial performance is a $4.2 million deficit against a planned deficit of $3.1 million, resulting in a year to date deficit against plan of 1.1 million. The forecast is being discussed at the Finance, Audit and Risk Committee (FARC) and progress will be tabled at the Board meeting.

From a volumes perspective, case weighted discharges was up 2.8% for the month of September compared to the previous year, however Emergency Department (ED) attendances and Mental Health bed days are down 6.8% and 10.5% respectively. On a year to date basis all indicators are down, case weights 0.9%, ED 3.3% and Mental Health bed days 6.6%.

Substantive level of detail has been provided in the report to the Hospital Advisory Committee (HAC) on case weighted discharges and raw discharges. However, there is considerable discussion occurring with regards to understanding what is tangibly happening with workload pressure. The case weight reporting are indicating:

- Acute medical case weights are down 8.2%
- Acute surgical case weights are up 5.8%
- Elective medical case weights are up 6.4%
- Elective surgical case weights are down 1%.

Acute medical case weights have also been impacted by a complex patient who has had a lengthy stay in the hospital being discharged with a case weight of circa 75 for the one patient. If this individual patient had not been present underlying case weights would have been down 9.7%. There are considerable questions with regards to this as staffing pressures on the wards (particularly Ward 8MED in Dunedin and the Medical Ward in Southland) are intense despite there being demonstrably lower case weight activity, and lower bed occupancy. Understanding this problem will provide some guidance as to the actions required. This will feed

into the process which is currently underway in terms of performance reporting from a volumes / workload / productivity perspective.

3. SOUTH ISLAND ALLIANCE

The Board will be aware that we have an Alliance with the other South Island DHBs. Over the past few months there has been a process focussed on Refocus / Reset process set up mid-year to review and advise on how the South Island Alliance could be set up to deliver better regional outcomes.

With the recent activity in Canterbury along with the broader Health System Review this has only resulted in an amplification of ensuring we take action to better align the regional activity.

A recent meeting between the Alliance Leadership Team (South Island DHB Chief Executives) and the Alliance Board (South Island DHB Chairs) agreed the following:

A simplified Vision, Purpose and Principles / Values

Vision

Best for people, Best for system.

Purpose

The five South Island DHBs are individually responsible for ensuring the planning, funding and provision of services for their populations.

Together, as the South Island Alliance, the DHBs collaborate to plan and co-ordinate a regional work programme where they agree it makes sense for the effective and efficient delivery of health services

The South Island DHBs will agree who will lead regional activity: DHBs collectively, a lead DHB or South Island Alliance Programme Office (SIAPO). regional work will complement DHBs' local work programmes and assist them to achieve their South Island Alliance (SIA) vision and purpose.

Principles/Values

Our shared commitment is to a sustainable South Island health system that delivers:

- equitable outcomes for Māori
- equitable access to services
- consistent, planned and integrated models of care
- a sustainable healthcare workforce
- consistent data and digital platforms.

Our agreed way of working is based on:

- collaborative culture and behaviours; mutual trust, respect and accountability
- active engagement in planning, implementation and decision making.

The criteria for collective South Island activity

a. Achieve a best for people, best for system planned, integrated, system of care
b. Achieve a viable sustainable service that

   i. Empowers the health workforce
   ii. Delivers the future of work
   iii. Turns data into insight into action

c. Reduce duplication of effort
d. Pool SIA/SIAPO skills, strengths
e. Ensure South Island DHBs are committed to delivery and implementation.

Organising Framework

A revised organising framework that simplifies the strategy, priorities development and decision process for regional activity:

- across a shorter timeframe to match DHB processes more directly
- that is fully led by General Managers Planning and Funding (or equivalent) as the conduits for DHBs into the regional context
- that ensures the regional work is more directed by, and connected to, the strategy and planning requirements of the DHBs in aggregate (with some allowance for local variation).

Next Steps

The Chief Executives and Chairs tasked the Steering Group with the required next steps to be fully reported back at the Board meeting in mid-December:

- collate DHB priorities for the 2021/22
- recommend options around ensuring a better fit between the regional and district plans
- complete the current Information Systems (IS) systems stocktake for the region and propose solutions for better delivery of regional data and digital services
- recommend three to five service areas for full regional analytical review and detailed proposal
- provide recommendations about the future form of the Alliance based on outcomes and progress against all of the above (i.e. form following function).

4. STRATEGIC PLAN REFRESH

The Request for Proposal (RFP) has been issued for resource to assist in the refreshing of our Strategic Plan. The responses close on 12 November, so it is likely the refresh will get underway fully early in the new year.

5. ANNUAL PLAN 2020/21

The annual plan for 2020/21 has now been approved by the Ministers of Health and Finance and has been published on our website.

6. SERVICE PLANNING

Strategy, Primary and Community are expanding a process this year for the development of Service Plans that are more closely aligned with Annual Plan processes. The timeline for the development of Service Plans and the Annual Plan is outlined in the following table. The Financial and Planning (Annual Plan, Service Plans) teams will work jointly with the services to the proposed timetable.

A staged approach will be used to embed the desired change in the process. This support will be prioritised first to the Medicine and Women's and Children's Health Directorate, and to other directorates on a request-basis. A rate limiting factor is when guidance from the Ministry of Health is provided to the DHBs. Prior to official guidance being received, it is expected that the services will undertake the planning process as per the timetable on the basis of previous guidance and assumptions. As official guidance comes to hand, the plans and budgets will be updated. This indicative timetable does not replace any specific budget or planning guidance and may be updated as such guidance is released

	SERVICE CHANGE	COSTS AND VOLUMES	SERVICE PLAN	ANNUAL PLAN
Supported by	Finance; Strategy and Planning	Finance; Strategy and Planning	Finance; Strategy and Planning	Finance; Strategy and Planning
July				
August	Monthly, review progress on service changes. If alterations are needed and not within mandate then escalate decisions as needed	Commence work for next FY volumes and budgets. Start review of assumptions	Monthly, review progress on service plan. If changes needed and not within mandate then escalate decisions as needed	Templates for quarter reports, and reporting to ELT and Board
September				
October	Services review previous year, and develop high level aims, and proposed service changes. Include stakeholders as appropriate	Baseline information on financial budget, volumes, actuals. Draft delivery volumes to understand capacity, and costs. Assumptions Guidance and forecast budget ($)	Review current service plan	Quarter reports and MOH feedback
November	High level proposals for service change are drafted according to template. All of Directorate workshops (plus stakeholders)	Preparation of next year's budget and volumes, alignment with strategic priorities and change proposals Submission to CEO (plus proposals)	Indicative alignment of service change proposals, service plan, and strategic priorities Check against current Annual Plan to identify gaps/possible issues	Review current annual plan
December	Check and update service change proposals against draft budget, annual plan advice, outcomes of workshop, and advice from CEO	Update budget and volumes Highlights of changes in expectations/assumptions	Update service plans	Annual plan advice from MOH
February	All of Directorate workshop – review service change proposals	Review budget and agree volumes	Review updated service plans	Update draft Annual Plan
March	ELT, Board Committees and ALT feedback on proposed service changes	Finalise budget and agree volumes	ELT, Board Committees and ALT feedback on service plans	Draft Annual Plan

April	ELT view and endorse proposed service changes	ELT view and endorse budget and volumes	ELT view and endorse service plans	Annual plan to MOH
May	Revisions as needed by ELT	Revisions as needed by ELT	Revisions as needed by ELT	Revisions as needed by MOH
June				Annual Plan approved by MOH

7. RECOVERY FUNDING

There are a number of funding streams that were available to DHBs to support COVID-19 Recovery. The majority of the funding is being made available to DHBs on a population based funding formula (PBFF) basis to support the delivery of volumes (both inpatient and outpatient activity) which needs to be recovered due to cancellation of activity during the COVID-19 period. There were however two other funding streams which were made available on a contestable basis. These were $50 million of capital funding and $7 million of innovation funding. This funding was available nationally and required DHBs to submit proposals.

Southern DHB, led by the Executive Director Specialist Services, submitted a number of proposals. On 24 October we were advised that the Ministry had assessed the proposals and made some tough decisions as the funding was oversubscribed. Southern however received a total of $5.9 million of capital funding and $1.3 million of innovation funding. This is significantly higher than our PBFF share would have been at $3.4 million and $0.5 million respectively.

The major capital items supported include:

- An additional CT Scanner for Dunedin
- Fifth operating theatre for Southland Hospital
- Rural and urban community respiratory equipment.

The significant innovation funding items include:

- Rolling out the prioritisation tools
- Embedding of Telehealth
- Direct Access to High Tech Imaging for Primary Care
- Innovations in Endocrinology
- Follow Ups in Rheumatology.

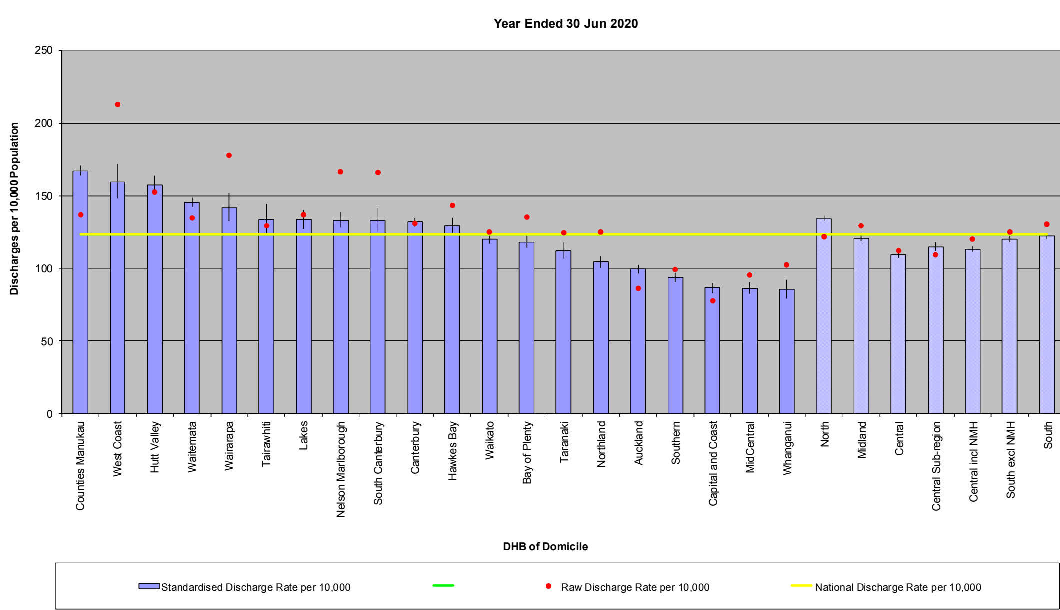
This is a great result for Southern and will provide an opportunity to make some real improvements in these targeted areas.

8. GASTROENTEROLOGY

As requested in the Board actions, the following data is included which shows 30 June year to date standardised intervention rates (SIRs). Southern DHB's SIR is low relative to other district health boards with Capital and Coast, Mid-Central and Whanganui all having lower SIR than Southern, but the other DHBs having a higher SIR than Southern.

One of the recommendations from the Bissett report that needs to be worked through is increasing scoping rates and the new Endoscopy Oversight Committee

will need to progressively work through a range of considerations to determine the most appropriate way to increase intervention rates. Possible approaches include modification of the acceptance criteria and encouraging greater referrals from primary care.



Following on from the Board Meeting in October a number of actions are being worked through in response to the Bissett report. These include the following:

- A project manager has been appointed and she is developing a draft programme of work which incorporates the recommended responses to the Bissett report together with prior actions that are being rolled up in the programme of work.
- A Terms of Reference has been developed in conjunction with the new Chair of the Endoscopy Oversight Group and this will be tabled at the last meeting of the Endoscopy User Group / first meeting of the Endoscopy Oversight Group on 23 October.
- An initial agenda is being constructed for the new Oversight Group in conjunction with the Chair. Initial items for consideration will be the classifications used for processing of referrals and a proposed definition for Gastrointestinal Specialist Override referrals (so that those which aren't intended to be override referrals can be clearly differentiated).
- We have started the development of the Terms of Reference for the weekly Referral Users Group.
- We have started regular meetings with the Information Technology team to work through opportunities to improve internal referral processes (e.g. digitise the internal referrals which remain paper based) and work through a way of livening another field in IPM which will enable Colonoscopies to be separately identifiable to other Gastroenterology referrals. This in turn will improve our ability to report on Colonoscopy referrals from within our patient administration system rather than relying on out of system work around options.
- There are a number of actions to now work through. However, one of the more important actions is to support the formation of the Endoscopy Oversight Group and ensure that the actions coming out of this group and worked through and create the desired improvements.

Colonoscopy waiting times as of 28 September 2020

	Dunedin					Southland				
	Bowel Screening	A	B	C	Surveillance	Bowel Screening	A	B	C	Surveillance
Number of patients	32	8	105	57	368	16	2	41	54	373
Average wait	15.97	5	26.61	31	111	22.25	13	21.02	74	153
Longest wait	32	11	202	122	253	47	17	62	237	362

Further work is underway to enhance the reporting for Colonoscopy wait times. More generally, there is a reasonable amount of information capture for the service which happens outside of the core patient administration system at present and we are hoping to enhance what can be reported from within the system. We also need to have highly robust data definitions in terms of what is reported and to be able to reconcile this accurately with Ministry reported data. This is an ongoing piece of work which we are incorporating into the overall work programme that is being developed in response to the Bissett report.

9. UPDATE ON GENERALISM

An updated copy of the Generalism business case has been presented to the Executive Leadership Team. Final feedback will now be incorporated, and further consultation will occur prior to the case being presented to the Southern DHB Board in December.

Key feedback was as follows:

- The case needs to assert that there will be an obligation on the workforces to adopt the Generalism approach, and the Clinical Council will be asked to drive this to ensure it occurs.
- Finance has asked for further input into the financial calculations (Net Present Value analysis of the options).
- The case need to provide a conceptual solution and cost for the services who will need to be moved from the existing physiotherapy gym to clear the space required for the development of the medical assessment unit next to the ED.

The case will be updated according to this remaining feedback and a final meeting will be held with the Chief Executive to gain overall endorsement. Once endorsed, the case will be put onto the Board agenda proposing agreement to the preferred option (a Generalist admitting model combined with a medical assessment unit developed next to the Emergency Department).

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

The steering group to oversee the Independent Review of the Southern Mental Health and Addiction System Continuum of Care has now been formed. The Steering Group is being chaired by Clive Bensemann. Proposals have been received and will soon be reviewed by the Steering Group, which is currently being established.

11. AGED RESIDENTIAL – PSYCHOGERIATRIC BED OCCUPANCY

The table below highlights Psychogeriatric bed capacity and occupancy across the country. One needs to take care in interpreting some of the DHB data as the beds are based on geographic location so those DHBs like Auckland, Waitemata and Counties, or Capital & Coast / Hutt Valley the data should be looked at together.

Fundamentally however this table demonstrates a picture which suggests that there are different models of care in use in the South Island. Canterbury, South Canterbury and Southern all have much higher percentage of the psychogeriatric bed stock than their PBFF proportion would suggest would be equitable. This in its own right does not provide an answer, but it does lead to a need to understand what the difference is to determine whether there are changes to the model of care required. This will be further followed through by Strategy, Primary and Community to understand the drivers and identify whether there is any change possible.

	PBFF	Psychogeriatric Beds	% of Psychogeriatric Beds	% Occupancy
Canterbury	10.71%	219	23.17%	96.5%
Waitemata	10.99%	131	13.86%	86.4%
Southern	6.86%	97	10.26%	94.7%
Waikato	9.20%	89	9.42%	91.0%
Capital & Coast	5.61%	84	8.89%	94.5%
Auckland	8.56%	47	4.97%	98.7%
Hawkes Bay	3.99%	45	4.76%	97.8%
Hutt	3.02%	41	4.34%	95.1%
Counties Manukau	10.92%	37	3.92%	100.0%
Bay of Plenty	5.99%	30	3.17%	83.3%
Nelson Marlborough	3.47%	21	2.22%	100.0%
South Canterbury	1.38%	20	2.12%	80.0%
Taranaki	2.65%	20	2.12%	100.0%
Northland	4.90%	20	2.12%	80.0%
Mid Central	4.07%	18	1.90%	77.8%
Lakes	2.64%	15	1.59%	93.3%
Whanganui	1.71%	10	1.06%	90.0%
West Coast	0.89%	1	0.11%	100.0%
Tairawhiti	1.30%	0	0.00%	0.0%
Wairarapa	1.14%	0	0.00%	0.0%
		945		

12. OUTPATIENT PERFORMANCE (ESPI 2)

Good progress has been made in recovering outpatient performance. Immediately post COVID (June) we had circa 2,600 breaches (patients who were accepted but waiting > 120 days for their outpatient appointment) out of a total wait list of 6,400. This represented a breach rate of circa 41% and was the situation we found ourselves in during the immediate aftermath of COVID. Since then we have managed to reduce the number of breaches and we are currently circa 1,100 breaches for a total wait list of 6,900. This translates into a breach percentage of 16%.

Historically, Southern DHB was the worst performing DHB in terms of total ESPI breaches (one of the worst in percentage of breaches and the worst in total number of breaches). With our improvement programme we have been aiming to get Southern DHB to the average percentage for breaches across all DHBs, which is

circa 11%, and from there we want to continually improve until all services have zero breaches and are therefore fully compliant. We are hoping to achieve our 11% target by late this year / early next year and we will then progressively improve our performance from there, with some assistance from the recovery funding.

Our initiatives for improving outpatient first specialist appointment (FSA) ESPI compliance are as follows:

- Implementation of the prioritisation tool for the surgical specialities. This continues to work well in Urology and Orthopaedics in Dunedin and is implemented in General Surgery in Southland. It has been implemented in test format in General Surgery in Dunedin. The Ears, Nose and Throat (ENT) service has agreed to trial it in Dunedin for both Dunedin and Southland (they triage Southland referrals), and we have resumed discussions with the Obstetrics and Gynaecology (O&G) service in Southland about the implementation of the tool. We really do need project support / project resources to systematically implement the tool across all services and this is one of the initiatives we have put forward when we applied for initiative money as part of overall recovery. We should find out on 23 October whether or not we have been successful in securing the necessary funding to put project and change resources in to support the roll out of the tool.
- Review of the longest waiting patients in the Medicine, Women's and Children's Health portfolio and ensure these are booked. We have tasked the General Manager with reviewing the longest waits with each of the services on a weekly basis and organise for these to be booked and we have built a Power BI tool that facilitates this review.
- Implementation and use of the 'acuity' tool across all specialities. A number of specialities are using the tool well but after an initial implementation in O&G in Southland we appear to have some hiccups. The Planned Care Manager is travelling to Invercargill at the end of this week and will spend a day with the booking teams and others to work through expectations with the aim of the acuity tool being in place across all of the specialities (who are booked by a central administration team in Southland).
- Implementation of recovery initiatives once the trajectories are agreed to with the Ministry.

We continue to meet with the surgical and medicine, women and children general managers and service managers on a weekly basis to track performance against

these initiatives and to determine whether additional initiatives need to be added to the programme.

13. INPATIENT PERFORMANCE (ESPI 5)

Unfortunately, the inpatient wait list is less easy to resolve (as reflected in the relatively static number of ESPI breaches as a proportion of the ESPI wait list in the diagram below.

The recovery funding will enable us to catch up some surgical activity with outsourcing or weekend lists but access to additional theatre lists is the inhibitor to making rapid progress. In the meantime, we have focused our energies on the longest waiting patients, as follows:

- We have developed a Power BI report which shows us all patients waiting > 8 months. We have started with all patients waiting > 24 months and set the expectation (with General Surgery and Orthopaedics in particular) that all patients waiting > 24 months must be systematically booked or otherwise appropriately removed from the waiting list. We are reviewing this on a weekly basis.
- To support the above decision making we have systematically reviewed all patients across all specialities > 8 months and have provided an initial assessment for the service manager to work from.
- The team has developed a 'transfer of care' policy and approach that had been partially developed by our predecessors but was never implemented. This is currently undergoing testing. Its intention is that if a patient is languishing on the wait list because a condition needs to be addressed before they will be eligible for surgery (e.g. weight loss or cessation of smoking) that their care is transferred until these conditions are met and they can then be reintroduced to the wait list.

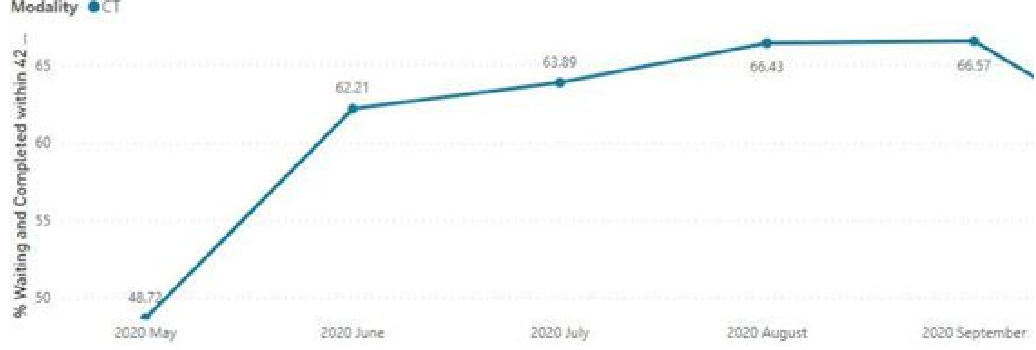
Our aim/s with the above initiative/s is to systematically pull back the longest wait from 2+ years in some cases to < 18 months and then < 12 months, then < 8 months and eventually < 4 months, whilst also having a good understanding of what is sitting on the wait list. However, it is the recovery money, both from this year and in the next two years that will enable us to meaningfully address those patients who have been waiting a long time on the wait list for their surgery.

14. MEDICAL IMAGING DIAGNOSTICS

Computed Tomography (CT) Performance

As shown by the following chart, CT performance (against the Ministry 42 day elective target) has systematically improved from circa 50% at the latter end of COVID to 66% currently. One off initiative money (which we applied to the Ministry for and subsequently received) in August assisted with initial improvement (enabling us to get more volumes done in Oamaru and with a provider). However, performance gains were subsequently impacted by an unplanned outage of the CT machine in Dunedin which required parts from Siemens in Germany. Performance in Dunedin was 52% at the end of September, whereas performance in Southland was 96%. The overall Ministry target is 95% scanned within 42 days so our performance in Dunedin is our key focal area.

We have made progress on the initiative agreed to earlier in the year. The Nuclear Medicine CT scanner is now equipped to do regular CT scans. And we have secured the first of the medical imaging technologists (MIT) staff who are required for us to complete the additional scanning proposed. We still need to recruit the registered medical officer (RMO) who will enable overnight contrast CTs to be completed but with the recruitment we have been able to achieve to date we are now able to do 20 more CT scans per week (non-contrast scans) and this will start to improve Dunedin CT performance going forward.

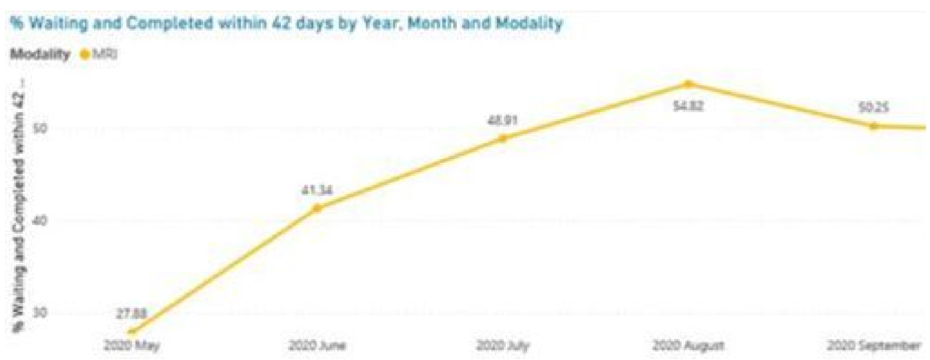


Magnetic Resonance Imaging (MRI) Performance

MRI performance at the tail end of COVID (in terms of the Ministry 42 day elective target) was at 27% and in a similar manner to CT, subsequent one-off recovery money funded additional activity that enabled this performance to be improved. However, we had two extended outages in September which impacted on MRI performance and will be reflected in our performance in October, too.

The first of these was a planned outage to replace the MRI machine in Southland. The machine that was replaced is 14 + years old and there were significant reliability challenges with it. Initially the new machine was going to be put in a new location, enabling the existing machine to remain in situ until the new machine had been installed. However, this proved to be too complex and the machine was pulled out and replaced in situ, leading to a 6 week period of not having a machine on site. This was managed using a provider (outsourcing) for emergencies, and some use of the Dunedin scanner, and the team managed to get a bit ahead of their wait list ahead of the implementation. As a consequence, Southland performance was still reasonable for September at 77% overall.

Dunedin had a major MRI outage during September. A major component failed, and the initial diagnosis led to a part being ordered from Singapore, which then got delayed due to COVID logistics. In parallel a new diagnosis confirmed a different part, and this had to come from Chicago, and also faced COVID related logistics delays. As a consequence, there was a 2 week unplanned outage which impacted on performance. Whilst the decline in overall performance was moderate when compared to the previous month (down from 55% to 50%) we anticipate that the impact will be felt in our October performance measures.



15. EMERGENCY DEPARTMENT (ED)

The first point to note with respect to the Emergency Departments is that overall volumes have been down during the quarter in Dunedin (and relatively static but down in September for Southland) when compared to the same period in the previous year.

Southland ED Volumes

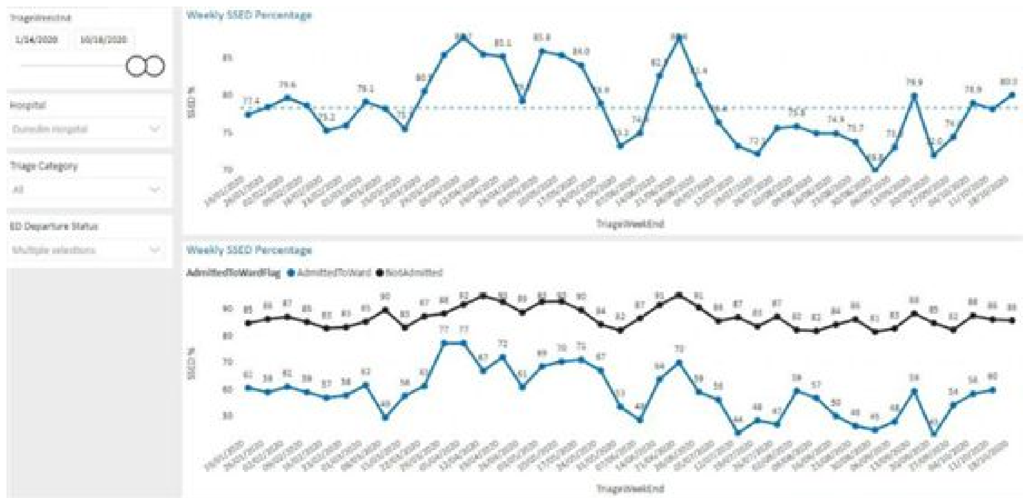
	2019	2020	Change
July	3,256	3,238	-1%
August	3,389	3,419	1%
September	3,243	3,018	-7%

Dunedin ED Volumes

	2019	2020	Change
July	4,222	3,913	-7%
August	4,180	4,046	-3%
September	4,060	3,733	-8%

ED performance in Dunedin (against the 6 hour target) varied on a weekly basis during September from 70% to 80% with an average of about 75%. As noted in the chart below, those who were not admitted had an average close to 85% whilst those who were admitted had an average that was closer to 55%. The Chief Medical Officer and General Manager Operations are working on the implementation of an escalation plan with the intention of getting specialist assessments happening faster and therefore reducing the time patients who are admitted spend waiting for a specialist assessment as part of their overall journey prior to inpatient admission. On the face of it, increased waiting times in the context of lower volumes (and better performance) in the previous year seems odd and requires further investigation.

Our key initiative which will meaningfully improve ED assessment times is the proposed business case for the implementation of the generalist admitting model and the development of a medical assessment unit which would be built next to the ED. Following further feedback from the Chief Executive we are completing the final steps to finalise the case before socialising it with relevant stakeholders and then putting it to the Board for their consideration.



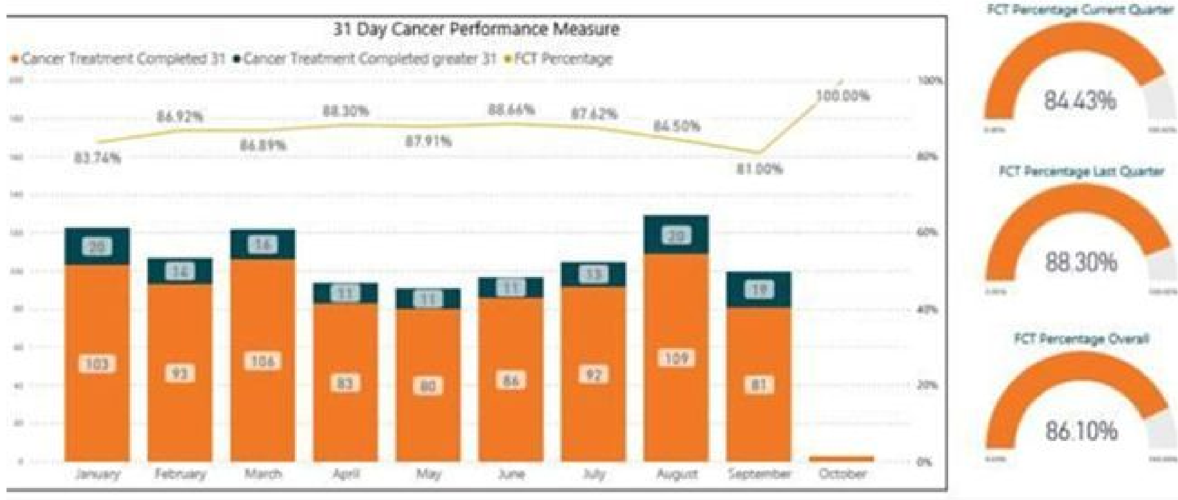
ED Performance in Southland is better and has averaged closer to 85% during September. Patients who are assessed and treated but not admitted are being seen in an overall timeframe which is close to the 95% target. Those requiring admission are averaging circa early 50s. There appears to be a robust model for internal medicine clinician assessment in Southland and we are currently undertaking an assessment to compare the waiting time for an internal medicine assessment as compared to a surgical specialist assessment.

We have formed a small working group in Southland with the aim of quantitatively assessing what is required to alleviate the winter pressures the ED faces every winter. The working group is focused on the following:

- Assessment of whether assessment unit beds, flexible beds or some other configuration would make the biggest difference to ED performance. A case will then be put forward for investment prioritisation for the capital and operating requirements required to develop this additional capacity.
- The team are implementing a discharge lounge which we believe will enable another 6+ beds to be freed up quicker on a daily basis (alleviating access block, assisting with ED wait times and reducing the cancellation of surgery).
- The team is now undertaking data analysis on the components of patients' journeys where the wait is the longest.

16. FASTER CANCER TREATMENT

Performance in the month of September appears to have dropped compared to the previous month and the current quarter to date performance is close to, but not quite at the 85% target mark.



17. OUR ONGOING CORONAVIRUS MANAGEMENT RESPONSE

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

Isolation Hotels

Following the decision by South African, New Zealand, Australian and Argentinian Rugby (SANZAAR) to hold the rugby championship in Australia, Southern DHB was advised that a sports Managed Isolation Facility (MIF) was not required in the Southern Region.

Public Health Response

Currently the active cases in NZ are still contained to Auckland and are shared between Managed Isolation Facilities (MIF). Public Health South has been doing a lot of work around an escalation plan to ensure that there are an appropriate number of people within teams to be able to escalate quickly to cope with a second wave of cases, while still trying to maintain business as usual.

There has been extensive training on the National Contact Tracing Service (NCTS) system across the Public Health and with Public Health Nurses. The requirement from the Ministry is that we need to be prepared to contact trace up to 24 cases a day with ability to quickly surge up to 34 cases a day. A training programme has been developed for other Southern DHB staff that would be unable to work in their usual jobs if we had a localised outbreak. This consists of a four-hour session to give them an understanding of our role in COVID-19 response work and training on how to use NCTS. There is also ongoing scenario training for all our staff (and Public Health Nurses) to keep practicing and retain competency in using the system. Alongside this all protocols and documentation have been reviewed and updated to ensure that our Public Health unit is prepared.

Planning is underway for the Christmas period. We will need to have more staff working over this period to ensure we are prepared to respond to COVID-19 cases and contact tracing should the need occur. With that in mind we are exploring some options for ensuring that we have sufficient staffing in place, while balancing the need for staff to have a break after an exceptionally busy year.

Significant work has been occurring around the requirements for surveillance of maritime workers and crew, as well as working with WellSouth around ensuring adequate testing and surveillance activity is happening in our district and ensuring we meet Ministry of Health requirements. There have been many changes in the maritime border space with the Ministry of Health requirement to test all border staff every two weeks. In addition, any crew wanting to disembark an international vessel need to meet the low risk criteria and have a negative COVID-19 test. A workshop was held to develop a sustainable plan for surveillance testing in the community and at the borders.

We are working with Infection, Prevention and Control to make sure that we have everything in place to ensure our workforce remains healthy. This includes regular messaging going out to staff to remind them about hand hygiene, using gels, wiping down equipment that is shared by others, cleaning workspaces, and maintaining appropriate physical distancing.

Primary Care Response

General Practice in all areas continue to provide assessment and testing as required. 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 Ministers expectation that swabbing facilities are available seven days per week. Public Health South have estimated that an average of 400 tests per day need to be undertaken to ensure a reasonable level of surveillance in the district.

Plans are in place to be able to mobilise Community Based Testing Centres (CBTCs) in the future if required. We are waiting for confirmation of how testing is to be funded after end of September 2020. The Ministry of Health contract value passed onto WellSouth for July to September was for $2,111,410.

Swabbing

Current volumes of swabbing undertaken in Primary Care since 1 July to 8 September include 22,303 simple, 627 virtual and 83 full assessments.

Based on the primary care volumes, the cost to date is $2,734,730.00. Plus, student health costs of approximately $181,500 for July and August. Approximate total cost to date of $2,916,230. Variance approximately ($804,820).

There is currently a discussion underway about the remaining national pool of $18m, which is what is left from the July to September appropriation, and there is an active debate underway currently about whether a PBF allocation unfairly penalises the Northern region, which has clearly borne the brunt of recent COVID related activity. To date, there has been no indication of whether ongoing funding will be made available to DHB’s to continue to deliver the testing regime.

As at 24 September 2020 there had been a total of 6,076 swabs taken in general practice for COVID-19.

Lakes District Hospital and Rural Hospitals Response

When moving to Alert Level 1, Lakes District Hospital revised its screening procedures to:

- All people presenting to Lakes District Hospital are still screened
- The COVID QR code is in place as are sign in books
- People who meet the criteria are swabbed and they are cared for in the Emergency Department negative pressure room when necessary
- Staff are mindful that direct flights from Auckland, and large numbers of visitors, make Queenstown a high-risk region for a positive patient, so this guides our heightened response.

The Rural Trust hospitals are following the Southern DHB Technical Advisory Group advice on screening of presentations / visiting hours / swabbing.

Where there have been pop up swabbing programmes Rural Trusts have provided assistance wherever possible.

Aged Residential Care (ARC)

There is continued stress to the sector, with the uncertainty of possible community transmission in Auckland, and that population moving throughout the country.

The ARC Steering Group continues to meet weekly via Zoom. There are ongoing concerns with Personal Protective Equipment (PPE) and they were pleased to endorse a PPE Calculator to help facilities quantify PPE requirements. At present, N95 masks are unavailable through normal supply chains.

Planning for a possible COVID-19 resurgence continues. The ARC Resurgence Plan continues to be refined and updated as necessary. Working with HR, we continue the recruitment and established of an appropriately ready team to support an ARC facility if required. This has been a challenge despite increased efforts to identify staff who could work in ARC in the case of an outbreak. This continues to be the highest risk issue.

Appointments have been made to the ARC infection Prevention and Control Clinical Nurse Specialist positions in Dunedin and Invercargill and the sector is keen to work closely with this staff.

Health Pathways have been updated to remain current with the evolving COVID situation and advice. Further work on education about Health Pathways is required to embed its use in the Sector, to become a common language between Primary Care, ARC and Secondary Care services.

Via the Steering Group, ARC facilities are organising locality based Coordinated Incident Management System (CIMS) training sessions, facilitated by South Island Alliance Programme Office (SIAPO).

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.

Psychosocial Recovery

The Central Lakes Wellbeing Group continues to meet. Key activities have been amplifying the messaging associated with Mental Health Awareness week working with Public Health promotion and Queenstown Lakes District Council. Maintaining briefing notes on demand and capacity, and scheduling community-based workshops. Increased FTE is being implemented by WellSouth via the Ministry of Health Access and Choice contract. Work is continuing on community engagement including focus on vulnerable groups. Learnings are being shared across the sector

Foreign National COVID Relief

Immigration NZ (INZ) has extended its contract with Red Cross NZ to deliver relief services to foreign nationals in NZ who have been affected by COVID-19 (i.e. unemployment, inability to repatriate). The contract has been extended until 15 December 2020.

We have been monitoring Southern DHB's delivery of healthcare to foreign nations who are not eligible for no-cost public healthcare. Considering the fact that there should be almost no foreign tourists in NZ and that the foreign national population should, if anything, be decreasing, Southern DHB's delivery of healthcare to this population should not be increasing. If there is an increase, then this would raise issues of payment for services and foreign nationals' failure to access healthcare via INZ/Red Cross relief services. Fortunately, the data gathered from Southern DHB Accounts Receivable indicates that the delivery of at-cost (billable) healthcare has decreased somewhat since the onset of Covid-19 (see table below). This situation will continue to be monitored

Time Period	Number of Foreign National Hospital Presentations	Average presentations per month
Lakes Hospital		
March thru June 2020	51	13
July and August 2020	22	11
Southland Hospital		
March thru June 2020	61	15
July and August 2020	29	15
Dunedin Hospital		
March thru June 2020	144	36
July and August 2020	57	29

18. IMPACT OF THE COVID-19 LOCKDOWN ON THE PROVISION OF POPULATION HEALTH SERVICES

Background

Southern DHB's Population Health Service is made up of a range of clinical programmes and services delivered to individuals in order to protect populations. Most services provided are for infants, children and youth, except for cervical screening, sexual health and sexual assault assessment and treatment service which are also provided to adults.

The focus of the service is on health and wellbeing. The service aims to reduce inequalities, minimise harm and the risk of outbreaks from communicable diseases. Within our core Public Health Nursing service, we are required 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.

In the first wave of COVID-19 most of clinical staff that supported the Public Health response came from Population Health Service. This was made possible as in National Alert Levels 4 and 3 lockdown schools, early childhood centres and community setting were closed, restricting the clinician's ability to deliver services. In addition, the Ministry of Health provided instruction that provision of ring-fenced funded contract such as B4 School Checks were to cease until it was safe to do so.

Opportunities

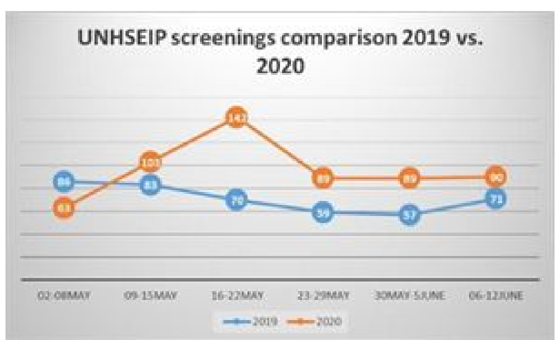
During this time new opportunities presented themselves particularly in relation to immunisations, the vaccine preventable disease and school based immunisation teams join up and using the oral health van based at Wakari, supported the DHB staff influenza vaccination programme vaccinating 500 staff. The Public health nurses ensured DHB staff working in rural areas also had access to the influenza vaccination.

He waka eke noa marae-based influenza program, Population Health and the Māori Health Directorate along with WellSouth worked in partnership with local Runaka and Māori Health providers to deliver the influenza vaccination for Koroua and Kuia over 65 years as a priority, along with other immunisation. These outreach mobile immunisation service clinics provided an opportunity for Māori communities to receive services closer to home, in an environment that is culturally responsive and minimised the risk of COVID-19 community transmission while continuing to ensure clinical best practice was upheld. Clinics were provided at Awarua, Puketeraki, Murihiku and Otakou:

- Total vaccinated: 195
- Total Māori vaccinated: 97 (49.7%)
- Total Māori receiving first flu vaccination: 71
- Total receiving first flu vaccination: 138 (70.8%)
- Total vaccinated aged 65+: 10

The clinics will also provide a framework for management of future COVID-19 vaccinations when this occurs. This work led to providing vaccination clinics alongside pop up community based assessment clinics.

In May 2020 post-COVID lockdown, the newborn hearing screeners initiated their service recovery plan in addition to delivering business as usual. This was multifaceted approach with community audiology clinics as well as extra screening clinics rurally and at the base hospitals. With the encouragement and support from lead maternity carers, parents, and Tamariki Ora nurses. The results are shown in the graph below:



Over the six weeks, 150 extra babies were screened in 2020 against the same period in 2019. This reflects the clearance of the backlog of outpatients post the COVID lockdown. This was achieved by the screeners increasing their working hours over this time and the extra capacity in audiology to assist with the clinics in the community.

All children that missed their B4 Schools Checks as a result of lockdown have been identified and a letter sent to parents. The capacity of the vision hearing technicians has been increased to provide catch up clinics for the vision hearing component of the check, prioritising Māori, Pacific and high needs. Providing catch up clinics for the public health nursing component has not been as straight forward as the nurses have been supporting Public Health and training for resurgence capacity. As a result, the service has been exploring options of providing some of the lower priority checks (i.e. parents and early childhood teachers haven't identified any concerns in the child health or development through their questionnaires) via telehealth. The challenge with this that height and weight needs to be measured using calibrated scales and an appropriate height chart, therefore this is not something that parents can be asked to do. With support from the Chief Allied Health, Scientific and Technical Officer and the Oral Health Service the dental assistants will be trained to do this via a clinical task instruction. This will be a reciprocation with the longer-term aim for public health nurses to provide some of the fluoride varnish work.

Challenges

With COVID resurgence still a threat, the Population Health Service are required to provide surge capacity to the local Public Health Unit. The longer the disruption continues the greater the impact of downstream negative effects on the children, young people and their families that we provide prevention and early intervention services to. This poses significant risk to the health and wellbeing of future generations. We are already seeing an increase in child protection cases and number referrals to public health nurses.

19. WANAKA AFTER HOURS PRIMARY CARE

Solutions to the desire of Wanaka General Practices to withdraw for the provision of overnight primary care have yet to be reached. Discussions between the practices, WellSouth, Southern DHB and Central Otago Health Services Ltd, have continued. However, there are different views regarding where the responsibility for providing this service lies. St John Ambulance have also been involved in these discussions. Their role is to provide emergency care, not primary care.

20. CO-LOCATION OF THE STROKE UNITS

Planning has commenced on establishing a Comprehensive Stroke Unit on the 6th floor of Dunedin Hospital. Agreement in principle was reached between Internal Medicine, Operations, and Older Person's Health on progressing this work. This means bring the acute stroke unit (8th floor) and rehabilitation stroke unit (6th floor and Wakari) services together. Done well there are real potential benefits for improved patient flow, journey, experience, and outcomes. The impacts the changes are greater than just shifting the beds. It is also requiring some thought and discussions about the impacts and/or opportunities for other services, workforce, space/facilities and how the collective works together.

21. MENTAL HEALTH, ADDICTIONS AND INTELLECTUAL DISABILITY (MHAID) DIRECTORATE

Demand for MHAID Services across the District

Referrals to WellSouth Brief Intervention Mental Health Services have more than doubled with almost 800 more referrals being received across the district between May and July this year compared to the same period in 2019. A particular hot spot for this service is the Central Lakes area which has seen an 87% increase in referrals over the last two months. Invercargill has experienced a 45% increase in referrals to Brief Intervention. WellSouth report that as the Integrated Primary Mental Health Service becomes established they are experiencing a decrease in referrals to Brief Intervention.

For Mental Health and Addiction NGOs the real pressure points seem to be in the provision of youth counselling and brief intervention services, Student Health and Adventure Development.

Most Specialist services are working at capacity and are managing demand with some services operating wait lists, noting this can be due to demand or because of other factors, for example, a resignation and the time to recruit and have a new person in post, annual leave of specialist roles such as Psychiatrist and Clinical Psychologist.

MHAID Crisis Services, Emergency Psychiatric Services (EPS) and the Southland Mental Health Emergency Team (SMHET) are experiencing similar levels of demand. People who present in crisis are seen immediately.

The DHB clinical teams with the biggest change in demand when the periods of May to July for the last two years are compared. For young people:

- Wakatipu has experienced an 86% (12 people) increase in referrals for young people and has one person waiting. More referrals were accepted in the 2020 period than in 2019.
- Waitaki has experienced a 30% (14 people) increase in referrals for young people and has 11 people waiting.
- Dunstan has experienced a 17% (8 people) increase in referrals for young people and has 16 people waiting.

For Adults:

- Wakatipu has had a 20% (19 people) increase in referrals, no waiting list and a four to five week wait to see a Psychiatrist due to the doctor being on planned leave.
- Specialist Addiction Services in Wakatipu have experienced a 118% (20 people) increase, with a resignation and a new staff member is now in post. More referrals were accepted in the 2020 period than in 2019.
- Specialist Addiction Services in Clutha experienced a 24% (4 people) increase.
- Some services received less referrals this year than previous years. It is important to note that if people need support then they would get this from someone else in the team while they are waiting.

Supported Accommodation Pressures

There is a waiting list of patients currently being managed in the DHB's mental health and addiction facilities that could more appropriately be managed in supported accommodation facilities in the community. Typically, these supported

accommodation facilities are non-government organisation (NGO) providers that operate under contract to the DHB.

We are compiling this waiting list to better understand the supply and demand of supported accommodation. The waiting list currently extends to some 14 patients. Until recently, there was a multi-disciplinary and multi organisational group meeting on a regular basis to discuss and allocate supported accommodation places. This group was effectively operating as single point of entry gatekeeper to and from supported accommodation across the Southern Mental Health and Addiction System. At this point in time the group no longer convenes on a regular basis because there are no (or very few) places to allocate to patients.

This situation is also exacerbated by the lack of budget allocation to build individual packages of care and support for patients to move from mental health inpatient settings to community-based settings.

This issue has been discussed at the Mental Health and Addiction Network Leadership Group (NLG) and supporting papers have been prepared outlining the situation in more detail. It is expected that this issue will be the subject of some focus during the Southern Mental Health and Addiction System Review when this gets underway in the near future. In the interim, services work hard to find creative solutions within the current service configuration.

Child and Family Service (CAFS) team peer discussion

The Southland Child and Youth service continues to have a high demand on services hampered by only having 0.6 FTE of senior medical officer (recruitment in progress for 1.0 FTE) and using locums when able to be sourced who can provide some continuity of care. Central Lakes service demand remains high exacerbated by on call requirements with staff expressing concerns. The Charge Nurse Manager and Clinical Nurse Specialist visited the team the week of 21 September and are developing a plan to support staff and manage workloads and the waitlist.

Police Response Issues

The service continues to rely on the assistance from the New Zealand Police to manage acute and challenging patients whose behaviour is linked to illegal substance ingestion. Overall, the Police continue to be supportive as our service is sometimes unable to safely manage these often highly volatile presentations. A recent example is where six police were required to safely manage the transportation of a new admission to Ward 9b.

Central Otago After Hours Cover

Resolving this continues to be a work in progress. With HR support there are two meetings scheduled over the next four weeks to progress discussions on an afterhours roster model that has been proposed by some of the team. This may lead to a request for an increase of FTE to make this occur which the service as a whole will be required to make some hard decisions for this to occur.

Ward 10A

Acuity remains high in Ward 10A and while patient numbers dropped during the month a further two acute admissions during the last week of the month has increased pressure. Staffing remains an issue although recruitment is progressing. Beds remain capped at nine.

Ligature Points

The Charge Nurse Managers have reviewed the ligature points and changed how they rate to fit with contemporary health and safety practice. Quotes to remove a range of hazards are being obtained.

Ministry of Health – He Ara Oranga Implementation

Youth Primary Mental Health Request for Proposal (RFP)

This RFP was released by the Ministry of Health in February this year and is aimed at providing greater access and choice to services for youth who experience mild to moderate distress aged between 12 and 24 years old.

We are aware that one of our local youth counselling services (Adventure Development Ltd) has been successful in securing funding under this RFP. This new funding will be used to extend the counselling service funded by the SDHB in terms of the age range covered. In effect, the age range will be extended to cover an age group aged from 12-24 years old (presently it is 12-19 years old). Adventure Development Ltd have also been successful in securing some additional funding for 'wellbeing coaches' as part of their suite of services. Adventure Development Ltd have advised that they are currently in the process of recruiting and training to additional positions to provide the extended service.

Mental Health Crises Support for Emergency Departments

The MHAID Directorate was successful in securing funding for 0.7 FTE (over three years) to be used to build the capability and confidence of staff working in Emergency Departments and other locations where people present in crisis. The Directorate is working collaboratively with the main Emergency Departments in the Southern area, in developing the newly funded Mental Health Educator role based in the ED departments. Advertising has occurred and interviews are planned for October.

The Directorate also secured additional funding (a one-off sum of $145k) for service support and capability planning to strengthen and improve mental health and addiction crisis support. We are in the process of developing an RFP to secure a contractor to develop this plan for us.

Primary Mental Health and Addiction Services for Pacific Peoples

This RFP was released in June 2020 and requested proposals for the provision of supports and services to address the needs of Pacific People who are experiencing mild to moderate levels of distress. The closing date for the RFP was the end of July 2020.

At this point, we have not heard whether the Ministry have completed their deliberations on submissions received.

Kaupapa Māori Primary Mental Health and Addiction Services Registration of Interest (ROI)

This RFP was released in July 2020 and, similar to the Pacific People's RFP, requested proposals for services to provide first point of contact services for people experiencing mild to moderate distress. These services could be delivered from a range of settings. The RFP stressed that it was open to two different streams of proposals. One was for Tuakana (or well established services) and the other was for Teina (or new or "incubator" type services). The closing date for proposals was early August and again we have not heard whether the Ministry have completed their deliberations on any proposals received.

Integrated Mental Health and Addiction Primary Mental Health and Addiction System (Access and choice)

From a contracting perspective, the agreement between the Ministry and Southern DHB was received and has subsequently been signed off by the Board at the September meeting.

This agreement provides for 25.3 FTE, being a mix of Health Improvement Practitioners (HIPS), Health Coaches and Support workers, as well as funding for implementation costs. The initial agreement has a term of one year and an annual value of $3.055. We have subsequently prepared a back-to-back agreement between Southern DHB and WellSouth to give effect to the same obligations and funding levels that are contained in the main agreement. This will be issued to WellSouth for execution.

In terms of progress in implementing the programme, the following practices have HIPS to support their patients:

- Te Kaika – Dunedin
- Invercargill Medical Centre
- Broadway Medical Centre - Dunedin
- Mornington Medical Centre - Dunedin
- Queenstown Medical Centre
- Wanaka Medical Centre
- Aspiring Medical Centre – Wanaka
- Clutha Health First – Balclutha

WellSouth advise that they have appointed 10.5 FTE HIPS and 11 Health Coaches to date. It is expected that a further three HIPS will be recruited and hosted in practices before the end of the year.

Further roles including Health Coaches and Community Support Workers will join designated practices in the coming month. WellSouth also have the first nationally accredited HIP trainer in the South Island.

Health Quality Safety Commission (HQSC) Mental Health and Addiction Quality Improvement Programme

Zero Seclusion

The service continues with its endeavours in reducing the use of seclusion while confronted with presentations whose behaviour and actions put others at significant risk. The service is planning to meet with ED colleagues in October to look at guidelines and pathways for the management of people presenting usually with the police under the influence of illicit substances. This group contributes to the use of seclusion considerably and if there is more of an organisational approach one outcome maybe a reduction in admissions and subsequent use of seclusion.

Connecting Care: Improving Transitions

Areas continue to work on pieces of work in Southland looking to link in with zero seclusion work. In Dunedin the project team are working on Transition guidelines, Staff education re referrals to community mental health teams (CMHTs), improvements in the referral process, allocation of case manager prior to discharge uploading of information at point of admissions, improving case manager attendance at ward multi-disciplinary team meetings (MDTs). Projects finalised include a Family involvement pamphlet and changes to social work assessment and documentation.

The MHAID directorate continuing focus on improving compliance and quality of Transition Plans is closely integrated with this project. Compliance across the service has remained stable with open referrals longer than one year with three or more face to face community contacts is 84% (national average is 62% in Q4) and 100% for inpatient transitions (national average is 75% in Q4)).

Learning from Adverse Events and Consumer, Family and Whanau Experience

Good progress with this work stream over the month. The co-design process is almost complete, and a number of 'Plan Do Study Act' (PDSA) cycles are being implemented, particularly around post incident processes and engagement with family/whanau. A workshop is being planned in both Otago and Southland to meet with those who provided feedback as part of the co-design process, update them on developments and seek further input into the process moving forward.

22. RURAL RADIOLOGY

A review of the Rural Radiology service is underway. Currently, the Southern District Health Board (Southern DHB) contracts for radiology services with a number of providers, including Clutha Health First, Central Otago Health Services Ltd, Gore Health, Maniototo Health Services Ltd and Waitaki District Health Services. It also provides services at Lakes District Hospital.

Recent funding pressures has resulted in the rural hospital Chief Executives agreeing to undertake a review of radiology services with a view to determining what the future configuration of radiology services should be to ensure ongoing sustainability.

This project is intended to focus on strategic decision making for the future model of radiology services for these providers. Taking into consideration any contracting relationships with private radiological providers who support this wider radiological system.

23. DISTRICT ORAL HEALTH SERVICE

The service continues to work hard on the back log of patients and all community clinics are operating to full capacity. The arrears are still very high and this is likely to continue for some time. Patient cancellations and staff sickness is impacting on appointment numbers. The staff are now working to Dental Council COVID-19 Alert Level 1 guidelines, less stringent screening questions and no requirement to social distance in the waiting areas.

The Dental Unit continues to work to capacity, annual leave, vacancy and illness are impacting on the numbers of patients being seen. Advertising continues for a Dentist to cover the vacancy. Planning is ongoing for a week of Mobile Surgical General Anaesthetic (GA) dental sessions which will have a considerable impact on the GA waiting list outstanding from the Dental School. The work underway to support a transparent and equitable district wide Dental GA waitlist for children continues.

Staff have been trained and supporting the COVID-19 testing pop ups in Dunedin, Balclutha, Oamaru and Gore, it has been great to have the team support this and be trained so that moving forward this workforce can be utilised if required. Those on the contact tracing lists continue to be available and are working through the training.

Tooth brushing and fluoride varnish programmes have now recommenced. The Health Promotion team are working on establishing new pre-school brushing and varnish programmes, we now have 19 fluoride varnish programmes and 26 tooth brushing programmes across the district.

24. COMMUNITY PHARMACY

The Client Led Integrated Care – Long Term Conditions (CLIC-LTC) pilot is progressing well in Gore. General Practices (GP) and local community pharmacies in Gore have been engaged in this project and are now able to implement the new model of care. This work is supported by a small team of Southern DHB and WellSouth staff.

The main objectives are to ensure that Medicines support for our LTC patients is provided through Community pharmacy integrated into the wider Multi-Disciplinary Team (MDT).

The Ministry of Health has made funding available to DHBs to support critical pharmacies if they are imminently going to have to close and/or cease services that are deemed critical, due to the impact of COVID-19. The Southern DHB pharmacy portfolio manager will work closely with any pharmacy that apply for access to this resource. Any applicant will have to demonstrate that their financial position is critical as well as demonstrating that their services are critical to the community, and that access will be significantly compromised for their population on closure.

25. BUILDING RELATIONSHIPS BETWEEN SPECIALIST SERVICES AND ARC – THE MDT SOUTHLAND SUCCESS STORY

A nurse led team consisting of the ARC facility manager, clinical leaders, older persons health nurse practitioner, hospice arc clinical nurse specialist, older persons mental health services and allied health professionals run a face to face or virtual MDT meeting fortnightly. The MDTs were initially set up with a large provider in Invercargill in 2013 as a way to allow the Nurse Practitioners to work in their scope and educate, empower and support registered nurses to work at the top of their scope. Many staff were deferring to the nurse practitioners to assess and plan care so there was a real need support the clinical staff within the facility.

The aim of the MDTs is to:

- allow complex residents to maintain an optimal level of functioning and health
- provide a co-ordinated clinical approach
- upskill and educate clinical staff
- empower clinical staff in further assessment and intervention suggests
- provide proactive intervention negating presentation at ED/ Hospital therefore decreasing inappropriate presentations
- decrease impact on speciality teams
- to facilitate an integrated, holistic and coordinated approach to resident care.
- provide a forum to debrief on deaths and hospital transfers
- promote end of life planning.

This model has since been rolled out in all multi-level facilities in Southland with noticeable success. One particular facility has recently audited its success in their specialised dementia care areas. They found that 55% of their psycho-geriatric

residents and 65 % of dementia residents have had a supported reduction in use of antipsychotics since January 2020. In the past 18 months 22 residents in dementia or psycho-geriatric have been reassessed to another level of care as a result of MDT review. The MDT is making a significant difference in health outcomes for each of these residents.

26. COMMUNITY HEALTH COUNCIL (CHC)

For the June to August 2020 period there were 31 CHC advisors working alongside staff on 20 projects across the Southern health system, this does not include the engagement occurring with the New Dunedin Hospital project. The majority of engagement projects are at a strategic partnership level and not so many projects occurring at a service level.

Work is underway with developing the annual report for the CHC, which will showcase the work of the CHC over the last year highlighting the CHC Symposium and the growth of community, whānau and patient engagement with projects occurring within the system.

27. PRIORITISATION OF EQUITY FUNDING

Based on the discussion at the last Iwi Governance Committee (IGC) meeting on 5 October it was agreed that the iwi representatives will hold a wanaka to discuss the prioritisation of the increased equity funding approved by the DHB Board for the 2020/21 financial year. The Māori Health Directorate proposed the allocation of new FTEs into secondary/tertiary DHB services and an increase in Māori health provider funding.

The FTE allocation put forward includes an FTE working across cardiology, nephrology and respiratory which is evolving into a dedicated long terms conditions position. The directorate has been working on establishing a Māori Cancer Clinical Nurse Specialist role and introducing a Child Health position that might be able to work across the district however would be based in the Southland Hospital.

As stated a business case will be developed to support the acceleration and delivery of Kaupapa Māori services which is an element in enabling Māori to exercise their

authority under Article Two as outlined in the DHB Annual Plan Guidelines 2020/21 – updated June 2020 based on IGC agreement for this prioritisation.

28. KAUMATUA RETIREMENT – SOUTHLAND

Mohi Timoko has advised he will be retiring from his role as Kaumatua for the Southern DHB Southland district from late November. Mohi has provided Māori Health leadership, mentorship, cultural supervision, Te Reo Māori language, cultural advice and support to Southern DHB services and staff across the Southern district for several years. Mohi inspires and supports staff to reach their goals and full potential through a supportive, grounded and cultural process. Mohi is a well-respected member of the Māori community across the Southern district and within his own iwi. We wish Mohi well for his retirement.

29. IPU WHENUA (HARAKEKE WOVEN VESSELS FOR MATERNITY SERVICES)

The Māori Health Directorate hospital based services (Te Ara Hauora – Dunedin and Te Huinga Tahi - Southland) will offer and teach weaving of Ipu Whenua (vessel to hold body parts/umbilical cord) to midwives, lead maternity carers, Well Child Tamariki Ora nurses and others once a month in Dunedin and Southland. The sharing of knowledge, strengthening of relationships, learning how to apply tikanga best practice into their work environment through weaving will enrich all those involved. The completed Ipu Whenua will be provided to maternity services or a gift to hapu mama from their lead maternity carer (LMC).

30. TE PŪTAHITANGA O TE WAIPOUNAMU

Te Pūtahitanga o Te Waipounamu (South Island Whānau Ora Commissioning Agency) was formed in March 2014 as a legal partnership of Ngā Iwi o Te Waipounamu, the nine iwi of the South Island mandated under Ngai 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. The Southern DHB recently followed up with Te Pūtahitanga o Te Waipounamu on a conversation held with the previous Commissioner back in October 2019 around the merits of coming together to discuss a shared vision surrounding Whānau Ora. The Chief Māori Health Strategy and Improvement Officer met with the CEO Helen Leahy on 25 September. We have become aware of a series of issues surrounding this kaupapa which has resulted in some political involvement. We will await developments in this space to see how best we can look to the fuller inclusion of Whānau Ora across our district.

31. COVID-19 MĀORI ESCALATION PLAN

The Māori Leadership Team developed a COVID-19 Māori Health Action Plan in lock down level 4 for the purposes of coordinating our activities over that period. An updated report was tabled at the October IGC meeting for the purposes of reporting on activities and milestones since the report template was actioned. As result of the last IGC meeting the plan will be reviewed and an escalation plan will be developed with view to align this process with the hospital and community resurgence planning being developed post the last COVID-19 waves.

7

32. GP CONFERENCE AND REGISTRAR TRAINING

The Chief Māori Health Strategy and Improvement Officer will be attending the 4th Annual GP/NP Education Weekend being held in Te Anau 16-18 October. WellSouth and the RNZCGP Otago and Southland Faculty are hosting this education weekend with diverse topics including COVID-19 in the South, Te Tiriti o Waitangi, new Asthma guidelines and older persons' health. The DHB Māori health educators will support with powhiri and we have two workshop sessions which will enable our team to introduce the our new education programme and stimulate local GPs to think about equity and their responsiveness to Māori patients and their whānau.

The Māori Leadership Team supported the recent GP Registrar Training delivered at WellSouth in collaboration with Aiisha Paulose, the GP training coordinator. The training included an overview of local tikanga and kawa, a case study using a local mana whenua whanau and their experience of the health and disability system. The day concluded with a series of role play including local Māori acting out an organised case study. Our team provided cultural feedback based on these role plays which was a useful opportunity in developing cultural engagement and responsiveness to Māori patients and their whānau.

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

The Southern DHB released an RFP on 25 August for the purposes of COVID-19 Māori Communities Outreach and Support. The closed RFP went out to contracted DHB Māori providers who can assist Maori 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 whanāu and communities and especially kuia and koroua healthy and independent during the COVID-19 outbreak. Services may include outreach and wrap around support, taking a holistic model of care in line with kaupapa Māori principles. An approval committee has considered all the applications and we are currently in negotiation with the providers in our attempts to expend this resource which was over prescribed within the funding that was available. Contract variations and service specifications are being developed to consolidate this process.

34. SOUTH ISLAND REGIONAL MĀORI COVID-19 COMMUNICATIONS PROJECT

The DHB has awarded the South Island Regional COVID-19 Communications Project to Mokowhiti Consultancy and we are currently in negotiation with Cazna Luke on behalf of the collective. Cazna Luke is the owner of the company and has significant health networks and experience. She currently holds the national contract for Kia Ora Hauora and has worked actively with Te Putahitanga o Te Waipounamu the South Island Whanau Ora Commissioning Agency. Phil Tumataroa has been the previous communications manager with Ngai Tahu Communications. He has strong relationship management skills, a strategic communications background and is a commercial photographer. Te Whenua Harawira is a social entrepreneur and has a company Creative Natives. More recently she has founded the #ProtectOurWhakapapa campaign in response to COVID-19 pandemic. The funding will deliver communications activities over the next nine months as part of the pandemic response targeted at DHB districts across the South Island. That this funding is used to strengthen current DHB communication approaches and craft tailored messaging relevant for Māori communities delivered through multimedia campaigns and traditional communications channels.

35. NEW MĀORI RESOURCE COLLECTION

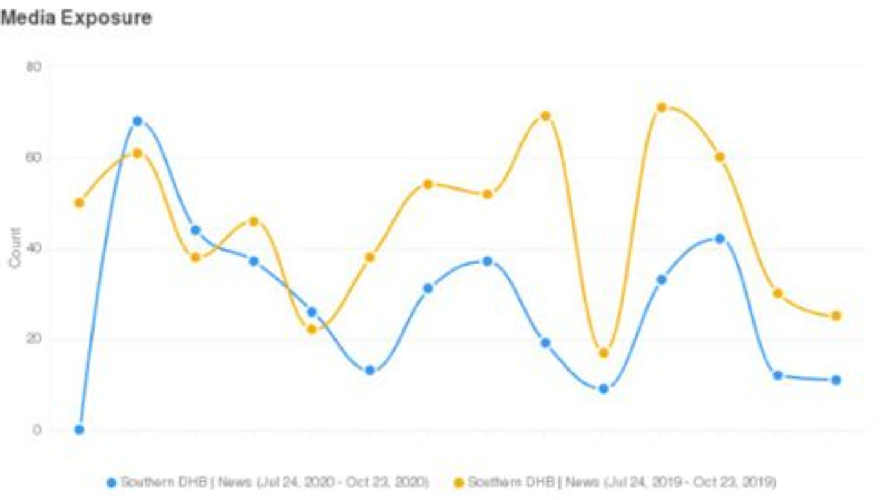
A new Māori literature collection has been established within the Dunedin and Southland Hospital libraries. These collections include existing and new books, journals and resources for library users to extend their knowledge on Māori Health, Te Aro Māori and Tikanga, Māori models of care, environmental and aspirational literature works. The Maori Health Directorate alongside the Library Services launched the successful opening of both collections in September 2020 with Southern DHB staff, Māori communities and Māori Health Providers attending. Taonga were gifted for the collection from the Māori communities.

36. MĀORI SUICIDE POST-VENTION

Suicide post-vention is a key element of the suicide prevention continuum. Evidence suggests that exposure to a suicide of a whānau/family member, or peer, increases risk of suicidal ideation, serious self-harm and/or suicide. The Southern District has eight post-vention community groups that cover the geographical regions of Southland and Otago. Active Māori contribution and participation within these groups is limited. Due to the number of Māori deaths by suicide experienced across the Southern District it is important that our Southern response for Māori is reflective of tikanga Māori pathways, solutions and support, led by Māori expertise and by community champions. It is proposed that we look to establish a Southern Māori post-vention group which is informed by strong leaders in suicide prevention/ post-vention and aligned to the Southern District Suicide Prevention Action Plan 2019-2023. We plan shortly to pull those Māori members from the post-vention groups together to identify the needs and aspirations from those involved in supporting whānau directly impacted by suicide.

37. COMMUNICATIONS

Volumes of daily media mentions are similar and slightly reduced when compared with the same period last year. Areas of interest over the past month have included colonoscopy services, progress on the primary maternity facilities in the Central Otago/ Wanaka area, and ongoing responses to COVID-19 including support for mental well-being. The New Dunedin Hospital progress continues to be well reported, with topics including plans for car-parking, progress with demolition, and the decision to include a multi-faith centre in the New Dunedin Hospital. Dave Cull's resignation from the Board for health reasons has also been widely reported.



Collaborative work continues to 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.

This month the communications team has also supported national initiatives including Stoptober (stopping smoking), stroke awareness, and the launch of a campaign to promote immunisation against measles for those aged 15 to 30 for whom there may not be reliable records regarding immunisation status. This will be a significant campaign over the coming months.

Internally, the promotion of the Staff Excellence Awards led to a record 132 nominations, an outstanding result and strong indication of the desire to acknowledge colleagues for their efforts.

Chris Fleming
Chief Executive Officer

27 October 2020

Southern DHB Financial Report

Financial Report for: 30 September 2020
Report Prepared by: Finance
Date: 12 October 2020

Report to Board

This report provides a commentary on Southern DHB's Financial Performance and Financial Position for the month and period ending 30 September 2020.

The net deficit for the period ending 30 September 2020 was $4.2m, being $1.1m unfavourable to budget.

During September 2020, Revenue was $3.3m favourable to budget, including a further $0.9m COVID-19 related 'pass-through' funding, $1.2m for Pharmacy funding and $0.7m for Integrated Primary Mental Health. Outsourced Services were $0.2m unfavourable to budget and Clinical Supplies were $1.2m unfavourable to budget, reflecting the Recovery Plan activity for the month. Provider Payments were $2.8m 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 30 September 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						
99,659	96,408	3,251	F	Government & Crown Agency	296,978	289,141	7,837	F	1,089,019	1,155,951
876	877	(1)	U	Non-Government & Crown Agency	2,312	2,632	(320)	U	11,047	10,528
100,535	97,285	3,250	F	*Total Revenue*	299,290	291,773	7,517	F	1,100,066	1,166,479
				EXPENSES						
38,775	38,543	(232)	U	Workforce Costs	114,664	114,498	(166)	U	450,139	462,125
4,056	3,822	(234)	U	Outsourced Services	12,559	11,285	(1,274)	U	41,837	43,556
9,505	8,282	(1,223)	U	Clinical Supplies	28,207	25,420	(2,787)	U	99,345	96,871
5,093	5,064	(29)	U	Infrastructure & Non-Clinical Supplies	15,199	15,352	153	F	63,258	60,354
42,296	39,461	(2,835)	U	Provider Payments	123,461	118,862	(4,599)	U	466,737	474,021
3,019	3,172	153	F	Non-Operating Expenses	9,359	9,413	54	F	34,951	40,469
102,744	98,344	(4,400)	U	*Total Expenses*	303,449	294,830	(8,619)	U	1,156,267	1,177,396
(2,209)	(1,059)	(1,150)	U	**NET SURPLUS / (DEFICIT)**	(4,159)	(3,057)	(1,102)	U	(56,201)	(10,917)

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 $303.4m which is $8.6m unfavourable to budget.

Outsourced Services are $1.3m unfavourable year to date reflecting support for the delivery of the Recovery Plans.

Clinical Supplies are $2.8m unfavourable year to date as hospital clinical activity lifted to deliver the Recovery Plan. This included Treatment Disposables, Instruments & Equipment, Implants & Prostheses and Other Clinical Costs.

Provider Payments are $4.6m unfavourable year to date for payments to NGOs supporting COVID-19 activity, including $3.2m COVID-19 testing in the community.

Year to Date Results – By Key Drivers

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 COVID-19, Holidays Act 2003, New Dunedin Public Hospital project and BAU.

SOUTHERN DISTRICT HEALTH BOARD
Summary of YTD Results - By Key Drivers
For the period ending 30 September 2020

	YTD COVID-19 $000	YTD Holidays Act $000	YTD NDPH $000	YTD BAU $000	YTD Total $000
REVENUE					
Government & Crown Agency	3,281	-	-	293,697	296,978
Non-Government & Crown Agency	-	-	-	2,312	2,312
Total Revenue	3,281	-	-	296,009	299,290
EXPENSES					
Workforce Costs	294	-	-	114,370	114,664
Outsourced Services	(3)	-	-	12,562	12,559
Clinical Supplies	5	-	-	28,202	28,207
Infrastructure & Non-Clinical Supplies	42	-	-	15,157	15,199
Provider Payments	3,281	-	-	120,180	123,461
Non-Operating Expenses	-	-	-	9,359	9,359
Total Expenses	3,619	-	-	299,830	303,449
NET SURPLUS / (DEFICIT)	(338)	-	-	(3,821)	(4,159)

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 30 Sep 2020

8.1

Actual 30 Jun 2020 $000		Actual 30 Sep 2020 $000	Budget 30 Sep 2020 $000	Actual 31 Aug 2020 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	16,016	1,162	19,364	7
49,819	Trade & Other Receivables	63,882	61,356	58,690	48,830
6,095	Inventories	6,547	5,665	6,376	5,235
86,925	*Total Current Assets*	86,445	68,183	84,430	54,072
	NON-CURRENT ASSETS				
326,463	Property, Plant & Equipment	326,569	337,336	325,788	355,122
3,307	Intangible Assets	3,907	11,837	4,023	20,149
329,770	*Total Non-Current Assets*	330,476	349,173	329,811	375,271
416,695	**TOTAL ASSETS**	416,921	417,356	414,241	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	-	-	16,259
64,666	Payables & Deferred Revenue	71,296	67,077	65,009	64,494
962	Short Term Borrowings	817	1,227	815	955
129,920	Employee Entitlements *	86,745	123,818	88,087	85,533
195,548	*Total Current Liabilities*	158,858	192,122	153,911	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	1,000	1,084	1,009	1,018
-	Holidays Act 2003*	41,166	-	41,215	-
19,810	Employee Entitlements	19,810	19,810	19,810	19,810
20,901	*Total Non-Current Liabilities*	61,976	20,894	62,034	20,828
216,449	**TOTAL LIABILITIES**	220,834	213,016	215,945	188,069
200,246	**NET ASSETS**	196,087	204,340	198,296	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
(394,210)	Accumulated Surplus/(Deficit)	(398,369)	(391,118)	(396,161)	(398,978)
200,246	*Total Equity*	196,087	203,340	198,296	241,274

Statement of Changes in Equity

Actual 30 Jun 2020 $000		Actual 30 Sep 2020 $000	Budget 30 Sep 2020 $000	Actual 31 Aug 2020 $000	Budget 30 Jun 2021 $000
172,410	Opening Balance	200,246	206,397	198,381	206,398
(56,201)	Operating Surplus/(Deficit)	(4,159)	(3,057)	(85)	(10,917)
84,744	Crown Capital Contributions	-	-	-	46,500
(707)	Return of Capital	-	-	-	(707)
200,246	Closing Balance	196,087	203,340	198,296	241,274

*Holidays Act 2003 actuals for FY21 have been re-classified to Non-Current Liabilities

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 30 September 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	286,341	281,473	4,868	1,156,983	262,376
Non-Government & Crown Agency Revenue	2,237	2,574	(337)	10,296	2,449
Interest Received	73	58	15	232	112
Cash was applied to:					
Payments to Suppliers	(182,803)	(177,042)	(5,761)	(675,364)	(168,547)
Payments to Employees	(112,904)	(113,494)	590	(499,568)	(105,881)
Capital Charge	-	-	-	(12,605)	-
Goods & Services Tax (net)	(625)	(464)	(161)	(486)	29
Net Cash Inflow / (Outflow) from Operations	(7,681)	(6,895)	(786)	(20,512)	(9,462)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	2	-	2		1
Cash was applied to:					
Capital Expenditure	(7,077)	(23,696)	16,619	(72,294)	(10,692)
Net Cash Inflow / (Outflow) from Investing Activity	(7,075)	(23,696)	16,621	(72,294)	(10,691)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions		1,000	(1,000)	45,763	
Cash was applied to:					
Repayment of Borrowings	(239)	(258)	19	(220)	1,219
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	(239)	742	(981)	45,543	1,219
Total Increase / (Decrease) in Cash	(14,995)	(29,849)	14,854	(47,263)	(18,934)
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	16,016	1,163	14,853	(16,252)	(28,822)

Cash flow from Operating Activities is unfavourable to budget by $0.8 million. The higher payments to suppliers is offset by higher revenue received, directly related to Mental Health and COVID-19 funding.

Cash flow from Investing Activities is favourable to budget by $16.6m. Existing capital projects continue to plan however the new projects continue to await approval of the 2021 Annual Plan. The Capital Expenditure cash spend is $3.6m less than same time last year largely reflecting the timing of approval.

Cash flow from Financing Activities is unfavourable to budget by $981k. Crown Capital contributions were unfavourable as delays in capital works progress impacts timing of requested Crown drawdowns.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure - Cash Flow
For the period ending 30 September 2020

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	1,841	5,354	3,513	U	5,275
Clinical Equipment	2,839	4,191	1,353	U	3,848
Other Equipment	194	386	192	U	170
Information Technology	990	5,223	4,234	U	727
Motor Vehicles	0	(0)	(0)	-	-
Software	1,213	8,542	7,329	U	672
Total Expenditure	7,077	23,696	16,620	U	10,692

At 30 September 2020, our Financial Position on page 3 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $330.5m, which is $18.7m less than the budget of $349.2m.

Information Technology and Software is a combined $11.5m contributing to the variance, 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. We are awaiting the approval of the 2021 Annual Plan by the Minister of Health which is now expected post-election in November 2020.

Sep-20				Sep-19	YEAR ON YEAR		YTD 2020/2021				YTD Sep-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,504	1,487	17	1%	1,530	(25)	Acute	4,497	4,575	(77)	-2%	4,901	(402)
331	306	26	8%	302	29	Elective	1,052	871	181	21%	989	63
1,835	**1,793**	**43**	**2%**	**1,832**	**5**	**Total Medical Caseweights**	**5,549**	**5,446**	**103**	**2%**	**5,889**	**(339)**
						Surgical Caseweights						
1,362	1,231	130	11%	1,190	172	Acute	3,788	3,752	36	1%	3,580	208
1,342	1,305	37	3%	1,452	(110)	Elective	4,333	4,113	220	5%	4,376	(44)
2,704	**2,536**	**168**	**7%**	**2,643**	**62**	**Total Surgical Caseweights**	**8,120**	**7,865**	**256**	**3%**	**7,956**	**165**
						Maternity Caseweights						
126	94	32	34%	84	42	Acute	333	286	46	16%	295	37
330	365	(35)	-10%	304	25	Elective	1,089	1,125	(36)	-3%	1,090	(2)
456	**459**	**(3)**	**-1%**	**387**	**68**	**Total Maternity Caseweights**	**1,422**	**1,411**	**11**	**1%**	**1,385**	**37**
						TOTALS						
2,991	**2,812**	**179**	6%	**2,804**	**188**	**Acute**	**8,618**	**8,613**	**5**	0%	**8,776**	**(158)**
2,004	**1,975**	**28**	1%	**2,058**	**(53)**	**Elective**	**6,474**	**6,109**	**365**	6%	**6,455**	**20**
4,995	**4,788**	**207**	**4%**	**4,862**	**134**	**Total Caseweights**	**15,092**	**14,722**	**370**	**3%**	**15,231**	**(138)**
						TOTALS excl. Maternity						
2,866	**2,718**	**147**	5%	**2,720**	**147**	**Acute**	**8,285**	**8,327**	**(41)**	-0%	**8,480**	**(194)**
1,674	**1,611**	**63**	4%	**1,755**	**(80)**	**Elective**	**5,384**	**4,984**	**401**	8%	**5,365**	**20**
4,540	**4,329**	**210**	**5%**	**4,474**	**66**	**Total Caseweights excl. Maternity**	**13,670**	**13,310**	**359**	**3%**	**13,845**	**(175)**

Sep-20				Sep-19	YEAR ON YEAR		YTD 2020/2021				YTD Sep-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,491	3,180	(689)	-22%	2,783	(292)	**Mental Health bed days**	7,869	9,752	(1,883)	-19%	8,425	(556)

Sep-20	Sep-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Sep-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,533	3,812	(279)	Dunedin	11,043	11,602	(559)
1,006	1,113	(107)	Lakes	3,392	3,698	(306)
2,893	3,046	(153)	Southland	9,303	9,250	53
7,432	7,971	(539)	**Total ED presentations**	23,738	24,550	(812)

8.2

SOUTHERN DISTRICT HEALTH BOARD

Title:	Performance Dashboard
Report to:	Board
Date of Meeting:	3 November 2020

Summary:

Of note on this month's dashboard are:

- The reporting of measures continues to move to the Power BI platform. A number of graphs were transferred this month. This is expected to overcome some of the issues we have been having. We expect the December paper to the Board will be drawn entirely from Power BI.

- The definition for Short notice postponements has been tweaked slightly. The figures now represent surgeries postponed within the last 24hours only, excluding acute theatre sessions. The Executive Director for Quality and Clinical Governance & Executive Director Specialist Services with continue to work on refining the definition used here. These totalled 81 for the month.

- Average actual theatre utilisation now measures elective surgery utilisation. Acute theatre time is excluded.

- The cumulative caseweight variance has been excluded for this month. There have been issues with the data for September and we would like to add volumes for next month.

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

Financial:	
Workforce:	Sickness and absence reporting is currently being rolled out. We expect that to be added to the reporting before Christmas
Equity:	
Other:	n/a

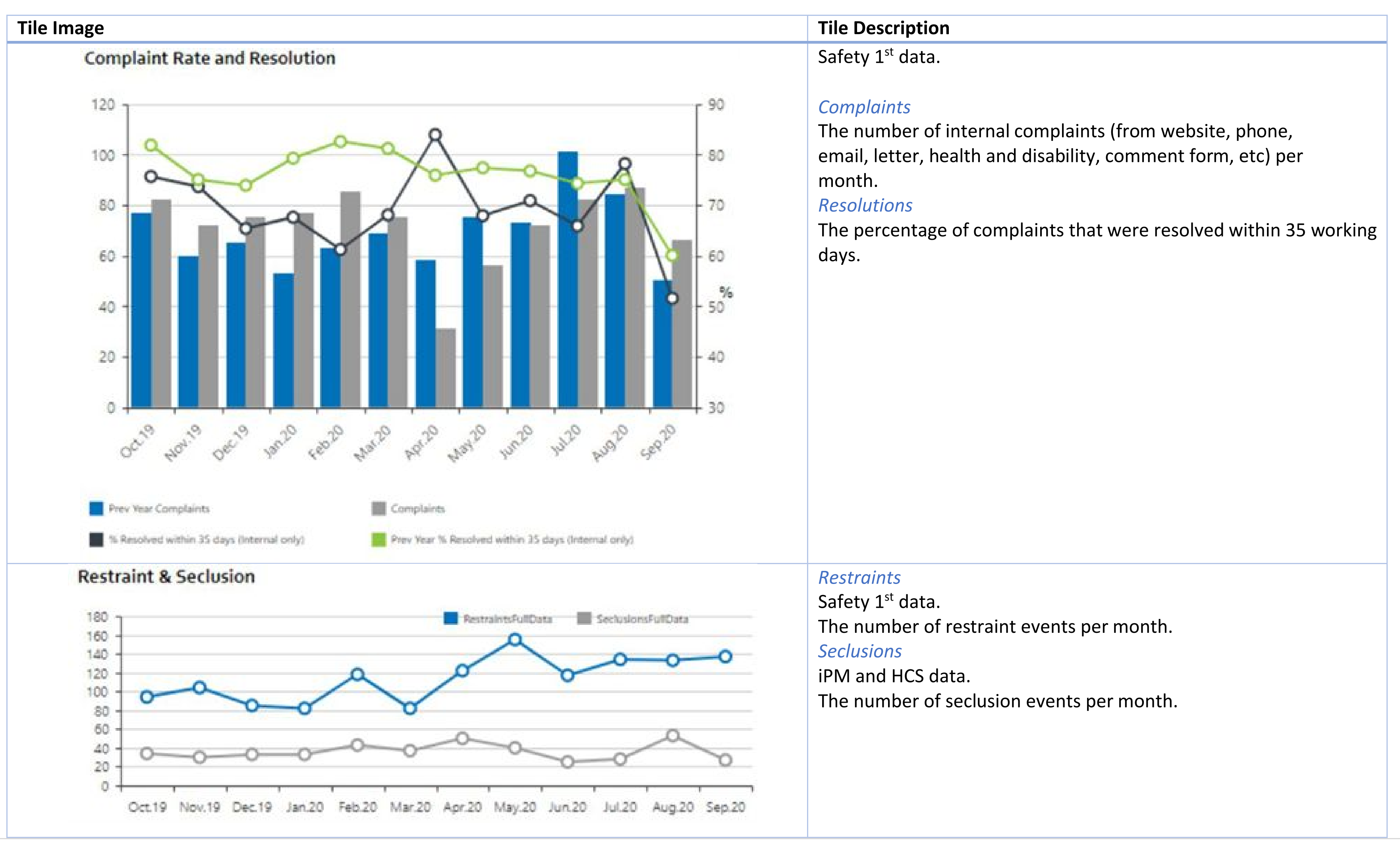
Document previously submitted to:	**n/a**	**Date: dd/mm/yyyy**
Approved by Chief Executive Officer:	Pending	**Date:** 3 November 2020

Prepared by:	**Presented by:**
Patrick O'Connor Quality & Performance Improvement Manager **21 October 2020**	Chris Fleming Chief Executive Officer **3 November 2020**

8.3

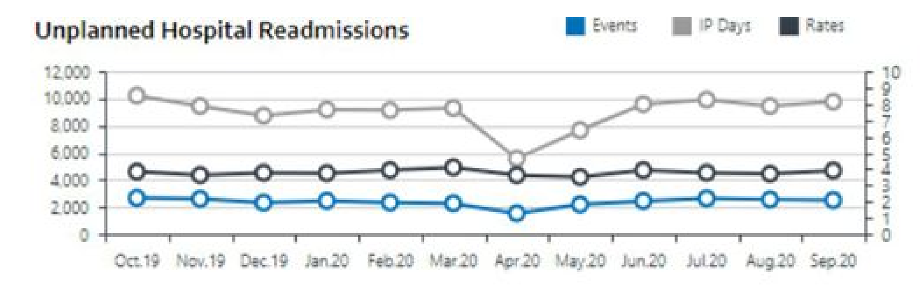
RECOMMENDATION: That the Board notes the Performance Dashboard

Performance Dashboard Tile Definitions (Southern)



Tile Image	Tile Description
Complaint Rate and Resolution	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.
Restraint & Seclusion	*Restraints* Safety 1st data. The number of restraint events per month. *Seclusions* iPM and HCS data. The number of seclusion events per month.

8.3



iPM data.

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

Referrals

Accepte

6,000
5,000
4,000
3,000
2,000
1,000
0

Oct.19 Nov.19 Dec.19 Jan.20 Feb.20 Mar.20 Apr.20 May.20 Jun.20 Jul.20 Aug.20 Sep.20

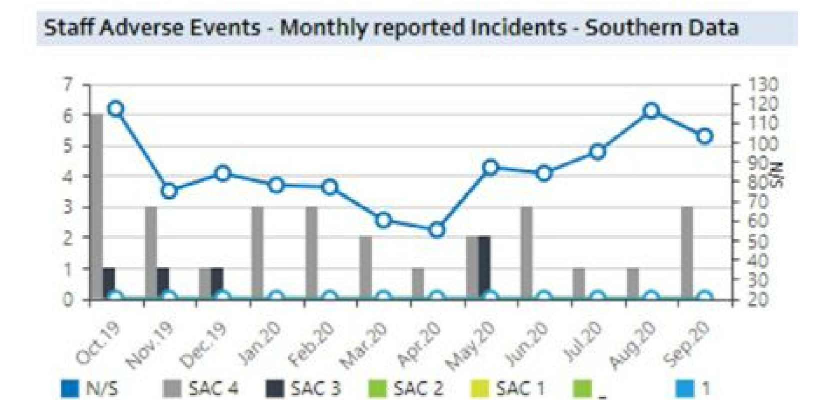
Accepted   Awaiting outcome

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

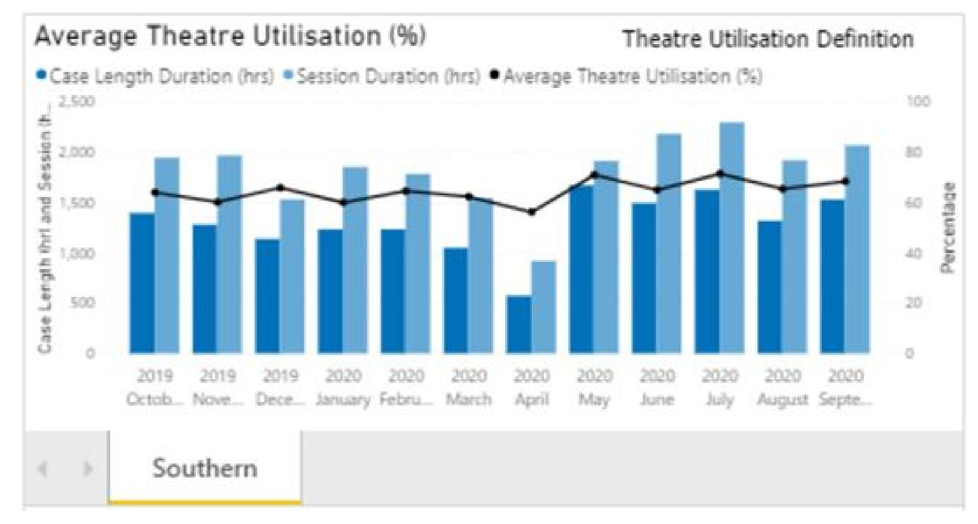


Safety 1st data.

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.

8.3



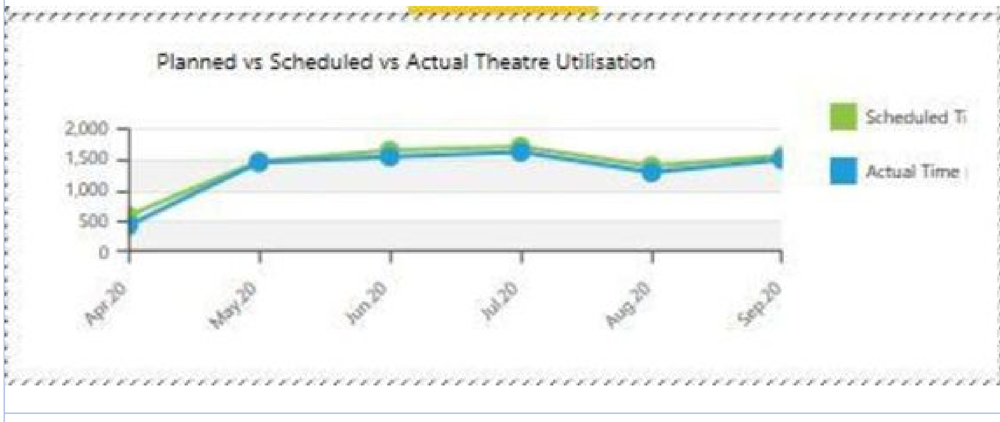
Caselength Duration
The monthly number of caselength minutes. Caselength = anaesthetic time
(a) plus the procedure time (p) for all specialties and theatres.
(a) = anaesthetic start time to ready for procedure start time,
(p) = procedure start time to procedure completed.
Total Session Duration
For all specialties and theatres.
Target Utilisation (85%)
The agreed target theatre utilisation rate.
Average Theatre Utilisation
(CaseLength Time) / (Session Time Scheduled) * 100
CaseLegth Time = Anaesthetic Time + Proceedure Time

Anaesthetic Time = Time duration between “Anaesthetic Start Time” and “Patient Ready for Procedure Time”

Procedure Time = Time duration between “Procedure Start Time” and “Procedure Complete Time” i.e. the Cut to Close Time

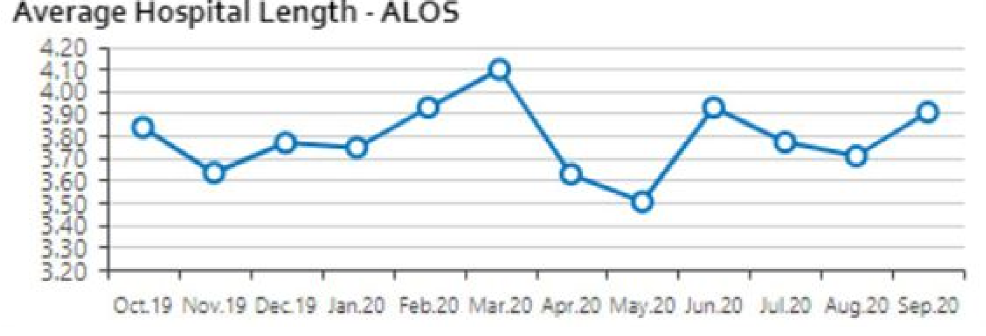
-Excluding Acutes, Extra Sessions and Not Specified
- iPM data

<table>
<tr><td>
</td><td>iPM data.

The number of deaths in hospital based on iPM discharge type.</td></tr>
<tr><td>
</td><td>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.</td></tr>
<tr><td></td><td>The monthly number of patients who have been discharged with a length of stay greater than seven days.</td></tr>
</table>

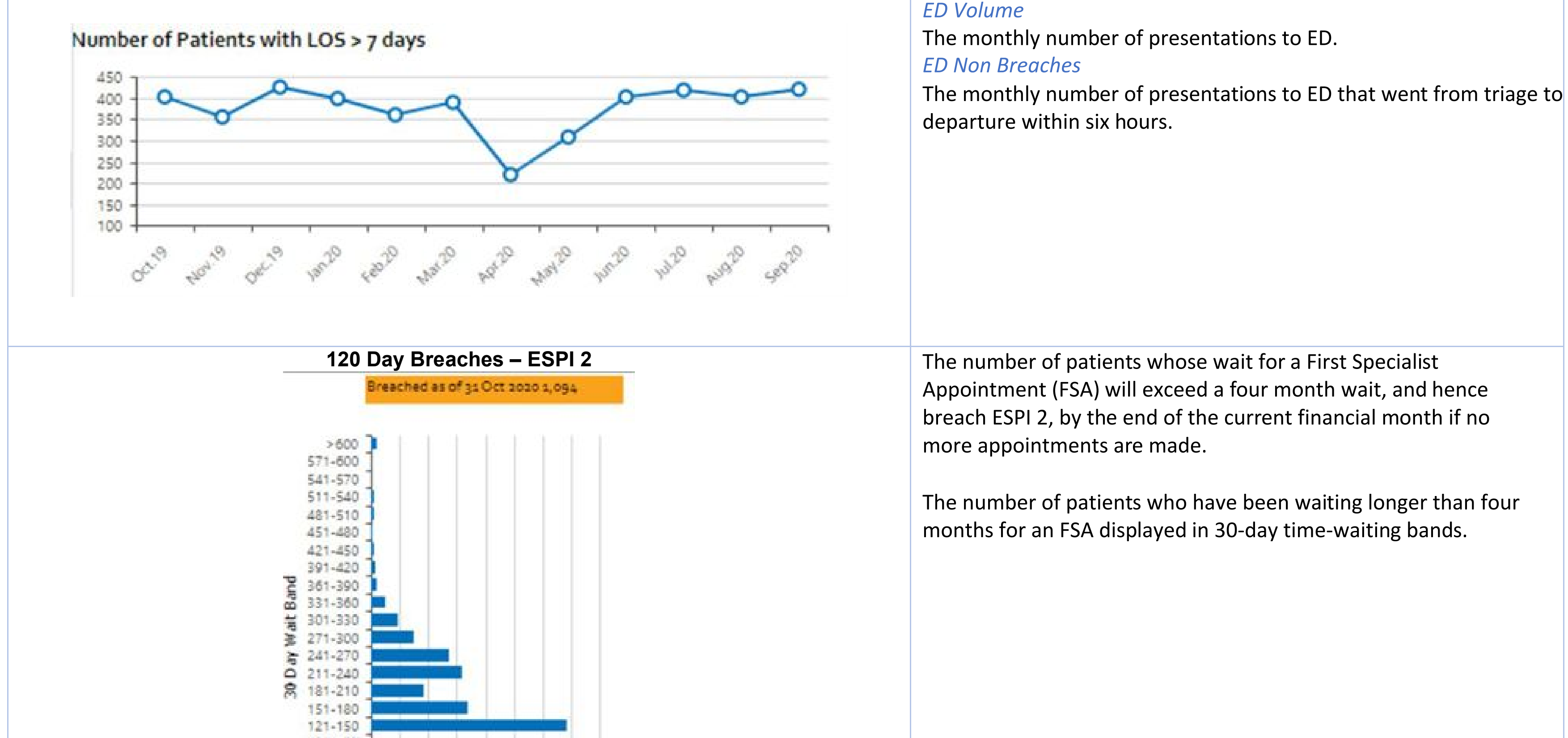


Short Notice Postponements defined as number of scheduled Surgeries Postponed within 24hours of the Proposed Surgery Date and time.

The data excludes ACUTE theatre Sessions.

The percentage Short Notice Postponements are calculated as the (number of short notice postponements) / (total number of scheduled surgeries) *100

8.3



ED Volume

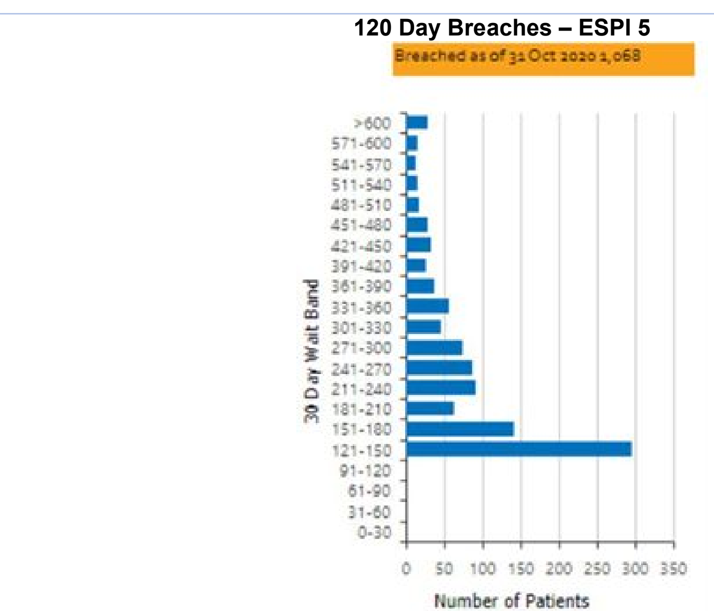
The monthly number of presentations to ED.

ED Non Breaches

The monthly number of presentations to ED that went from triage to departure within six hours.

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

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

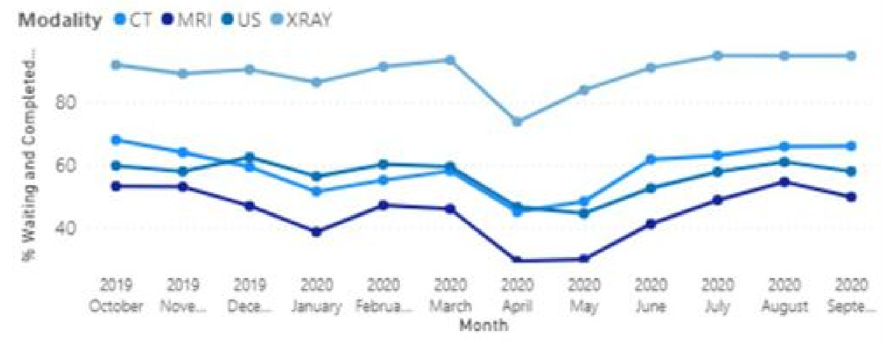


The number of patients whose wait for surgery will exceed a four month wait, and hence breach ESPI 5, by the end of the current financial month if no more surgeries are completed.

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

8.3

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



The percentage of CT/ MRI/ US/ XRAY examinations completed each month within the MoH target of 42 days from request date.

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

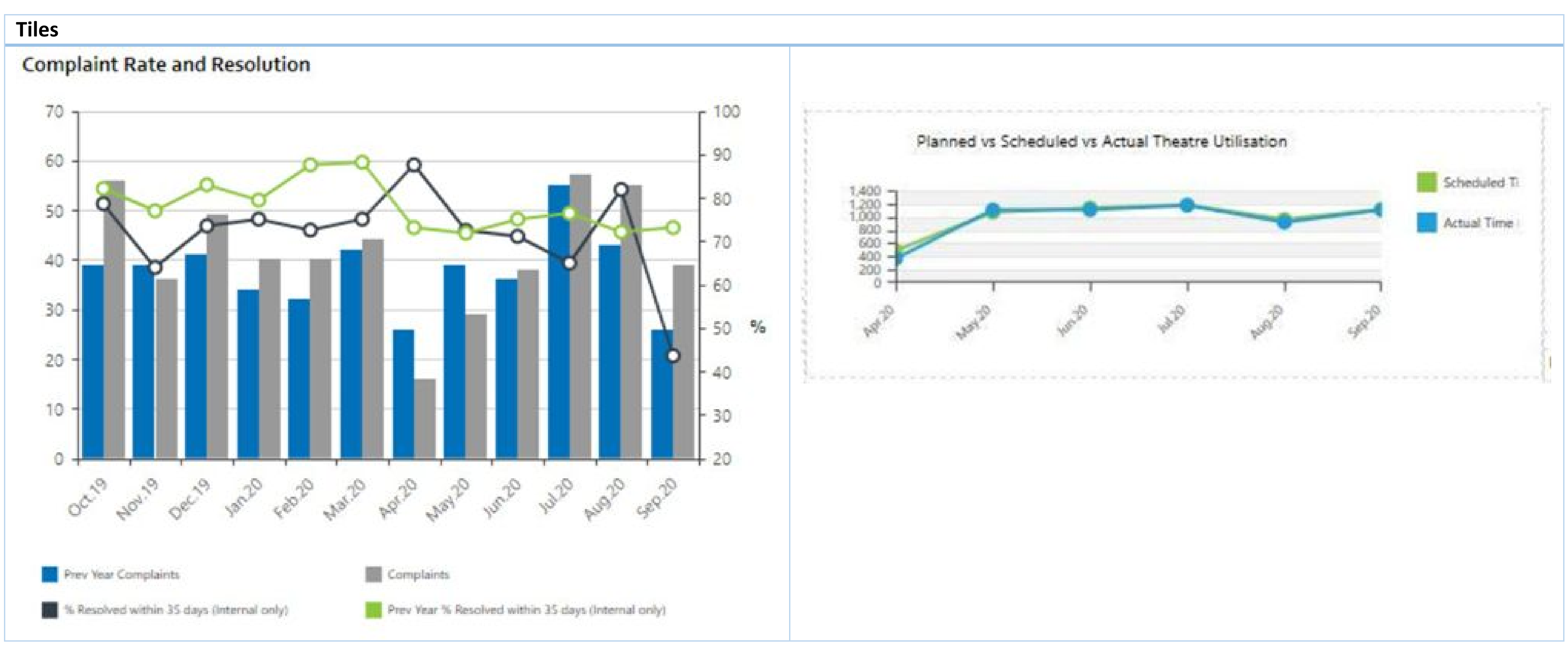
Table Key

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

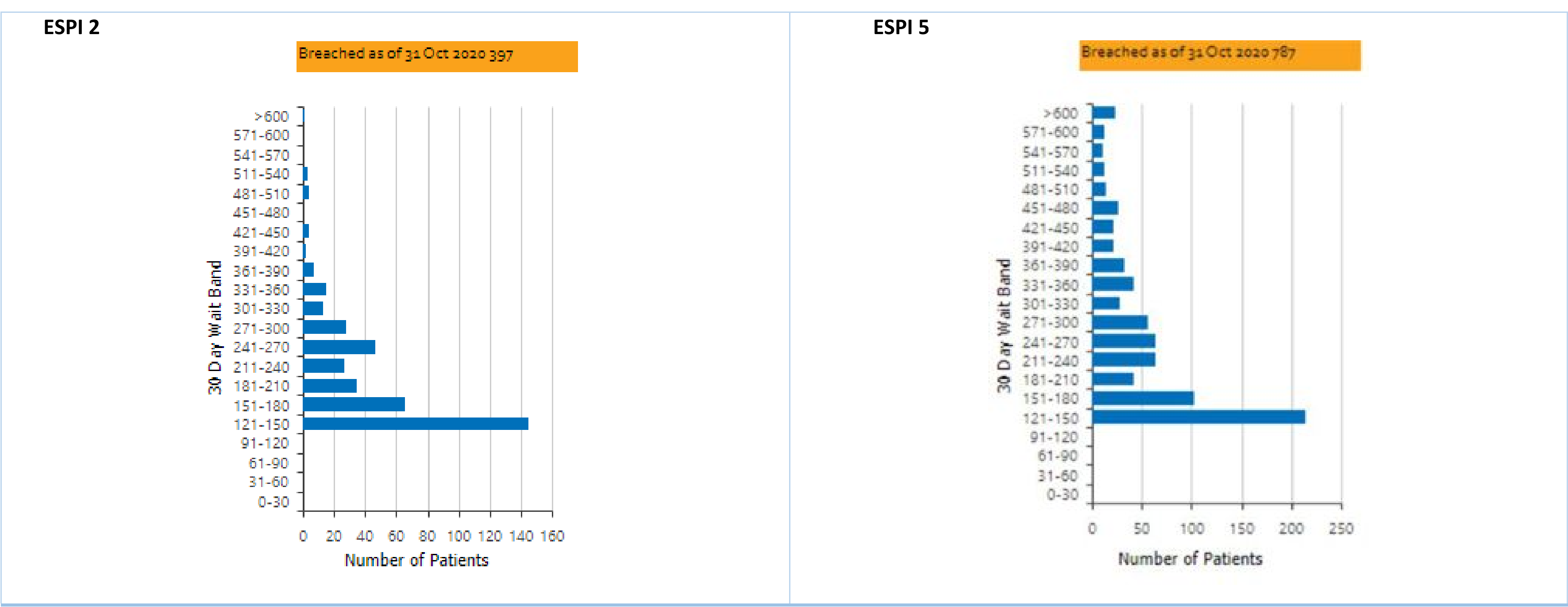
8.3

Performance Dashboard Tiles October (Dunedin)



8.3

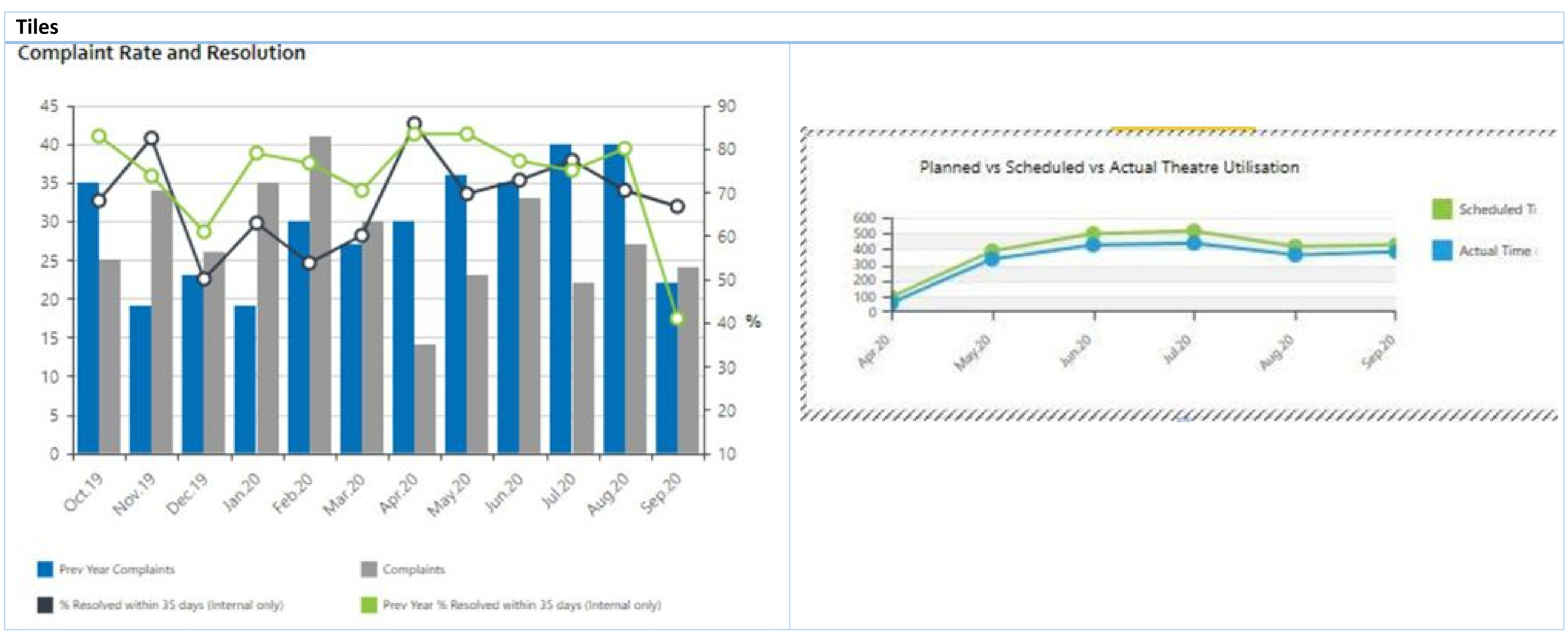
Average Theatre Utilisation (%)
Theatre Utilisation Definition
Case Length Duration (hrs) Session Duration (hrs) Average Theatre Utilisation (%)
2019 October 2019 Nove... 2019 Dece... 2020 January 2020 Febru... 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 Septe...
Dunedin
Referrals
Accepted
Awaiting outcome
Oct.19 Nov.19 Dec.19 Jan.20 Feb.20 Mar.20 Apr.20 May.20 Jun.20 Jul.20 Aug.20 Sep.20
Percentage Waiting and Completed within 42 days
Modality CT MRI US XRAY
% Waiting and Complete...
Month



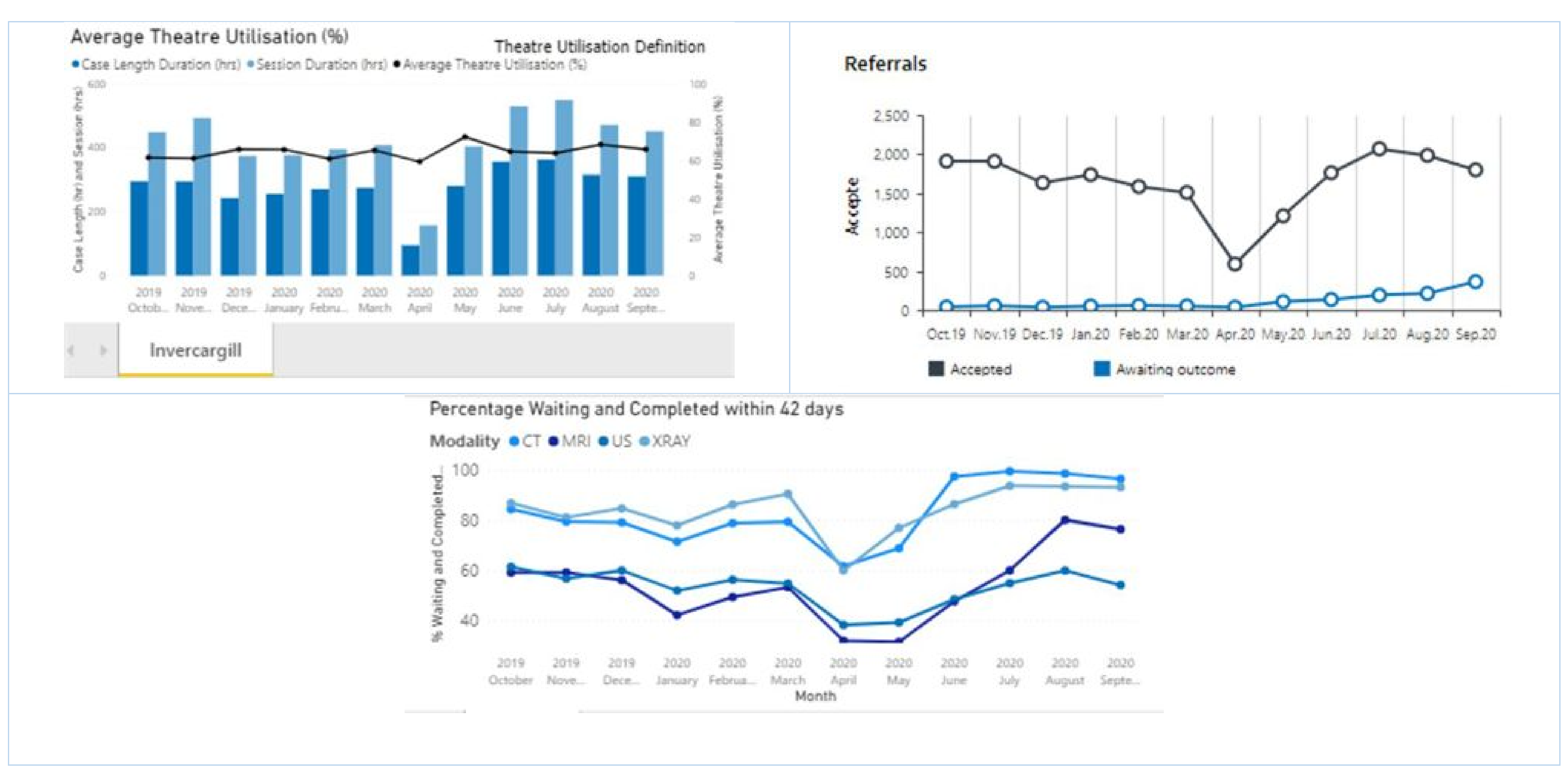
8.3

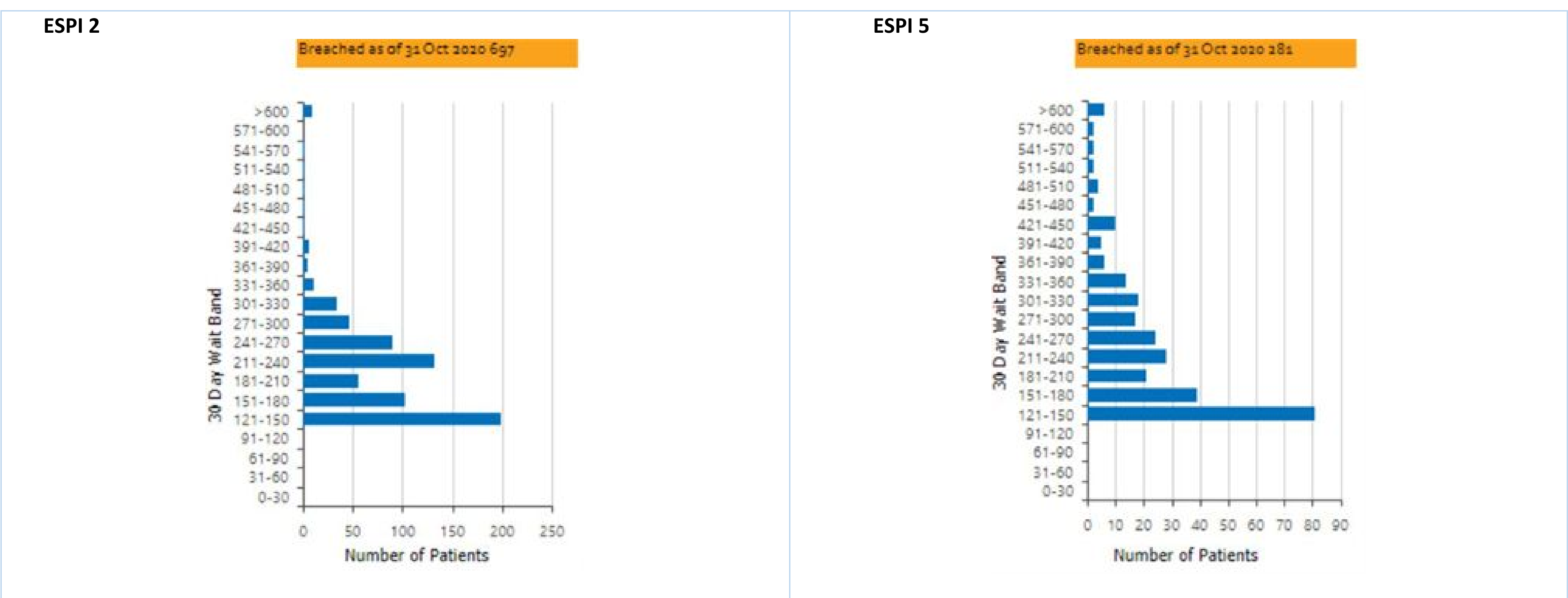
Performance Dashboard Tiles October (Invercargill)

Tiles



Restraint & Seclusion
RestraintsFullData
SeclusionsFullData
Oct.19 Nov.19 Dec.19 Jan.20 Feb.20 Mar.20 Apr.20 May.20 Jun.20 Jul.20 Aug.20 Sep.20
Death
Unplanned Hospital Readmissions
Events
IP Days
Rates
Average Hospital Length - ALOS
ED Monthly 6 Hour Target %
SSED %
Short Notice Postponements
Short Notice Definition
Invercargill
Invercargill


Average Theatre Utilisation (%)
Theatre Utilisation Definition
Case Length Duration (hrs) Session Duration (hrs) Average Theatre Utilisation (%)
Invercargill
Referrals
Accepte
Oct.19 Nov.19 Dec.19 Jan.20 Feb.20 Mar.20 Apr.20 May.20 Jun.20 Jul.20 Aug.20 Sep.20
Accepted
Awaiting outcome
Percentage Waiting and Completed within 42 days
Modality CT MRI US XRAY
% Waiting and Completed...
Month



8.3

SOUTHERN DISTRICT HEALTH BOARD

Title:	**PERFORMANCE REPORTING UPDATE**
Report to:	Board
Date of Meeting:	3 November 2020

Introduction:

As the Board will be aware, we have been working to synthesise our reporting efforts in order to:

- clearly and easily identify areas of risk for relevant statutory committees and the Board
- amalgamate our reporting on change management and our business as usual reporting to create a single comprehensive overview of all activity
- reprioritise our efforts to ensure that our Statutory Committees and Board take precedence over external audiences such as the Southern Partnership Group (SPG) and Ministry of Health
- take more of a current view of performance, rather than a retrospective view.

Our revised format remains a work in progress, and we will continue to refine the reports as we identify sharper ways of presenting the data. For this month we have moved to current quarter reporting, which means that the Board are now receiving data with the same timeliness as the Ministry of Health. Although this doesn't allow for inclusion of Ministry feedback, we will endeavour to capture any surprising or unexpected feedback that arrives in subsequent quarterly reports.

In addition to the above, please note:

- The Summary dashboard reports against Annual Plan 2020/21 Strategic Intentions. These reports will be produced monthly. For this month it remains a work in progress, so the Board should note:
  - The report from the New Dunedin Hospital team remains in a separate format and will be consolidated over the next month to fit the new templates
  - Māori Health's update will not be able to be populated until the next reporting round because along with the Iwi Governance Committee (IGC) their six strategic priority areas were only agreed upon in the last fortnight.
  - The Valuing Patients' Time template remains a work in progress as the renewed detailed plan has not been finalised so this is very high level of what the criteria will look like but no update towards it as such.

<table>
<tr><td colspan="4">Specific implications for consideration (financial/workforce/risk/legal etc):</td></tr>
<tr><td>Financial:</td><td colspan="3">Recovery due to missed targets may have financial implications.</td></tr>
<tr><td>Workforce:</td><td colspan="3">Recovery due to missed targets may have workforce implications.</td></tr>
<tr><td>Equity:</td><td colspan="3">Gaps in equity are highlighted in some reports. Gaps need to be addressed to meet targets and ensure that there is equitable service delivery in the Southern district to improve outcomes for Māori and other vulnerable populations.</td></tr>
<tr><td>Other:</td><td colspan="3"></td></tr>
<tr><td>Document previously submitted to:</td><td colspan="2">Executive Leadership Team</td><td>Date: 1 October</td></tr>
<tr><td>Approved by Chief Executive Officer:</td><td colspan="2">Yes</td><td>Date: 23 October</td></tr>
<tr><td colspan="2">Prepared by:

Strategy, Primary and Community
Date: 19 October 2020</td><td colspan="2">Presented by:

Lisa Gestro
Executive Director Strategy, Primary & Community</td></tr>
<tr><td colspan="4">RECOMMENDATIONS:

1. That the Board note the content of these papers.</td></tr>
</table>

Annual Plan Strategic Intentions Reports

Annual Plan Strategic Intentions Reports provide at a glance the highlights and issues for each directorate in relation to Annual Plan Strategic Intentions. Written "exception" reports will be provided when necessary. Reports will be produced monthly by Executive Leadership Team (ELT) members.

Annual Plan Quarterly Reports

9

Southern DHB submits quarterly reports to the Ministry of Health against the actions within the Government Planning Priorities section of the Annual Plan:

- Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System
- Give Practical Effect to He Korowai Oranga – the Māori Health Strategy
- Improving Mental Wellbeing
- Improving Sustainability
- Better Population Health Supported by Primary Health Care
- Improving Wellbeing Through Prevention
- Improving Child Wellbeing - Improving Maternal Child and Youth Wellbeing

The DHB is required to report on achievement of every action within the Annual Plan. The Ministry provides a rating for each Planning Priority based on our performance for the quarter.

Strategy, Primary and Community compiles a summary of Annual Plan Quarterly Reports for ELT and the Board following the allocation of final ratings by the Ministry of Health. Reports include an overall summary for each Planning Priority as well as detail on every action for those who are interested. Annual Plan Reports are attached for quarter four 2019/20 and quarter one 2020/20.

Reports on Ministry of Health Non-Financial Performance Measures

The Ministry of Health monitoring framework sets out DHB requirements to report achievement against selected Performance Measures and Crown Funding Agreements. Reports on Non-Financial Performance Measures are submitted to the Ministry on a quarterly, six monthly or Annual basis, as per Ministry of Health expectations.

Once the Ministry has finalised ratings and feedback for the year, Strategy, Primary and Community compiles the attached report for distribution to ELT and the Board. The Quarter 4 2019/20 Performance Report is attached.

SP&C Performance monthly report for Oct 2020

Southern District Health Board
Piki Te Ora

EXECUTIVE SUMMARY

This has been a busy month with a combination of regional and local planning in focus. Significant catch up planning is underway to ensure activity that was lost to COVID is caught up. This includes not only our own internal services but also those delivered by the PHO. Great progress on the Mental Health review. Primary and Community Strategy on track.

Positioning Public Services for the Future	Previous month	Current month	
South Island Alliance Activity			GM's Planning and Funding to undertake a review of the current activity underway Proposal for change re SIAPO - The initial Refresh, Reset, Refocus recommendations were presented to, and accepted by the South Island CE's and Chairs at their meeting in October. There was general consensus with the overall direction, and phase two of the programme has now been agreed, which will build on the original recommendations.
Psychosocial Response Planning			The first phase of the plan has been implemented with the Central Lakes Wellbeing Recovery Group now established to work within the framework of the MOH Kia Kaha, Kia Maia, Kia Ora Aotearoa, COVID-19 Psychosocial Mental Wellbeing Recovery plan. This has been meeting weekly focussing on key streams of monitoring/briefing/updates and a communication strategy with the aim of supporting people to look after their mental Health. A facilitated workshop is planned to consider immediate, medium and long-term actions. Alongside this workshops are being delivered throughout the district aimed at supporting resilience and wellbeing within the community.
Immunisation			Measles Immunisation Campaign for 15 to 29 year olds and active recall of children 5 to 14 years who have not had any or had only one measles, mumps & rubella (MMR) vaccine is underway. In addition: • SDHB Measles Immunisation Plan accepted and signed off by MoH • MMR vaccines delivered to target groups and data collection processes are in place Business as usual for other immunisation programmes
Maternity			Primary Maternity - An options paper was publicly released in July 2020 detailing four possible configurations of services for stakeholder and public feedback. These options were developed after considering stakeholder and public feedback during the first round of consultation. The Steering Group have now reached consensus on a preferred option and this was presented to ELT on the 15th of October and was subsequently agreed. The recommendation is now ready to be tabled for endorsement by the Board at their November meeting.
Community Services			Improvement of the Non-Acute (NAR) Rehabilitation pathway: Pilot designed and approved end of Q1, including pilot wards identified and assessment requirements agreed - Over the past 3-4 months the EDRS team have been supporting a NAR patient and the plan is to continue to support at least one of these patients to build up a greater understanding of the implications of this work on service delivery. Older Persons health is working hard to recruit the required nurse resource to enable a shift back down to the main Dunedin campus from Wakari and there are preliminary conversations underway about the benefits of creating one integrated Stroke unit at

Lead Executive: Lisa Gestro

Current Issues	Type of risk	Mitigation
Waitaki District Health Services	Clinical safety and non clinical sustainability	Senior Medical Officer support from Southern DHB
Wanaka After Hours Primary Care	Clinical safety	Engage with key stakeholders
Public Health Communicable Disease Nurse Capacity	Insufficient nurse capacity	Development of a plan when surge capacity is required
Invercargill After Hours	Issue with population having reasonable access to primary care	Working with the PHO to resolve, under the guidance of the Alliance Leadership team
Catch up Activity	Lack of access to population health services	Plans in place for catch up of activity

COVID Response

- A significant amount of work continues in this area. Work is ongoing as we continue to refine our processes and procedures.
- A resurgence plan is in place for meeting the Ministry of Health Phase 1 and 2 targets of 24 and 34 new cases per day. This requires us to build our capacity from outside our service. Work is underway to obtain staff from the wider DHB to support this plan. A training plan has been implemented to support this as well as on-going scenario training exercises for Public Health and Public Health Nursing staff. Escalation pathway has been developed for releasing staff to surge the workforce when required
- There has been extensive training on the National There has been extensive training on the National Contact Tracing Service (NCTS) system across the Public Health and with Public Health Nurses. Planning is underway for the Christmas period. We will need to have more staff working over this period to ensure we are prepared to respond to Covid-19 cases and contact tracing should the need occur. General Practice in all areas continue to provide assessment and testing as required. Public Health South have estimated that an average of 400 tests per day need to be undertaken to ensure a reasonable level of surveillance in the district

Mental Health and Addiction system transformation

- Referrals to WellSouth Brief Intervention Mental Health Services have more than doubled with almost 800 more referrals being received across the district between May and July this year compared to the same period in 2019. A particular hot spot for this service is the Central Lakes area which has seen an 87% increase in referrals over the last two months. Invercargill has experienced a 45% increase in referrals to Brief Intervention. For Mental Health and Addiction NGOs the real pressure points seem to be in the provision of youth counselling and brief intervention services, Student Health and Adventure Development.
- MHAID Crisis services, Emergency Psychiatric Services and Southland Mental Health Emergency Team are experiencing similar levels of demand. People who present in crisis are seen immediately.
- MHAID Medical Director and Director of Allied Health have engaged with Central Lakes General Practice to develop a service specification and contract for GPSI mental health service
- Expand primary care services - 10.5 FTE for Health Improvement Practitioners and 11 health coaches recruited. NGO support workers in place. Contract for service agreed with MoH.

Valuing Patient Time – Acute Patient Flow report for Sept. 2020

Lead Executive: Jane Wilson

EXECUTIVE SUMMARY

SAFER is a Patient Flow bundle and practical tool from the NHS to reduce delays for patients in adult inpatient services (excluding maternity) blending five elements of best practice to achieve cumulative benefits.

Components of the SAFER bundle have been implemented in a number of wards such as Red to Green and Rapid Rounds, but a systematic approach is required to embed all best practices consistently in order to make the gains in length of stay, patient flow and improvements in patient safety.

SAFER metrics have been identified, some existing and some new which provide reports by specialty, SMO and ward level. Once the suite of metrics are pulled together, this will form reporting at a service level through Service Level Accountability and to ELT and HAC on a regular basis. Other performance metrics including run charts and safety metrics are already available and reported through Quality and Clinical Governance reports.

Two best practice Rapid Round videos have now been produced and uploaded onto the intranet. One explains the Rapid Round concept and benefits and the second video explains the process. These will be shared widely and used to ensure consistent processes and build engagement.

SAFER bundle service level accountability baseline assessment tool modified and ready for use. For discussion and endorsement at next Clinical Council meeting and then to be rolled out.

A refreshed VPT Patient Flow plan focusing on the SAFER bundle will be completed by end of October

Elements (Safer Bundle)	Previous month	Current month	Commentary
S - Senor Review	→	→	• SAFER assessment templates developed for completion at Service level as part of Service Level Accountability
A - All patient have expected date of discharge (EDD & CCD)	→	→	• Rapid Round Audit tool customised to Southern Health completed • SAFER bundle metrics developed
F - Improved flow from ED to inpatient wards	→	→	• Meeting held with IT to discuss and address any functionality issues to using 'Red to Green' on electronic whiteboard
E - Early Discharge	→	→	• Undertake (repeat) a full case review of all stranded patients over 21 days.
R - Review (multi-disciplinary team review of stranded patients)	→	→	• Development of associated action plan to address top constraints working with system partners

Current Issues	Update/Achievements	Upcoming key deliverables
Cultural engagement	Best Practice Rapid Round videos have now been released on PULSE and will be used widely at team meetings.	• SAFER bundle presentation to Clinical Council with request for • VPT Sponsors to attend Clinical Directors meeting • SAFER to be embedded in Generalism Business case and Service Level Accountability
Governance/Sponsor-ship model	Sponsors meeting held and next steps agreed re metrics,	• Refreshed Sponsors meeting and VPT leaders meetings to be scheduled for November
Dedicated VPT QIF role ending in Nov		• Awaiting outcome of the QCGS Decision Document to have resourcing support clarified.

9

• Older Persons Health

Frailty work progressing to enact a whole of system approach to managing individuals with frailty across our health system with the aim to reduce average ED wait time, reduce frail elderly presentations and readmission rates.

Key secondary care level priorities relative to improving care for older people are to:

- Change the model of care for frail elderly when they present or admitted to secondary care service
- Have a joined up care plan visible cross the health system and for the person & family/whanau
- Redesign the transition of care back to the community

Reporting on progress with be through OPH directorate

• Emergency Department

- Refer EDSS reporting regarding ED performance, and work on Southland ED and Discharge Lounge concept.
- 'FiT to Sit' development in Dunedin Hospital expected to be completed in December

• Medicine

- Refer to EDSS report regarding Enhanced Generalism Dunedin Hospital Business Case.
- Draft presented to ELT on 15 October. To be presented to the Bipartite Action Group (BAG) week of 19 Oct.

Systems for Success & Improvement monthly report for 30 Sept 20

Lead Executive: Julie Rickman

EXECUTIVE SUMMARY

- The financial results are $1.1m unfavourable to budget for the quarter ended 30th Sept 2020. This reflects increased expenditure against budget for ARC and outsourced services and unbudgeted COVID-19 expenditure. The key risks to delivery of the unbudgeted deficit include COVID-19, Holidays Act 2003, the new Dunedin Hospital and actuarial valuation. Most of which have external drivers that are beyond our control.

Current Issues	Update/Achievements	Upcoming key deliverables
Savings plans	Had been progressing well yr. to date 70% of target.	Mitigating risk of savings phasing.
FPIM go live date	Discussions with national project team to push date from Feb to May 2021	Revising workload once date confirmed
Holidays Act 2003	Review phase almost complete. Delay of 1 month.	Understanding of exposure to enable reassessment of provision.

Key Projects	Previous month	Current month	Commentary
Financial Sustainability	→	↓	The delivery of savings is fundamental to achievement of the budgeted deficit.
Holidays Act 2003	→	→	The review phase is to be completed by 31 Oct. 2020 at which time we will have an understanding of the extent of non-compliance.
FPIM: Finance Procurement & Information Systems	↓	→	The internal project plan has progressed however disrupted by national project team delivery of data access. The issue was raised and discussion underway to resolve.
New Dunedin Hospital Business Case	→	→	The detailed business case was submitted and cabinet have approved in principle with an expectation of a refreshed detailed business case being submitted in 2021.

Systems for Success

- Review of systems and processes as part of FPIM project
- Input from procurement team to clinical teams as part of reviewing clinical supplies

Systems for Improvement

- Working with people and IT teams on training for leave management
- Increasing procurement team activity to achieve opportunities which mitigate under-delivery of savings in other areas.

Facilities

- Refresh of the detailed Business Case to be prepared
- Increasing pace of maintenance and development of physical facilities post covid-19 lockdowns

People & Digital Performance monthly report for Oct 2020

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

Digital & Tech Performance Indicators	Previous month	Current month	
My Lab (Physical space developed to assist with Change in technology and behaviours)	↑ (green)	↑ (green)	Location confirmed, GETS proposal re partner for virtual technology in the market, Establishment governance group progressing well. Next step will be to brief the virtual design and finalise operating model/budget.
Digital Programme of Work			
New Dunedin Hospital (Digital)	↑ (green)	→ (orange)	Draft programme business case 90% complete as per deadlines. Meeting with treasury 21 Oct pre formal case for gateway approval. Only reason for orange rating is uncertainty re next trench of funding source.
Digital Strategy Update	↑ (green)	↑ (green)	Progressing to plan and qtly projects updated under the "Digital Strategy" section to this report.
New Dunedin Hospital (Workforce)	↓ (red)	→ (orange)	Until this month there has been concern re the resource to support the workforce planning associated with the NDH. Changed to orange this month with the appointment of leadership in this area. Programme of work with milestones will be developed during November.
South Island PICS	→ (orange)	→ (orange)	Remains at Orange given the business case has been approved at our BOARD and still awaiting ministry support via Capital Investment Committee (CIC). Now delated two months from expected approval timeframe.
BAU			
Telecommunications	↑ (green)	↑ (green)	Tracking to budget with further efficiencies being identified.
Iaas (Bureau & Outsourcing	→ (orange)	↓ (red)	Forecasted growth within budget, but external review of contract and costing structure being carried out by third party given concerns raised to the board. Risk as current contract not formally approved yet costs being incurred.
Consulting Services	↑ (green)	↑ (green)	Tracking to budget and no foreseen concerns.
E-subscriptions	→ (orange)	↓ (red)	Clinical e-subscriptions continues to increase in cost of our subscriptions and in US dollars. Services are used consistently.
Software Licensing	↑ (green)	↑ (green)	Tracking to budget, reviewed monthly for efficiencies. Review of regional software solutions currently underway in terms of products and costs. Note increased MS Licencing being offset again for 2020/21
Crown Storage/mgt of records	→ (orange)	↓ (red)	Continues to be of concern moratorium remaining for many years so unable to remove records and storage costs increasing. Digital solution being sourced to digitise paper based records.

Current Issues	Update/Achievements	Upcoming key deliverables
Funding for Digital Work plan	Draft programme business case developed.	Further progress programme development
Resource and team structure to support Digital Roadmap	People forum formalised and establishment to support or culture work.	Develop workforce planning programme of work
Regional Collaboration Review	HR proposal for change developed for consultation	Regional shared digital roadmap and resource structure to support
Workforce Planning		

Implementation of Workforce Strategy

- Progressing Q2 & 3 actions within the strategy document (focus on the new recruitment system, workforce planning. Management of BAU tasks within HR remains constant. Draft proposal for change out for review during November.

Culture and change initiatives

- People Forum established and work plan to be formalized.

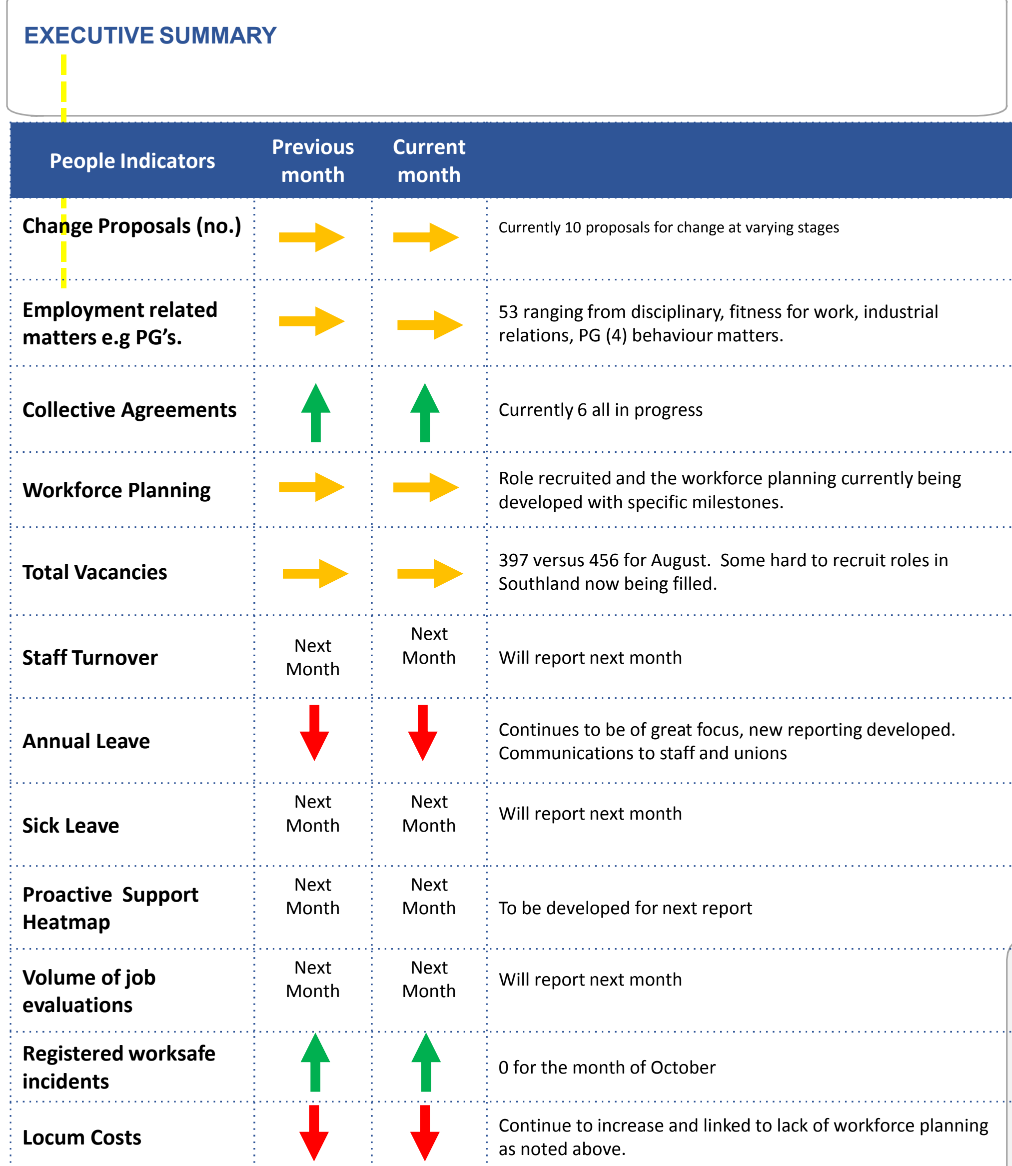
Digital Strategy

- Emergency Department Information System Update (due May 2021) on track
- Network and Desktop replacement pool progressing 2020/21
- Healthone access across ARC and Maori Health Providers – Good progress on track
- Cyber security role appointment made as per Audit NZ request
- E-pharmacy go live complete
- SI PIC's on hold pending CIC approval
- Wireless improvements on track progressing well
- EDIS upgrade delayed pending resource availability
- Patient track draft business case complete going to Exec in Nov 2020
- FPIM dates changed go live Q4 FY20/21
- Tap to go, on track progressing well
- Scanning Solution to digitize records business case to Exec in Nov 2020
- MS office 365 – Complete
- Recruitment Upgrade go Live Feb 2020
- RIS Replacement on track to complete Q2 FY20/21
- Human Capital System Upgrade business case complete Exec review in Nov.

People & Digital Performance monthly report for Oct 2020

Lead Executive: Mike Collins

EXECUTIVE SUMMARY



People Indicators	Previous month	Current month	
Change Proposals (no.)	→	→	Currently 10 proposals for change at varying stages
Employment related matters e.g PG's.	→	→	53 ranging from disciplinary, fitness for work, industrial relations, PG (4) behaviour matters.
Collective Agreements	↑	↑	Currently 6 all in progress
Workforce Planning	→	→	Role recruited and the workforce planning currently being developed with specific milestones.
Total Vacancies	→	→	397 versus 456 for August. Some hard to recruit roles in Southland now being filled.
Staff Turnover	Next Month	Next Month	Will report next month
Annual Leave	↓	↓	Continues to be of great focus, new reporting developed. Communications to staff and unions
Sick Leave	Next Month	Next Month	Will report next month
Proactive Support Heatmap	Next Month	Next Month	To be developed for next report
Volume of job evaluations	Next Month	Next Month	Will report next month
Registered worksafe incidents	↑	↑	0 for the month of October
Locum Costs	↓	↓	Continue to increase and linked to lack of workforce planning as noted above.

Current Issues	Update/Achievements	Upcoming key deliverables
Management of BAU within HR	Southern Excellence Award Nominations complete 130 applications.	Staff Engagement Survey to launch November 2020
	New recruitment system progressing well launch in Feb 2021	People Forum first engagement
	Completion of the LEADS development programme second round	
	Workwell programme underway	

Health & Safety

- HS&W Team Development and Training
- Policy Development
- PSR work plan and rollout
- Workwell work plan
- Implementation of Risk Management Tool

Green Healthcare Strategy

- Q2 and Q3 actions within the strategy
  - Carbon footprint
  - Energy Supply and Efficiency
  - Waste
  - Travel
  - Procurement
  - Built Environment
  - Staff engagement and culture

Regional Collaboration

- Proposal for change re SIAPO
- Regional stock take of Digital Solution and Cost Structures
- Regional workshop shared digital roadmap
- Handover meetings with CDHB CDO
- New role "Chair South Island CIO/CDO monthly forum)

Specialist Services monthly report for Sept 2020

Lead Executive: Patrick Ng

EXECUTIVE SUMMARY

- We have been challenged in the first quarter with reduced access to beds for inpatient elective surgery resulting in less elective case weight delivery than normal / planned for.
- We have also been challenged with high costs being incurred in some areas, e.g. cardiac implants ostensibly related to a post COVID wave.
- Outpatient performance has seen a positive improvement and we are tracking well towards our objective of systematically getting outpatient services towards compliance.

Performance area	Previous month	Current month	Commentary
Case weights surgery	↑ (green)	→ (amber)	Within 35 caseweights of plan (electively) for year to date September once the additional delivery we started as part of recovery planning is accounted for.
Discharges	→ (amber)	→ (amber)	Discharges are lower than the same period last year. A deep dive into the data points to a number of factors including a long stay complex patient who consumed 4 surgical beds for all of August, most of September. This lost circa 20-30 surgeries per month.
ED six-hour target	→ (amber)	→ (amber)	Improvement programme underway in Southland. Discharge lounge will be operational within 1 month. Making a case for more assessment beds in the ED space. Generalism business case for Dunedin proposes a medical assessment unit.
Cancer target <31 days	↑ (green)	↑ (green)	Performance has been hovering very close to the target of 85% - current month 84.43% and previous quarter 88.30%
FSA (ESPI 2)	→ (amber)	↑ (green)	Good progress made lowering breaches. We are targeting 11% breaches by end of the calendar year which would get us to the 50th percentile. DHB has previously been a poor performer compared to others.
Elective treatment< 4 months ESPI 5	↓ (red)	↓ (red)	Relatively static at the moment but several initiatives underway to address the issue and get the waitlists down including weekly reviews, new powerBI reporting & implementation of 'Transfer of Care' Policy for long waits.
Medical imaging CT	→ (amber)	→ (amber)	CT performance in Dunedin particular focus (impacted recently by unplanned outage & parts needed from Germany) Southland tracking at 96% & Dunedin 52% against ministry target of 95%. Additional evening shifts now resourced and improvement will start to occur from October onwards.
Medical imaging MRI	↓ (red)	↓ (red)	Impacted by a 2 week outage in Dunedin and a 6 week outage (planned) in Southland. Southland tracking to 77% of target & Dunedin 50%. However, further impacts likely in October from the outages before we then begin to recover performance.
Colonoscopy 14 days	↑ (green)	↑ (green)	Meeting target
Colonoscopy 42 days	↑ (green)	↑ (green)	Meeting Target
Colonoscopy 84 days	↓ (red)	↓ (red)	Currently at 35% (target 70%). Performance has been steady but measures in place to address prioritisation of patients in this group.

Current Issues	Update/Achievements	Upcoming key deliverables
Elective surgical delivery	Outpatient (ESPI 2) performance improving with initial post COVID implementation plan.	Generalism Business Case. Second draft has been to the Executive Team. Final version to Board in December.
Financial Performance	ED Southland improvement programme initiated. Discharge lounge will be an early deliverable.	Formation of Endoscopy Oversight Committee and implementation of work programme.
ICU air handling issues (for stage 2) slow to be addressed.	Sterile Services new build programme on track with conceptual design work now well underway.	Formulation of financial recovery plan. Execution of the plan will be key to recovering to full year financial performance.

Planned Care Recovery

- Final piece of work occurring between the planned care team and the Ministry to agree the baseline volume measures so that planned care money can be accessed.
- Some funding has been spent (and the revenue accrued) in anticipation. This was due to no initial guidance on what recovery would focus on so an initial plan was developed and executed to do additional surgery in June and July.
- The planned care recovery plan focuses on a number of specific initiatives in outpatients, inpatients and medical imaging to recover performance in key areas. However, the available funding does not allow for all specialities to be recovered so specific targeting has been applied based on criteria which focused on entrenched backlogs, risk, ability to move volume into primary care and ability to comprehensively recover a specific backlog in a specific service (e.g. outpatients in Obstetrics & Gynaecology).

Expenditure Improvement Plan

- A review is being undertaken across all secondary care expenditure for the first quarter of 2020/21, as we have incurred more expenditure than was planned for in the quarter.
- The review looks at the major cost elements – medical workforce, nursing workforce, allied workforce, outsourced clinical services, clinical supplies and infrastructure and non-clinical supplies. These are the elements where we have incurred materially more costs than planned.
- A recovery plan is being formulated from this review to identify expenditure that can be targeted to focus on bringing the expenditure lines closer to plan. Some costs appear to relate to post COVID volumes and we need to carefully manage these back to normal run rates.
- The overall plan proposes a fixed term resource to own the plan, which will have circa 40 actions that need to be owned.

Gastroenterology

- Creation of Endoscopy Oversight Committee in response to the Bissett report and earlier reports. The committee will oversee the implementation of the recommendations from the Bissett report and any outstanding actions from earlier reports.
- The oversight committee will provide direction. We have also appointed a project manager to systematically work through the recommendations and we have commenced work with the IS team to enhance the internal referral process and to establish a separate colonoscopy code in IPM which will enable us to differentiate colonoscopy from endoscopy in the patient administration system.

9

Systems for success monthly report for Sept 20

Lead Executive: Gail Thomson

EXECUTIVE SUMMARY

Quality Symposium concept planning underway with a small steering group identified to lead. Request for the symposium has come from the DHB SMO community and supported by other disciplines. The symposium will provide an opportunity for CME in the absence of national and international travel, and be a good forum for front line staff to share great quality work. A plan will come to ELT in November for endorsement.

The colonoscopy patient review is complete and has been released to internal teams and the public via the open part of the Board meeting. Proactive communication took place with the CMO at the Ministry ahead of the documents release who in turn briefed the DG and Minister on what was a 'well written non-punitive report. Media attention has not been as anticipated, possibly in part due to the impartiality of the report and in part due to timing.

Current Issues	Update/Achievements	Upcoming key deliverables
Staff leave	Regular communications and reporting of high leave balances underway.	Some management plans already in place.
Change proposal	Need decision document approved and communicated so staff uncertainty is dealt with.	Presentation to ELT 15 October.

Quality Improvement Activities	
Safe	Paediatric Early Warning system (PEWS) development underway across Dunedin, Invercargill & Lakes sites.
Effective	Audits underway; Hand Hygiene (84% compliance), Pressure Injury – point prevalence, Falls assessments, Family violence intervention – children under 2 yrs, Delerium & NZBS.
Patient Centred	HQSC on site visit to launch the Consumer Engagement Quality & Safety Marker. Members from Q&CGS directorate, CHC and Clinical Chiefs attended and engaged in good dialogue with the commission on all aspects of the marker, due in 2021.
Equitable	Equity issues identified during pathway development captured for discussion at pathways group and with EDSPC & EDSS.
Efficient	Rapid rounds roll out in wards 7 & 8 complete.
Timely	CHC raised a concern in regards storage of MHAID patient records at Wakari in light of the Mental Health Enquiry. CHC facilitator is coordinating key stakeholders in a meaningful improvement approach and response to public concerns.

Service updates	Previous month	Current month	Commentary
Emergency Management	→ (amber)	↑ (green)	COVID 19 debrief complete, draft report discussed at Business Continuity meeting with some lead Executive Directors. A few amends to take place before presentation to ELT.
Infection Prevention & Control	↓ (red)	→ (amber)	Recruiting staff to back fill ARC IPC staff loaned for the fixed term period.
Reviews	→ (amber)	↑ (green)	Colonoscopy Patient Review complete and Ministry well briefed ahead of public availability of the report. To date minor media interest, Minister on board and supporting 'look forward' approach.

Health Pathways

- Abscess pathway trial commenced in surgery with wide acceptance from clinicians. Work has been supported by an Allied Health QI staff member as opposed to the traditional model of GP editors. Anticipated patient centred benefits of less in hospital care required, will be monitored.

New pathways under development

- Psychosis in Children & Youth
- Nephrology; advice and assessment pathways
- Telehealth

Clinical Governance

- **Clinical Council** meeting 3 with new membership – going from strength to strength, great engagement of members, part 2 harms to 'Older People' presented by a DON & MD, data and intelligence driven by QI Manager, high level concept plan to tackle harms agreed.
- Southern **Mortality** Review Model complete and published on MIDAS end September. - Distribution to M&M Chairs and Clinical Directors underway.
- **Clinical Practice Committee** making great progress with approvals of new technologies & techniques, also supporting procurement on how to review consumables that have grown exponentially. Enthusiastic group very committed to patient safety and innovation.
- **Credentialing** of Urogynaecology mesh implants review underway, supporting CMO office to understand and approach issue (Southland) appropriately.

Risk Management

- Workshop One held with Clinical Council, feedback from members shared with Risk Management Advisor to enhance workshop two with ELT.
- Discussions underway in regards Board workshop and use of external facilitator. HQSC unavailable, Suzie, Julie & Gail to progress with CE.
- Risk Management Policy will be reviewed following the rounds of workshops.
- Risk Management Advisor networking well across the organisation, good feedback about the engagement and opportunity to learn and engage in risk from clinicians, IT, HR and other areas.

Annual Plan Quarterly Report
Quarter One 2020/21

Overview

Southern DHB submits quarterly reports to the Ministry of Health against the actions within the Government Planning Priorities section of the Annual Plan.

Quarter one reports are summarised for the following Planning Priorities:

- Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System
- Give Practical Effect to He Korowai Oranga – the Māori Health Strategy
- Improving Mental Wellbeing
- Improving Sustainability
- Better Population Health Supported by Primary Health Care
- Improving Wellbeing Through Prevention
- Improving Child Wellbeing- Improving Maternal Child and Youth Wellbeing

Each report includes an indication of whether actions are track, according to the RAG Guidelines below. Comments are added where actions have not been achieved for the quarter. Overall progress is also summarised for each Planning Priority.

Reporting RAG (Red Amber Green) Guidelines		
OVERALL STATUS	GREEN	On track
	AMBER	Planned delivery at risk / concern with action underway to resolve
	RED	Significant concern with delivery / intervention required to prevent failure

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Acute Demand		
Performance improvement of our 6 hour ED target		
SLAT established to focus of Urgent and After Hours Care in DN and INV	Green	
Establish of Valuing Patient Time Groups	Green	
ED escalation pathway completed	Green	
Other initiatives identified	Green	
ED Performance Improvement Steering Group provides guidance	Green	
Introduction of new educator role (mental health)	Green	
Business case for generalism completed and submitted by Q1	Amber	Going to the Board in Q2
Business case (establish Medical Assessment Unit at ED in DN) completed and submitted by Q1	Amber	Going to the Board in Q2
Regular meetings established (cultural appropriateness)	Green	

Investigate the technical IT issues to collect SNOMED codes in ED Info System		
Resolution of identified issues	Amber	Pending detail of EDIS v21 to review integration requirements. Expected Q3 FY20/21
EDIS Version 21 upgrade complete	Amber	EDIS v21 is not due until May '21

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Healthy Ageing		
Refresh detailed work programme highlighting critical milestones and objectives		Delayed due to the team focussing on ARC COVID resurgence planning.
Improvement of the Non-Acute (NAR) Rehabilitation pathway: Pilot designed and approved end of Q1, including pilot wards identified and assessment requirements agreed		Over the past 3-4 months the EDRS team have been supporting a NAR patient and the plan is to continue to support at least one of these patients to build up a greater understanding of the implications of this work on service delivery. One of the key learnings from this initial patient was that although the referral indicated it was a routine rehabilitation case, it proved to be highly complex requiring substantial wrap around by the wider team including Psychology. The length of stay within the service was over 3 months (nearly double the expected time for complex NAR patients), however a successful outcome was achieved with the patient remaining at home despite anxiety being a significant issue. The team assumes that this case was an outlier but it highlights the need for some discussion with ACC on how they wish to manage these more complex patients. Overall the interdisciplinary nature of the team is well placed to support the needs of this patient cohort and the feedback from ACC was very positive in relation to how the team were able to support this patient. Without the comprehensive community wrap around this patient may have transitioned to residential care. We are reviewing the contact data and comparing it against the proposed contract.
Agreement on NAR funding and reporting requirements with ACC and national GM's P+F, agreed by end of Q1		Discussions with ACC and national GM's P+F are continuing. New NAR case mix funding model is yet to be released. DHBs are required to adopt and implement between 1 Dec 20 and Dec 22.

Healthy Ageing (continued)		
Agree common geographical areas (locality) for community teams to align. Introduce locality based MDT meetings.		The teams under the Dunedin community and Rehab services are using the same geographic map with "soft" boundaries. This is also being considered by the Otago Hospice service.
Establish HCSS Steering group		Delayed to quarter two
ARRC Steering Group identifies and implements improvements		
PDSA used to test solutions to ED presentations for people 75+ by Q1		
Agree common geographical areas (CLIC in General Practice)		Delayed to quarter two
Participation in the South Island survey (dementia education)		
Locality based MDT established in first area (ARRC and Home Based Support Services)		

9

Annual Plan Reporting: Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Bowel Screening and Colonoscopy Wait Times		
National Access Criteria utilised		National access criteria utilised. Process for referral management currently under review.
Quarterly waiting list review		Waiting list review undertaken. We have a number of patients waiting greater than maximum due to COVID in the surveillance category. All other categories fine. Recovery money has been applied to recover these volumes
Regular review of participation data to direct activities and ensure equity gaps do not develop and take action if they do		Latest MoH data shows Māori participation rate in Southern at 75% (vs a target of 60%), the highest of all DHBs currently running bowel screening. Overall participation for the Southern region is 73%
Target active follow-up of patients for Māori populations		WellSouth's outreach team are contracted to follow up with Māori who have not returned their test kit, through a combination of phone calls and home visits, as required
Target promotional activity to areas of high Māori populations		Through WellSouth, the DHB's bowel screening team works with community-based Māori health providers to promote the programme to the Whānau they support. Promotional activities over Q1 have been limited due to COVID.
Target active follow-up of patients for Pacific island populations		WellSouth's outreach team are contracted to follow up with Pacifica people who have not returned their test kit, through a combination of phone calls and home visits, as required. WellSouth works with PIACT in Invercargill when working with Pacifica families in Invercargill and Bluff
Target promotional activity to areas of high Pacific island populations		Through WellSouth, the DHB's bowel screening team works with community-based Pacifica health providers to promote the programme to the families they support. Promotional activities over Q1 have been limited due to COVID.
Active promotion of Bowel Screening Programme with GPs, NGO		A paid media campaign was in place for July and August, using online, radio and outdoor (posters and bus backs) advertising. In person promotional activities over Q1 have been limited due to COVID

Bowel Screening and Colonoscopy Wait Times		
Review of facility and personnel resourcing and resource utilisation		Endoscopy users group has met but is currently being revised to meet the needs of the service.

Annual Plan Reporting: Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

New Zealand Cancer Action Plan		
Cancer pathways - Strategies implemented for early stage breast cancer		Complete and being monitored. National work continues using the radiation oncology collection data, to explore opportunities for improvement where variation may exist in current clinical practice. SBCS fractionation for breast cancer is now consistent and is optimising throughput
Implementation of Improving the Cancer Pathway for Māori Plan		Maori are flagged in the system as a group to be seen as a priority. Continuing to develop this to enhance service collaboration and coordination with the DHB Maori Health Units once patient flagged. Maintaining patient follow up by the CNC with referral to Cancer Kaiarahi services to Arai Te Uru Whare Hauora or Nga Kete Matauranga Pounamu. Cultural competency within cancer services to be progressed. Cultural competence and workforce development as well as targeting Maori health workers is a work in progress. Service Plans have a strong focus on Maori health.
Analyse journey and wait times for 20 Māori patients with lung cancer		20 Maori lung cancer patient records and pathways have been reviewed – full analysis still to be completed
Report of end of treatment services provided		Collaborating with Cancer Society and Phys Ed School to increase utilisation of Bridge to Health and EXPINKT exercise programmes – information on programmes being provided and promoted to patients by medical, nursing and allied health staff. The Cancer Psychosocial Service formerly the CPSSS is fully recruited which ensures the ability to maintain full services to patients.
Measure data and identify any areas for improvement		The SRH and Faster Cancer Treatment steering group to support analysis of data. This data is captured via the SDHB FCT system and reported ¼ to the SDHB FCT Steering Group.

New Zealand Cancer Action Plan (continued)		
Identify local actions within the Cancer Plan		The standardization of anti-cancer treatment project (SACT) is due to commence with an initial meeting set for 15th October. This is being facilitated by the Cancer Control Agency.

9

Annual Plan Reporting: Quarter 2020/21

Minister of Health's Planning Priorities: Better Population Health Outcomes

Supported by Strong and Equitable Public Health and Disability System

Workforce		
Review and support planning processes re public health needs		Ongoing. Work in progress with services to plan for resurgence for COVID-19. NDH workforce planning progressing alongside service planning.
Te Tiriti o Waitangi training provided to ELT and the Board		The Southern DHB Board is committed to holding each year a board meeting on a local marae. It is planned that within the next quarter that a board meeting will be held on marae and at this meeting training will be delivered
Nurse practitioner (NP) Professional Development guideline		National rather than local guideline being developed for consistency.
Funding identified for NP professional development		Funding from the SDHB Nursing training budget identified for NPs; however due to COVID, limited out of district professional development available or cancelled.
Guideline implemented		Awaiting national guideline
Health, Safety and Welfare (HSW) committees formed		Southern Health, Safety and Welfare Governance Group – Attendees Tier 1 & 2
Designate Chief Security Officer (CSO) and Chief Information Security Officer (CISO)		
HSW Continuing improvement process		Complete quarter 2
System implemented for transfer of staff health records		Complete quarter 3 – staffing changes caused delay
EOCs implemented as required		Review conducted – lessons learnt recommendations to Q2
SDHB Health Emergency Plan maintained		

Workforce (continue)		
Support provided for staff with COVID related needs		Psychological First Aid, Change Cycle Program has been rolled out and made available to all managers. Work continues to focus on need for Welfare Officer role and how to support the Staff needs in this regards.
Redeployment strategies formalised		Contact tracing and case management in hand. ARC remains problematic with no immediate staff identified. Other alternative strategies being considered including hiring of casual staff with advance training provided.
Implement a Māori Response Action Plan as required (COVID)		
People Forum established Q1 with scheduled meetings and endorsed mandate		People Forum has been endorsed by ELT and first meeting scheduled for November 2020.

Annual Plan Reporting: Quarter 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Workforce		
Health Literacy Action Plan		
Plan to be well this winter' campaign	Red	Campaign was not undertaken due to COVID-19
Community pharmacists supported in SDHB contracting to deliver influenza vaccine	Green	
GP portal enrolment increased	Green	
Consumer portal access expanded	Green	
Cultural education programme executed	Green	
Patient participation and partnership model implemented	Green	The Community Health Council continues to encourage and engage staff with consumers in projects, clinical service redesign and in the development and design of the new Dunedin Hospital. Tools to support consumers with engagement include a position description, a guide with tips of how to engage with staff and support provided by CHC members. Staff are also provided with some tips for how to engage with consumers.
Continued improvements of Southern district website	Green	
Health Info localised and updated	Green	

9

Annual Plan Reporting Quarter 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Data and Digital		
Signing of Heads of Agreement with My Lab partner agencies		Terms of Reference Agreed
Finalisation of implementation plan for MyLab		Still in planning
Regular and ongoing reporting to the SPG		
Continued recruitment of key roles to the Early Works Team		
Network Replacement Pool		Ongoing as part of capital activities for FY20/21
Cisco DNA (Modern local area network, Dunedin Hospital)		Ongoing as part of operational activities for FY20/21. Dunstan site complete
Activity undertaken to expand access to HealthOne		Good progress with the onboarding of community agencies, ARC facilities & Maori health providers.
Security model design		Cyber security role appointed and activity underway
e-pharmacy Go live		Complete in SDHB & SCDHB
SI PIC's MoH approval		SI PICS approval still pending with CIC, SDHB team working closely with MoH & Treasury to resolve.
Wireless Network Improvement completed		On track to complete Q2 FY20/21

Data and Digital (continued)		
EDIS upgrade complete		Delays to resource availability, project expected to complete Q2 fy20/21
Patientrack Approval		Draft business case complete, Exec review expected Nov '20.
Tap 2 GO complete		On track to complete Q2 FY20/21
Scanning Approval		Draft business case complete, Exec review expected Nov '20.
Microsoft 365 complete		
HCM approval		Draft business case complete, Exec review expected Nov '20.
Pilot nursing agencies onboarded into Health One		Pilot going live Nov '20
Telehealth Steering Group formed		
API developed to surface secondary appointment information into the Consumer Portal.		Ongoing discussions with WellSouth with an update expected now in Q2

Implementing the New Zealand Health Research Strategy		
Continued agreement with the University of Otago		
Policy and process development		
Nomination of Māori member of Board		Nominations to be presented to the November meeting – delayed due to meeting cancellations

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

Care Capacity Demand Management (CCDM)		
Governance - Completion of reports		
Terms of Reference (TOR) reviewed		Completed and endorsed by CCDM Council July 2020
Reports to partners		Completed via updates to CCDM Council
Annual plan status reported		Completed via updates to CCDM Council and Patient Acuity/TrendCare meetings
Monthly education reports		Completed via updates to CCDM Council and Patient Acuity/TrendCare meetings.
Reports on CCDM implementation		Completed via updates to CCDM Council and Patient Acuity/TrendCare meetings. LDC implemented for all 34 Inpatient Wards utilising TrendCare.
Local Data Councils meet		Reported against at Patient Acuity/TrendCare meeting and via monthly line manager report.
Validated Patient Acuity - Reports		Monthly Patient Acuity/TrendCare meetings continue
TrendCare upgrade		Delayed as TrendCare Version 3.6.1 upgrade not released by Vendor as yet
Electronic Core Data Set (CDS) tool implemented		Progress continues with Power BI production testing of the CDS electronic tool. At this point 17/23 measures are in place in test. Of the remaining 6; 2 will be delayed and the final 4 are being worked on by the solutions analyst. Aiming for end 2020 production.
Local Data Council education		Education continues at each LDC meeting
FTE Calculation - Roster testing		Completed for the 13 eligible wards
Report drafted		Report in draft for 13 wards, planned to be completed by end September/early October 2020.

Care Capacity Demand Management (CCDM) continued		
Roster and FTE implemented		Plan to submit multi-ward FTE report to CCDM Council via Executive Leadership Team end October 2020
Variance monitored		Delayed until multi-ward report endorsed
Variance response management – VIS tool embedded		X11 wards remain to implement VRM of which are x8 Mental Health wards who are implementing as a service, and x3 wards who are actively developing both actions plans and indicators. Aiming for full implementation end 2020.
VRM action plans reviewed		
Measurable reduction in variance, both positive and negative		Total number of significant negative shifts across the SDHB remains variable, however the trend line suggests an overall minimal upward increase in significant negative variance, +/- 2% for the timeframe August 2018 to August 2020. Total number of positive variance shifts remains variable, however the trend line suggests a minimal downward decrease in positive variance, +/- 4% for the timeframe August 2018 to August 2020.

Delivery of Regional Service Plan (RSP) Priorities		
South Island Regional Alliance activity		
GM's Planning and Funding to undertake a review of the current activity underway - Presentation of key findings and recommendations made to ALT by end of Q1		The initial Refresh, Reset, Refocus recommendations were presented to, and accepted by the South Island CE's and Chairs at their meeting in October. There was general consensus with the overall direction, and phase two of the programme has now been agreed, which will build on the original recommendations.

9

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

Disability and Disability Action Plan		
Promote better collection of disability needs information - admission form reviewed Q1	(amber)	This will commence when the Disability Steering group is established. People with lived disability experience will be part of this process.
Community Engagement Roadmap	(green)	The Community Health Council (CHC) has developed significant connections with the disability community across the district and continue to engage them in projects occurring including in the new build of Dunedin Hospital. The disability community is also represented on the CHC by a member of the community with lived experience.
Rural Health		
Commission review of the Central Lakes/Queenstown Locality	(green)	Reviewer has been engaged from University of Otago. Background information has been gathered.
Agree TOR	(green)	Terms of Reference have been agreed Questions have been formulated
Programme of work agreed to refresh and refocus the Rural Hospitals Alliance; resources identified	(green)	A Radiology project has been commenced to review provision of Radiology services across the District, with a specific focus on Rural areas.
Review of number of telehealth clinics provided	(amber)	Data being gathered but not yet complete
Review of activity	(green)	Activity has been reviewed and compared to 2019/2020. A steady increase in demand is driven by population increase. International visitor numbers have been replaced by visitors from across New Zealand.

Improving Quality		
Improving Equity		
Catch up programme for Diabetic Annual Reviews designed and agreed by the end of Q1	(amber)	In planning stages with the LDT
Number of diabetics referred into secondary care	(amber)	Reporting to be developed at LDT
Improving community, whānau and patient engagement		
Southern DHB governance group established	(amber)	This was put on hold until the HQSC staff met with Southern DHB in Oct. Their presentation was to inform the DHB further on the QSM. A small governance group is proposed to be established shortly and will have DHB staff and some CHC members to guide this marker.
Governance group established to ELT	(green)	The Executive Director for Quality & Clinical Governance is informed regularly of where engagement activities are currently occurring. When the governance group future opportunities for engagement will be identified.

Delivery of Whanau Ora		
Support provided , including through current and future investment, with whānau, hapu and iwi, and identify opportunities for alignment	(green)	The Southern DHB has increased its equity funding and is working with our Iwi Governance Committee (IGC) to establish priorities to be funded from this new resource allocation. A meeting is being scheduled with IGC on 4 Nov 20 to allocate this resource. In line with DAP guidance part of this allocation will increase funding to our kaupapa Māori health provider network, some of which are Runaka/hapu providers of services.

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Better Population Health Outcomes
Supported by Strong and Equitable Public Health and Disability System

Planned Care		
Implementation of equity lens for referrals		This in place now via reports and power BI dashboard for FSA referrals
Achieve case weight and discharge target for the first quarter		End of first quarter was affected by high cancellations with over 200 patients having their surgery cancelled primarily due to acute pressure on beds, ICU and HDU. End result was caseweights (24.33) and discharges (46.60) negative.
Recovery plan commences for the recovery of the 1,200 case weights of lost surgical activity that occurred during COVID		Additional outsourcing has commenced as part of the recovery plan. However the majority of other actions have not begun due to the final recovery plan having not been approved by the MOH and the funds unavailable to start the actions. Once the funding has been received the recovery plans will commence.
Existing ESPI 2 and ESPI 5 plans continue to be followed.		Weekly ESPI meetings and focus on booking long wait patients continues to be our priority.
Acuity tool rollout continues in surgical and medical services		Continuing to be implemented.
Prioritisation tool roll out continues in surgical services		Continuing to be implemented across the surgical services. Currently in place in Orthopaedics, General Surgery and Urology.
Part two: Measures for Planned Care plan tbc		Planned Care Funding schedule has been approved by the MOH and production plan published for Southern DHB.

Planned Care (continued)		
Exploration of seven-day hospital service provision		The concept of a 7 day hospital service represents a significant change and needs to be incorporated into the change programme that accompanies the new hospital build. The team associated with the new hospital business case are well aware of the requirements in respect of this as it is an essential part of enabling the overall services (including future growth) to be delivered from the new buildings. In the meantime, we are undertaking practical changes to provide more services outside of regular hours. This includes weekend theatre list work and the generalism business case proposes weekend allied health cover to ensure the right level of input to support timely discharge. We will collectively advocate for the need to move our services towards a 7 day model in the lead up to the new hospital. This is a logical part of the change programme that will be necessary and some of the challenges will be complex – e.g. agreeing 7 day cover for Allied Health and Medical workforces who are accustomated to working on a Monday to Friday roster pattern. Will be reported to CPHAC and HAC respectively from November
Comprehensive implementation of telehealth		This programme continues to exceed expectations with a strong steering group and a large (up to 70) number of clinical champions engaged in the programme. The next phase involves reflecting the telehealth range of service enhancements into a more generic framework that is currently being developed for the three year planned care plan, which is on track for approval at the Alliance Leadership team meeting in December.

9

Annual Plan Reporting: Quarter 1 20/21

Minister of Health's Planning Priorities: Give Practical Effect to He Korowai Oranga – the Māori Health Strategy

Reducing Health Inequities The Burden of Disease for Māori		
Long term conditions		
Identify Māori aged 50 years and older by General Practice		Hauora Wellness Checks are underway utilising the WellSouth Primary Health Network call centre. Maori patients have been identified GP practice by practice based on priority numbers of high risk patients.
Undertake assessment using the WellSouth Call Centre, providing free GP visit and screening services, with referrals made as appropriate		Hauora Wellness Checks are underway utilising the WellSouth Primary Health Network call centre. An electronic portal is being developed to capture this data collection and analysis. This data is currently being captured manually.
All Māori patients to have a CHA completed by the end of Q1		47.83% of all Maori registered under CLIC have had a CHA completed. The CLIC programme has recently been evaluated and redesigned.
Respiratory admissions in children - The WellSouth PHN and Southern DHB Māori Health Directorate will establish a new service targeting respiratory admissions for Māori children age 0-4 years in Dunedin (EOA)		
Service established Q1		Contract for service in placed with Awarua Whanau Service with a whānau ora navigator in place.
Māori respiratory admissions identified		Māori 0-4 years respiratory hospital admissions identified over the last three years.
Assessments completed		The Harti Hauora Assessment tool has been developed by Awarua Whanau Services on an electronic platform. Assessments are undertaken with whanau admitted into hospital and/or in the home environment.
Referrals made		The Harti Hauora Assessment Tool allows for referrals to local health and social services including examples such as car seats, warm homes, Awarua synergies, WellChild Tamariki Ora services, Immunisations, Oral health services and others.

Reducing Health Inequities The Burden of Disease for Māori (continued)		
Cardiovascular disease		
Māori representation and participation across SI Alliance groups to progress and improve health equity		The first Cardiac Alliance meeting this financial year is scheduled for 10 Nov 20. Nancy Todd the associated Māori Health Strategy and Improvement Office for secondary and tertiary will be attending this meeting on behalf of Te Herenga Hauora.
NB: Additional actions reported in other templates: Child Wellbeing, Mental health, Diabetes, Long term conditions, New Zealand Cancer Action Plan		

Annual Plan Reporting: Quarter 1 20/21

Minister of Health's Planning Priorities: Give Practical Effect to He Korowai Oranga – the Māori Health Strategy

Māori Health Action Plan – Shifting Cultural and Social norms		
Māori Cultural Education Programme in place Q1		The Southern DHB has a draft academic delivery subcontract in place under the Otago Polytechnic for the purposes of the OT5164 Certificate in Bicultural Competency (Level 4). This proposal is designed to assist Southern DHB to build bicultural competency across the organisation. Two cultural educators are in place and are delivering training across our health system which has included training to GPs under the WellSouth Primary Health Network.
DHB Board and Executive Leadership Team to complete Te Tiriti o Waitangi training by Q1		The Southern DHB Board is committed to holding each year a board meeting on a local marae. It is planned that within the next quarter that a board meeting will be held on marae and at this meeting training will be delivered
Te Reo Māori will be incorporated into the Southern Health website and strategic documents		Work is underway to enhance the Southern DHB website using cultural imaging and the use of Te Reo Māori. As part of a regional COVID-19 Māori communications project it is planned to utilise some of these resources to enhance this website. The contractor Mokowhiti Ltd have strong communications expertise which includes #protectyourwhakapapa.

Māori Health Action Plan – Strengthening System Settings		
Māori representation and participation across South Island Alliance groups to progress and improve health equity		The Southern Māori DHB directorate are participating on the regional alliance groups including the Cardiac Alliance, South Island Public Health Partnership Alliance and Te Herenga Hauora o Te Waipounamu (Regional Māori DHB Alliance). The Chief is currently the acting Chair of Te Herenga Hauora o Te Waipounam.

9

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Mental Wellbeing

Mental Health and Addiction System Transformation		
Placing People at the Centre		
Lived experience networks established in Dunedin and Invercargill	Green	Lived experience networks established, refresh in progress with a view to obtaining a more diverse range of views.
Two listening groups are convened	Amber	Listening group activities were curtailed during this quarter because of Covid19. We expect activity to resume in subsequent quarters.
HQSC programme milestones are met towards zero seclusion	Green	Programmes continue to meet HQSC requirements.
Embedding a wellbeing and equity focus		
HoA executed to signal our commitment to a partner with local iwi and MSD to create a high needs health Hub in South Dunedin	Amber	Work in progress. HOA not executed yet.
Metabolic Monitoring Guideline is refreshed in Q1	Green	Completed. Guidelines have been refreshed after consultation within the service.
Increase access and choice of services		
Number of workshops delivered in Q1	Green	Workshops held in various communities. These will continue to roll out in Queenstown Lakes area.
Service plan developed	Green	Complete
Terms of Reference finalised and Review commenced	Amber	Procurement process – RFPs have been received for a contractor to assist in the Review. Steering group membership is being finalised. Review is expected to commence in Q2.

Mental Health and Addiction System Transformation (continued)		
Develop sustainable SI Addiction system		
Engagement with General Practice in Queenstown Lakes. Develop a service specification and contract for GPSI mental health service by end of Q1.	Amber	MHAID Medical Director and Director of Allied Health have engaged with Central Lakes General Practice. Awaiting further information from primary care sector to determine feasibility of establishing a mental health and addictions GPSI in Queenstown.
Expand primary care services		
Report on activity	Green	10.5 FTE for Health Improvement Practitioners and 11 health coaches recruited. NGO support workers in place. Contract for service agreed with MoH.
Public Health actions		
Measure resiliency in Southern Youth - Survey priority populations	Amber	Queens High School reported. Logan Park High School Surveyed post-COVID
Complete learnings project	Red	Agreement in principle to undertake this though a stakeholder workshop. Not progressed due to COVID and service changes.
Reduce Youth Self Harm - Programme designed and implementation commences	Red	Not appropriate for this quarter
Suicide Prevention		
Collection of suicide/self harm data	Green	

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Mental Wellbeing

Performance area – Mental Health and Addiction System Transformation (cont)		
Workforce		
Workforce development on NLG agenda		Peer workforce development project has oversight from NLG. Standing item on the NLG monthly agenda
Work in partnership with workforce centres		Regular forums and contact with mental health workforce centres.
Programme plan developed		Integrated primary care programme (including the training of key workers by Te Pou) is progressing in line with implementation plan.
IGC representation on NLG		Request to IGC has been made. We expect to be able to complete this action in Q2.
Assist kaupapa Māori organisations to respond to RFP for He Ara Oranga implementation		We undertook a process of making relevant organisations aware of the opportunity as well as offering assistance with documentation and process.

Performance area – Mental Health and Addiction System Transformation (cont)		
Forensic services		
NGO partner for community step down beds identified through an RFP process by the end of Q1		Progress has been delayed, we expect the RFP process to commence in Q2.
Additional staff recruited for both prison in reach and youth forensic service by the end of Q1		Progress has been delayed. Recruitment is currently underway.
Participate in New Zealand Forensic Advisory Group (NZFPAG)		We do have active participation but this is somewhat restricted due to travel restrictions.
Commitment to demonstrating quality services and positive outcomes		
The number of Māori on Compulsory Treatment Orders is monitored and reduced		Southern DAHMS has embarked on a project to develop clear understanding of Māori consumers currently subject to the MH Act.

Maternal Mental Health		
NLG confirms the Maternal Mental Health model of care in Q1		We have experienced delays in this project during the Covid19 pandemic. A draft is in the final stages which will be consulted upon with our Network Leadership Group

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Mental Wellbeing

Addiction	Status	Comment
Procurement of agency to partner with NLG to undertake the Review of the Southern Mental Health and Addiction System	Green	
Southern Psychosocial and Wellbeing Recovery Plan approved with implementation commencing in Q1	Green	The first phase of the plan has been implemented with the Central Lakes Wellbeing Recovery Group now established to work within the framework of the MOH Kia Kaha, Kia Maia, Kia Ora Aotearoa, COVID-19 Psychosocial Mental Wellbeing Recovery plan. This has been meeting weekly focussing on key streams of monitoring/briefing/updates and a communication strategy with the aim of supporting people to look after their mental. A facilitated workshop is planned to consider immediate, medium and long-term actions. Alongside this workshops are being delivered throughout the district aimed at supporting resilience and wellbeing within the community.
Addiction Plan in draft Q1	Green	NLG subgroup has completed the first draft
Participation in SI sector workshops	Green	We have attended forums as they occur.
Southern region Addiction Plan in draft	Amber	Work is in progress in alliance with other SI DHBs but is slightly behind timeline.
Māori Mental Health Staff have increased role within MDTs	Green	Involvement of Maori mental health staff in MDTs in both Dunedin and Invercargill is consistent
Participation in development of National AOD model of care	Amber	Awaiting request from Ministry which is yet to release draft for input. Delayed by Covid19.

Mental Health and Addiction Improvement Activities	Status	Comment
Improvement in number/quality of transition plans	Green	Focus continues with steady improvement. 85% compliance against national target for current patients. 100% compliance for inpatient discharges.
Supported decision making prioritised	Green	Mental Health Advance Preferences/Statements continues to rollout. SDHB consumer advisor delivered a webinar that attracted local and international attendance.
Review opportunities to support the delivery of key services as close to home as possible	Green	Opportunities have been identified but realisation of opportunities will form part of the Southern System Review for Mental Health and Addiction Services.
Use of seclusion reduced	Green	Focus continues. Whilst number of events have not decreased this quarter the number of hours has decreased. Debriefing of staff utilising seclusion has recommenced. Work continues on pathways for substance affected people. Every seclusion event is reviewed within 24 hours.
Single Session Family Therapy Training delivered	Amber	The Supporting Families Health Child group has further developed an audit tool aiming to completed in November to support further development of the next phase of the workplan. Single Session Family training has been completed the next phase is to identify how it is being used post training and identify gaps. There is a plan to refresh CAPA in the Invercargill CAFS team which should support this as well. Our NGO partner, ABLE continues to work alongside with a range of activities, including promoting resources and developing community network.

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Sustainability

Savings Plans – In Year Gains		
Pharmaceuticals		
Database created as a tool for analysis and monitoring of Southern district pharmaceutical utilisation.		The first tranche (one month only) of data has been received from MOH in Oct.
Complete pharmaceutical benchmarking framework against other DHBs		Contingent on complete data (as above)
Draft report produced by SI Alliance DHBs explaining key factors driving pharmaceutical use and expenditure relative to PBFF		Paper in draft
In collaboration with WellSouth, pilot practice support tools		Contingent on complete data (as above)
Procurement and clinical supplies		
Monthly reporting against the workplan for FY2021 targeted to deliver expenditure management benefits from clinical and non-clinical products/services		
Management of workforce and annual leave		
Monthly reporting against plan		

Savings plans – In Year Gains (continued)		
Valuing Patients Time		
Ongoing monitoring and reporting to ELT in respect to VPT baselines and targets		Presentation to ELT and Hospital Advisory Committee completed twice in Q1. Full implementation of the SAFER (patient flow) bundle which includes Senior Review, Rapid Rounds, Red to Green, Expected Date of Discharge (EDD), Clinical Criteria for Discharge (CCD) and Stranded Patient Review to be the priority focus and vehicle for improving patient flow in 2020/21. Metrics identified end of Q1 and to be presented to ELT in Q2.
Completion of ED Escalation pathway end of Q1		The Dunedin Hospital ED Escalation plan is in Draft, and has now been presented to the following groups: Medical Directors Clinical Directors Clinical Council It will be presented to ELT in November and prior to this it will be circulated to the Unions
Generalism Business case signed off by the Board by end of Q1		The enhanced Generalism business for Dunedin Hospital will be presented to the 08 December Board meeting.
Mental health		
Complete review of the model of care for mental health services to deliver improved value of $3.4m		Savings target delivered against budget for Q1. Review of southern Mental Health and Addiction system has commenced with establishment of a review team and RFP to identify a contractor to assist with the Review. We expect the Review to commence during Q2.

9

Annual Plan Reporting Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Sustainability

Savings plans - Out Year Gains	
Health System Structure and Healthcare Delivery mechanisms	Milestones under development
Consumable and Pharmaceutical Utilisation:	Milestones under development
Re-engineering the workforce to achieve better outcomes for workforce and patients	Milestones under development
Procurement and Contract management	Milestones under development
Bed and Theatre capacity scheduling to optimise the utilisation of in-house resources	Milestones under development
Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability	Reported in individual templates

Savings plans -Working with Sector Partners to Support Sustainable System Improvements		
DHB leadership involvement in Whāngaia Ngā Pā Harakeke (police initiative		Southern DHB attendance at Whāngaia Ngā Pā Harakeke Rōpū Manawhakahaere governance meetings and the Otago district domestic violence network facilitated by the NZ Police.
Evidence of strategies that support the improvement of health care in Puketai Care and Protection Residence		Southern DHB attendance at the Puketai interagency meeting inclusive of the executive, population health and mental health, addiction and intellectual disability DHB services. Strategies including gateway assessments provided by population health are currently being reviewed. Runaka have an interest in provided this service in negotiation with Oranga Tamariki.

Annual Plan Report Quarter 1 2020/21

Minister of Health's Planning Priorities: Better Population Health Supported by Primary Health Care

Performance area – Diabetes and other Long Term Conditions		
Long term conditions		
All patients who are enrolled on the CLIC programme will have a CHA (comprehensive health assessment) completed by the end of Q1		A review of CLIC has been undertaken and there may be some structural changes to this programme.
A pilot programme for Community Pharmacy service linking to CLIC with initial cohort of patients identified and MDTs underway in Q1		Complete
Finalise and Implement the COPD Integrated Care Pathway		
Diabetes		
The Local Diabetes Team will be reformed with new TOR and agreed membership – LDT in place Q1		Complete
Number of diabetics referred into secondary care		The LDT is considering this action along with the aspects of the Living Well with Diabetes Standards. A prioritisation of actions will result.
Catch-up programme for HbA1c DARs in primary care -Catch up programme designed and rolled out		Catch up programme is still in the planning stages at the LDT
Catch up programme - regular reporting to the LDT		PHO reporting into the LDT is underway
Process in place to actively monitor patients identified as high risk or active		In planning stages at the LDT

Primary Health care Integration		
Agreement by the ALT of the proposed new HCH model in Q1		HCH Tranche three is underway.
Plan for the 2020/21 year signed off by ALT		ALT have approved the areas of focus and are now looking to further prioritise Actions
Endorsement of the Health Hub model specific to South Dunedin agreed, including signed Heads of Agreement		There has been a decision to move directly to an RFP for a Health and Wellness Hub in South Dunedin. The RFP is to be reviewed and endorsed at their next meeting. The RFP will go onto GETS during Q2
Health Hub reports to ALT and IGC		As above

Pharmacy		
Support community pharmacists in their contracting with Southern DHB to deliver influenza immunisations for those over 65 years		

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Wellbeing Through Prevention

Antimicrobial Resistance (AMR)		
Whole of system approach to AMR		
Champions established in Primary care	Green	
Surveillance and research		
Active surveillance and review of data	Green	Active surveillance is happening through MDRO reporting however full iCNet implementation will be delayed, until Q3. Limited function iCNet, COVID-19 monitoring, is in place.
IPC surveillance	Green	
Infection prevention and control		
Active surveillance	Green	
Antimicrobial stewardship		
Implement IV to oral switch programme	Green	Went live in October 2020
Audits conducted	Green	Audits underway as part of hospital AMS plan
Pharmacists work with GPs	Green	Supported via WellSouth PHO Clinical Pharmacy Services
Regular reporting to clinical governance/ Senior leadership	Amber	Regular reporting and development of reporting disrupted due to COVID-19 focused activities.
Work programme for AMR services	Green	
Governance, collaboration and investment		
Antimicrobial Stewardship Steering Group meets regularly	Green	

Antimicrobial Resistance (AMR) (continued		
Regular reporting to clinical governance/ Senior leadership	Amber	Regular reporting and development of reporting disrupted due to COVID-19 focused activities.

Smokefree 2025		
Increase the number of secondary care referrals to the Southern Stop Smoking Service by taking an opt off referral approach in secondary care – report Q1	Red	84 referrals. 27 of these were from Public Health South. These numbers are very low.

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Sexual Health		
Finalise the Southern district's Sexual Health Syphilis Plan	Amber	The draft plan is under review and delayed, due to Covid. awaiting further information from Maori Health Directorate and Southern Community Laboratories and Public Health
Implementation of Syphilis plan	Amber	The implemented is behind schedule due to plan not being finalised, expectation to implement in Q2.
Regular updates to the Sexual Health Steering Group	Green	
PHNs upskilled (long-acting reversible contraceptives)	Amber	The LARCs aspect is well underway. The work with GPs is on hold until Feb 2021, as delegated to Nurse Practitioner to progress after staff member left.
Introduce asymptomatic sexual health self-testing processes at the two hospital based sexual health clinics (EOA) – pilot reviewed	Amber	Pilot delayed due to delays on asymptomatic testing due to Covid CBACs.
Quality improvement survey to assess barriers for Māori young people to access sexual health services	Green	
Promotion of Genital Dermatology Services clinic to primary care	Green	
HealthPathways established to identify referral pathways in Sexual Health and Women's Health	Amber	

Reducing Alcohol Related Harm		
Develop a triage tool to assess and prioritise licence applications	Red	Due to Covid-19 there has been no progress on triage tool. The intention to undertake this work continues.
Evaluation in INV of the pilot of 'The Plan' (initiative that aims to supports parents to reduce alcohol related risk to teens)	Green	A process evaluation has been completed and indicates that as the stand is not appropriate for off-licences it is still OK for events, foyers and waiting rooms. WellSouth and Public Health South will continue to collaborate on the roll out that will target lower decile schools.
Evaluate the 'Good One' Party Register	Amber	The Department of Preventive and Social Medicine, University of Otago has been approached for assistance with a comprehensive evaluation. They have suggested that this would be a good masters thesis topic. Currently we are waiting to hear if the PostGrad Course Director and Student Research Convenors have any students looking for projects and it is being advertised on the research projects web page for students.

9

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Environmental Sustainability		
Energy Supply and Efficiency		
Dunedin Energy Leaders Accord joined	Green	
Behaviour education campaign	Amber	
Waste		
PVC recycling extended	Green	
Feasibility study of food waste composting	Red	Delayed – no food composter on Dunedin site.
Behaviour education campaign on waste minimisation	Green	
Travel		
Staff transition to electric vehicles and hybrids	Amber	New fleet vehicles include hybrids – 18% complete.
Built Environment		
Environmental sustainability Design Plan implemented	Green	
Engagement of staff and culture change		
Green Healthcare Champions network	Green	
Workshops	Green	
Research links with others	Amber	Resource not allocated to task
Promote strategy within the wider health care sector	Green	

Healthy Food and Drink		
Implement Healthy Food and Drink Policy in Early Learning Services, primary, intermediate and secondary schools	Green	Eligible schools = 55 (decile 1 to 4; Māori+pasifika rolls > 35%; schools with need identified by MoE) Eligible ECE= 28 (EQI 1-4; Māori+pasifika rolls > 35%) Further contact was made with schools and ECE around the water only and healthy food initiatives although most physical meetings and a teacher PD workshop were postponed due to Covid-19 alert level 2 measures during most of term 3. Similarly the Waitaki Clued up Kids initiative, around community safety and awareness, had to be cancelled. Several active transport initiatives were supported in schools in collaboration with other agencies e.g. developing Walking Time Zone Maps, and supporting BikeReady initiatives and an active transport workshop. A funding application to the DCC waste minimisation fund was supported to finance the purchase of reusable drinking bottles. This will further support the free access to drinking water and adress the need identified in some Dunedin schools after COVID-19 measures closed drinking fountains on school grounds. Similarly in Southland the Eastern Southland Clued up Kids was postponed and is now planned for October 2020, Otauatu (Western Southland) Clued up Kids also postponed until later in Term 4.
Healthy food and drinks policy (HF&DP) clause appended to contracts	Green	Clause developed in 19/20 and is appended in all applicable contracts upon renewal/Establishment943 Contract signed since Q1 2019 – 80 contracts eligible for HF&DP clause to be appended (8.5%). 80 Contracts with clause appended. 100% of applicable contracts
HF&DP clause added to the audit tool	Green	All Audits conducted commencing in the 20/21 year will include audit against compliance of the HF&DP

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Communicable Disease	Status	Comment
Timely response to COVID 19 (Includes quality improvement plan)	Green	Work is on-going as we continue to refine our process and procedures. A resurgence plan is in place for meeting the Ministry of Health Phase 1 and 2 targets of 24 and 34 new cases per day. This requires us to build our capacity from outside our service. Work is underway to obtain staff from the wider DHB to support this plan. A training plan has been implemented to support this as well as on-going scenario training exercises for Public Health and Public Health Nursing staff. Escalation pathway has been developed for releasing staff to surge the workforce when required.
Notified Disease cases documentation is audited	Amber	Some work has been done on individual disease protocols as needed but an overall audit has not been undertaken.

Cross-sectoral Collaboration including Health in All Policies	Status	Comment
COVID-19 Psychosocial and Mental Wellbeing Recovery Plan - Stakeholder meeting to develop programme in Q1	Green	Psychosocial recovery planning was commenced in QLDC and is being progressively rolled out across the Southern District. Public Health South have been working with stakeholders in Local Government, NGO Mental Health services. Maori Health Services, and Primary and Secondary Mental Health Services. The Plan has activities right across the wider Mental Health and Addictions sector. Public Health South's contribution has been in the amplification of the Mental Health Foundation's All Right campaign that is marketed as "getting Through Together" This work has been done with the support of communications teams of SDHB and QLDC as well Volunteer South for the distribution of resources in the communities.

Drinking Water	Status	Comment
Reporting of activities in undertaking required functions	Green	Work undertaken as required
Stakeholder meetings with Iwi and Regional and Local Government in Southern District to address public health risks associated with Recreational water and Drinking Water quality.	Amber	A recreational water stakeholders meeting has been scheduled for October 9. Drinking water one was not scheduled due to Covid-19. We intend to run both these meetings together in the near future as they involve the same Iwi, Local and Regional Government stakeholders.
Plan developed by Q1	Green	A 5-point plan has been developed for drinking water. Work is being done by stakeholders in the background as we have not met yet.
Annual survey of drinking water supplies	Green	
Complete risk assessment to identify priority supplies	Green	Was completed for all supplies serving over 100 people as part of the Annual Survey

9

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Wellbeing through Prevention

Breast screening	Status	Comment
Engage with Pacific Church groups to improve Pacific access	Green	
Engagement with industry employing Māori	Green	
Engagement with industry employing Pacific	Green	

Environmental and Border Health	Status	Comment
Quality improvement plan implemented (issuing permits re use of 1080 and cyanide)	Red	A data and process audit was carried out in the latter part of 2019-20. Due to COVID this has not been taken any further. It remains an outstanding action that will be completed at our earliest opportunity.
Engage with Te Ao Marama and Aukaha in relation to environmental health decision making	Green	Engagement with Te Ao Marama to introduce Medical Officer of Health and discuss closed ICC landfill. We have had one situation in Q1 where we supported Aukaha with a renewal of a Resource Consent.

Cervical Screening	Status	Comment
Recruitment of 1 FTE registered nurse and development of appropriate skills	Green	
Support from Navigators on patient continuum of care	Green	Southern DHB Māori Health Directorate have been working with Kaupapa Māori health services to increase their knowledge on cervical screening services and promote this with eligible woman in the community. Māori health services navigators will promote the weekend cervical screening clinics and support wahine to attend.
Southern DHB Cervical Screening Service to engage with kaupapa Māori health services	Green	
Identification/ engagement with key industries to promote cervical screening	Green	

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Child Wellbeing

Immunisation	Status	Comment
Increase clinical governance to streamline Vaccine Preventable Disease (VPD)		
Assessment of VPDSG and members added as required	Green	
TOR developed	Green	
VPDSG meets quarterly	Amber	First meeting to occur in Q2
Immunisation data checking via NIR to support early enrolment with general practice		
Data checking by NIR team	Green	
NIR advises general practices of unenrolled babies	Green	
General practices refer unimmunised babies to immunisation outreach service	Green	
Measles Immunisation Campaign for 15 to 29 year olds and active recall of children 5 to 14 years who have not had any or had only one measles, mumps & rubella (MMR) vaccine		
SDHB Measles Immunisation Plan accepted and signed off by MoH	Green	
MMR vaccines delivered to target groups and data collection processes are in place	Green	
Evaluation processes established and information is collected	Green	

Maternity and Early Years	Status	Comment
Early engagement programme for young Māori and Pasifika- Leaflet published and distributed with partner agencies	Green	
Commence whole of system planning for Maternal, Child and Youth Health and Wellbeing Model of Care - First planning day	Amber	Work was undertaken to begin preparing for the planning day. Delayed due to commencing Alliance South's First 1000 days and Immunisation project planning and the need for clarity in strategic planning across the many different work streams for child and youth health.
SUDI - Postnatal extension to Southern Stop Smoking (SSS) Incentive Scheme	Green	
Breastfeeding - Enhance Breast feeding peer support programme	Green	Discussions commenced with WellSouth PHO
Well Child/Tamariki Ora (WCTO) - WCTO providers to provide list of late referrers	Green	
WCTO - Contact late referrers	Green	
WCTO Steering Group meets	Green	
Implement Maternal Care Child Protection Wellbeing (MCWCP) steering group recommendations	Amber	Work currently underway but not completed.

9

Annual Plan Report Quarter 1 2020/21
Minister of Health's Planning Priorities: Improving Child Wellbeing

Maternity and Midwifery Workforce		
International placement offered		
Midwifery employment opportunities advertised		
Open Day hosted in Queen Mary to showcase midwifery and nursing roles in secondary and tertiary maternity care		Online expo was held with Otago Polytechnic, this was changed to an online approach due to COVID restrictions
Offer Nursing Entry to Practice (NetP) nursing positions in Dunedin and Southland Maternity wards		

School Based Health Services (SBHS)		
The Youth Service Level Alliance Team will meet no less than two monthly to monitor service delivery, identify gaps in service provision and make recommendations – Two monthly SLAT meeting occur		
Quarterly MoH reporting on SBHS		

Family Violence and Sexual Violence (FVSV)		
Regular attendance at Whāngaia Nga Pa Harakeke with the VIP coordinator		
Refreshed Terms of Reference for Maternal Care Child Protection Wellbeing (MCWCP) groups ratified		Work currently underway but not completed.
All MCWCP members sign Memorandum of Understanding		Work currently underway but not completed.

Southern DHB Non-Financial Performance Reporting Q4 2019/20

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

Performance Measure Reporting
Performance Measures are categorised into five different areas related to Government planning priorities.

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

9

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

Assessment Criteria/Ratings for Performance Measures

Rating	Abbrev	Criteria
Outstanding performer/sector leader	O	1. This rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations. 2. This rating is applied when the DHB has met the target agreed in its Annual Plan and has achieved the target level of performance for the Māori population group, and the Pacific population group. Note: this rating can only be applied in the fourth quarter for measures that are reported quarterly or six-monthly. Measures reported annually can receive an ‘O’ rating, irrespective of when the reporting is due.
Achieved	A	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. For those measures where reporting by ethnicity is expected, this rating should only be applied when the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and the Pacific population group.

		4. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	1. Target/expectation not fully met, (including not meeting expectations for Māori and Pacific population groups) but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved, and a resolution plan satisfies the assessor that the DHB is on track to compliance for the requirements not met.
Not achieved – escalation required	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

Annual Plan Reporting

Reporting against Annual Plan actions is provided through Status Update Reports. Reporting is categorised according to Planning Priority area.

CFA Variation Reporting

Reporting is required against Crown Funding Agreements (CFAs). Assessment criteria are different to the criteria applied to performance measures. The progress and developmental reporting nature for CFA variations is more compliance based, and therefore the target-oriented nature of performance measure assessment is not considered appropriate. The assessment criteria detailed below reflect the more qualitative nature of this component.

Assessment Criteria/Ratings for CFA Variations

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

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

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

Index of reports

Item	Page
Executive Summary, with Performance Measures Overview	4
Summary of Reports with 'N' Ratings	5
Summary of Quarter 4 Ratings	6
Reports with 'N' Ratings - Southern DHB Performance Reporting	9
All Reports - Southern DHB Performance Reporting	25

9

Executive Summary: Southern DHB Non-Financial Performance Reporting

Performance Measures Overview

Performance area	Number of outstanding measures	Number of achieved measures	Number of partially achieved measures	Number of not achieved measures	Unreported measures	Total number of measures
Child Wellbeing		3	4	2		9
Improving mental wellbeing		5	5			10
Better Population Health Outcomes supported by Strong and Equitable Public Health Services		10	7	3	1	21
Improving Wellbeing through Prevention				1		1
Better Population Health Outcomes supported by Primary Health Care		2	1	1		4
Status Update Reports – Annual Plan Actions		1	4			5
Totals		21	21	7	1	50

Crown Funding Agreements

	Number of satisfactory ratings	Number of further work required ratings	Number of not acceptable measures	Unreported	Total number
Crown Funding Agreements	5	3			8

Summary of Reports with 'N' Ratings

Code	Performance Measure	Final Rating	Change from previous rating	Page number	Owner initials
Child Wellbeing					
CW05	Immunisation coverage FA3: HPV coverage	N	→	9, 26	LG
CW09	Better help for smokers to quit (maternity)	N	↓	9, 27	LG
Better Population Health Outcomes supported by Strong and Equitable Public Health Services					
SS10	Shorter stays in emergency departments	N	↓	11, 49	PN
SS11	Faster Cancer Treatment (62 days)	N	→	14, 53	PN
SS13	Improved management for long term conditions FA5: Stroke service	N	↓	16, 56	PN
Improving Wellbeing through Prevention					
PV01	Improving breast screening coverage and rescreening	N	→	21, 63	LG
Better Population Health Outcomes supported by Primary Health Care					
PH04	Better help for smokers to quit (primary care)	N	→	23, 66	LG

Key to Owner Initials

Initial	Owner	Title/Directorate
LG	Lisa Gestro	Executive Director Strategy, Primary & Community
PN	Patrick Ng	Executive Director Specialist Services
MC	Mike Collins	Executive Director People Culture & Technology
GiT	Gilbert Taurua	Chief Māori Health Strategy & Improvement Officer
JW	Jane Wilson	Chief Nursing and Midwifery Officer

Summary of Quarter 4 Ratings 2019/20

Code	Performance Measure	Final Rating	Change from previous rating	Page number	Owner initials
Child Wellbeing					
CW05	Immunisation coverage FA3: HPV coverage	N	→	9, 26	LG
CW09	Better help for smokers to quit (maternity)	N	↓	9, 27	LG
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	P	↑	25	LG
CW05	Immunisation coverage FA2 5-year old immunisation coverage	P	→	25	LG
CW10	Raising healthy kids	P	↓	28	LG
CW12	Youth mental health initiatives (Youth primary mental health and Improve the responsiveness of primary care to youth)	P	↓	29	LG
CW07	Improving newborn enrolment in General Practice	A	→	26	LG
CW08	Increased immunisation at 2 years of age	A	↑	26	LG
CW05	Immunisation coverage: FA1 8-month old immunisation coverage	A	↑	25	LG
Improving Mental Wellbeing					
MH02	Improving mental health services using wellness and transition (discharge) planning	P	→	32	LG
MH03	Shorter waits for non-urgent mental health and addiction services for 0-19 years of age	P	→	33	LG
MH04	Mental Health and Addiction Service Development: FA1 Primary Mental Health	P	↓	33	LG
MH04	Mental Health and Addiction Service Development FA3 Improving Crisis Response Services	P	→	34	LG
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	P	→	35	LG
MH01	Improving the health status of people with severe mental illness through improved access	A	→	32	LG
MH04	Mental Health and Addiction Service Development FA2 District Suicide Prevention and Postvention	A	→	34	LG
MH04	Mental Health and Addiction Service Development FA4 Improve outcomes for children	A	→	34	LG
MH04	Mental Health and Addiction Service Development FA5 Improving employment and physical health needs of people with low prevalence conditions	A	→	35	LG
MH06	Mental health output delivery against plan	A	→	36	LG

Better Population Health Outcomes supported by Strong and Equitable Public Health Services					
SS10	Shorter stays in emergency departments	N	↓	49	PN
SS11	Faster Cancer Treatment (62 days)	N	→	53	PN
SS13	Improved management for long term conditions FA5: Stroke service	N	↓	56	PN
SS08	Planned Care Three Year Plan	NR		47	LG
SS03	Ensuring delivery of service coverage	P	↓	36	PN
SS05	Ambulatory sensitive hospitalisations (ASH adult)	P	→	38	LG
SS07	Planned Care Measures	P	→	38	LG
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA2 Improving the quality of data submitted to National Collections	P	→	47	MC
SS13	Improved management for long term conditions FA3: Cardiovascular health	P	→	54	LG
SS13	Improved management for long term conditions FA4: Acute heart service	P	↓	55	PN
SS15	Improving waiting times for colonoscopies	P	→	62	PN
SS01	Faster cancer treatment (31 days) indicator	A	↑	36	PN
SS02	Delivery of Regional Service Plans	A	→	36	LG
SS04	Implementing the Healthy Ageing Strategy	A	→	37	LG
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA1 Improving the quality of identity data within the NHI	A	↓	47	MC
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections FA3 Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	A	→	48	MC
SS12	Engagement and obligations as a Treaty partner	A	→	54	GiT
SS13	Improved management for long term conditions FA1: Long Term Conditions	A	↑	54	LG
SS13	Improved management for long term conditions FA2: Diabetes services	A	↑	54	LG
SS17	Whanau ora	A	→	46	GiT
	Care capacity demand management calculation	A	→	36	JW
Improving Wellbeing through Prevention					
PV01	Improving breast screening coverage and rescreening	N	→	63	LG
Better Population Health Outcomes supported by Primary Health Care					
PH04	Better help for smokers to quit (primary care)	N	→	66	LG
PH03	Improving Māori enrolment in PHOs to meet the national average of 90%	P	→	65	LG
PH01	Improving system integration and SLMs	A	↑	65	LG

9

PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	A	↑	65	LG
Status Update Reports – Annual Plan Actions					
Updates	Annual Plan actions: Improving wellbeing through prevention	P	↓	67	LG
Updates	Annual Plan actions: Improving child wellbeing	P	→	68	LG
Updates	Annual Plan actions: Improving mental wellbeing	P	↓	69	LG
Updates	Annual Plan actions: Better population health outcomes supported by primary health care	P	→	69	LG
Updates	Annual Plan actions: Better population health outcomes supported by strong and equitable public health services	A	→	70	PN

FA=Focus area; NR=No report

Crown Funding Agreements (CFA) Variations		**Final Rating**	**Change from previous rating**	**Page number**	**Owner initials**
CFA	Primary Health Care Services	B	↑	72	LG
CFA	Appoint cancer psychological and social support workers	B	→	72	PN
CFA	Appoint regional lead cancer psychological and social support initiative	B	↑	73	PN
CFA	B4 School Check Services	S	→	71	LG
CFA	Well Child Tamariki Ora Services	S	→	71	LG
CFA	DHB level service component of the National SUDI Prevention Programme	S	→	71	LG
CFA	Disability Support Services	S	→	71	LG
CFA	CFA Health Services for Emergency Quota Refugees	S	→	71	LG

Reports with 'N' Ratings - Southern DHB Performance Reporting – Quarter 4 2019/20

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
Child Wellbeing	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
CW05: Immunisation coverage HPV (Cohort 2006)	N	LG	Result: Total DHB coverage is 64.0% against target of 75%. Southern DHB result: Immunisation coverage HPV (Cohort 2006) Final dose coverage / Total % / Māori / Pacific Girls / 65.4% / 65.2 / 62.1% Boys / 62.8 / 61.0% / 60.9% Target: equitable immunisation coverage across their Māori, Pacific (where relevant) and total populations, aiming at coverage of 75 percent for each group for those in the relevant birth cohort MoH feedback: • National HPV immunisation coverage for the 2006 birth cohort is 60.4 percent for girls and 60.9 percent for boys It is concerning that the national coverage for both girls and boys is significantly lower than the 75% coverage target. • Your DHB has total coverage of 65.4 percent, Māori coverage of 65.2 percent and Pacific coverage of 62.1 percent for girls. Your DHB's total coverage for girls is comparable to the 62.8 percent total coverage for boys. The Ministry looks forward to seeing the outcomes of your actions to carry out clinics on marae and increase opportunistic vaccinations to reduce barriers to access and review the data collection and the reporting templates of the SBIPs for consistency. • We acknowledge the pressure DHBs have been experiencing due to COVID-19, however, continuing to provide immunisation events on time even during fluctuating alert levels, as per the National Immunisation Schedule, is critical for the health of our communities. • Children at the age of 14 who have had an incomplete HPV vaccination course or who have not yet commenced HPV vaccination must be recalled by general practice. We note that your DHB communicates all School Based non-consents to General Practitioners (GP's) for follow up for pre- call. This 14 year recall provides children to be caught up on HPV as well as any other vaccinations they may have missed (such as MMR and the 11 year Tdap).
CW09: Better help for smokers to quit- Maternity	N	LG/PN	Result: 88.9% of pregnant women and 90.5% of pregnant Māori women were given brief advice and support to quit smoking. Rank: 14 out of 20 DHBs (total population). Target: 90 percent MoH feedback: • This quarter the overall result was 88.9% and the Māori wāhine result was 90.5% of pregnant women were given brief advice and support to quit smoking. You did not met the target this quarter, but we accept there has been disruption due

Southern DHB result: Immunisation coverage HPV (Cohort 2006)

Final dose coverage	Total %	Māori	Pacific
Girls	65.4%	65.2	62.1%
Boys	62.8	61.0%	60.9%

9

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			to the response to COVID 19 this quarter. When will the universal referral begin? Who is monitoring this, and how long will it continue for? • We acknowledge the continuing support the DHB provides to the local stop smoking service. Well done, let's hope for an improvement in quarter one. Keep up the good work. The number of events is likely to be lower than the number of births recorded in any one quarter; however until the National Maternity Record is fully operational (approx. 2021) then reporting on this indicator will be from data collected from MMPO and DHB employed midwifes and remains developmental. Southern DHB response to MoH feedback: • The universal referral is an embedded part of our DHB Outreach Midwifery Service. Our Charge Midwife and Director of Midwifery are responsible for monitoring. We continue to promote the Southern Stop Smoking service and incentives programme with LMC midwives and with pregnant women and families. There is not currently a mechanism to mandate a universal referral to smoke cessation services for self-employed LMC midwives, so we rely on education, promotion and communication. Southern DHB report: What planning has occurred in your DHB to support the maternity health target, specifically for Māori and Pacific women? • Incentives Programme to support Smokefree Pregnancies and Smokefree Families Please include information on how your DHB is supporting LMCs and/or DHB-employed midwives to increase the number of pregnant women being offered brief advice and support to quit smoking. • Trial of Universal Referral to Southern Stop Smoking Service for DHB-employed Outreach midwifery service. • Promotion of Incentives Programme with LMC midwives What actions and/or projects is your DHB undertaking that reduces smoking in pregnancy, specifically for Māori and Pacific women? • Stop Smoking Programme delivered by Kaupapa Māori provider Nga Kete Matauranga. Increased funding for Incentives Programme to include two new postnatal incentives to improve chances that future pregnancies will be smokefree.

Better Population Health Outcomes supported by Strong and Equitable Public Health Services	Final Rating	Owner Initials	Achieving Government's Priority Goals/Objectives and Targets
SS10: Shorter stays in emergency departments	N	PN	Result: 85.9% admitted, discharged, or transferred from an Emergency Department (ED) within six hours (target is 95%). Ranked 17th out of 20 DHBs. National result is 90.4%. MoH feedback: Thank you for your report. It's good to see an improvement on Q3 >1.5%. As you step out of COVID it will be good to see improvement on your health target. Can you please confirm whether you expect to see improvement in the indicator during the next quarter? If not, what additional actions can be taken to address the barriers you have identified? Southern DHB report: Percent managed within 6 hours by facility Facility: % managed within 6 hours Dunedin ED: 86.4% Lakes District ED: 100% Southland ED: 92.3% Southern DHB: 89.7% Actions undertaken this quarter to maintain or improve the indicator • During COVID 19 Levels 3 and 4 SDHB EDs were operating at 50% of normal demand during the acute phase. • The need to stream patients red and green in the Emergency Department and on the wards meant that flow through the department was not improved for the following reasons ○ Patients screened as 'red' were required to be treated in a separate area with full PPE being utilised ○ The available resource in the Emergency Department was split between 'Red' and 'Green' areas ○ The departments were physically split between 'red' and 'green' areas effectively reducing the capacity of the EDs ○ There was a desire to treat 'red' patients out of the hospital so much as was possible leading to extended lengths of stay in the ED

- 6 team structure in General Medicine to manage to cover for all medicine acute admissions, decision made to continue with 6 teams post COVID. As red and green streams continued to be required, there was still further pressure placed on the achievement of the six hour target
- Post COVID EDs reverting to normal use of its facilities, red and green streaming dismantled

Planned work for next quarter

- Fit 2 to Sit 8 expansion to ambulatory area
- Draft template for electronic handover for whole of Dunedin hospital
- Older Person's Assessment Liaison process continuing
- Board rounding/zone option by SMO group considered
- Drafting up next patient/over capacity protocol
- Continue to embrace use of telehealth to enable care to be delivered to anywhere within SDHB.
- SDHB is supporting patients to remain at home or if an admission is necessary to return home as soon as possible establishment of HOME teams across Southland and Dunedin.
- Emergency departments having regular contact and liaison with Mental Health services. Work to increase performance has involved looking at ED assessment times (through a trial of Early Specialist Assessment), and admissions, through the establishment of an Older Person's Assessment Liaison service.
- Despite this, increasing numbers of people attending EDs in the Southern district continue to place pressures on the system
- Additional resource to fully implement generalist acute admitting model of care by December 20

Barriers to achieving or maintaining the indicator

- As a result of COVID 19 alert level 4 the delay in planned care as well as anyone in our community accessing acute care will place our system under continued pressure in the weeks and months ahead.

Data on acutely admitted patients

Provide your data on target performance split by those patients who are discharged from the Emergency Department directly and those who are admitted to an inpatient hospital ward (not a statistical 'admission' based on the three-hour funding rule)

	Total Attendances	In ED over 6 hrs	% over 6 hrs
Not admitted	13626	897	6.58%
Admitted	4403	1652	37.52%
Total	18029	2549	14.14%

For those Admitted to an inpatient ward, provide a separate report of target performance by service

	Total admitted from ED	In ED over 6 hrs	% over 6 hours
Medical (incl. all subspecialties	2325	1030	44.3%
Surgical (all subspecialties excl Ortho and O&G)	1244	443	65.61%
Orthopaedics	471	115	24.42%
O&G	132	14	10.61%
Other	212	31	14.62%
Total	4384	1633	37.25%

Provide data on the number and proportion of patients admitted to an Emergency Department Short Stay Unit (SSU) that are subsequently admitted to an inpatient ward

	Admitted to SSU	Transferred to inpatients from SSU	% transferred
Total	1399	189	13.51%

Provide data on what proportion of patients counted in your denominator that have an Emergency Department stay <15 minutes and where they go (discharged or admitted)

	Total ED attendances	# under 15 mins and discharged	# under 15 mins and admitted	Total stayed under 15 mins	% < 15 mins
Total	18029	275	130	305	16.93%

Acute demand actions from Annual Plan 19/20

Acute Data Capturing: Please provide an update on your plan to implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021

- DXC (Vendor) has been requested to modify EDIS to allow capture of SNOMED codes. DXC have estimated that this upgrade and functionality will be available to all EDIS clients by Q4 2020/21 (dependency on DXC). Note this is a delay from Q2 2020.

9

			• SDHB EDIS User Group has been engaged with the requirement to implement SNOMED coding by July 2021. However with the delay in delivery of required functionality in EDIS the review of code sets and process changes have been delayed until Q2 2020. • A detailed implementation plan will be provided to the Ministry in Q3 2020/21. Including review of code sets, process changes, iPM collection for rural ED's, report and NNPAC extract reviews/changes, interfacing review, testing and training. • SDHB is targeting Q4 2020/21 for the implementation of SNOMED for ED (dependency on DXC delivery). To improve Patient Flow, please report on actions from your Annual Plan that: Improves patient flow for admitted patients • We have completed a draft business for additional to implement a new model of care-generalism in Dunedin hospital which will when implemented improve ED performance. Work to increase ED performance includes the establishment of an Older Person's Assessment Liaison service (OPAL).Work is occurring at both Dunedin & Southland EDs and initiatives include Fit 2 Sit with 8 ambulatory chairs, a fast track area, a PAU and scoping out opportunities for facility upgrades to provide a dedicated short stay unit. Improves management of patients to ED with long-term conditions • Supporting patients to remain at home or, if an ED presentation or hospital admission is necessary, to return home as soon facilitated by allied health (HOME) Team established across Dunedin and Southland sites. Improve wait times for patients requiring mental health and addiction services who have presented to the ED • Work closely in an integrated manner with Mental Health services to ensure ED is responsive to the needs of those suffering acute or chronic mental health conditions Q1-Q4 Improves Māori patients experience in ED • Established Southern DHB steering group, to include Māori Health Directorate and identified actions to address needs of Māori patients Q1, Māori Health Directorate worked with ED staff to identify their training needs Q1, Cultural training delivered to ED staff to address training needs.
SS11: Faster cancer treatment (62 days)	**N**	PN	Result: 64.3% achievement (target 90%), ranked 18th out of 20 DHBs. National average: 85.3%. Target is 90% (Data based on patients who received their first cancer treatment (or other management) between 1 Jan 2020 and 30 Jun 2020). Ministry feedback: 65 percent achievement noted

Southern DHB report:
Analysis of Breaches - A heat map of 62 day capacity breaches 1 Jun 2019-to 30 June 2020 demonstrates breaches by treatment modality

Heat map of 62 day capacity breaches by treatment modality, 1 Jun 2019-to 30 June 2020

Treatment modality	Breast	Gynaecological	Haematological	Head and neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urological
Chemotherapy	2	2	4	0	1	5	0	0	0	1	0
Concurrent radiation therapy and chemotherapy	0	1	0	3	2	1	0	0	0	1	0
Non-intervention management	0	1	4	0	0	0	1	1	0	1	0
Other	0	0	0	0	1	0	0	0	0	0	0
Palliative care	0	1	0	0	0	1	0	0	0	1	0
Radiation therapy	0	0	0	3	3	6	0	0	0	2	0
Surgery	7	7	0	3	14	1	0	0	3	0	7
Targeted therapy	2	0	0	0	1	1	0	0	0	0	1

Southern DHB report:

- In May 2020, all major tumour streams met to undertake a stocktake post COVID and plan for catch up. This is available and was uploaded with this report. The aim of this report is to quantify the impact of level 3 and 4 lockdown on the main tumour streams; agree key risk areas and forecast bottlenecks; plan to mitigate risks; brief wider organisation about what is planned and what else is required.
- A review of cases not diagnosed during this time has been undertaken but it is still not clear why Southern DHB was an outlier in this area. All aspects of national guidance for diagnostics were followed. It could have been because 1) our previous year diagnoses was up due to Urology catch up and introduction of Bowel Screening, 2) We were affected early on in COVID and had to close outpatient clinics earlier than others.
- Due to the decline in performance in Lung and Urology (62 day), we are undertaking a case review of the 30 patients that breached for capacity reasons. Both of these services should be reasonably up to date with their diagnostic pathways, so we want to verify the reasons for delay. This information will be presented at the Faster Cancer Steering Group. From this actions and recommendation will be implemented.
- The DHB is developing FCT Dashboards which will assist to identify problems more quickly and using real time data from multiple sources. We will be able to update in the next quarterly report our progress with this.

9

SS13: Improved management for long term conditions FA5: Stroke service		PN	MoH feedback:

MoH feedback:

- Dunedin is the only hospital to achieve Ind 1 – There is no lead stroke physician in Invercargill.
- Dunedin is the only hospital to have any presenting pts thrombolyse.
- The Southern DHB, given its size as a large DHB is consistently the worst performing DHB for acute stroke services. Could you please indicate if there are any plans to improve these services?
- It would be good to get further commentary about your participation in the regional telestroke service, could you please provide some further commentary. Your report only provides information for Q2 could you please provide Q3 data and commentary. You do not provide any information for Māori for Inds 2, 3 and 4. Could you please do so. The report is not signed off by the lead stroke physician and the lead stroke nurse could you please ensure this happens.

Southern DHB result: Indicator 1

Indicator 1: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	60	75	80.0%	Dunedin	64	72	88.9%
Invercargill	0	56	0.0%	Invercargill	61	74	82.4%
Dunstan	0	14	0.0%	Dunstan	0	16	0.0%
Oamaru	0	10	0.0%	Oamaru	0	7	0.0%
Total	60	155	38.7%	Total	125	169	74.0%

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 1: Dunedin site Southern DHB commentary

Quarter 3

- Dunedin Hospital (DPH) achieved the target of admissions to the Acute Stroke Unit. DPH continue to manage most acute stroke patients at some point in their acute episode of care within the Acute Stroke Unit. Almost all those not in the ASU we are co-managing with other service e.g. post cardiac surgery or the patient is on a palliative pathway. At times the ASU is full and we attempt to collocate patients in adjacent rooms to the ASU.
- We continue to work to upskill nursing staff in all areas of acute stroke management including getting a cohort of nurses skilled in stroke swallow assessment. Ongoing resignations/reappointment make this an uphill journey. Workload is high for all staff members involved who are consistently keen to learn and facilitate the best outcomes for patients and family and whanau.

Quarter 4

- We continue to manage most acute stroke patients at some point in their acute episode of care within the Acute Stroke Unit. Almost all those not in the ASU we are co-managing with other service e.g. post cardiac surgery or the patient is on a palliative pathway. At times the ASU is full and we attempt to collocate patients in adjacent rooms to the ASU.
- We continue to work to upskill nursing staff in all areas of acute stroke management including getting a cohort of nurses skilled in stroke swallow assessment. Workload is high for all staff members involved who are consistently keen to learn and facilitate the best outcomes for patients and family and whanau.
- The end of this quarter has seen changes in the organisation of all rehabilitation services in Dunedin arising due to COVID-19. The need to isolate a COVID-19 inpatient ward led to a reduction in rehabilitation bed numbers and transfer of the Dunedin Hospital Based rehabilitation service to Wakari Hospital.
- This has led to changes in practice for patients being transferred from the ASU to inpatient stroke rehabilitation. We will review the impact of this as we get the data for the next Quarter.

Indicator 1: Invercargill site Southern DHB commentary

Quarter 3

- Due to staff vacancy (designated Lead Stroke Physician) Southland continues to report that 0% of patients are admitted to an organised stroke service

Quarter 4

- Results have been provided for patients entered in to an acute stroke unit/organised stroke service, although we acknowledge that without a designated lead stroke physician we technically do not meet the definition. Despite this, the stroke service is meeting the targets for patients.

Southern DHB result: Indicator 2

Indicator 2: 10% of potentially eligible stroke patients thrombolysed 24/7							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	8	59	13.6%	Dunedin	6	55	10.9%
Invercargill	0	54	0.0%	Invercargill	2	65	3.1%
Dunstan	0	12	0.0%	Dunstan	2	15	13.3%
Oamaru	0	10	0.0%	Oamaru	2	6	33.3%
Total	8	135	5.9%	Total	12	141	8.5%
+Lakes	1	1	100%				

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

9

			Indicator 2: Dunedin site Southern DHB commentary Quarter 3: • Thrombolysis rates in Dunedin vary but in this quarter we have had a higher number of cases thrombolysed and at 13.6% achieved the target of 10%. Two patients were transferred to Christchurch for consideration of Clot retrieval. They were both thrombolysed in the Dunedin ED prior to leaving for Christchurch. We are preparing to move from using alteplase to tenecteplase. This required work between the acute stroke team, ED, pharmacy and radiology. Including education sessions for staff involved and updating our pathways. We are phoning the Christchurch team for advice for potential Stroke Clot Retrieval patients. The rural teams are working directly with the Christchurch neurology service for acute stroke management and the Dunedin Team is not usually involved. Quarter 4: • In this quarter we have transferred from using alteplase to tenecteplase for thrombolysis. This is simpler to use and also facilitate administering this earlier and hopefully we will see reduced door to needle time. Staff find this easier to use. Looking at these 6 cases the range of DTN is 36 to 160 minutes and an average of 77 minutes and similar to the average for the last year (72 minutes). This is not yet achieving target of under 60 minutes. We will need larger numbers to provide more analysis. • Since the beginning of February 2020 medical registrars on the Dunedin site are contacting the Christchurch Neurology by phone for advice on the management of all acute stroke patients during afterhours and weekend. This is working well and we are well supported by our Christchurch colleagues. • In this quarter, six patients were transferred by helicopter for potential Stroke Clot Retrieval. • Since the establishment of the Dunedin Acute Stroke Unit in 2010 a daily meeting is held, Monday to Friday, to review all new admissions and plan for ongoing management and rehabilitation for all patient in the ASU. Attendees are the lead stroke physician, the Stroke CNS, nurses in the ASU, PT, OT, SLT and ward social worker and once a week a Stroke Foundation Member attends. Indicator 2: Invercargill site Southern DHB commentary Quarter 3: • On inspection of the data kept by the stroke CNS, 54 patients during this period presented outside the window for thrombolysis or had an unknown onset of symptoms. The other main reasons for not considering thrombolysis were poor baseline and improving symptoms. • During this period 7 patients presented with Haemorrhagic stroke and 1 case thrombolysed from Lakes district and transferred to Dunedin Quarter 4: • On inspection of the data kept by the stroke CNS, 65 patients during this period presented outside the window for thrombolysis or had an unknown onset of symptoms. The other main reasons for not considering thrombolysis were poor baseline and improving symptoms.

- During this period 7 patients presented with Haemorrhagic stroke. The two cases thrombolysed were transferred to other regions for ongoing care, including one to Christchurch for clot retrieval.

Southern DHB result: Indicator 3

Indicator 3: 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission

Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	25	33	75.8%	Dunedin	16	25	64.0%
Invercargill	12	13	92.3%	Invercargill	14	17	82.4%
Dunstan	0	0	0.0%	Dunstan	0	0	0.0%
Oamaru	0	0	0.0%	Oamaru	0	0	0.0%
Total	37	46	80.4%	Total	30	42	71.4%

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 3: Dunedin site Southern DHB commentary

Quarter 3:

- The percentage of people transferred to rehabilitation services remains around 75%. Dunedin has a generic community rehabilitation service and this varies for those generally younger patients who have stroke rehabilitation at Wakari Hospital and those who rehabilitate at Dunedin Hospital with the stroke rehabilitation team.

Quarter 4:

- Stroke rehabilitation services have been impacted by Covid-19, and we have temporarily relocated of all rehabilitation services to the Wakari Hospital site.. There is now higher level of medical stability required before transfer from the Dunedin site. Some stroke patients, who would have previously transferred to OPH stroke rehabilitation service are now having to receive all their inpatient rehabilitation within the Acute Stroke Unit where resourcing and experience of staff is different from a dedicated rehabilitation service.

Indicator 3: Invercargill site Southern DHB commentary

Quarter 3:

- The target was achieved and is a significant improvement from the previous report.

Quarter 4:

- Target achieved

9

Southern DHB result: Indicator 4

Indicator 4: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	1	21	4.8%	Dunedin	1	20	5.0%
Invercargill	0	4	0.0%	Invercargill	0	7	0.0%
Dunstan	0	0	0.0%	Dunstan	0	0	0.0%
Oamaru	0	0	0.0%	Oamaru	0	0	0.0%
Total	1	25	4.0%	Total	1	27	3.7%

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 4: Dunedin site Southern DHB commentary

Quarter 3:

- No comments

Quarter 4:

- Advised at Stroke Governance meeting, that patients with stroke in the community have been seen more quickly as a backlog has been caught up over the COVID lockdown period (Q4). Allied health hoping this will continue if they can introduce a new model of care, though this is in early stages.

Indicator 4: Invercargill site Southern DHB commentary

Quarter 3:

- We are currently recruiting additional AH staff to support our REACH team who provide our community rehab. Patients who have a delay in being seen by REACH are sent home with exercises to work on and if required have Home Team follow up (RN/OT/PT/AHA) while waiting for the REACH programme to start, however Home Team is not community rehab.

Quarter 4:

- Recruitment process is ongoing with REACH team who provide our community rehab. Patients who have a delay in being seen by REACH are sent home with exercises to work on and if required have Home Team follow up (RN/OT/PT/AHA) while waiting for the REACH programme to start, however Home Team is not community rehab.

			Other Southern DHB comments (Quarter 4) • The regional Telestroke service is still struggling with IT issues around the telestroke carts across the district. IT are now replacing some of the hardware to see if this will address the connectivity issues. Once fully operational this would assist the assessment of our stroke patients, especially out of hours/weekend when medical registrars are having to phone Christchurch directly. • Stroke Clot Retrieval activity - (Q3) three patients transferred to Christchurch for SCR – 1 deceased a week later from other complications, 1 successfully repatriated to UK, 1 successful SCR outcome • Two patients transferred to Christchurch for SCR – 1 no SCR intervention & 1 successful outcome
Improving Wellbeing through Prevention	**Final Ratings**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
PV01: Improving breast screening coverage and rescreening	N	LG	Result: BSA coverage (%) of women aged 50-69 years in the Southern district, for the two years ending 30 Jun 2020: Total 71.4%; Māori 69.9%; Pacific 60.1%; Asian 34.8%; other 73.8%. Target: 70%. National total: 70.8%. MoH feedback: • For this period coverage for the Southern DHB region was: Māori 69.9%, Pacific 60.1%, Asian 34.8%, Other 73.8% and Total 71.4%. • Coverage for Māori has been trending upwards and the coverage target of 70% has almost been met which is very positive. • Coverage for Pacific has been trending down for the last three years. It is positive to hear about plans to engage with Pacific Church groups and large employers starting in Dunedin. It would be good to hear more about the initiatives Southern DHB is planning to implement that you mention in your report. Southern DHB response to MoH feedback: Actions from the Annual Plan that will impact on equity and outcomes: • Contribute to discussions regarding whānau ora approaches with Māori communities. Demonstrate meaningful activity moving towards improved service delivery. This will be undertaken under the auspices of a new Southern whanau ora policy. This will look towards the greater inclusion of whānau in health care plans and decision making that supports whānau and families to achieve their aspirations in life. It places whānau at the centre of decision making and supports them to build a more prosperous future. Importantly, this policy will overtly propose changes to the way that whanau ora services are purchased, and provide a new funding and contracting framework for our Kaupapa Māori health providers. • Support and collaborate, including through current and future investment, with whānau, hapu and iwi, and identify opportunities for alignment (EOA)

9

Southern DHB report:
Southern DHB plans to implement initiatives that contribute to the achievement of national targets for Breast Screen Aotearoa (BSA). These initiatives demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services and will lead to the elimination of equity gaps in participation between Māori and non-Māori/Non-Pacific woman and between Pacific and non-Māori/Non-Pacific woman, and achievement of a participation rate of at least 70% for Māori and Pacific woman aged 50-69 years in the most recent 24 month period.

Quarter 4		Breast Screening Coverage
Southern DHB		Exceptions reporting
Ethnic Group	Coverage	Outline DHB activities, including contribution to regional coordination planning, to achieve 70% coverage if this target has not been met
Māori	63.2%	• Engage with kaupapa Māori health providers to improve screening rates for Māori Q2-Q4 • Engage with Industry (large employers) where high numbers of Māori are employed, starting with Dunedin
Pacific	55.8%	• Engage with Pacific Church groups to improve Pacific access • Engage with Industry (large employers) where high numbers of Pacific are employed, starting with Dunedin
European /Other	66.2%	
TOTAL	65.9%	Data-matching with WellSouth PHO to identify screening gaps in the eligible population • Coordinator to engage with GP practices to enrol participants based on data matching results • Provide education to GP registrars on the breast screening service

Better population Health Outcomes supported by Primary Health Care	Final Rating	Owner Initials	Achieving Government's Priority Goals/Objectives and Targets
PH04: Primary health care: Better help for smokers to quit (primary care)	N	LG	Result: • 72.9% (total population) were given brief advice and support to quit smoking, (decrease of 3.3% from last quarter). • 73.7 percent of Māori and 69.6 percent of Pacific people were given brief advice to quit smoking. Rank: 18th out of 20 DHBs (total population). National result: 80.0% (total population) • Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit. MoH feedback: • Your final Q4 result is 72.9 percent. The DHB result decreased by 3.3 percent and you did not achieve the target. • We understand that the response to COVID-19 has been all encompassing for the majority of this year, however I am excited to hear more on what the new 'normal' opportunities are, and how they might improve performance. • The Practice Development Plans and the Māori Health plans are something I am particularly interested in. 73.3 percent of Māori and 69.6 percent of Pacific populations were given brief advice to quit smoking. • Well done on the work this quarter to sustain and improve target performance including a new data analyst product and reviewing the current approach to incentivising practices. We expect to see an improvement in Q3. • Please note that the result for Southern DHB's cessation support indicator is 26 percent. The national result for this indicator is 35.5 percent. This indicator shows the percentage of current smokers who have been given or referred to cessation support services in the last 15 months. The cessation support indicator result is for DHB use only and will not be publicly reported. You can use this indicator as a proxy measure of how well the clinicians are engaging with cessation services and how frequently they refer smokers to these services Southern DHB report: Do you think you have met the overall target (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? • The target will not be achieved in this quarter. The impact of COVID-19 and efforts to get back to "business as usual" in the post-lockdown period has taken the focus of both primary care teams and WellSouth support teams away from smoking cessation efforts. • The new "normal" does however provide an opportunity to rethink how practices approach their proactive care efforts over the coming months. WellSouth will implement Practice Development Plans where practices agree their objectives for

			proactive care for the coming year that will include specific smoking cessation goals. WellSouth will tie these plans in to funding incentives. Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? • The target will not be achieved for Māori and Pacific people this quarter. The reasons are the same as above. • WellSouth are working with the Māori Health team at the DHB to implement Māori Health Plans at general practice that will include specific targets for Māori and Pacific patients that will be tied to funding incentives.

Southern DHB Performance Reporting – Quarter 4 2019/20

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
Child Wellbeing	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
CW04: Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	**P**	LG	Result: 2019 result 74.7%. This compares to 75% in 2018. Target of 85% was not achieved. MoH feedback: Southern's results remain stable. Further progress is required to meet the 85 percent target.
CW05: Immunisation coverage: FA1 eight-month old immunisation coverage	**A**	LG	Result: 94.9% total coverage; Māori infant immunisation coverage at 90.0%. Rank 2nd[h] out of 20 DHBs (total coverage). Target: 95%
CW05 Immunisation coverage FA2: 5-year old immunisation coverage	**P**	LG	Result: 92.3% for total population and 91.1% for Māori population. Target: 95%. Rank 3rd out of 20 DHBs (total population). National result: 89.7% for total population. Southern DHB report: • During Covid-19 level 4 lockdown, 8 month olds and 2 year olds where prioritised over 5 year olds for immunisation. This was due to 5 year olds having their primary course plus their first MMR. • The Before School Check programme wasn't being delivered during level 4 and opportunities were lost for referrals for the missed 4 year old event. Families reported that they were not comfortable going into practices during Covid-19 or having outreach staff enter their bubble. • During this quarter practice nurses were redeployed to managing Covid-19. Practices didn't do their usual referrals and were having less follow-up from NIR, due to staff being seconded into other areas such as contact tracing. Now that we are back to business as usual, the VPD team are noticing an increase in referrals and catch-up immunisations. The VPD team and NIR are working closely to action these referrals. MoH feedback: • At age five years the total coverage has decreased by 0.4 percent and coverage for Māori children has decreased 1.2 percent.

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>The Ministry is currently promoting timely childhood immunisation, in the expectation that parents may have delayed vaccination during Level 4. Please keep a close eye on your communities' tamariki over the coming months to ensure that any delayed vaccinations are caught up.
We appreciate your commitment to this mahi and note that your plan has been received by the measles project team. The Ministry looks forward to the contribution your DHB makes to improve equitable MMR coverage.
Please continue to vaccinate your vulnerable communities as the influenza season continues. Good stocks of Afluria Quad are available for our most vulnerable populations, particularly newly pregnant women who may not have been eligible for free vaccination earlier this year. As advised in our previous quarterly reporting feedback, please ensure you work closely and establish strong working relationships with your DHB's Māori General Manager and Pacific lead to ensure they have a clear line of sight into immunisation work. It is important that your DHB commits fully to the actions you have set to address the increasing inequities. Continuing to improve equitable immunisation coverage is key to the success of the immunisation programme moving forward. Thank you for your ongoing drive and dedication to improving the health and wellbeing of children and our communities.</td></tr>
<tr><td>CW07: Improving newborn enrolment with General Practice</td><td>A</td><td>LG</td><td></td></tr>
<tr><td>CW08: Increased immunisation at 2 years of age</td><td>A</td><td>LG</td><td>Result: 95.0% for total population and 95.6% for Māori population. Rank 2nd out of 20 DHBs (total population). Target: 95 percent.</td></tr>
<tr><td>CW05: Immunisation coverage HPV (Cohort 2006)</td><td>N</td><td>LG</td><td>Result: Total DHB coverage is 64.0% against target of 75%.

Southern DHB result: Immunisation coverage HPV (Cohort 2006)
<table>
<tr><td>Final dose coverage</td><td>Total %</td><td>Māori</td><td>Pacific</td></tr>
<tr><td>Girls</td><td>65.4%</td><td>65.2</td><td>62.1%</td></tr>
<tr><td>Boys</td><td>62.8</td><td>61.0%</td><td>60.9%</td></tr>
</table>
Target: equitable immunisation coverage across their Māori, Pacific (where relevant) and total populations, aiming at coverage of 75 percent for each group for those in the relevant birth cohort

MoH feedback:
National HPV immunisation coverage for the 2006 birth cohort is 60.4 percent for girls and 60.9 percent for boys
It is concerning that the national coverage for both girls and boys is significantly lower than the 75% coverage target.</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• Your DHB has total coverage of 65.4 percent, Māori coverage of 65.2 percent and Pacific coverage of 62.1 percent for girls. Your DHB's total coverage for girls is comparable to the 62.8 percent total coverage for boys. The Ministry looks forward to seeing the outcomes of your actions to carry out clinics on marae and increase opportunistic vaccinations to reduce barriers to access and review the data collection and the reporting templates of the SBIPs for consistency. • We acknowledge the pressure DHBs have been experiencing due to COVID-19, however, continuing to provide immunisation events on time even during fluctuating alert levels, as per the National Immunisation Schedule, is critical for the health of our communities. • Children at the age of 14 who have had an incomplete HPV vaccination course or who have not yet commenced HPV vaccination must be recalled by general practice. We note that your DHB communicates all School Based non-consents to General Practitioners (GP's) for follow up for pre- call. This 14 year recall provides children to be caught up on HPV as well as any other vaccinations they may have missed (such as MMR and the 11 year Tdap).
CW09: Better help for smokers to quit- Maternity	N	LG	Result: 88.9% of pregnant women and 90.5% of pregnant Māori women were given brief advice and support to quit smoking. Rank: 14 out of 20 DHBs (total population). Target: 90 percent MoH feedback: • This quarter the overall result was 88.9% and the Māori wāhine result was 90.5% of pregnant women were given brief advice and support to quit smoking. You did not met the target this quarter, but we accept there has been disruption due to the response to COVID 19 this quarter. When will the universal referral begin? Who is monitoring this, and how long will it continue for? • We acknowledge the continuing support the DHB provides to the local stop smoking service. Well done, let's hope for an improvement in quarter one. Keep up the good work. The number of events is likely to be lower than the number of births recorded in any one quarter; however until the National Maternity Record is fully operational (approx. 2021) then reporting on this indicator will be from data collected from MMPO and DHB employed midwifes and remains developmental. Southern DHB response to MoH feedback: • The universal referral is an embedded part of our DHB Outreach Midwifery Service. Our Charge Midwife and Director of Midwifery are responsible for monitoring. We continue to promote the Southern Stop Smoking service and incentives programme with LMC midwives and with pregnant women and families. There is not currently a mechanism to mandate a universal referral to smoke cessation services for self-employed LMC midwives, so we rely on education, promotion and communication.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			Southern DHB report: What planning has occurred in your DHB to support the maternity health target, specifically for Māori and Pacific women? • Incentives Programme to support Smokefree Pregnancies and Smokefree Families Please include information on how your DHB is supporting LMCs and/or DHB-employed midwives to increase the number of pregnant women being offered brief advice and support to quit smoking. • Trial of Universal Referral to Southern Stop Smoking Service for DHB-employed Outreach midwifery service. • Promotion of Incentives Programme with LMC midwives What actions and/or projects is your DHB undertaking that reduces smoking in pregnancy, specifically for Māori and Pacific women? • Stop Smoking Programme delivered by Kaupapa Māori provider Nga Kete Matauranga. Increased funding for Incentives Programme to include two new postnatal incentives to improve chances that future pregnancies will be smokefree.
CW10: Raising Healthy Kids	P	LG	Result: Referrals sent: 97% for total and 95% for Māori Referrals sent and acknowledged: 92% for total and 90% for Māori Target: 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions MoH feedback: Thank you for your report. We acknowledge the impact of COVID on referrals, and note your mitigation planning. Southern DHB report: • In Q3, the targets were exceeded with 100% of all referrals sent. A total of 99% were acknowledged, for Māori this was 100%. The referral service continued to be split between General Practice with 79% of referrals and Public Health Nursing 21%. The total referral declined rate remained at 23% and was 5% lower the National decline rate. Whereas the decline rate for Māori increased by 8% to 25%, this was 8% lower than the National average. • In Q4, the total of referrals sent was 97%, for Māori this was 95%. The targets were not met though as there was a 5% negative variance between referrals sent and those acknowledged, this was slightly higher than the National variance which was 3%. This set back in the progress that has been made with getting referrals acknowledged, was due to the impact of the COVID-19 pandemic and the number of cases that we had in the Southern region. The Public Health Nurses were seconded to the National Contact Tracing Centre, Public Health response and Immunisation services. This quarter 84% of referrals were to GPs with the remaining 16% to Public Health Nursing. The total referral declined rate is down to

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			15%, this is an 8% decrease on the Q3 results, and is 11% lower the National decline rate. The decline rate for Māori decreased by 6% to 19%, this is 13% lower than the National average. Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs. • With the COVID-19 outbreak in Southern region a large proportion of staff from both Primary Care and Population Health Service were redeployed to the COVID-19 response prior to national lockdown. Leaving no capacity to forward plan, we are currently looking at mitigation strategies in relation to acknowledgement of referrals in the event of another outbreak. Collective action and link to broader approach to reducing childhood obesity across government agencies, the private sector, communities, schools, families and whānau. • Due to COVID-19 national lockdown all interagency meetings were cancelled during this period. What the DHB is doing to build in evaluation, measure effectiveness, and monitor outcomes over time. • Due to COVID-19, work in this area has not been undertaken during this period.
CW12: Youth mental health initiatives	**P**	LG	MoH feedback: • Good to hear Decile 5 expansion is progressing well after being delayed by COVID-19. Well Done. Could you please keep me updated on the progress in future reports? • Thank you for including detail on the Southern District Youth Networks' meeting discussions. We look forward to linking with you on the SBHS enhancements work programme. • Please note that the DHB's rating is based on reports on Initiatives 1, 3 and 5 of the Youth Mental Health Project. For comments on Initiative 3 (Primary Mental Health), please see MH04 FA1. Southern DHB report: Initiative 1: School Based Health Services The ability to delivery school based programme was significantly disrupted by COVID10 closure of schools for 6 weeks. All decile 1-4 schools are now up and running. Deciles 5 school roll out was unable to be established due to COVID. In the first part of the year we recruited 3 of 4 nurses for the additional four schools and used their time during COVID to complete training requirements and to liaise with schools remotely. Three of the four schools are now operational as at 1 July 2020 and in the final school (Southland Girls) the new nurse started on 10 August is undergoing training. Quantitative data has been provided on the follow: • Availability of primary health care services in secondary schools • Youth access to appropriate primary health care services • Number of interventions

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• Youth health population health outcomes • Improved quality of SBHS Initiative 3: Youth primary mental health (reported in MH04) Initiative 5: Improve the responsiveness of primary care to youth Describe actions undertaken this quarter to ensure the high performance of the youth SLAT in local alliancing arrangements • Late last year we focussed two Network meetings on increasing understanding of Alliancing principles. We had hoped to increase knowledge of and engagement with the Southern Alliance but due to Covid19 this was not the priority over the last six months. We will revisit local Alliancing arrangements in the future. • Relationships established in this Network assisted engagement during Covid19 lockdown. • Debrief on the different experiences during lockdown have supported understanding of the responsibilities and priorities of the different organisations involved in the Network. It is particularly important to understand these in time of crisis so we make connections to better support young people and their whanau. Describe actions the Youth SLAT has undertaken in this quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per SLAT(s) work programme. • During lockdown focussed on the support needed by essential services. Each organisation worked to ensure those most needing support knew where/how to access it – communication with communities ensured important messaging got to those who needed it in a timely manner. • Information was shared by different members of the Network during lockdown, in particular to supporting Maori and Pacific and other vulnerable youth population groups. Regular cross sector engagement with organisations enabled the provision of support. We also learnt a lot about different population groups during this time, for example where young people go for help when really needed. Many young people and their whanau reached out to community organisations for support, when they had never done so before. This will enable ongoing engagement and support to better meet needs. • The Southern district Youth Network did not meet during lockdown but came together in June to reflect on experiences and discuss learnings. Discussions at June meeting focussed on sharing information on: • School Based Health Services – detailed the role of public health nursing services in high schools, access to contraception, HPV by primary care and public health nurses;

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• MoE supporting schools to get student back to school; experiences for students of other cultures and refugee families; concern for mental health; 51 learning support coordinators across Otago and Southland particularly in Actions undertaken to identify opportunities to work collaboratively together on improving health and wellbeing outcomes for young people, particularly opportunities that have dual benefit to other agencies. • Pacific representative discussed how they operated during lockdown and how they will work with newly identified young people going forward especially in relation to youth employment; working hard to understand health and social need of young people and their whanau; • Measles, Mumps and Rubella catch up programme 15-30 years – discussion focussed on about out of the box ideas especially for Maori and Pacific; Will continue discussion at next meeting to get ideas from Network members and the identification of opportunities they can provide for working together to increase vaccinations in this group and their whanau ; • Psycho social – strengthening mental health workers in schools working closely with school counsellors; rural areas supported by public health nurses and primary care; supported by school clusters working with multiple agencies. • DCC – detailed COVID activity and their social wellbeing and welfare response; Aspiring young leaders and other funding focussing on young people is delayed; • Public Health South – detailed Covid19 activity – 216 cases in district was a challenge for the service especially as one of them was a large cluster; ongoing involvement of staff in response and preparedness; discussed changes in the family violence programme; • PHS – post Covid19 schools can no longer have drinking fountains, conversations with school principals and gifting of water bottles to lower decile schools has occurred; Name and describe progress on concrete and targeted actions in 2019/20 to address identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the DHB's youth population, as per your SLATs work programme • Work continues to progress on working collaboratively to help improve youth health outcomes: • Southern DHB has launched Rautaki Hauātanga me te Mahere Mahi – Disability Strategy and Action Plan for consultation and feedback. This describes vision, goals and actions to be undertaken to provide equitable health and disability services throughout the Southern district. It provides leadership on how to do this. • Public Health South – project Te Kapehu continues to work to improve youth resilience – it uses technology in schools and other youth settings to provide a robust platform to measure wellbeing. A website is under construction with a direct link to Southern Health. Research earlier in 2019 identified an at risk cohort whose vulnerability was exacerbated by their invisibility. Through engagement with MSD a data sharing agreement was established. This revealed the number of young people with medically deferred jobseeker status. Out of nearly 700 young people, 80% had a medical deferral for a mental health reason – leading reason for 18-24 year olds was anxiety or depression.

9

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• Public Health South - No Safe Limit aims to reduce youth alcohol consumption and availability of alcohol to youth by being online resource for parents and those working with rangatahi. • Southern DHB staff are continually working to support other organisations knowledge of health by increasing engagement and understanding to support access to services. • Public Health Nursing staff are supporting Community of Learnings in schools with benefits to both the education and health sector. • Southern DHB continues to have a health equity lens on youth work especially for those young people who are not engaged with health and social services – need to consider different ways to connect with these young people. MMR campaign will further develop cross sector identification of disengaged young people, particularly Maori and Pacific – will discuss this further at the next Youth Network i.e. how to identify and engage across different sectors. • Public Health Nurses have been recruited for additional School Based Services – nurses have completed youth health training and services are nearly 100% operational. SDHB/Schools.
Improving Mental Wellbeing	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
MH01: Improving the health status of people with severe mental illness through improved access	A	LG	
MH02: Improving mental health services using well and transition (discharge) planning	P	LG	Results: Improving mental health services using well and transition (discharge) planning (see table below) Notes: Report is based on DHB data, rolling 1 year (3 months in arrears). The data being referenced covers the period April 2019 to March 2020. Data comprises referrals open longer than 3 months with 3 or more face-to-face contacts. MoH feedback:

	Percent of clients with a transition (discharge) plan	Target	Percent of clients with a wellness plan	Target
Community	54.2%	95%	82.6%	95%
Inpatient	100%	95%		

32

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td colspan="2"></td><td></td><td></td><td>

- Thank you for your report. It is great to see that 100% of people discharged from an inpatient setting have a plan. It is also good to see the significant improvement in people discharged from community teams with a plan. It would be good to have audits undertaken to test the quality of plans

Southern DHB report:
Community clients:

- Up-to-date tracking of community clients (current and discharged shows improvements over *time*

Inpatient clients:

- All clients discharged from inpatient settings have in place a discharge plan that is uploaded into the clinical workstation (Health Connect South), accessible also by GPs / PHOs via HealthOne.
</td></tr>
<tr><td colspan="2">MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds</td><td>P</td><td>LG</td><td>

Results: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds

<table>
<tr><th></th><th>Percent of 0-19 year olds seen within 3 weeks</th><th>Target</th><th>Percent of 0-19 year olds seen within 8 weeks</th><th>Target</th></tr>
<tr><td>Mental Health Provider Arm</td><td>69.8%</td><td>80%</td><td>88.1%</td><td>95%</td></tr>
<tr><td>Addictions (Provider Arm and NGO)</td><td>73.9%</td><td>80%</td><td>95.6%</td><td>95%</td></tr>
</table>

Rolling annual waiting time data is provided from PRIMHD (3 months in arrears).
The most recent data being referenced covers the period April 2019 to March 2020.

Southern DHB report:
Identify what processes have been put in place to reduce waiting times

- In context of increasing access rates for this age group we are pleased to note sustained stable wait times. Recruitment has occurred in some areas for key vacancies which will assist over time.
- Ongoing monitoring occurring within teams occurs.
</td></tr>
<tr><td>MH04: Mental health and addiction</td><td>FA1 Primary mental health</td><td>P</td><td>LG</td><td>

MoH feedback: Please provide actuals for quarter 3.

Southern DHB response to MoH feedback:

- We do not have a completed template for Q3
- Management of Covid19 at a local level took precedence over most of our business as usual activity. However we have a count of total presentations for that period which gives us a volume of 1007.
</td></tr>
</table>

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
service development	FA2 District suicide prevention and postvention	A	LG	
	FA3 Improving crisis response Services	P	LG	MoH feedback: • We note the service is currently looking at transportation options for areas where greater than 2 hours travel is required, with the consideration of the option of flying is being investigated. You advise that the use of technology in initial assessments in crisis situations continues to be promoted to improve response times, we would like you to update us on how this is contributing to reducing the rate of known clients being referred by police to crisis teams. We would like to see specific actions related to the above. Southern DHB response to MoH feedback: • Unfortunately this is not able to be quantified. What has happened is a gradual acceptance of the use of telehealth across our rural areas but this continues to be clinician dependent. At times a telehealth assessment has actually prolonged the face to face time with a specialist based in one of the urban centres as the outcome has been this more detailed assessment has been indicated. Equally it has also contributed to a more positive outcome for the patient concerned through reducing the need to travel significant distances. • It's also worth stating that not all crises assessments involve the police but when they are there is the expectation a telehealth assessment is always considered as the first option unless it is clearly indicated by the persons presentation that this is not appropriate Southern DHB report: • The service is currently looking at transportation options across the district and for areas of greater than 2 hours the options of flying is being worked up initially during working hours. • The use of technology in initial assessments in crisis situations continues to be promoted to improve response times • Ongoing monitoring of workload continues.
	FA4 Improve	A	LG	

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
	outcomes for children			
	FA5 Improving employment and physical health needs of people with low prevalence conditions	A	LG	
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders		P	LG	Result: For the period between Apr19 - Mar20, the percentage (of DHB population) of patients under section 29 in Southern DHB who are: Māori 261/100,000, non-Māori 89/100,000. Due to data availability, data are 3 months in arrears for each quarter. Expectation: Reduce the rate of Māori under s29 of the Mental Health Act by at least 10% by the end of the reporting year. Results for this quarter are the same as results reported for the fourth quarter of 2018/2019. Southern DHB report: • Following the review of the Southern DHB Māori Directorate, Māori health staff have been allocated to the range of MHAID services, while maintaining a team base. Although many orientations to their respective new services have been interrupted by the COVID period, the majority are settling into their roles, and we hope with this approach we will achieve better integration and access to cultural care, particularly where Māori may present in crisis, and in the CMHT settings. MHA client numbers by ethnicity (including Māori) continue to be incorporated into SMO annual performance reviews to raise awareness of personal and relative numbers of Māori under the MH Act.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• While this data is subject to ongoing scrutiny and monitoring, the Zero Seclusion strategy group is also currently being re-energised, with a continued focus on the point of admission through the crisis teams and CMHT's, and emphasis on the quality of EWS and RPP's. It is hoped the combination of this focus and increased cultural access may help to reduce use of the MH Act at the point of relapse or crisis and/or during the course of their inpatient stay overall, but in particular for Māori.
MH06: Mental health output delivery against plan	A	LG	
Better Population Health Outcomes Supported by Strong and Equitable Public Health Services	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
Care capacity demand management calculation	A	JW	
SS01: Faster cancer treatment (31 days)	A	PN	Result: 84.7% achievement (target 85%), ranked 18th out of 20 DHBs. National result: 88.1%
SS02: Delivery of Regional Service Plans	A	LG	SIAPO reports on activity and progress on the South Island Health Services Plan.
SS03: Ensuring delivery of Service Coverage (Includes reporting on Urogynaecological procedures	P	PN	Ministry response: • Thank you for your reports on surgical mesh, support for the Pacific and access to abortion services. In relation to surgical mesh -Thank you for our report. We have previously been advised by SDHB that Jim Faherty had been credentialed to undertake these procedures at Southland Hospital. Can you please confirm who Jan Lanki is and whether they have been appropriately credentialed to undertake these procedures?

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

involving surgical mesh, Support to the Pacific and Abortion services)			Southern DHB report:
			Confirm that your DHB is collecting data on urogynaecological procedures involving surgical mesh as per the minimum data set. For the period 1 January 2020 – 30 June 2020 please identify the number of surgeons that performed urogynaecological procedures involving surgical mesh:
			• Response: 1 (Jan Lanki in Southland) 2 (Michael Stitely & Elliot Mackenzie in Dunedin)
			The number of urogynaecological procedures involving surgical mesh performed by each of the surgeons identified in above:
			• Response: 5 by Southland and 1 mesh sling in public & 1 x private in Dunedin
			
			Southern DHB response to MoH feedback:
			There appears to have been a misunderstanding and reassurance was taken from the fact that Mr Jan Lanki, who is an Obstetrician Gynaecologist, was working under supervision as part of his Provisional Vocational Registration by Mr Jim Faherty (who is credentialed in urogynaecological mesh procedures).
			Mr Lanki has not been credentialed locally for urogynaecological mesh procedures, however, he is credentialed in SDHB in Obstetrics and Gynaecology. We will be taking immediate actions to reinforce the implementation of the credentialing process including:
			• Ensuring that Mr Lanki does no more urogynaecological mesh procedures until, and if, he is credentialed for these procedures
			  • Specifically communicating the exact limitation on these procedures to only the named credentialed surgeons to:
			  ○ Theatre and Service Managers
			  ○ General Managers of Surgery and Women's Health
			  ○ Urology and Gynaecology Surgeons
			  ○ Medical Directors of Surgery and Women's Health
			  ○ Executive Director of Specialist Services
			• Commencing a review of this particular event
			• Please be assured that this is a matter we take very seriously and that we will take the necessary steps to closely manage the process for urogynaecological mesh procedures. We will correct any deficiencies in our credentialing process we find from the review.

SS04: Implementing the Healthy Ageing Strategy	A	LG	

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td colspan="2">SS05: Ambulatory sensitive hospitalisations (ASH adult)</td><td>P</td><td>LG</td><td>Result: Southern total (2,952/100,000), Southern Māori (4,976/100,000). National total rate: 3,858 per 100,000 (Standardised ASH rates, 12 months to March 2020 for those aged 45 to 64 years)

MoH response:
Great to hear you have ASH 45-64 in the SLM plan. We look forward to seeing the outcomes of planned initiatives over the next year

Southern DHB report:
• The Southern District Health Board has not achieved against the ASH 45-64 measure for Māori but is very close for the Total ASH rate.
• For Southern Māori the rate remains significantly higher than the National and SDHB total rate. This equity gap is evident across almost all conditions for the 45-64 year Māori population.
• The Total ASH rate is well below the national average, which is positive however the SDHB set a milestone target in the 2019-20 annual plan of achieving <2925 and we achieved 2952. This is very close to the milestone set.
• To address this equity gap we have the ASH 45-64 rate in our SLM plan. This is a contributory measure for Acute Readmissions to Hospital SLM. Please refer to the 2020-21 SLM plan for more detailed actions and milestones that will target improving our outcomes for Māori in the SDHB</td></tr>
<tr><td>SS07 Planned care measures</td><td>Planned care measure 1: Planned Care Interventions</td><td>P</td><td>PN</td><td>MoH feedback:
Thank you for the information provided. Thank you also for the related information contained in your Planned Care Improvement Action Plan and Three Year Plan. Please provide additional information about the timeframes you are likely to achieve compliance with these indicators if this information is not already provided in your Improvement Action Plan.

Southern DHB report: Planned Care Interventions
<table>
<tr><th>Procedure</th><th>Result</th><th>Target</th><th>For 2019/20 (1 July 2019 to 30 June 2020) has achieved:</th><th>Actions to achieve compliance</th></tr>
<tr><td>Inpatient Surgical Discharges</td><td>88.8%</td><td>95%</td><td>Inpatient Surgical Discharges of 11,179 against a plan of 12,588 with a variance of (1,409)</td><td>• The actions that form part of the improvement action plan to address the ESPI 5 waitlist will also improve the number of surgical discharges.
• Currently achieving over target for July 2021.</td></tr>
</table>
</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

Minor Procedures	89.5%	95%	Minor Procedures 7,179 against a plan of 8,623 with a variance of (904)	• For 2020/21 skin lesions previously treated in the hospital will be seen and treated in the community which will increase the number of community minor operations by approximately 800-1000 for 2020/21. • The programme will commence in the second quarter of 2020/21.
Inpatient CWDs	94.9%	95%	Inpatient Surgical Caseweights of 17,202.4 against a plan of 18,134.4 with a variance of (932)	• The actions that form part of the improvement action plan to address the ESPI 5 waitlist will also improve the surgical CWD. • Currently achieving over target for July 2021.
Planned care interventions	88.8%	100%		• The physical therapy programme for spinal patients introduced in 2019/20 in Southland will be extended onto the Dunedin site for 2020/21. • The programme will commence in the third quarter of 2020/21.

Southern DHB commentary:

- Southern DHB was forecast to achieve the 2019/20 caseweight target and be under target for volumes if it had not been for the onset of COVID-19 in March which had a severe effect on our theatre and outpatient production capacity.
- In order to achieve the full year of funding Southern DHB was required to achieve 85% of the June target. In June 2020 Southern DHB achieved 92% of the monthly volume target across planned care intervention and has fulfilled the MOH requirements for full funding of 2019/20.

Specific actions:

- An Improvement Action Plan in draft form has been approved by the MOH and implementation of actions to reduce the ESPI 2 and ESPI 5 waitlist has commenced. This will include additional outsourcing for long wait surgical patients, additional clinics for outpatients and implementing changes to models of care that will ensure the gains made via the improvement plan will be sustainable.
- Areas targeted for the first year of the Improvement Action Plan are:

9

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				○ Locum to maintain medical oncology performance ○ Gastroenterology locum ○ Urology / General Surgery ESPI 5 surgeries ○ Ophthalmology Dunedin specifically to clear risky follow up ○ Orthopaedics Dunedin half of ESPI 5 problem (circa $1m). ○ Orthopaedics Southland ESPI 2 & ESPI 5 half of the problem (circa $500k). ○ Half of Medical Imaging wait lists focused on MRI and CT Dunedin ($600k). ○ Rheumatology one-off funding to move follow-up backlog into primary care. ($80k). ○ Skin lesions and minor procedures, primarily for the ENT service ($310k). ○ O&G ESPI 5 both sites
	Planned care measure 2: Elective Service Patient Flow Indicators		PN	Southern DHB report: Elective Service Patient Flow Indicators

	Result	Target	Actions to achieve compliance
ESPI 1	100%	90%	Not required
ESPI 2	34.8%	100%	• Actions that are part of the improvement action plan are to introduce the MOH prioritisation tool to balance capacity and demand for FSA appointments, run additional clinics with current staff, to employ Fellow's for Orthopaedics and General Surgery for 12 months, to use the acuity tool to ensure that long wait patients are seen, waitlist maintenance i.e. regular checking of long waiting patients, employ specialist nurses for general surgery and orthopaedics to see patients within their scope which allows SMOs to see FSA patients, ensure that clinics are booked with a minimum number of FSA's. When will compliance be achieved? • For those services with a lesser number of breaches i.e. less than 100 the aim is to be compliant within 6 months. • For those greater than 100 such as Orthopaedics and ENT to target is a downward trajectory leading to compliance by Sep/Oct 2021
ESPI 3	0.1%	0%	Not required
ESPI 5	44.2%	100%	• Actions that are part of the improvement action plan are to apply additional funding for private hospital lists to focus on long wait patients, from July 20 to Dec 20 we are running Saturday elective surgery lists for long wait patients, daily meetings to review elective list utilisation, additional 16 hours of acute

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				(continued table)

			theatre time each week to reduce the number of elective cancellations, list maintenance to ensure that long wait patients are prioritised, evening lists being run to add one additional patient for orthopaedics, introduction of the CPAC score for Urology and employment and to introduce the prioritisation tool into ESPI 2 which will reduce the conversion rate to the inpatient surgical waitlist. When will compliance be achieved? • For those services with a lesser number of breaches i.e. less than 100 the aim is to be compliant within 6-12 months. • For the services that are greater than 100 such as Orthopaedics and General Surgery Southern DHB plans to focus for the next 12 months on reducing ESPI 2 breaches and then will focus on ESPI 5 breaches. During this time we plan to not deteriorate our ESPI 5 compliance further.
ESPI 8	99.9%	100%	Not required

Expectations:
ESPI 1 target: DHB services will appropriately acknowledge and process more than 90% of referrals in 15 calendar days or less.
ESPI 2 target: No patients are waiting longer than four months for their first specialist assessment (FSA.)
ESPI 3 target: 0 patients in Active Review with a priority score > the aTT (Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)
ESPI 5 target: 0 Assured patients are waiting over 120 days (Patients given a commitment to treatment but not treated within four months)
ESPI 8 target: 100% of patients were prioritised using nationally recognised processes or tools

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
	Planned care measure 3: Diagnostics waiting times		PN	Result: For quarters 3 and 4, Southern DHB did not achieve the CT and MRI indicators: 95 and 90% of referrals (respectively) receiving their scan within 42 days of acceptance during quarter one of 2019/20. Southern DHB exceeded the Angiography indicator that 95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Southern DHB report: diagnostic waiting times

Diagnostic	Result	Target	Actions to achieve compliance
Angiography	98.9%	95%	Not required
CT	60.1%	95%	• Result driven by Dunedin CT.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses			
	Angiography, Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)						• Actions that are part of the improvement action plan are to apply additional funding for private scans. • Approval has also been gained from the DHB board to resource permanent evening shifts with MITS, RMO and Nursing. Recruitment underway and expected start date is September 2020. • A full business case for a second CT scanner is being developed. When will compliance be achieved? • First quarter 2021/22
				MRI	41.2%	90%	• Results driven by Dunedin MRI. • Weekend and evening shifts are already part of business as usual. • Actions that are part of the improvement action plan are to apply additional funding for private and South Canterbury DHB scans. There has been an increase in the budget for Dunedin outsourcing however it is unlikely that either of these mitigations will create a sustainable solution and this will need to be revisited during the year to find a more sustainable solution. When will compliance be achieved? • First quarter 2021/22

CT Monthly Performance

Month	CT Performance
Jan 2020	52.27%
Feb 2020	55.5%
Mar 2020	57.21%
Apr 2020	44.36%
May 2020	47.35%
June 2020	60.32%

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				CT - additional commentary • The January result was consistent with the progressive deterioration in performance seen since September 2019. This is also in line with previous years, where January saw reduced performance due to the impact of statutory holidays in this month. Performance recovered somewhat, before dropping off in April/May which can be viewed as a direct consequence of COVID Alert Levels 4-2. • Excluding COVID related issues, as with previous reporting periods, much of the issue relates to High levels of urgent, high acuity outpatient demand for CT at Dunedin Hospital. • Furthermore, current hours of operation do not allow for capacity increase to meet demand. This has also been true at Southland Hospital since July 2019, but to a lesser extent and with the exception of the Alert Level 4-2 period, performance at that site has not dropped below 70%. • While two rural hospitals and now Queenstown Lakes District Hospital have CT capability, the majority of patients waiting for CT in the District live in Dunedin City and many are unwilling to travel the 2 hours (return) to Oamaru, 4 to Dunstan or 6 to Queenstown. • We also note an apparent decrease in the proportion of Māori patients scanned against the total since we have been encouraging patients to travel. It is likely that access to transport is a barrier here. June saw a recovery, a consequence of increased outsourcing and travel to rurals, particularly to Oamaru. Southern DHB has three initiatives underway to address the issues principally being experienced at Dunedin: • Increase funding in the short term to provide for increased outsourcing of urgent CT outpatients awaiting scan at Dunedin – includes sending greater than usually funded volumes to rurals. • Funding has been approved to increase CT staffing at Dunedin with a view to extending the hours of operation (Evening shift to 2300 Mon – Thu) which will increase elective capacity. Friday was not included due to rostering considerations and higher levels of acute demand. Increase in elective capacity is expected to commence c. 7 September 2020. Utilise SPECT CT during nuclear medicine down time for diagnostic CT – this required staffing and capital investment and will commence 04 August 2020. • Invest in second diagnostic CT for Dunedin – on approved Capital list for 2020/21 year. MRI monthly performance

Month	MRI Performance
Jan 2020	38.7%
Feb 2020	47.27%
Mar 2020	46.03%

9

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				Apr 2020: 29.56% May 2020: 30.12% June 2020: 41.3% MRI - additional commentary: • Similarly to CT, MRI performance appeared to be recovering from the January drop in performance seen each year, following a slide from reasonably consistent performance in the 50-55% range since February to November 2019. A COVID related drop was seen between April – May 2020 and a relatively sharp recovery to pre-COVID levels of performance appears to be underway. • This has to a large extent been driven by additional sessions at Southland and increased outsourcing in Otago. Southern DHB has increased outsourcing budgets for 2020/21 and this will be targeted particularly at Cardiac MRI patients, a group for whom there is very little capacity and consequently there are long waits for these patients. • Southland MRI will be replaced from 14 August to 02 October 2020 and consequently it is envisaged that performance will deteriorate. Additional sessions worked up until this date will see the outage commence with a predicted 65-80 elective patients waiting. These efforts see Southland's performances against the target at 61.81% as of 29 July. While there is capacity in private to manage acutes and some urgent outpatients, Dunedin will also be assisting with urgent outpatient demand over this period. We expect the waitlist to increase to c. 300 patients by the time the new scanner is commissioned. Additional sessions at Southland are planned to commence shortly after installation is completed to address this. The variance in MRI from the required target is explained by several factors: • Demand for both acute and elective MRI exceeds capacity • Age and stage of Southland MRI
	Planned care measure 4: Ophthalmology Follow-up		PN	Southern DHB report: Ophthalmology Follow-up Waiting Times Ophthalmology Follow-up Waiting Times — Result: 7.0% — Target: 0% — Actions to achieve compliance: • Dunedin 1211 Southland 958 over 50% of follow up date. • Actions that are part of the improvement action plan are to address costs for locums. Currently fully staffed on both sites however it will likely take most of the year to recover (without further COVID resurgence). • Ophthalmology is particularly susceptible to reductions during COVID due to overcrowding in waiting rooms and close proximity during outpatient clinics.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
	Waiting Times			When will compliance be achieved? • Quarter 4 Expectation: No patient will wait more than or equal to 50% longer than the intended time for their appointment. Additional commentary: • Recovery phase complete and working on quality improvement. • To improve planning a 12 month forward view forecasting tool of expected follow-up waitlist load is being developed. Once complete this will enable improved leaving management and locum use during high volume periods • New model of care being introduced which will see more actions done by technicians than nurses. This is a similar model to that being used in the North Island DHB's and reduces the number of times a patient needs to see staff. • We're are now fully staffed for the first time in five years
	Planned care measure 5: Cardiac Urgency Waiting Times		PN	Southern DHB report: Cardiac Urgency Waiting Times (see table below) Expectation: All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency Additional comment: • Additional lists have been scheduled at a Mercy hospital, a private facility • On-going work to improve access and utilisation of ICU beds

Southern DHB report: Cardiac Urgency Waiting Times

	Result	Target	Actions to achieve compliance
Cardiac urgency waiting times	7.0%	0%	• We continue to monitor and prioritise clinical need. This includes, weekly MDT meeting for the following week surgery plus outplacing at private hospital for lower risk outpatients. • The completed ICU build (main constraint to delivery) is estimated to be 12 months away. Whilst there are no more ICU beds, there is likely to be more flexibility with increased staffing across the week When will compliance be achieved? • Currently achieving target end of July 2020

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
	Planned care measure 6: Acute Readmissions		PN	Result: Southern DHB rate 12.0% against year end target of ≤11.7%. National rate: 12.8% (Year to Mar 2020) Southern DHB report: Acute Readmissions

	Result	Target	Actions to achieve compliance
Acute readmissions	12.0%	≤11.7%	• The implementation of the discharge bundles to reduce emergency readmissions within 28 days of discharge commenced in the Dunedin medical ward from May 2018. Some components of the bundle are consistently achieved, for others processes are being reviewed & staff educated. • Nurse led discharge checklists which prompt nursing staff to communicate with patients/family whanau, around their hospital admission, instructions following discharge and what to do if they have any difficulties. • All patients on 8 Med are advised to see their GP within 5 days of discharge for review. GP's are prompted to consider patient enrolment in CLIC. • Referrals to the Home team are made where appropriate – Embedded • A discharge checklist was introduced for patients admitted with COPD from July 2019 to the Dunedin respiratory ward and Invercargill Medical ward as part of an integrated care plan in conjunction with primary and community services. Dunedin more successful than Invercargill. Contacted Invercargill respiratory CNS to understand utilisation in Southland better. • COPD patients are offered a free GP follow up appointment on discharge (funded by Well South). Early data indicates positive results • Health Care Homes initiative continues to roll out with 14 practices (115,000 patients) working through this process. Freeing up available primary care appointments through GP triage. When will compliance be achieved? • Quarter 4

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
SS08: Planned Care Three Year Plan		**NR**	LG	Southern DHB report: • The process for finalisation of the Southern Three Year Plan has not been completed. We anticipate that the final draft Three Year Plan will be available by the end of the 2020 year.
SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	**A**	MC	

	Focus Area 2: Improving the quality of data submitted to National Collections	**P**	MC	MoH response:
				Thank you for your feedback for Indicator 2 'National Collections Completeness'. There is no cause for concern at this stage regarding the NMDS and NNPAC volumes.
				
				Indicator 1: NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures. Southern DHB result: 31%. Achieved is greater than or equal to 90% and less than 95%, based on average rating across the three collections.
				
				Southern DHB Indicator 1 report:
				There are 3 broad areas in NPF
				• Mandatory fields – we are submitting all mandatory fields
				• Missing services – we are submitting all required services as well as radiology, cancer diagnoses, presenting problems and related referrals to provide episodes of care.
				• Timeliness – this is where our problems are.
				  ○ We have many records in DHB error (approximately 17,000 going back to July 2018), so these records are not available to MoH to match to records held in the other extracts. Correcting these requires action from three parties: SDHB Information Services Extract Team, SDHB Services, and Alcidion, our extracts vendor.
				  ○ The following is our high-level plan to address and rectify these errors. While it is our intention to correct all the existing errors by 31 December 2020 there will always be a certain level of errors. The plan includes actions to minimise these, scheduled to February 2021

<table>
<tr><th colspan="2">Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>Target month for completion</td><td>SDHB IT - Extracts SDHB Services Alcidion (Vendor)</td></tr>
<tr><td>Aug</td><td>• Accurate measurement of current error situation
• Control of sync's and batching to DHB
• Batch Acknowledgement changes working correctly – giving control of syncing and batch mgt to DHB</td></tr>
<tr><td>Sep</td><td>• Review interfaces for issues causing unnecessary errors or missing data</td></tr>
<tr><td>Oct</td><td>• Identify/group errors – target large volume errors first
• Education and 'buy in' to fix identified errors</td></tr>
<tr><td>Nov</td><td>• Improve audits to front line staff to correct in a timely fashion
• Education and 'buy in' to fix identified errors</td></tr>
<tr><td>Feb</td><td>• Implement reconciliation of NPF data
• Work with Alcidion to understand and improve the 'linking' ID's between NPF and other extracts
• Review and improve 'linking' ID's between extracts</td></tr>
</table>

Indicator 2: National Collections completeness.
Southern DHB result: 91.41%. Partial achievement (Achieved is greater than or equal to 94.5% and less than 97.5%, based on an average ratings across the collections - NMDS, NNPAC, PRIMHD.

Southern DHB Indicator 2 report:
The Extract Team have reviewed this result and are comfortable that we have met the deadlines for submitting our data. The reduction in numbers could be as a result of COVID period. We expect these numbers to come back up next quarter.

Indicator 3: Assessment of data reported to the National Minimum Data Set (NMDS) - Achieved</td></tr>
<tr><td></td><td>Focus Area 3: Improving the quality of the Progra</td><td>A</td><td>MC</td><td></td></tr>
</table>

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
	mme for the Integration of Mental Health data (PRIMHD)			
SS10: Shorter stays in emergency departments		N	PN	Result: 85.9% admitted, discharged, or transferred from an Emergency Department (ED) within six hours (target is 95%). Ranked 17th out of 20 DHBs. National result is 90.4%. MoH feedback: Thank you for your report. It's good to see an improvement on Q3 >1.5%. As you step out of COVID it will be good to see improvement on your health target. Can you please confirm whether you expect to see improvement in the indicator during the next quarter? If not, what additional actions can be taken to address the barriers you have identified? Southern DHB report: Percent managed within 6 hours by facility Facility / % managed within 6 hours Dunedin ED / 86.4% Lakes District ED / 100% Southland ED / 92.3% Southern DHB / 89.7% Actions undertaken this quarter to maintain or improve the indicator • During COVID 19 Levels 3 and 4 SDHB EDs were operating at 50% of normal demand during the acute phase. • The need to stream patients red and green in the Emergency Department and on the wards meant that flow through the department was not improved for the following reasons ○ Patients screened as 'red' were required to be treated in a separate area with full PPE being utilised ○ The available resource in the Emergency Department was split between 'Red' and 'Green' areas ○ The departments were physically split between 'red' and 'green' areas effectively reducing the capacity of the EDs

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td>(red)</td><td></td><td>

There was a desire to treat ‘red’ patients out of the hospital so much as was possible leading to extended lengths of stay in the ED
6 team structure in General Medicine to manage to cover for all medicine acute admissions, decision made to continue with 6 teams post COVID. As red and green streams continued to be required, there was still further pressure placed on the achievement of the six hour target
Post COVID EDs reverting to normal use of its facilities, red and green streaming dismantled

Planned work for next quarter

Fit 2 to Sit 8 expansion to ambulatory area
Draft template for electronic handover for whole of Dunedin hospital
Older Person’s Assessment Liaison process continuing
Board rounding/zone option by SMO group considered
Drafting up next patient/over capacity protocol
Continue to embrace use of telehealth to enable care to be delivered to anywhere within SDHB.
SDHB is supporting patients to remain at home or if an admission is necessary to return home as soon as possible establishment of HOME teams across Southland and Dunedin.
Emergency departments having regular contact and liaison with Mental Health services. Work to increase performance has involved looking at ED assessment times (through a trial of Early Specialist Assessment), and admissions, through the establishment of an Older Person’s Assessment Liaison service.
Despite this, increasing numbers of people attending EDs in the Southern district continue to place pressures on the system
Additional resource to fully implement generalist acute admitting model of care by December 20

Barriers to achieving or maintaining the indicator

As a result of COVID 19 alert level 4 the delay in planned care as well as anyone in our community accessing acute care will place our system under continued pressure in the weeks and months ahead.

Data on acutely admitted patients
Provide your data on target performance split by those patients who are discharged from the Emergency Department directly and those who are admitted to an inpatient hospital ward (not a statistical ‘admission’ based on the three-hour funding rule)
<table>
<tr><th></th><th>Total Attendances</th><th>In ED over 6 hrs</th><th>% over 6 hrs</th></tr>
<tr><td>Not admitted</td><td>13626</td><td>897</td><td>6.58%</td></tr>
<tr><td>Admitted</td><td>4403</td><td>1652</td><td>37.52%</td></tr>
</table>
</td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

Total	18029	2549	14.14%

For those Admitted to an inpatient ward, provide a separate report of target performance by service

	Total admitted from ED	In ED over 6 hrs	% over 6 hours
Medical (incl. all subspecialties	2325	1030	44.3%
Surgical (all subspecialties excl Ortho and O&G)	1244	443	65.61%
Orthopaedics	471	115	24.42%
O&G	132	14	10.61%
Other	212	31	14.62%
Total	4384	1633	37.25%

Provide data on the number and proportion of patients admitted to an Emergency Department Short Stay Unit (SSU) that are subsequently admitted to an inpatient ward

	Admitted to SSU	Transferred to inpatients from SSU	% transferred
Total	1399	189	13.51%

Provide data on what proportion of patients counted in your denominator that have an Emergency Department stay <15 minutes and where they go (discharged or admitted)

	Total ED attendances	# under 15 mins and discharged	# under 15 mins and admitted	Total stayed under 15 mins	% < 15 mins
Total	18029	275	130	305	16.93%

Acute demand actions from Annual Plan 19/20

Acute Data Capturing: Please provide an update on your plan to implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021

9

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			• DXC (Vendor) has been requested to modify EDIS to allow capture of SNOMED codes. DXC have estimated that this upgrade and functionality will be available to all EDIS clients by Q4 2020/21 (dependency on DXC). Note this is a delay from Q2 2020. • SDHB EDIS User Group has been engaged with the requirement to implement SNOMED coding by July 2021. However with the delay in delivery of required functionality in EDIS the review of code sets and process changes have been delayed until Q2 2020. • A detailed implementation plan will be provided to the Ministry in Q3 2020/21. Including review of code sets, process changes, iPM collection for rural ED's, report and NNPAC extract reviews/changes, interfacing review, testing and training. • SDHB is targeting Q4 2020/21 for the implementation of SNOMED for ED (dependency on DXC delivery). To improve Patient Flow, please report on actions from your Annual Plan that: Improves patient flow for admitted patients • We have completed a draft business for additional to implement a new model of care-generalism in Dunedin hospital which will when implemented improve ED performance. Work to increase ED performance includes the establishment of an Older Person's Assessment Liaison service (OPAL).Work is occurring at both Dunedin & Southland EDs and initiatives include Fit 2 Sit with 8 ambulatory chairs, a fast track area, a PAU and scoping out opportunities for facility upgrades to provide a dedicated short stay unit. Improves management of patients to ED with long-term conditions • Supporting patients to remain at home or, if an ED presentation or hospital admission is necessary, to return home as soon facilitated by allied health (HOME) Team established across Dunedin and Southland sites. Improve wait times for patients requiring mental health and addiction services who have presented to the ED • Work closely in an integrated manner with Mental Health services to ensure ED is responsive to the needs of those suffering acute or chronic mental health conditions Q1-Q4 Improves Māori patients experience in ED • Established Southern DHB steering group, to include Māori Health Directorate and identified actions to address needs of Māori patients Q1, Māori Health Directorate worked with ED staff to identify their training needs Q1, Cultural training delivered to ED staff to address training needs.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
SS11: Faster cancer treatment (62 days)	N	PN	Result: 64.3% achievement (target 90%), ranked 18th out of 20 DHBs. National average: 85.3%. Target is 90% (Data based on patients who received their first cancer treatment (or other management) between 1 Jan 2020 and 30 Jun 2020). Ministry feedback: 65 percent achievement noted Southern DHB report: Analysis of Breaches - A heat map of 62 day capacity breaches 1 Jun 2019-to 30 June 2020 demonstrates breaches by treatment modality

Heat map of 62 day capacity breaches by treatment modality, 1 Jun 2019-to 30 June 2020

Treatment modality	Breast	Gynaecological	Haematological	Head and neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urological
Chemotherapy	2	2	4	0	1	5	0	0	0	1	0
Concurrent radiation therapy and chemotherapy	0	1	0	3	2	1	0	0	0	1	0
Non-intervention management	0	1	4	0	0	0	1	1	0	1	0
Other	0	0	0	0	1	0	0	0	0	0	0
Palliative care	0	1	0	0	0	1	0	0	0	1	0
Radiation therapy	0	0	0	3	3	6	0	0	0	2	0
Surgery	7	7	0	3	14	1	0	0	3	0	7
Targeted therapy	2	0	0	0	1	1	0	0	0	0	1

Southern DHB report:

- In May 2020, all major tumour streams met to undertake a stocktake post COVID and plan for catch up. This is available and was uploaded with this report. The aim of this report is to quantify the impact of level 3 and 4 lockdown on the main tumour streams; agree key risk areas and forecast bottlenecks; plan to mitigate risks; brief wider organisation about what is planned and what else is required.
- A review of cases not diagnosed during this time has been undertaken but it is still not clear why Southern DHB was an outlier in this area. All aspects of national guidance for diagnostics were followed. It could have been because 1) our previous year diagnoses was up due to Urology catch up and introduction of Bowel Screening, 2) We were affected early on in COVID and had to close outpatient clinics earlier than others.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				• Due to the decline in performance in Lung and Urology (62 day), we are undertaking a case review of the 30 patients that breached for capacity reasons. Both of these services should be reasonably up to date with their diagnostic pathways, so we want to verify the reasons for delay. This information will be presented at the Faster Cancer Steering Group. From this actions and recommendation will be implemented. • The DHB is developing FCT Dashboards which will assist to identify problems more quickly and using real time data from multiple sources. We will be able to update in the next quarterly report our progress with this.
SS12: Engagement and obligations as a Treaty partner		**A**	GiT	
SS13: Improved management for long term conditions (LTC)	Focus Area 1: Long term conditions	**A**	LG	
	Focus Area 2: Diabetes services	**A**	LG	
	Focus Area 3: Cardiovascular health	**P**	LG	MoH feedback: Thank you for your report, reporting has not fully addressed the following aspects of the template: Identifying priority populations and new groups as well as mechanisms to reach these populations and Specific models of care implemented to support risk factor management. Southern DHB response to MoH feedback: • SDHB and WellSouth identify all at risk (based on the new algorithm) enrolled patients and make their information available across the district to all primary care providers on a monthly basis. This then informs the practice who needs to be seen, and who has at risk factors that need to be managed. • On the first of each month the system will calculate who is in the age cohort that is targeted for a CVD RA (the denominator), and then whether that person has had a CVD RA in the past five years (numerator). Ras are only funded for high needs patients.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				• Each month people are added or removed from the cohort as per the rules set by MoH, so the denominator will change as appropriate. • This information is provided through a live platform that is interactive for the user interface to make the process seamless for the Practice. Southern DHB report: • WellSouth is working with our data analytics provider, Datacraft and our data management provider, Karo, to implement the CVD Risk Assessment algorithm here in Southern. To date, Karo and Datacraft have developed the tool to measure CVD Risk. Karo and Datacraft have run test cases against the proposed solution and we propose to launch the new calculation criteria via the WellSouth portal in September 2020 • The proposed solution is compliant with the data dictionaries published by the MoH • WellSouth is redesigning its incentive programme for CVD RA and will implement the new scheme in Q4 • WellSouth will promote the new approach to CVD RA with CME evenings, a communications plan and an incentive programme. The comms and education programmes will be utilised to support the rollout of the new tool. • WS will reviewing the funding for CVD Risk Assessments at general practice for high needs patients (Māori, Pacifika, deprivation index Q5) and for mental health patients • Patients whose CVD Risk calculation suggests that they need active management will be managed via WellSouth's long-term conditions management programme CLIC, which provides funding to patients based upon their stratification after a Comprehensive Health Assessment – to be developed following the CLIC review implementation • All practices will provide long-term conditions care to patients under the CLIC programme by the end of Q4
	Focus area 4: Acute heart services	**P**	PN	Ministry response: Well done on achieving the key door to cath target, and being proactive in pursuing improved results for the medication indicator. Southern DHB result: Acute heart services

	Expectation	Performance
Indicator 1	Door to cath within 3 days for ≥ 70% of ACS patients undergoing coronary angiogram.	91%
Indicator 2	Registry completion- ≥95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge	100%
Indicator 2b	99% within 3 months	Data not available

9

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<tr><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>Indicator 3</td><td>ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).</td><td>89.9%</td></tr>
<tr><td>Indicator 4</td><td>Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance ≥ 85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge -
○ Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) and
○ an ACEI/ARB if any of the following – LVEF <50%, DM,HT,in-hospital HF (Killip Class II to IV) (4 classes), and
○ Beta-blocker if LVEF<40% ((5-classes).
○ An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.</td><td>73.3%</td></tr>
<tr><td>Indicator 5a</td><td>Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure</td><td>98.1%</td></tr>
<tr><td>Indicator 5b</td><td>Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device ICD forms completed within 2 months of the procedure.</td><td>98.1%</td></tr>
</table>
Southern DHB report:
Where the indicator has not been met, identify the indicator and provide narrative on any barriers/challenges to achieving the indicator and any mitigation strategies for these to be applied over the next quarter.
• Indicator 5a Device registry completion. – Almost there for registry completion. No Anzac-QI forms completed during lockdown.
• Indicator 4 again not met. Have asked consultants to further discuss this at their peer review meetings</td></tr>
<tr><td></td><td>Focus Area 5: Stroke service</td><td>N</td><td>PN</td><td>MoH feedback:
• Dunedin is the only hospital to achieve Ind 1 – There is no lead stroke physician in Invercargill.
• Dunedin is the only hospital to have any presenting pts thrombolyse.
• The Southern DHB, given its size as a large DHB is consistently the worst performing DHB for acute stroke services. Could you please indicate if there are any plans to improve these services?</td></tr>
</table>

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				• It would be good to get further commentary about your participation in the regional telestroke service, could you please provide some further commentary. Your report only provides information for Q2 could you please provide Q3 data and commentary. You do not provide any information for Māori for Inds 2, 3 and 4. Could you please do so. The report is not signed off by the lead stroke physician and the lead stroke nurse could you please ensure this happens.

Southern DHB result: Indicator 1

Indicator 1: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	60	75	80.0%	Dunedin	64	72	88.9%
Invercargill	0	56	0.0%	Invercargill	61	74	82.4%
Dunstan	0	14	0.0%	Dunstan	0	16	0.0%
Oamaru	0	10	0.0%	Oamaru	0	7	0.0%
Total	60	155	38.7%	Total	125	169	74.0%

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 1: Dunedin site Southern DHB commentary

Quarter 3

- Dunedin Hospital (DPH) achieved the target of admissions to the Acute Stroke Unit. DPH continue to manage most acute stroke patients at some point in their acute episode of care within the Acute Stroke Unit. Almost all those not in the ASU we are co-managing with other service e.g. post cardiac surgery or the patient is on a palliative pathway. At times the ASU is full and we attempt to collocate patients in adjacent rooms to the ASU.
- We continue to work to upskill nursing staff in all areas of acute stroke management including getting a cohort of nurses skilled in stroke swallow assessment. Ongoing resignations/reappointment make this an uphill journey. Workload is high for all staff members involved who are consistently keen to learn and facilitate the best outcomes for patients and family and whanau.

Quarter 4

- We continue to manage most acute stroke patients at some point in their acute episode of care within the Acute Stroke Unit. Almost all those not in the ASU we are co-managing with other service e.g. post cardiac surgery or the patient is on a palliative pathway. At times the ASU is full and we attempt to collocate patients in adjacent rooms to the ASU.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				• We continue to work to upskill nursing staff in all areas of acute stroke management including getting a cohort of nurses skilled in stroke swallow assessment. Workload is high for all staff members involved who are consistently keen to learn and facilitate the best outcomes for patients and family and whanau. • The end of this quarter has seen changes in the organisation of all rehabilitation services in Dunedin arising due to COVID-19. The need to isolate a COVID-19 inpatient ward led to a reduction in rehabilitation bed numbers and transfer of the Dunedin Hospital Based rehabilitation service to Wakari Hospital. • This has led to changes in practice for patients being transferred from the ASU to inpatient stroke rehabilitation. We will review the impact of this as we get the data for the next Quarter. Indicator 1: Invercargill site Southern DHB commentary Quarter 3 • Due to staff vacancy (designated Lead Stroke Physician) Southland continues to report that 0% of patients are admitted to an organised stroke service Quarter 4 • Results have been provided for patients entered in to an acute stroke unit/organised stroke service, although we acknowledge that without a designated lead stroke physician we technically do not meet the definition. Despite this, the stroke service is meeting the targets for patients. Southern DHB result: Indicator 2

Indicator 2: 10% of potentially eligible stroke patients thrombolysed 24/7							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	8	59	13.6%	Dunedin	6	55	10.9%
Invercargill	0	54	0.0%	Invercargill	2	65	3.1%
Dunstan	0	12	0.0%	Dunstan	2	15	13.3%
Oamaru	0	10	0.0%	Oamaru	2	6	33.3%
Total	8	135	5.9%	Total	12	141	8.5%
+Lakes	1	1	100%				

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 2: Dunedin site Southern DHB commentary
Quarter 3:

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				• Thrombolysis rates in Dunedin vary but in this quarter we have had a higher number of cases thrombolysed and at 13.6% achieved the target of 10%. Two patients were transferred to Christchurch for consideration of Clot retrieval. They were both thrombolysed in the Dunedin ED prior to leaving for Christchurch. We are preparing to move from using alteplase to tenecteplase. This required work between the acute stroke team, ED, pharmacy and radiology. Including education sessions for staff involved and updating our pathways. We are phoning the Christchurch team for advice for potential Stroke Clot Retrieval patients. The rural teams are working directly with the Christchurch neurology service for acute stroke management and the Dunedin Team is not usually involved. Quarter 4: • In this quarter we have transferred from using alteplase to tenecteplase for thrombolysis. This is simpler to use and also facilitate administering this earlier and hopefully we will see reduced door to needle time. Staff find this easier to use. Looking at these 6 cases the range of DTN is 36 to 160 minutes and an average of 77 minutes and similar to the average for the last year (72 minutes). This is not yet achieving target of under 60 minutes. We will need larger numbers to provide more analysis. • Since the beginning of February 2020 medical registrars on the Dunedin site are contacting the Christchurch Neurology by phone for advice on the management of all acute stroke patients during afterhours and weekend. This is working well and we are well supported by our Christchurch colleagues. • In this quarter, six patients were transferred by helicopter for potential Stroke Clot Retrieval. • Since the establishment of the Dunedin Acute Stroke Unit in 2010 a daily meeting is held, Monday to Friday, to review all new admissions and plan for ongoing management and rehabilitation for all patient in the ASU. Attendees are the lead stroke physician, the Stroke CNS, nurses in the ASU, PT, OT, SLT and ward social worker and once a week a Stroke Foundation Member attends. Indicator 2: Invercargill site Southern DHB commentary Quarter 3: • On inspection of the data kept by the stroke CNS, 54 patients during this period presented outside the window for thrombolysis or had an unknown onset of symptoms. The other main reasons for not considering thrombolysis were poor baseline and improving symptoms. • During this period 7 patients presented with Haemorrhagic stroke and 1 case thrombolysed from Lakes district and transferred to Dunedin Quarter 4: • On inspection of the data kept by the stroke CNS, 65 patients during this period presented outside the window for thrombolysis or had an unknown onset of symptoms. The other main reasons for not considering thrombolysis were poor baseline and improving symptoms.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
				• During this period 7 patients presented with Haemorrhagic stroke. The two cases thrombolysed were transferred to other regions for ongoing care, including one to Christchurch for clot retrieval.

Southern DHB result: Indicator 3

Indicator 3: 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	25	33	75.8%	Dunedin	16	25	64.0%
Invercargill	12	13	92.3%	Invercargill	14	17	82.4%
Dunstan	0	0	0.0%	Dunstan	0	0	0.0%
Oamaru	0	0	0.0%	Oamaru	0	0	0.0%
Total	37	46	80.4%	Total	30	42	71.4%

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 3: Dunedin site Southern DHB commentary

Quarter 3:

- The percentage of people transferred to rehabilitation services remains around 75%. Dunedin has a generic community rehabilitation service and this varies for those generally younger patients who have stroke rehabilitation at Wakari Hospital and those who rehabilitate at Dunedin Hospital with the stroke rehabilitation team.

Quarter 4:

- Stroke rehabilitation services have been impacted by Covid-19, and we have temporarily relocated of all rehabilitation services to the Wakari Hospital site.. There is now higher level of medical stability required before transfer from the Dunedin site. Some stroke patients, who would have previously transferred to OPH stroke rehabilitation service are now having to receive all their inpatient rehabilitation within the Acute Stroke Unit where resourcing and experience of staff is different from a dedicated rehabilitation service.

Indicator 3: Invercargill site Southern DHB commentary

Quarter 3:

- The target was achieved and is a significant improvement from the previous report.

Quarter 4:

- Target achieved.

Measure		Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

Southern DHB result: Indicator 4

Indicator 4: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge							
Quarter 3				Quarter 4			
Site	Numerator	Denominator	Percentage	Site	Numerator	Denominator	Percentage
Dunedin	1	21	4.8%	Dunedin	1	20	5.0%
Invercargill	0	4	0.0%	Invercargill	0	7	0.0%
Dunstan	0	0	0.0%	Dunstan	0	0	0.0%
Oamaru	0	0	0.0%	Oamaru	0	0	0.0%
Total	1	25	4.0%	Total	1	27	3.7%

Note: Indicator results and numbers are for the previous quarter (i.e. Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities

Indicator 4: Dunedin site Southern DHB commentary

Quarter 3:

- No comments

Quarter 4:

- Advised at Stroke Governance meeting, that patients with stroke in the community have been seen more quickly as a backlog has been caught up over the COVID lockdown period (Q4). Allied health hoping this will continue if they can introduce a new model of care, though this is in early stages.

Indicator 4: Invercargill site Southern DHB commentary

Quarter 3:

- We are currently recruiting additional AH staff to support our REACH team who provide our community rehab. Patients who have a delay in being seen by REACH are sent home with exercises to work on and if required have Home Team follow up (RN/OT/PT/AHA) while waiting for the REACH programme to start, however Home Team is not community rehab.

Quarter 4:

- Recruitment process is ongoing with REACH team who provide our community rehab. Patients who have a delay in being seen by REACH are sent home with exercises to work on and if required have Home Team follow up (RN/OT/PT/AHA) while waiting for the REACH programme to start, however Home Team is not community rehab.

<table>
<tr><th>Measure</th><th>Final Rating</th><th>Owner Initials</th><th>Ministry of Health Comments and DHB Responses</th></tr>
<tr><td></td><td></td><td></td><td>Other Southern DHB comments (Quarter 4)
• The regional Telestroke service is still struggling with IT issues around the telestroke carts across the district. IT are now replacing some of the hardware to see if this will address the connectivity issues. Once fully operational this would assist the assessment of our stroke patients, especially out of hours/weekend when medical registrars are having to phone Christchurch directly.
• Stroke Clot Retrieval activity - (Q3) three patients transferred to Christchurch for SCR – 1 deceased a week later from other complications, 1 successfully repatriated to UK, 1 successful SCR outcome
• Two patients transferred to Christchurch for SCR – 1 no SCR intervention & 1 successful outcome</td></tr>
<tr><td>SS15: Improving waiting times for colonoscopies</td><td>P</td><td>PN</td><td>MoH feedback:
• Ministry notes the impact of COVID-19 on CWTIs and bowel screening performance; this was taken into account when revising 2019/20 Q4 and Q1-2 2020/21 expectations that DHBs prioritise meeting maximum wait times.
• We appreciate your compliance with urgent and BS 306 targets, note your expectations to meet non-urgent recommended wait times by Q1 20/21 and prioritisation of people due for 1 year surveillance colonoscopies. However, as the DHB continues to have a significant total number of people waiting over maximum (452 in June), Ministry needs to see a Recovery Plan (by September 30) outlining when the DHB expects to achieve all maximum wait times.

Southern DHB report: Improving waiting times for colonoscopies
<table>
<tr><th></th><th>Indicator</th><th>Q4 Result</th><th>Comments</th></tr>
<tr><td>Improving waiting times for colonoscopies</td><td>90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.</td><td>77.3% total</td><td></td></tr>
<tr><td></td><td>70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.</td><td>33.1% total</td><td>• Recovering volumes post COVID.
• Initial emphasis was on bowel screening and urgent patients.
• Attention turned to non-urgent, expect to meet target by Q1 2020/21</td></tr>
<tr><td></td><td>70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their</td><td>38.8% total</td><td>• Recovering volumes post COVID.</td></tr>
</table></td></tr>
</table>

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			procedure in 84 calendar days or less of the planned date, 100% within 120 days or less. | | • Lowest priority group as least likelihood of finding sinister pathology • One year surveillance prioritised. • Recovery will take at least 6 months. 95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system. | 88.2% total (86.0% Māori) | • Bowel screening colonoscopies were prioritised for recovery post-COVID however the result for June still reflects the period of recovery. • Target to be met by Q1 2020/21
SS17 Delivery of Whānau Ora	A	GiT	
Improving Wellbeing through Prevention	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
PV01: Improving breast screening coverage and rescreening	N	LG	Result*:* BSA coverage (%) of women aged 50-69 years in the Southern district, for the two years ending 30 Jun 2020: Total 71.4%; Māori 69.9%; Pacific 60.1%; Asian 34.8%; other 73.8%. Target: 70%. National total: 70.8%. MoH feedback*:* • For this period coverage for the Southern DHB region was: Māori 69.9%, Pacific 60.1%, Asian 34.8%, Other 73.8% and Total 71.4%. • Coverage for Māori has been trending upwards and the coverage target of 70% has almost been met which is very positive.

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses

- Coverage for Pacific has been trending down for the last three years. It is positive to hear about plans to engage with Pacific Church groups and large employers starting in Dunedin. It would be good to hear more about the initiatives Southern DHB is planning to implement that you mention in your report.

Southern DHB response to MoH feedback:
Actions from the Annual Plan that will impact on equity and outcomes:

- Contribute to discussions regarding whānau ora approaches with Māori communities. Demonstrate meaningful activity moving towards improved service delivery. This will be undertaken under the auspices of a new Southern whanau ora policy. This will look towards the greater inclusion of whānau in health care plans and decision making that supports whānau and families to achieve their aspirations in life. It places whānau at the centre of decision making and supports them to build a more prosperous future. Importantly, this policy will overtly propose changes to the way that whanau ora services are purchased, and provide a new funding and contracting framework for our Kaupapa Māori health providers.
- Support and collaborate, including through current and future investment, with whānau, hapu and iwi, and identify opportunities for alignment (EOA)

Southern DHB report:
Southern DHB plans to implement initiatives that contribute to the achievement of national targets for Breast Screen Aotearoa (BSA). These initiatives demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services and will lead to the elimination of equity gaps in participation between Māori and non-Māori/Non-Pacific woman and between Pacific and non-Māori/Non-Pacific woman, and achievement of a participation rate of at least 70% for Māori and Pacific woman aged 50-69 years in the most recent 24 month period.

Quarter 4		Breast Screening Coverage
Southern DHB		Exceptions reporting
Ethnic Group	Coverage	Outline DHB activities, including contribution to regional coordination planning, to achieve 70% coverage if this target has not been met
Māori	63.2%	• Engage with kaupapa Māori health providers to improve screening rates for Māori Q2-Q4 • Engage with Industry (large employers) where high numbers of Māori are employed, starting with Dunedin
Pacific	55.8%	• Engage with Pacific Church groups to improve Pacific access • Engage with Industry (large employers) where high numbers of Pacific are employed, starting with Dunedin

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			European /Other — 66.2% TOTAL — 65.9% — Data-matching with WellSouth PHO to identify screening gaps in the eligible population • Coordinator to engage with GP practices to enrol participants based on data matching results • Provide education to GP registrars on the breast screening service
Better population Health Outcomes supported by Primary Health Care	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
PH01: Improving system integration and SLMs	**A**	LG	
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	**A**	LG	
PH03: Improving Māori enrolment in PHOs to meet the national average of 90%	**P**	LG	Result: PHO enrolment for Māori reached 86.6% in the second quarter, an increase of 0.6% since quarter 1. Target: 90%. MoH feedback: • Southern DHB has achieved a partially achieved rating. The Ministry acknowledges the work put in to increase Māori PHO enrolment rate and we look forward to the next report. Southern DHB report: • Increasing the ownership and capacity (skills and knowledge) of Māori communities to help improve and protect their wellbeing.

9

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
PH04: Primary health care: Better help for smokers to quit (primary care)	N	LG	Result: • 72.9% (total population) were given brief advice and support to quit smoking, (decrease of 3.3% from last quarter). • 73.7 percent of Māori and 69.6 percent of Pacific people were given brief advice to quit smoking. Rank: 18th out of 20 DHBs (total population). National result: 80.0% (total population) • Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit. MoH feedback: • Your final Q4 result is 72.9 percent. The DHB result decreased by 3.3 percent and you did not achieve the target. • We understand that the response to COVID-19 has been all encompassing for the majority of this year, however I am excited to hear more on what the new 'normal' opportunities are, and how they might improve performance. • The Practice Development Plans and the Māori Health plans are something I am particularly interested in. 73.3 percent of Māori and 69.6 percent of Pacific populations were given brief advice to quit smoking. • Well done on the work this quarter to sustain and improve target performance including a new data analyst product and reviewing the current approach to incentivising practices. We expect to see an improvement in Q3. • Please note that the result for Southern DHB's cessation support indicator is 26 percent. The national result for this indicator is 35.5 percent. This indicator shows the percentage of current smokers who have been given or referred to cessation support services in the last 15 months. The cessation support indicator result is for DHB use only and will not be publicly reported. You can use this indicator as a proxy measure of how well the clinicians are engaging with cessation services and how frequently they refer smokers to these services Southern DHB report: Do you think you have met the overall target (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? • The target will not be achieved in this quarter. The impact of COVID-19 and efforts to get back to "business as usual" in the post-lockdown period has taken the focus of both primary care teams and WellSouth support teams away from smoking cessation efforts. • The new "normal" does however provide an opportunity to rethink how practices approach their proactive care efforts over the coming months. WellSouth will implement Practice Development Plans where practices agree their objectives for

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
			proactive care for the coming year that will include specific smoking cessation goals. WellSouth will tie these plans in to funding incentives. Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored? • The target will not be achieved for Māori and Pacific people this quarter. The reasons are the same as above. • WellSouth are working with the Māori Health team at the DHB to implement Māori Health Plans at general practice that will include specific targets for Māori and Pacific patients that will be tied to funding incentives.
Annual Plan Status Update Reports	**Final Rating**	**Owner Initials**	**Achieving Government's Priority Goals/Objectives and Targets**
Annual Plan Status Update Reports - Improving Wellbeing through Prevention	**P**	LG	MoH response: • For Healthy Food and Drink - It is acknowledged the work done to develop the healthy food policy clause and plans to append to contracts coming up for renewal. Note the update on education settings with water only and healthy food policies.

9

Annual Plan Status Update Reports - Improving Child Wellbeing		LG	MoH feedback: Annual Plan Status Update Reports - Improving Child Wellbeing

Area	Feedback
Immunisations	• Thank you for your continued efforts to improve equitable immunisation coverage. We acknowledge the impact COVID-19 has on immunisation coverage and the delivery of immunisation services. We appreciate the mahi that your DHB has done to adapt your action areas and the services you provide to meet the needs of your communities. • Congratulations on successfully achieving three of your milestones. With regards to the milestones you partially achieved, we appreciate the detailed commentary you provided around the hold ups your DHB has experienced.
School-based health services	• Congratulations and thank you for your achievements this year. We note that COVID-19 has created issues for your progress, and your QI workplan has been carried over to the current annual plan. • We look forward to hearing about your progress with implementation of SBHS into Decile 5 schools, and your QI Plan, and linking with you on the SBHS enhancements work programme.
Midwifery workforce - hospital and LMC	• Good to see VPM is making progress. • Good to see the work being done to strengthen the Midwifery workforce, ensuring cultural competency and support for current Māori and Pasifika midwifery students. • Acknowledge the impact of COVID has had on some areas of work force education.
First 1000 days	• Well done for delivering all your First 1000 days Q4 milestones.
Family Violence and Sexual Violence	• We recognise the impact COVID-19 has had on some programmes of work within health, resulting in some delays in actions being completed, as is the case with your DHB. We look forward to reading about the completion of these actions in your next report. Keep up the good work.
SUDI	• Thank you for your focussed commitment to the SUDI programme. COVID 19 has certainly impacted on many things. • However, it is good to see the impacts your activities have had particularly the safe sleep device distribution, SUDI as a prioritised item in meetings, smoking cessation, young mothers and general efforts to improve whanau wellbeing and safe sleep environments for babies. Well done.

Annual Plan Status Update Reports - Improving Mental Wellbeing	P	LG	MoH feedback: Annual Plan Status Update Reports - Improving Mental Wellbeing **Inquiry into Mental Health and Addiction:** • Great to see SPC appointed and the Suicide Prevention Plan has been completed. **Population Mental Health:** • Thank you for your report **Mental Health And Addictions Improvement Activities:** • Thank you for your report. **Addiction:** • We note the delays that the decision to undertake a system wide review of the Southern Mental Health and Addiction system has had, and that of Covid-19. Despite those challenges some progress was made on other key actions. The filling of the Relationship Manager role will enable further progress, hope this goes well. **Maternal Mental Health:** • We note the delay due to COVID-19, and new timeframe
Annual Plan Status Update Reports - Better population Health Outcomes supported by Primary Health Care	P	LG	MoH feedback: • For Pharmacy - Thank you for your update. We acknowledge your efforts in progressing activities despite the challenges of COVID-19. We are interested in hearing the outcome of the Gore LTC pilot and if this model can be adopted across Southern / nationally. • For the activity targeted at improving influenza vaccination rates in Māori, Pacific and Asian people (Action 3), have vaccination opportunities through community pharmacy closed the equity gap? National data suggest that whilst the uptake of vaccinations by Māori, Pacific and Asian people has increased, uptake has also increased in non-Māori Non-Pacific groups, so the equity gap has not reduced. What is the situation in Southern DHB? Southern DHB response to MoH feedback: • The pharmacy CLIC to LTC pilot in Gore is aiming to deliver a model for community pharmacy that is targeted to a smaller total number of LTC patients, aligned to primary care. Service will be expanded to include a MUR and MDT involvement for all eligible patients. It is expected that this will replace the current LTC schedule for all of the SDHB ICPSA holders once the model has been evaluated and is sustainable. • For the activity targeted at improving influenza vaccination rates in Māori, Pacific and Asian people (Action 3), have vaccination opportunities through community pharmacy closed the equity gap? National data suggest that whilst the

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			uptake of vaccinations by Māori, Pacific and Asian people has increased, uptake has also increased in non-Māori Non-Pacific groups, so the equity gap has not reduced. What is the situation in Southern DHB? Southern DHB response to MoH feedback: • The pharmacy CLIC to LTC pilot in Gore is aiming to deliver a model for community pharmacy that is targeted to a smaller total number of LTC patients, aligned to primary care. Service will be expanded to include a MUR and MDT involvement for all eligible patients. It is expected that this will replace the current LTC schedule for all of the SDHB ICPSA holders once the model has been evaluated and is sustainable. • It is quite possible that this model (could) be adopted nationally, however it is important to note that some critical aspects for this have been delivered through Primary Care. It is a genuine integrated model. • The SDHB approves all requests by ICPSA holders to provide flu vaccination. Whilst pharmacy updates the NIR through Immunise Now, NIR data for this is quite unreliable, as many immunisation events occur and are not available to be seen on the NIR, so the exact population position is unknown. Focus is on increasing the total number given in any flu season.
Annual Plan Status Update Reports - Better population Health Outcomes supported by Strong and Equitable Public Health Services	**A**	PN	

Crown Funding Agreements (CFA) Variations

Measure	Final Rating	Owner Initials	Ministry of Health Comments and DHB Responses
CFA B4 School Check Services	**S**	LG	
CFA Well Child Tamariki Ora Services	**S**	LG	
CFA DHB Level Service Component of the National SUDI Prevention Programme	**S**	LG	
CFA Disability Support Services	**S**	LG	
CFA Health Services for Emergency Quota Refugees	**S**	LG	
CFA Primary Health Care Services	**B**	LG	MoH feedback: • Thanks for providing your summary on general practice services - I have emailed David Murray - our DHB primary care contact to arrange a zoom discussion re after-hours pharmacy services. Southern DHB report: After Hours Primary Care Initiatives – April 2020 – June 2020 Coverage for access to Zero Fees for Under Sixes and Zero Fees for Under Fourteens Urgent Care (after-hours) Services (this includes general practice and pharmacy services) Dunedin ED Overnight Service • WellSouth continues to pass 100% of this funding directly onto Dunedin Hospital ED as the provider of overnight primary care services in Dunedin city. HML Telephone Triage

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• WellSouth continues to use this funding to procure telephone triage for mostly rural practices across the region with all available funding being paid to HML for this service. This service costs more than the funding that is provided and WS meets the deficit out of its flexible funding.

Free After Hours Under 14s
• Invercargill Urgent Doctor Service is the only after-hours provider that charges under-14s for services. All other parts of Southern District provide free care to under 14 patients after hours
• After-hours services are free for under-14s across Southern district except in Invercargill, where the after-hours provider declines to offer zero-fees for under 14s. The under-14 population in Invercargill is 13,477, which represents 23% of all children in this age group in Southern.
• Only Invercargill urgent doctors refuses to provide zero-fees for U14s care after hours.

<table>
<tr><th></th><th>U14 Population</th></tr>
<tr><td>Southern District</td><td>57,745</td></tr>
<tr><td>Invercargill Urgent Doctors</td><td>13,477</td></tr>
<tr><td>% Without Access to Zero Fees U14 care after hours</td><td>23%</td></tr>
<tr><td>% With Access to Zero Fees U14 care after hours</td><td>77%</td></tr>
</table>

Southern DHB commentary
• As part of our Alliance, WellSouth and Southern DHB have established a Service Level Alliance Team (SLAT) to address the provision of urgent care in Invercargill, including access to after-hours care, zero-fees for under 14s, access to diagnostics, ED presentations and greater clinical contact between providers. Terms of Reference are being confirmed, including the composition of the SLAT and timeframes for reporting back to the Alliance Leadership Team.
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<tr>
<td>CFA Appoint Cancer Psychological and Social Support Workers</td>
<td>B</td>
<td>PN</td>
<td>
MoH feedback: Thanks, have noted the 2.2 FTE

Southern DHB report:
Clearly define the functions of the role at any given point along the diagnostic and treatment pathway
• In progress. In recent months the CPSSS team has been merged with the SBCS psychological support service (now CPS) so that the pathway and capacity is seamless. All roles including Social Workers report into the Service Manager of SBCS and Clinical Lead of CPS (i.e. no longer report to Allied Health

Clearly define how the role differs and/or complements existing roles that the DHB has invested in, and ensure that the cancer psychological and social worker job description aligns with the regional approach
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			• The SBCS is district wide. CPS is integrated into the SDHB Oncology and Radiology services working with consultants, cancer nurse coordinators as well as building relationships with surgical specialities and primary care Ensure that appropriate administration resource is available to support the cancer psychological and social support worker/s • Admin requirements are being revised due to full team being employed. Additional comment: • CPSSS initiative staff and SBCS staff (2.2FTE) are now merged under one team, namely Cancer Psychosocial Service (CPS) for Southern Blood and Cancer Service (SBCS).
CFA Appoint Regional Lead Cancer Psychological and Social Support Initiative	**B**	PN	MoH feedback: • Have noted the 0.6 FTE Southern DHB report: • Appointment of 0.6 FTE from 1.7.2020 to 30.6.2021 (secondment to cover extended SL since mid-2019)

9

Southern District Health Board

SDHB Board

Digital Programme Update

October 2020

Action required:
• **Note** the status of the Digital Programme • **Note** outcomes from the business case review clinic held with Treasury on 21st of October 2020

Presented by	Mike Collins - ED People Culture & Technology, Southern DHB
Purpose	This paper provides a status update of the digital programme.
Attachments	Draft Digital Programme Business Case

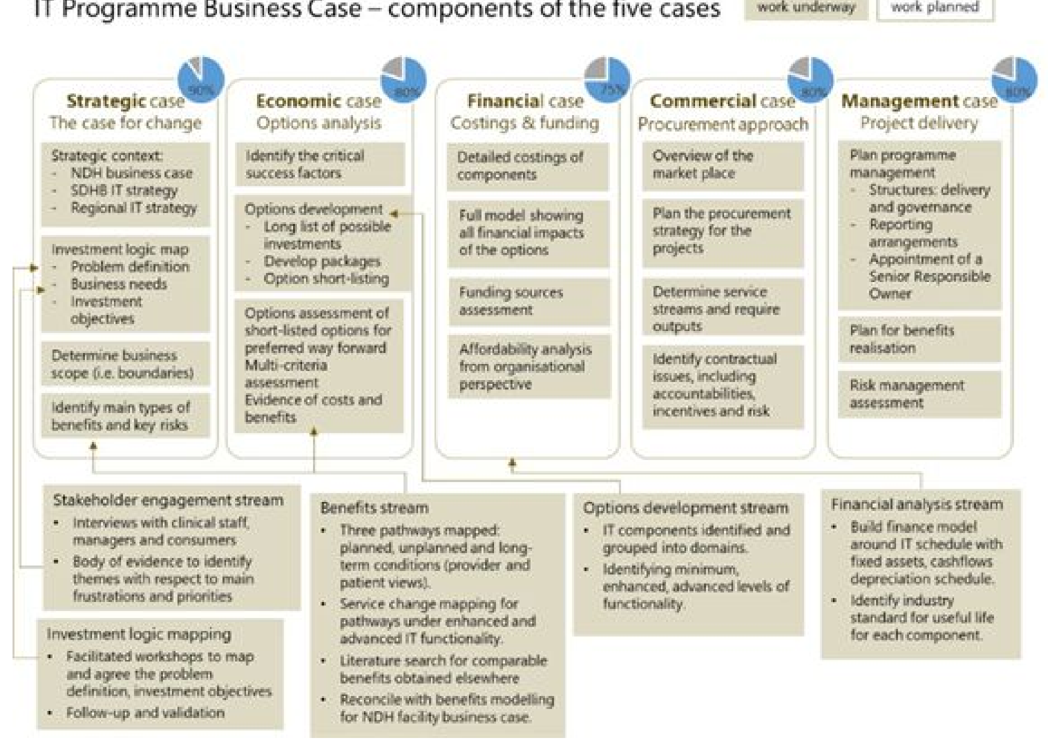
1. Background

In June 2020 the NDH Digital Approach Paper was discussed at SPG and endorsed by the SDHB Executive and Board. The paper outlined the proposed groupings and budget estimates ($197.3M) based on proposed funding sources and responsibilities.

The governance groups also endorsed the development of a programme level business case inclusive of all groups, with an initial draft for review to be presented in late September 2020 with a final version to be presented in late October.

2. Status Update

Development of the digital programme business case has progressed well during the period with all cases now at 75% + and a consolidated draft attached for review.



3. Business Case Review Clinic

On Wednesday 21st of October 2020, at the request of the SDHB, Treasury facilitated a review clinic based on an early draft of the digital programme business case issued the week prior. The clinic was hosted by Treasury in Wellington and well represented by central agencies including Ministry of Business, Innovation and Employment, Public Service, Infrastructure Commissioning, Digital Government and Ministry of Health.

Overall, the meeting was very positive and confirmed we are on the right path. Constructive feedback was provided on how to strengthen the business case and there was an obvious desire to assist in making the business case successful. Generally, the feedback and discussion can be summarised as follows.

i. Service transformation and the digital context

A key theme was the need to provide evidence of service transformation works (including new models of care, health pathways and workforce) and alignment to the digital programme. Service transformation was seen as critical to the success of the digital programme and the NDH project and it was requested that a section be included upfront in the business case that shows the broader change approach and the context of the digital programme within.

Suggestions also included the development of a service transformation “blueprint” similar to the digital blueprint to describe the structure and target state for the SDHB and the group recommended a high-level integrated schedule showing the time line and interdependencies of the NDH project, service transformation and digital programme.

ii. Tactical feedback

Tactical feedback was provided on how to strengthen specific areas of the business case. A complete register will be issued by Treasury in the coming week and will include points discussed such as:

- Provide additional linkages between the objectives and recommended option
- Highlight the consultation that was undertaken with other digital hospital projects
- Detail the process of reviewing the NDH functional design brief to confirm the scope
- Elaborate on the potential benefits – to be developed in the detailed business case
- Highlight the HIMMS maturity assessment and confirm linkages to the objectives
- Consider the resequencing of the systems stream with refence to the tranches
- Confirm the end state and whether further enhancement is expected
- Plan for a quantitative risk assessment and development of an assurance plan
- Acknowledge that a recruitment strategy will be developed

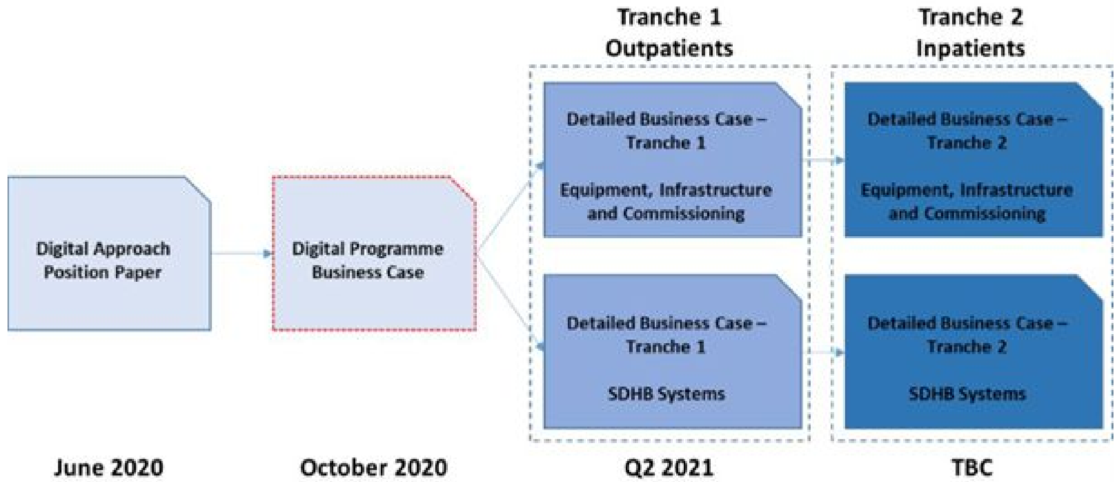
iii. Progressing the business case

The process to approve the programme business case was discussed and a follow up meeting will be scheduled. In summary the expected pathway is SDHB Board > SPG > CIC > Minister > Cabinet (target March 2021 for Cabinet approval).

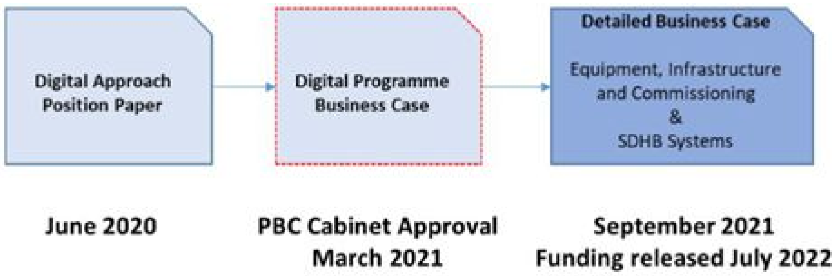
Following approval of the programme business case a detailed business case will be required to follow the same process. The group indicated a single detailed business case would be preferential and more efficient than multiple detailed business cases as previously proposed. The single detailed business case could include multiple tranches and funding points achieving the same result.

In order to release funding in FY22 the detailed business case would need to be submitted to Cabinet for approval in September 2021.

Previously proposed business case approach



Newly proposed business case approach



iv. Short term funding

It was recognised by the group there is a gap between now and when funding is likely to be available based on the above approval processes (July 2022). It was also acknowledged that in the meantime funding is required to maintain momentum, develop the detailed business case, and progress critical design works as to not delay the NDH construction programme. This was contemplated in the business case as Tranche 0 however based on the revised approach this tranche will run for 18 months rather than 12 months as previously planned (refer below for the proposed Product Breakdown Structure of Tranche 0). The quantum of funds for the 18-month duration is estimated at $15M (excluding PICS), approximately 50% of which is related to the systems scope which is proposed to be funded by the SDHB through internal cashflows and 50% of which is related to NDH infrastructure to be funded through the MOH.

A number of options to secure short-term funding were discussed including:

- Progress further discussions with MOH to access interim funds.
- Proposal to Cabinet for interim funds noting the final investment decision would be approved with the detailed busines case.

Proposed Tranche 0 Product Breakdown Structure (18 months)

ID	Product	Start	End
01	**Programme Management Office**		
01.01	**Programme established**		
01.01.01	Digital structure finalised and endorsed	Jan 21	Jan 21
01.01.02	Roles defined (position descriptions)	Jan 21	Jan 21
01.01.03	Physical locations confirmed and available	Jan 21	Feb 21
01.01.04	Key roles appointed	Jan 21	Mar 21
01.01.05	Remaining roles appointed	Apr 21	Jul 21
01.01.06	Digital charter developed	Mar 21	Mar 21
01.01.07	Management processes, tools and templates implemented	Jan 21	Mar 21
01.01.08	Key governance forums established	Jan 21	Mar 21
01.01.09	Management, governance and reporting ongoing	Jan 21	Jun 22
01.02	**Detailed business case**		
01.02.01	Business case consultant engaged	Jan 21	Jan 21
01.02.02	Problem definition developed	Jan 21	Feb 21
01.02.03	Investment logic map developed	Jan 21	Feb 21
01.02.04	Solutions options analysis complete	Feb 21	Mar 21
01.02.05	Detailed delivery plan developed	Feb 21	Mar 21
01.02.06	Detailed business case finalised and endorsed	Apr 21	Sep 21
01.03	**Finance and procurement**		
01.03.01	Detailed cost model updated	Jan 21	Mar 21
01.03.02	Detailed procurement plan finalised	Jan 21	Mar 21
01.03.03	Industry briefing conducted	Mar 21	Mar 21
02	**Change and Engagement**		
02.01	**Change and Engagement**		
02.01.01	Detailed change management plan developed	Jan 21	Mar 21
02.01.02	Clinical governance forums established	Jan 21	Mar 21
02.01.03	External advisors identified and engaged	Jan 21	Mar 21
02.02	**Communications**		
02.02.01	Communications material developed	Feb 21	Mar 21
02.02.02	Awareness campaign executed	Mar 21	Jun 21
02.02.03	Digital programme communications ongoing	Jun 21	Jun 22
03	**Design, Data and Integration**		
03.01	**Digital Design**		
03.01.01	Digital design approach defined	Jan 21	Mar 21
03.01.02	Design process, tools and templates implemented	Mar 21	Jun 21
03.01.03	Digital models of care documented (SDHB change programme)	Jan 21	Dec 21
03.01.04	High level data design completed	Jan 21	Mar 21
03.01.05	High level data design updated	Jun 21	Aug 21
03.01.06	High level systems design completed	Jan 21	Mar 21
03.01.07	High level systems design updated	Jun 21	Aug 21
03.01.08	High level integration design completed	Jan 21	Mar 21
03.01.09	High level integration design updated	Jun 21	Aug 21
03.02	**Requirements and Testing**		
03.02.01	Requirements and testing approach defined	Feb 21	Mar 21
03.02.02	Requirements & testing process, tools, templates implemented	Apr 21	Jun 21
04	**Systems**		
04.01	**Corporate (Finance, Payroll, HRIS)**		
04.01.01	Gather and document detailed requirements	Jan 21	Mar 21
04.01.02	Prepare EOI documentation	Mar 21	Apr 21
04.01.03	Execute EOI process and assess responses	May 21	Jul 21
04.01.04	Prepare RFP documentation	Aug 21	Oct 21
04.01.05	Execute RFP process and assess responses	Oct 21	Dec 21
04.01.06	Negotiation and contract signing	Jan 22	Apr 22
04.01.07	Implementation planning and commencement	Mar 22	Jun 22
04.02	**Patient support (PAS, Enterprise Scheduling, Consumer Portal)**		
04.02.01	Gather and document detailed requirements	Jan 21	Mar 21

ID	Product	Start	End
04.02.02	Confirm regional PAS solution	Mar 21	Mar 21
04.02.03	Progress regional PAS solution implementation	Apr 21	Dec 21
04.02.04	Prepare EOI documentation	Mar 21	Apr 21
04.02.05	Execute EOI process and assess responses	May 21	Jul 21
04.02.06	Prepare RFP documentation	Aug 21	Oct 21
04.02.07	Execute RFP process and assess responses	Oct 21	Dec 21
04.02.06	Negotiation and contract signing	Jan 22	Apr 22
04.02.07	Implementation planning and commencement	Mar 22	Jun 22
04.03	**Care delivery (EMR, Specialty Systems)**		
04.03.01	Gather and document detailed requirements	Jan 21	Mar 21
04.03.02	Confirm the scanning solution	Jan 21	Jan 21
04.03.03	Progress scanning solution implementation	Feb 21	Dec 21
04.03.04	Prepare EOI documentation	Mar 21	Apr 21
04.03.05	Execute EOI process and assess responses	May 21	Jul 21
04.03.04	Prepare RFP documentation	Aug 21	Oct 21
04.03.05	Execute RFP process and assess responses	Oct 21	Dec 21
04.03.06	Negotiation and contract signing	Jan 22	Apr 22
04.03.07	Implementation planning and commencement	Mar 22	Jun 22
04.04	**Other projects (enhancements and changes)**		
04.02.0x	Progress other projects	Jan 21	Dec 21
05	**Infrastructure**		
05.01	**NDH facility design**		
05.01.01	Participate in facility design workshops	Jan 21	Jun 21
05.01.02	Infrastructure design principles developed	Jan 21	Jun 21
05.02	**Digital facility infrastructure design (Group 1)**		
05.02.01	MOH design consultant appointed	Jan 21	Jan 21
05.02.02	Group 1 infrastructure specification and HLD completed	Jan 21	Mar 21
05.03	**Remaining digital infrastructure design (Group 2/3)**		
05.03.01	Design consultant specification developed	Jan 21	Jan 21
05.03.02	Procurement and appointment a design consultant completed	Feb 21	Feb 21
05.03.03	Group 1 infrastructure specification and HLD completed	Mar 21	Oct 21
05.03.04	Infrastructure procurement plan finalised	Aug 21	Oct 21
05.03.05	Prepare EOI documentation	Nov 21	Dec 21
05.03.04	Execute EOI process and assess responses	Jan 22	Mar 22
05.03.05	Prepare RFP documentation	Apr 22	Jun 22

SOUTHERN DISTRICT HEALTH BOARD

- PUBLIC MEETING -

Title:	**Decision paper: Where should we locate primary maternity facilities in Central Otago / Wanaka?**
Report to:	SDHB Board
Date of Meeting:	03 November 2020

Summary:

The Central Lakes Locality Network (CLLN) and SDHB project team are making the following recommendation arising from the consultation on the above question:

That the Southern DHB implement Option 4 which locates primary maternity facilities at Wanaka and at Dunstan Hospital in Clyde. There is an important caveat to this recommendation which is that this 2 facility model can only be financially sustainable if the DHB and local LMC midwives potentially working a local trust or NGO can jointly develop and implement a sustainable model of care. The most affordable model is where midwives deliver both the LMC care and support running the facility, as is the case in other facilities in the district i.e. Oamaru and Balclutha. There is an opportunity to innovate and work together to find the best solution for this area.

If this agreement cannot be achieved, then we would need to reconsider options 1 and 2, a single site solution based at Cromwell or located at Dunstan Hospital in Clyde.

In brief, the rationale for this decision is as follows.

1) On the strength of level of improvement to travel times, addressing population growth, the unique NZ scenario which sees a significant number of pregnancies (160+) located at 3.5 hours travel time from a base hospital and the associated risks of babies Born Before Arrival (BBA) the project team supports a facility in Wanaka. This discounts the single facility options proposed.

2) When comparing the two facility options, one involves retaining the current Charlotte Jean facility in Alexandra. The project team are not in favour of retaining the Charlotte Jean facility as it is not possible to improve helicopter access on the existing site. The building also present challenges for stretcher access and limited space.

3) This leaves option four – a facility at Wanaka and a facility at Dunstan. There is strong support for a facility collocated with Dunstan Hospital for safety and access reasons. In addition, there are benefits for implementation at Dunstan as the SDHB own the land, reducing capital costs and ensuring we can progress the capital development quickly.

4) However, a two facility option requires local LMC midwife buy in/support to working in a case loading model to ensure the services are financially sustainable and can provide adequate 24/7 on call midwife cover. If this agreement cannot be achieved then we have to revert to one of the single facility options.

The consultation and process to arrive at this decision has been extensive and detailed and the full paper below sets out in detail the factors considered in making this recommendation

Specific implications for consideration (financial/workforce/risk/legal etc):	
Financial:	Capital costs estimate: Between $4.2m and $4.9m Operating costs estimate: Total opex of recommended 2 unit option is $2,060k per annum. Less S88 income and current funding to primary facilities, sustainability payments and the Wanaka Hub gives net impact of $174k increase. These costs will need further work to validate.
Workforce:	Impact for staff currently employed at Charlotte Jean Maternity Hospital. Impact for Lead Maternity Carers to work in case loading model rather than as self-employed.
Equity:	The recommendations made should ensure increased access for rural women to primary birthing and ensure there is good access for Maori women.
Other:	nil

Document previously submitted to:	N/A	**Date:** N/A
Approved by Chief Executive Officer:	Chris Fleming	**Date: 24/10/2020**

Prepared by:	**Presented by:**
Demelza Halley **Project Manager, Primary Maternity** **Date:** 21 October 2020	Mary Cleary-Lyons **General Manager Primary Care and Population Health, and** Heather LaDell **Director of Midwifery**

RECOMMENDATIONS:

1. **Note the contents of the Decision Paper: Where should we locate Primary Maternity Facilities in Central Otago/ Wanaka?**
2. **That the Board endorse the recommendation of the CLLN and DHB project group that the SDHB implement Option 4 which locates primary birthing units at Wanaka and at Dunstan Hospital in Clyde and**
3. **Endorse the caveat to this recommendation which is that this 2 unit model can only be financially sustainable if the DHB can work with local LMC midwives to implement a sustainable model of care which means that midwives deliver both the LMC care and support running the unit.**
4. **Note that if this agreement cannot be achieved, then we will need to further reconsider the single site options of either Cromwell or Dunstan.**

Decision Paper: Where should we locate Primary Maternity Facilities in Central Otago/ Wanaka?

Executive summary and recommendation to the Board

The Central Lakes Locality Network (CLLN) and Southern DHB project team are making the following recommendation arising from the consultation on the above question:

That the Southern DHB implement Option 4 which locates primary maternity facilities at Wanaka and at Dunstan Hospital in Clyde. There is an important caveat to this recommendation which is that this 2 facility model can only be financially sustainable if the DHB and local LMC midwives potentially working a local trust or NGO can jointly develop and implement a sustainable model of care. The most affordable model is where midwives deliver both the LMC care and support running the facility, as is the case in other facilities in the district i.e. Oamaru and Balclutha. There is an opportunity to innovate and work together to find the best solution for this area.

11

If this agreement cannot be achieved, then we would need to reconsider options 1 and 2, a single site solution based at Cromwell or located at Dunstan Hospital in Clyde.

In brief, the rationale for this decision is as follows.

1) On the strength of level of improvement to travel times, addressing population growth, the unique NZ scenario which sees a significant number of pregnancies (160+) located at 3.5 hours travel time from a base hospital and the associated risks of babies Born Before Arrival (BBA) the project team and CLLN supports a facility in Wanaka. This discounts the single facility options proposed.

2) When comparing the two facility options, one involves retaining the current Charlotte Jean facility in Alexandra. The project team and CLLN are not in favour of retaining the Charlotte Jean facility as it is not possible to improve helicopter access on the existing site. The building also presents challenges for stretcher access and limited space.

3) This leaves option four – a facility at Wanaka and a facility at Dunstan. There is strong support for a facility collocated with Dunstan Hospital for safety and access reasons. In addition, there are benefits for implementation at Dunstan as the Southern DHB own the land, reducing capital costs and ensuring we can progress the capital development quickly.

4) However, a two facility option requires local midwife buy in/support to work in a case loading model to ensure the services are financially sustainable and can provide adequate 24/7 on call midwife cover. If this agreement cannot be achieved then we have to revert to one of the single facility options.

The potential funding models and estimate financial implications in terms of capital and operating costs, of this recommendation are outlined in *Appendix 5*.

The consultation and process to arrive at this decision has been extensive and detailed and the full paper below sets out in detail the factors considered in making this recommendation.

Introduction

In 2018, the Southern District Health Board (Southern DHB) launched the Integrated Primary Maternity System of Care which recommended the best long-term location of a primary maternity facility in Central Otago/ Wanaka be explored.

Primary maternity facilities need to be located in the right place to meet the needs of the population. Over the last 9 months, the Central Lakes Locality Network (CLLN) and Southern DHB have worked together to consult with the population of the area and with maternity professionals and other stakeholders to consider the best options for location of primary maternity facilities to provide services for people in Central Otago and Wanaka.

What do we mean by primary birthing and why is providing facilities for primary birthing important?

International and New Zealand evidence shows that healthy women with low-risk pregnancies who labour and birth in a primary maternity facility have better health outcomes for both mother and baby, compared to those who birth in a secondary or tertiary base hospital. Both the Ministry of Health and Southern DHB support a strong and cohesive primary maternity system of care.

A primary maternity facility provides a physical setting for assessment, labour and birth, and postnatal care. It may be a stand-alone facility or a facility within a Level 1 or 2 general hospital. The primary maternity facility, in conjunction with the Lead Maternity Carer or DHB-funded Primary Maternity Services Provider, provides primary maternity inpatient services during labour and birth and the postnatal period until discharge or transfer.

Primary maternity facilities have no inpatient Secondary or Tertiary Maternity Services - such as epidural, Caesarean section, or usage of medications to induce or augment labour. Women or babies who develop a complication requiring urgent treatment either antenatally or postnatally, or in labour, require urgent transport to base hospital. Approximately 10-20% of women who start off in labour at a primary maternity facility will require an intrapartum transfer to secondary care. The majority of these transfers are time-critical but not life-threatening. Women and new-borns who have maternity complications outside of labour (preterm labour for example) are often assessed at the local primary maternity facility prior to urgent transport to base hospital.

What are we required to provide?

There is a national service specification for primary maternity facilities. The Ministry of Health Service Coverage Schedule requires DHBs to provide primary maternity facilities for catchment areas with 100 or more pregnancies, which are 60 or more minutes from secondary/tertiary facilities. The Service Coverage Schedule does not detail what acceptable travel times are to the primary maternity facility.

In respect of the Ministry of Health Service Coverage Schedule, independent legal advice is as follows:

"Clause 4.8 of the Service Coverage Schedule is imprecise and does not lend itself to one single obvious interpretation. In circumstances where there is uncertainty as to the precise meaning we think the DHB:

(a) should adopt an interpretation that is capable of practical application and implementation. Theoretical interpretations are of no value if they cannot be practically applied.

(b) must be guided by the New Zealand Public Health and Disability Act 2000 (NZPHD).

(c) must act reasonably. This includes considering all relevant guides and precedents. Our understanding is that there are no such guides or precedents. "

Ultimately, where there are different interpretations, we think SDHB, as the statutory decision-maker tasked with the responsibility of making such decisions, retains discretion as to how it applies the principle – subject to meeting its obligations above.

In working through the options available the SDHB has remained mindful of the legal advice above which was sought in respect of challenges to the decision to replace the primary maternity facility at Lumsden with a Maternal and Child Hub.

Why are we consulting about primary maternity facilities for Central Otago and Wanaka?

Wanaka and Central Otago are remote rural areas with growing populations living 2 to 3.5 hours from base hospital. The Central Otago district of Alexandra, Cromwell, Clyde, Ranfurly and Roxburgh is currently serviced by a primary maternity facility in Alexandra, Charlotte Jean Maternity Hospital. This facility also services Wanaka, being located approximately 60 minutes away by road. There is also a primary maternity facility at Lakes District Hospital in Queenstown and there are Maternal and Child Hubs in Wanaka and Ranfurly.

In 2018, 57 women birthed at Charlotte Jean, which accounts for 18% of the births attributed to the Central Otago and Wanaka catchment area. *See Appendix 1 for the data sets used to inform this paper.*

Women who travel to the base hospitals for labour and birth, can then choose to return to their local primary maternity facility for postnatal care. In 2018, there were 209 total in-patient stays at Charlotte Jean Maternity Hospital, out of 323 births within the Central Otago/ Wanaka catchment. This represents Charlotte Jean Maternity Hospital providing services to 65% of the catchment.

It is worth noting the role that rural primary maternity facilities play in acute and emergency maternity response for the whole catchment area. Primary maternity facilities provide support for all pregnant women and new families in the area, and their midwives, including providing space equipment and support for acute assessments and for the assessment, treatment and transport of women and newborns having a maternity-related emergency.

Our intention throughout this work is to provide primary maternity facilities that are:

- The preferred place of birth for healthy, well, low-risk women in the area
- The preferred place of postnatal care for all women/families in the area
- A safe place for coordinated emergency maternity care.

A Southern DHB project team has worked alongside the Central Lakes Locality Network to engage with stakeholders and local communities to develop options and a recommendation to meet the need for primary maternity facilities.

The consultation was undertaken in two phases which are set out below.

Consultation Phase 1

Feb – June 2020

Consultation Phase One: **Inform Options Design** → Stakeholder Workshops → Online Submissions → Stakeholder Meetings

In February 2020, an online submission form was launched and face to face or online engagement meetings were held with key stakeholders through to July. This phase was originally scheduled to be completed by Easter 2020 but was paused during the Covid-19 outbreak.

More than 330 submissions were received through the online submission form where stakeholders were asked what they thought the most important issues were for the DHB to consider when deciding on a location for a primary maternity facility. Submissions were received from members of the community including LMCs, GPs and parents.

In addition to the web form, during this first phase of consultation meetings were held with LMCs, core midwives, Well Child providers, primary care practitioners, Māori healthcare provider and the Southern District Maternity, Quality and Safety group.

Key considerations that emerged from the first phase of the consultation are:

- 24/7 midwifery availability at birthing facilities is preferred by LMCs as this provides additional back up in remote rural areas
- Rapid access to urgent transport, especially a helicopter is essential. A significant proportion of the online feedback focused on safety and the importance for women and whānau to know that there are excellent arrangements to deal with emergency situations
- Equity of travel times and access to primary birthing facilities for all parts of the region is important
- Co-location with other health services, especially medical support, is highly valued by public and professionals
- Need to take account of pace and locations of population growth and develop a future proofed proposal
- Quality of the whole pathway of maternal care emerged as a key theme. While people want to know facilities are available, many respondents focused on care quality and availability of a highly skilled workforce.
- Feedback from Māori respondents noted that Māori have experienced care that was not respectful e.g. ‘being talked down to’ and in particular have not always received supportive care in the weeks following birth
- The experience of care at Charlotte Jean Maternity Hospital is highly valued by women and the community.

Options Paper Release

On the 21st of July 2020 the DHB project team publicly released the *Options Paper – Where should we locate primary maternity facilities in Central Otago/ Wanaka? (Appendix 2)*

The paper outlined four possible options for the location of primary maternity facilities. They are summarised as follows:

Option One:

Locate a single new primary maternity facility, with helipad, in Cromwell catering for the population of Central Otago and Wanaka. This would be supplemented by provision of Maternal and Child Hubs in Wanaka, Alexandra and Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.

Option Two:

Locate a single new primary maternity facility, with helipad, on the Dunstan hospital site in Clyde, catering for the population of Central Otago and Wanaka. This would be supplemented by provision of Maternal and Child Hubs in Wanaka and Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.

Option Three:

Locate a new primary maternity facility in Wanaka and retain the current facility in Alexandra (Charlotte Jean Maternity Hospital) to cater for the population of Central Otago and Wanaka. This would be supplemented by provision of a Maternal and Child Hub in Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.

Option Four:

Locate a new primary maternity facility in Wanaka and relocate the current facility in Alexandra (Charlotte Jean Maternity Hospital) to be co-located with Dunstan Hospital in Clyde, to cater for the population of Central Otago and Wanaka. This would be supplemented by provision of a Maternal and Child Hub in Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.

Consultation – Phase 2

Following the release of the Options Paper the next phase of consultation started with a public meeting in Cromwell on July 23 2020. A summary of topics raised by the audience questions and comments is attached in *Appendix 3.*

The second consultation phase ran for six weeks throughout July and August and included:

- an online survey/web form
- our engagement page hosted a recording of the meeting and a copy of the paper

- the ability for the public to contact us directly with their thoughts/submissions
- continued engagement face to face and online with stakeholders

Through the above forums the groups and individuals we spoke with or heard from included (but is not limited to):

• Otago Rescue Helicopters • Charlotte Jean Maternity Hospital Staff • Maternity Quality and Safety Programme members • Representatives (clinical and management) of Dunstan Hospital • Mayor Jim Boult • QLDC CEO Mike Theelen • Wanaka based LMCs and colleagues	• Alexandra based LMCs • Central Otago Mothers Group • St John • Paediatrics/Obstetricians • Uruuruwhenua Health • NZCOM • Roxburgh Medical Services Trust • Members of the public

Second phase consultation online survey/ web form results

As part of the second phase of consultation, the web form launched on 21 July 2020. Details of the questions asked are provided in *Appendix 4.*

277 responses to the web form were received by the deadline of 22 August 2020. The majority of respondents (196) identified as parents. 30 pregnant women responded, and 37 respondents identified as health professionals.

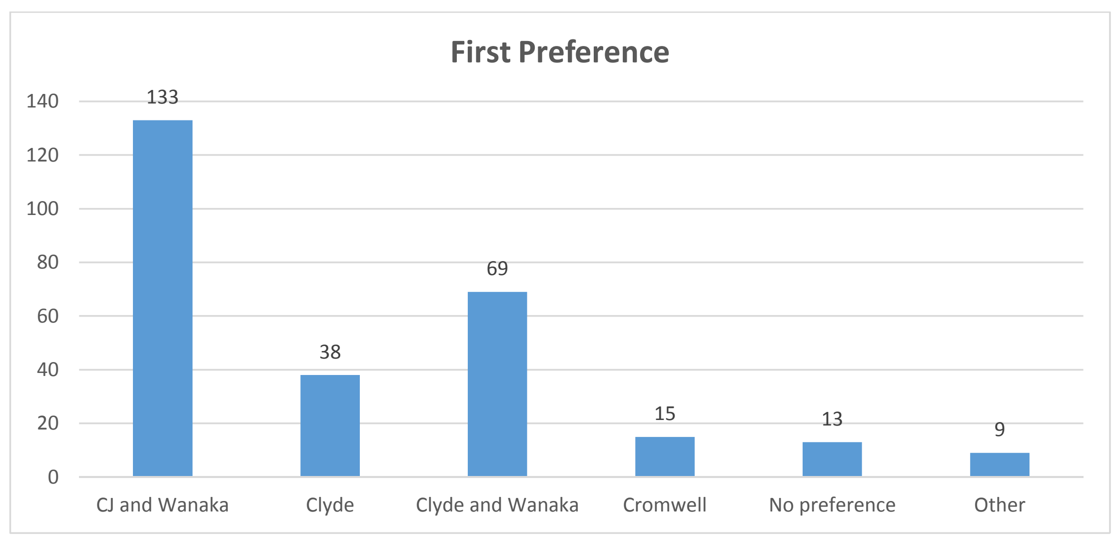
We also asked people where they are from. 65% of respondents identified as being from Wanaka/Hawea, with 10% from Alexandra and 8% from Cromwell. The remaining submissions were from other parts of Otago, Southland and rest of the South Island.

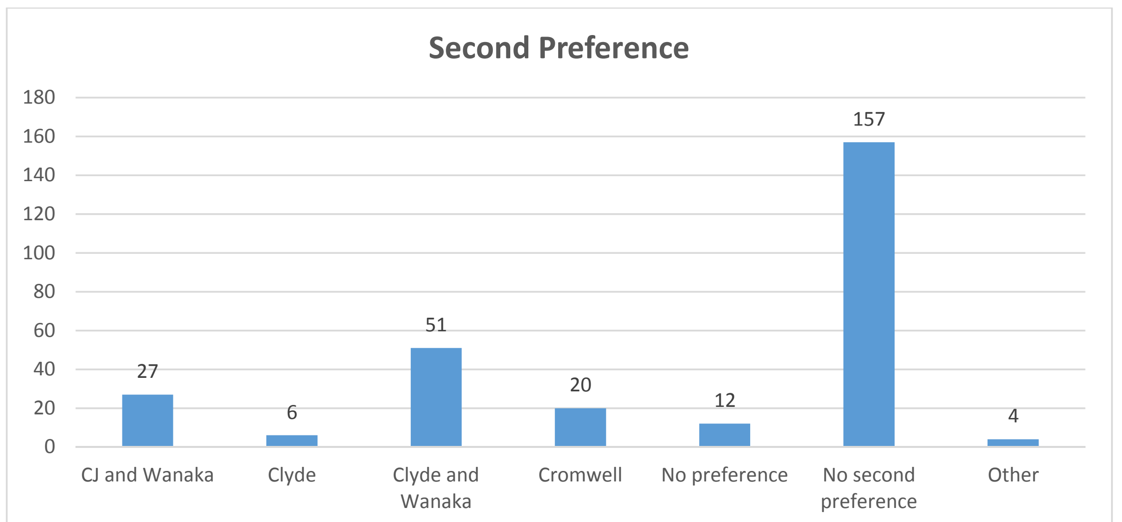
Given the substantial amount of responses coming from Wanaka/ Hawea the project team decided to host a second public meeting in September 2020 in Wanaka.

Respondents were asked to rate the relative importance of 4 statements based on the key safety factors raised in the first round of consultation from 1 (least important) to 4 (most important). This was to help us understand the relative importance of different aspects of safety from the public perspective.

Safety statement	Priority (4 highest)
Offers acceptable travel times to primary birthing facilities for the most people	4
Expedited transport to secondary care in an emergency	3
Can allow for highest level of midwifery staffing at a primary facility	2
Co-located with existing health services, 24/7 support and access preferred	1

Respondents were asked to identify their first and second preference from the four location options. There is a strong preference for a two-facility solution to be implemented. Wanaka based respondents influenced the first and second preference results.





The majority of respondents did not articulate a second preference. Where second preferences were expressed, a two-facility solution continued to be more favoured than the single facility options.

In addition to completing the survey, around 100 additional comments were submitted. These comments, were considered alongside the project teams one to one consultation meetings and submissions received directly to maternity@southerdhb.govt.nz and synthesised into themes that largely aligned with the themes arising from the first round of consultation.

What we heard

What follows in this section reflects the key themes and discussion points of what the project team heard across both rounds of consultation, through the web forms, public meetings and face to face conversations with stakeholders.

Staffing

Primary maternity facilities must provide a midwife on-call or on-site 24/7, to support the provision of labour care by Lead Maternity Carer (LMC) midwives and inpatient postnatal care. Postnatal care can be either provided by a midwife, or be provided by a nurse under the direction of a midwife (either the LMC or the on-call midwife). LMCs articulated the benefits of having a midwife onsite at the facility who is immediately available for support with acute assessments and/or labour and birth. There are other activities that a primary facility midwife can undertake that support women and also LMCs, including coordinating obstetric telemedicine clinics, undertaking follow up checks for women such as blood pressure monitoring, offering women a pregnancy tests and referral to a local midwife, and drop-in breastfeeding support. Facility midwives prefer secure staffing rather than an all on-call model, as the on-call rates within the MECA are viewed as insufficient and low utilisation facilities do not provide enough guaranteed work.

24/7 rostered midwives on shift requires 4.2 FTE per facility. For a smaller facility with lower utilisation, this would mean that approximately a third of the time that midwives were rostered on shift there would be no inpatients in the facility. The project team was clear in all of its conversations and presentations that 24/7 on site staffing would likely be unaffordable with a two-facility solution as the operational expense of this model would be too high. In addition to affordability, there are issues with retaining skills and best utilisation of a scarce resource. There is also still a question about whether there would be enough staff available in the area to provide 24/7 staff to a facility and have sufficient LMCs available for the population.

During the consultation, the choice was presented as 24/7 rostered midwifery versus an all on-call system. However, there are mixed-model alternatives that provide a component of rostered shifts combined with after hours on-call that are working well in similarly-sized primary maternity facilities elsewhere in the country. These include models where midwives are rostered for a guaranteed number of hours every day to guaranteed daytime support for acute antenatal assessments (this could also include obstetric telemedicine) and outpatient postnatal support. Other alternatives include the employed caseloading model (where an employed team manage the LMC work and support the facility). Oamaru and Balclutha utilise this model. This option has the advantage of being able to draw an income source (Section 88 payments) to partially offset expenditures. At this stage, this model would require a Trust or NGO to run the service, and midwives willing to work in this model. While currently DHBs cannot claim Section 88 funding, it is anticipated that this may change if recommendations in the Simpson Review are implemented.

Transport & Access

Most urgent transport in labour from locations over two hours from base hospital occur by helicopter. Rapid access to urgent transport, especially a helicopter, is essential. A significant proportion of the online feedback focused on safety and the importance for women and whānau to know that there are excellent arrangements to deal with emergency situations.

Weather and fog were issues that came up throughout consultation. We spoke with Otago Rescue Helicopters about their experiences with weather and they advised that over the last year they have had equal issues with access whether they were trying to access Wanaka, Alexandra, Cromwell or Clyde. From their perspective, Queenstown is the most reliable location for access.

Otago Rescue Helicopters support a primary maternity facility being built in Wanaka, Cromwell or Clyde, so long as there is direct access to a helipad. Landing in Alexandra, at a local park, to gain faster access to Charlotte Jean Maternity Hospital has happened on occasion but it is not a supported option going forward. Charlotte Jean Maternity Hospital is sited in a residential area in a repurposed home. The current set-up at Charlotte Jean Maternity Hospital has some drawbacks. Concerns raised with us throughout consultation include not having a helipad and difficult access for ambulances and stretchers. Because there is not the ability to have direct helicopter access at Charlotte Jean, an ambulance is required to bring either the retrieval team to Charlotte Jean, or the patient to the helipad at Dunstan. There have been occasions where delay in ambulance availability has been a significant concern.

In clear weather conditions, with a paramedic on board it is a 35 minute trip from the helicopter base to Dunstan Hospital. Taking into account loading times, it is 1.5 hour round trip to Dunedin. The same trip to Cromwell is an estimated 40 minute one way and 1 hour, 40minutes return. The same trip to Wanaka is an estimated 50 minutes one way and two hours return. These trips can take longer if the helicopter needs to first fly to Dunedin to pick up medical staff, the flying conditions are challenging or if the available helicopters are on another mission when called.

From Helicopter Base	Estimate Total Times
To Dunstan	35mins
+ loading & Dunstan return	1hr, 30mins
+ pick up of team from Dunedin Hospital	1hr, 50mins
To Cromwell	40mins
+ loading & Cromwell return	1hr, 40mins
+ pick up of team from Dunedin Hospital	2hrs
To Wanaka	50mins
+ loading & Wanaka return	2 hrs
+ pick up of team from Dunedin Hospital	2hrs, 20mins

In the case of a retrieval, a partner or family are not able to fly with the pregnant woman and must travel by road. In the case of a neonatal retrieval, mum or other whānau are not able to fly with the baby to Dunedin and must travel by road. It was also noted in the consultation that where neonatal teams travel to rural locations to retrieve an unwell baby it is vitally important that there is sufficient space in the primary facility to accommodate the team, the equipment and the whānau so that parents can stay with their unwell baby for as long as possible and have the opportunity to see the care that the baby is receiving. This time with the baby for whānau is critical both in terms of future attachment issues and, as it is impossible at this point to predict outcomes, may be the only time parents have with their child.

When an ambulance is required for either transfer to a helipad site or to hospital, it may not always be available and in some cases, there may not be a paramedic on board.

Southern DHB Neo natal teams and Otago Rescue Helicopters support a new facility based at Dunstan Hospital for a number of reasons, including the reduced need for ambulance involvement in any retrievals if a helipad is present.

Overall there was a high level of feedback received on the impact of an emergency transfer on women and their whānau. Concerns were expressed by some health professionals about the level of

awareness among the public about times for transfer and the risks involved. A key recommendation from this consultation is the need to ensure women and whānau have excellent information on both the benefits and risks of primary birthing in rural locations so they can make fully informed decisions.

Road Travel Times

Equity of travel times and access to primary maternity facilities for all parts of the region is important. In our second phase of consultation we released a web form and asked respondents to rank four safety factors in order of most important to least important. The factor ranked most important was "Offers acceptable travel times to primary birthing facilities for the most people".

We have modelled the impact on travel times that each of the options has for the population group of women aged 15-49. All options offer an improvement. A two-facility option would offer the greatest travel coverage, followed closely by a single facility in Cromwell.

Population covered within travel time

Option	30 min	45 min	60 min	30 min	45 min	60 min
Current	11,670	12,191	12,670	73.6%	76.9%	79.9%
1:Cromwell	11,792	15,042	15,502	74.4%	94.9%	97.8%
2:Dunstan	11,802	12,169	14,492	74.4%	76.7%	91.4%
3:CJ & Wanaka	15,047	15,464	15,643	94.9%	97.5%	98.6%
4:Dunstan & Wanaka	15,179	15,406	15,643	95.7%	97.1%	98.6%

Additional travel time creates an increased potential for birth before arrival at the chosen place of birth. Birth is unpredictable, and it is not always easy to predict whether or not a labour is advancing quickly. Whilst rapid births are often uncomplicated, birthing in a cold location without access to personnel and emergency medications if necessary places both mothers and babies at risk.

Women have told us that, if they perceive that the distance to the primary maternity facility is too far, they may bypass the primary maternity facility as the risk of a birth en route to the primary maternity facility is too great and they will plan to birth at base hospital instead. This not only creates additional cost, separation and inconvenience for families, but also can contribute to unnecessary intervention rates for women (NMMG 2018).

While travel times are a key concern for women and their families, other aspects of this issue are the inconvenience, cost and child-care concerns that arise when a woman needs to travel to Dunedin and stay there for a period of time ahead of her delivery.

Throughout the consultation we heard stories of women also choosing to base themselves in a city centre, often at significant cost, to be closer to a secondary facility in the weeks leading up to birth. The project team would like to explore this issue further and recommends some work is undertaken to look at other models across healthcare that contribute to travel and accommodation costs.

Co-location with other health services

Many members of the public and healthcare providers perceive that there would be an increased level of safety to services that are co-located with medical services. This needs to be contextualised as the primary maternity facility model of care is a midwifery-led model, and a stand-alone facility meets contemporary expectations. Co-location with medical services is not possible or desirable in all settings, and we do not want to create the impression that current facilities in the district are unsafe.

However, the Southern DHB project team and the CLLN believe that, in the context of remote rural populations, co-location with 24/7 rural generalist services can offer some benefit, including access to additional personnel who have maternal and neonatal resuscitation training, assistance in an emergency situation, and in the case of Dunstan Hospital, access to blood bank. This offers benefits in emergencies, and also would be beneficial in increasing public confidence in primary maternity settings. For these reasons, we consider co-location to be beneficial where available, but not required. It was also noted that co-location with helipads in particular is critical to support rapid transport in an emergency, and this is one of our required safety elements.

Co-location with other health services could be developed in all options that are purpose-built with space for other health services, including LMC antenatal consultations, Well Child providers, pregnancy and parenting educators, breastfeeding support, and maternal mental health providers, creating a single 'one stop shop' for services for women and young families. Other benefits of co-location are the additional security of having other people on site, opportunities to share overhead costs and opportunities for LMCs and midwives to develop supportive relationships with colleagues from other professions.

Account for growth of the population

Feedback stressed the importance of the need to take account of pace and locations of population growth and develop a future proofed proposal. Central Otago and Wanaka are both experiencing population growth and that is expected to continue through the next 20-30 years.

Population growth will impact on the utilisation of a primary maternity facility. There is no one methodology for determining utilisation of a facility. However, the minimum viable primary maternity facility design could cope with volumes of births and postnatal stays that future proof the build and allow for services to evolve as the population changes. The population projections used to inform this consultation are shown in *Appendix 1*.

Quality of care

Quality of the whole pathway of maternal care emerged as a key theme. While people want to know facilities are available, many respondents focused on care quality and availability of a highly skilled workforce.

Many factors contribute to the quality of care delivered at a primary maternity facility, including the physical environment, its location, staff, the culture and management of the facility, and the relationships with LMC midwives, obstetric and neonatal specialists and other health professionals.

Primary maternity facilities provide a midwife-led model of care that promotes the wellbeing of mothers, babies and families. A homelike, private and spacious environment with care from skilled and sensitive professionals helps women and whānau to feel comfortable and safe. Staff who are professional and welcoming, specially trained in the care of mothers and new-borns, culturally competent, work well with LMC midwives, and are well-linked into the rest of the maternity system, provide the support that families need to birth and adjust to life as new families.

High quality labour and birth care in a primary maternity facility is aimed at supporting women and babies to experience personalised care that facilitates physiological normal birth, and supports the timely detection of complications that require assistance or transfer to base hospital. Women in labour receive care from LMC midwives who need to feel well-supported, in a well-stocked and organised facility with consistent policies and guidelines, and with support from a second midwife skilled in normal physiological birth as well as responding to emergencies. From the feedback, the project team and CLLN have developed a set of required and desired quality factors for any future primary maternity facility. These quality criteria have been presented to and discussed with the Southern DHB Clinical Council, the Southern DHB Community Health Council and the Maternity, Quality and Safety Group.

Required quality elements

Physical environment

- Home-like and whānau –friendly – Māori cultural practices will be considered in the design and decoration of new facilities
- Sufficient birthing rooms for the population, with birth pools
- Spacious private postnatal rooms with space for support person to stay
- Acute assessment space
- Consultation rooms

Staffing

- 24/7 midwife on call
- Midwifery coordination
- Education specialised in care of mothers and new-borns, supporting physiological birth, maternity emergencies, and bicultural competency
- Expert lactation support

Location

- In direction of travel for majority of population to base hospital

Desirable quality elements

- Space for education/community groups/other services and providers
- Whānau Rooms

Māori respondents and equity

Feedback from Māori respondents noted that Māori have experienced care in the community (not at the birthing facility) that was not respectful e.g. ‘being talked down to’ and in particular have not always received supportive care in the weeks following birth. The feedback locally focused on the importance of a welcoming, culturally safe environment with time spent with new mothers and ability for whānau to be involved.

The Southern DHB project team recommends that more work is undertaken to understand these experiences and to explore ways of making improvements with Uruuruwhenua Health who work alongside whānau and the wider community to ensure Health and Social Services are accessible and tailored to meet the needs of whānau.

Throughout New Zealand, Māori are more likely to utilise primary maternity facilities. Of concern is the data we reviewed on the percentage of Māori birthing in primary maternity facilities in Southern. 15% of Māori in Southern in 2015 had a primary birth compared to 9% in 2019, with the average for 2015 to 2019 being 11%. Māori respondents considered that a facility at Clyde or Dunstan would be more likely to be utilised by Māori than a facility in Wanaka.

Charlotte Jean Maternity Hospital

The care women and families have experienced at Charlotte Jean Maternity Hospital is highly valued by the community. Many of the online responses shared wonderful memories and positive experiences at Charlotte Jean. There is strong community support for Charlotte Jean to remain operating.

The Charlotte Jean Maternity Hospital currently relies on an ambulance transfer to the heli-pad at Dunstan Hospital in Clyde when a helicopter to base hospital is required. While the transfer time by ambulance from Charlotte Jean to Dunstan is shorter that the time taken for the helicopter to reach Dunstan, there are occasions when an ambulance or a driver is not available in Alexandra and so there is a delay in the transfer. In addition, moving an unwell mother or baby in a critical situation (from Charlotte Jean, to an ambulance, to treatment room in Dunstan and then onto a helicopter) creates additional risks and can increase the overall time to treatment.

When people talked about a new facility, they stressed the importance of it offering the same level of quality and care currently offered by Charlotte Jean. If Charlotte Jean were to be decommissioned it was important that the essence of Charlotte Jean - high quality, supportive care in a homely, welcoming environment - was not lost.

Pace of Programme of Work

It is important to our stakeholders that this work progresses as quickly as possible. It is important that following a decision being announced, the pace and momentum of the work continues and that stakeholders are regularly updated on the progress of the design and build processes.

Secondary vs Primary Services

There is confusion about what is meant by primary birthing and many people would like to see availability of secondary birthing facilities including epidural and access to Caesarean sections in the area.

At this point we are not in a position to have secondary care birthing available in the area. While there are some examples in New Zealand (such as West Coast) where there is limited access to some secondary birthing options available rurally, the DHB considers that we cannot provide the level of quality and safety required for secondary birthing in rural hospital environments. Clearly this region is experiencing significant population growth. This project is focused on primary birthing options only. However, we recognise that within this we need to address the concerns and aim to deliver future proofed options that will allow for services to evolve as the population changes.

Some respondents noted that primary birthing is not well understood and that more education and support is needed to ensure that women who are suitable for primary birthing feel confident choosing this option.

Trade-offs in decision making

There is good understanding among the population of the decision-making trade-offs i.e. financial sustainability and 24/7 staffing vs shorter drive times.

When considering the options that offers two facilities there are several key factors that make it less favourable. A two-facility solution will see the facilities sharing the birthing population and potentially reducing utilisation of both facilities. A two-facility solution will have both higher capital and operational costs. There has been a theme in feedback received that it would be better to have one well-resourced facility rather than two partially resourced facilities. A two-facility solution will also see the facilities sharing the available workforce.

Both two facility solutions proposed include a facility in Wanaka. A Wanaka based facility may have decreased numbers due to likely utilisation only from Wanaka and Hawea, as women and families are unlikely to travel to Wanaka from Cromwell for instance, away from base hospital.

This may be balanced out by shorter drive times increasing overall utilisation of primary maternity facilities, as the community has stated that minimal drive times are an important criteria and may improve overall utilisation. So, two facilities may result in overall increased utilisation.

We received feedback that a two-facility solution was the only solution that offered an improvement on the current model of a single facility in Alexandra. However, a new build under option one or two would result in a fit for purpose building allowing expanded services and improved safety, co-location opportunities and faster access to emergency transport and some reduction in driving times to the facility for more of the population.

Wanaka Preference

Wanaka residents strongly prefer a facility based in Wanaka. In phase two of the consultation, 65% of online responses came from Wanaka/Hawea. It is because of this that the project team decided to hold a second public meeting, this time in Wanaka. Despite potential low utilisation, the community strongly expressed a desire for a facility based in Wanaka. There is likely to be strong opposition to the decision made if it does not include a Wanaka based facility.

Child and Maternal Safety

Child and Maternal Safety is the strongest theme to arise out of both rounds of consultation from both the public and professional stakeholders. Safety issues raised with the project team are wide ranging and included issues such as:

- accounting for the geographic spread of the birthing population and associated drive times
- weather conditions
- availability of emergency transport
- availability of in hours and after-hours medical support
- safe staffing levels

As part of the decision-making process, the project team defined what the DHB's bottom lines for a safe provision of a primary maternity service would be.

A remote rural primary maternity facility can be considered the emergency room for all pregnancies in the area. The first responder for maternal or neonatal complications or emergencies is the LMC midwife with support from the facility midwife. The facility would need an acceptable and safe level of midwifery staffing potentially supported by nurses for inpatient postnatal care. The facility would need to be either open 24/7 or operate an 'on call and close by' model.

Safe staffing means adequate numbers of well supported, well paid staff, who have access to further education and training. This is an important aspect of attracting quality staff and ensuring adequate staffing levels.

‘Lock up and leave modes’ where the facility is not staffed if there are no patients may result in a reduction in interested staff as on call rates are not attractive. Staffing could be inclusive of nurses providing inpatient postnatal care under the direction of midwives. We heard strong feedback from midwives who do not want to work on call and want employment models that will give them guaranteed income.

Expedited transport to a base hospital is another bottom line for the DHB decision making process. This includes heli-pad access, without reliance on an ambulance transfer. The rooms in the facility must have good stretcher access.

Co-location was discussed throughout the consultation periods. While not a bottom line, onsite additional medical support available 24/7 is beneficial. This would be strengthened by the support available being rural generalists who are new-born life support trained and adult resus trained. Having access to a blood bank would be desirable.

Quality leadership of a facility is also important – clinical coordination, operational management, education, and quality management are all critical roles that contribute to the overall safety of a facility.

Discussion on the options

In considering the options it is important to note that the discussion is about the location of the facilities, the model of care options that arise from the locations and the impacts of a two facility versus single facility options. ***The options make no assumptions about who the provider of the services could be****. All options could be delivered directly by the Southern DHB or by a rural trust or private providers. This includes the options that may be located at Dunstan Hospital.*

Option 1: Locate a single new primary maternity facility in Cromwell

The Cromwell option offers the benefits of a single facility in terms of potential ability to staff it 24/7 and the potential to offer good terms and conditions for staff. As it will be a completely new build it can be developed with a helipad on site and transfer times by helicopter are only marginally longer than from Alexandra/Clyde.

A single facility has the potential to get ‘more bang for the buck’ by maximising what could be done with the build. A single facility would mean we could provide more postnatal stay rooms and more space for other services, for example, more consulting rooms, a space for education/meetings, better storage for midwives to use.

Travel times are improved for Wanaka women though it may be less attractive for women from Clyde/Alexandra/Roxburgh as they will feel they are travelling away from secondary services so this may impact on utilisation.

A single facility in Cromwell would be farther away from a base hospital than a single facility in Clyde. There is no current opportunity in Cromwell for the additional safety benefit of co-location with medical services.

The closure of Charlotte Jean Maternity Hospital may be of concern to some members of the community, as would not providing a service in Wanaka under this option. This option was least preferred by online respondents, however 65% of the online respondents were Wanaka/ Hawea based.

Option 2: Locate a single new primary maternity facility in Clyde at Dunstan Hospital

A single facility located at Dunstan is an attractive option from a safety point of view as it has all the benefits of co-location with a rural hospital. There is potential for a model of care that is integrated with rural generalists and has a broader range of services available. It offers the same single facility benefits as the Cromwell option in terms of staffing and maximising what could be done with the build.

While this option is within 60 minutes of all larger population groups, it offers the 'least best' solution in terms of improvement in travel time particularly for women from Wanaka. It may also be difficult to staff as it represents a long travel time to work for midwives who live in Wanaka; however this may be mitigated by the potential for better working conditions as a single facility is less likely to rely on an on-call model and has the benefits of working in an environment with other health staff.

The closure of Charlotte Jean Maternity Hospital may be of concern to some members of the community, as would not providing a service in Wanaka under this option.

Option 3: Locate a new primary maternity facility in Wanaka and retain Charlotte Jean Maternity Hospital

This option has the highest public support and results in increased coverage and improved travel times.

This option raises several concerns. Firstly, it splits the birthing numbers of the catchment reducing utilisation of both facilities. The Wanaka facility may not be utilised to full potential due to distance from secondary services. It is unlikely to be utilised by anyone outside of Wanaka.

A two-facility option requires the highest staffing levels. Charlotte Jean's provider organisation currently has a lock up and leave model when the facility isn't occupied. They employ a clinical co-ordinator and a quality co-ordinator and would likely want to retain its existing levels of staffing though this would have to be reviewed to ensure a two-facility model was financially viable. The Wanaka facility would likely be a 'lock up and leave' model with staffing reliant on local midwives being prepared to work 'on call'.

However, there is the opportunity to develop an innovative workforce model that could combine case loading LMCs with staffing a Wanaka facility, which has the potential to bring an additional income stream.

We were struck by the strength of the feedback from both public and professionals about the problems associated with transfers and retrievals from Charlotte Jean due to the lack of an onsite helipad and restricted access to the patient area of the facility. The Southern DHB does not think that it is possible to amend/upgrade the facilities at Charlotte Jean to incorporate key safety features such as improved access and a helipad as the existing facility is located in a repurposed house on a residential street.

Option 4: Locate a new primary maternity facility in Wanaka and relocate the current facility in Alexandra (Charlotte Jean Maternity Hospital) to be co-located onsite at Dunstan Hospital in Clyde.

This option has the second highest level of public support in our online survey and results in increased coverage and the most improved 60-minute travel times given that this will provide a birthing environment in Wanaka ensuring the best possible travel times across the region.

It also works well from a safety perspective as the Wanaka facility could be co-located with the primary care facility ensuring easy access to the helipad or built on a new site that allows for an alongside helipad, while as outlined above, the Dunstan Hospital option rates highest for safety given the co-location with a rural hospital and an existing helipad on site.

This option will likely mean both the Dunstan facility and Wanaka would have a 'lock up and leave' model with staffing reliant on midwives being prepared to work 'on call'.

However, there is the opportunity to develop an innovative workforce model that could combine case loading LMCs with staffing at both facilities which has the potential to bring an additional income stream.

The utilisation of each facility will be lower than that of a single facility but overall utilisation will be higher delivering a strategic benefit of supporting as many rural women to access primary birthing as possible.

Key factors in making a final decision

Given the feedback and the assessment of the advantages and disadvantages of each option, the CLLN and Southern DHB project team considered that there were two critical questions to consider.

These are:

1) What is the likely utilisation of the option chosen?
2) What are the safety risks and benefits of a primary maternity facility in Wanaka given the distance from base hospitals?

What is the likely utilisation of the option chosen?

Utilisation of primary maternity facilities as a chosen place of birth or postnatal care is driven by multiple factors. Perceptions regarding quality and safety, clinical need for care at base hospital, preferences for care in hospital versus a home-like setting, and distance to base hospital all play a role, as evidenced in the submissions we have received. A Wanaka based facility is likely to have a limited catchment as women and families would be unlikely to travel to Wanaka from Cromwell for instance, away from base hospital. In addition, some Wanaka/Hawea based women who choose primary birthing may opt to do this at Lakes Hospital in Queenstown or at Dunstan due to the benefits of those facilities being co-located with a rural hospital. This may be balanced out by shorter drive times increasing overall utilisation, as the community has stated that minimal drive times are an important criteria and may improve overall utilisation.

The project team undertook an assessment of likely utilisation rates as follows:

Utilisation Estimates

Proposed Facility	Catchment Size est	Utilisation rate est	Est Annual births	Est postnatal stays	Est PN occupancy rate
Wanaka	160	30-40%	48-64 (birth every 6-8 days)	104 families (208 days)	.57
Central Otago	225	30-40%	68-90 (birth every 4-5 days)	146 families (292 days)	.8
One combined unit Central Otago	385	20-30%	77-115 (birth every 3-5 days)	250 families (500 days)	1.4

Assumptions behind utilisation estimates:

All facilities' estimated postnatal stays are estimated on 65% of their current catchment size. This is based on the current postnatal utilisation of Charlotte Jean Maternity Hospital, as we did not have any evidence that this would change with a different location. However, it may be that, if there was only one primary maternity facility in the area, families who lived farther away and birthed at base hospital may just have their full postnatal stay at the base hospital and then go directly home.

The Wanaka catchment size estimate is based on caseload information provided by Wanaka midwives. The midwives' current percentage of women birthing in primary maternity settings (home or Charlotte Jean Maternity Hospital) is 40%, so we estimate that this will remain high. It is unknown how many women who currently birth at home in Wanaka would choose instead to utilise a primary maternity facility, hence the range of 30-40%.

The Central Otago catchment size estimate is based on Ministry of Health data. If a larger purpose-built facility was built, and especially if it was co-located with Dunstan Hospital, we project a higher utilisation rate than Charlotte Jean Maternity Hospital due to increased perceptions of safety and increased capacity.

The one-facility utilisation rate for births is estimated lower than the two-facility options as we believe there would be lower utilisation by residents of Wanaka, and by residents of Alexandra and those closer to Dunedin, as women do not generally choose to travel to birth at facilities that are farther from base hospital.

Note that the estimated occupancy rate is based on postnatal stays only, with an assumption of a two-day length of stay. The actual occupancy rate would be higher as it would include births.

What are the safety risks and benefits of a primary maternity facility in Wanaka given the distance from base hospitals?

A facility based in Wanaka will be the most remote primary maternity facility in the country. There are 51 facilities nationwide, six are in the southern region. The estimated median distance from a base hospital is 65.75kms and the estimated average distance is 71.39kms. A Wanaka based facility would be 274km to Queen Mary by road, and 243kms to Southland Hospital. Charlotte Jean Maternity Hospital is currently the farthest away from a base hospital at 190kms.

As the population of Wanaka is the population that is underserved in the current configuration of services, the project team considered that it was important to conceptualise the relative safety benefits and risks of a two-facility option, placing a primary maternity facility within the township of Wanaka, versus offering a single facility option at Cromwell or Clyde.

Wanaka Facility + Central Otago Facility	Single Facility at Clyde or Cromwell
Shortest travel times to primary maternity facility; lowest risk of baby born before arrival. “Born before Arrival” or BBA, is the least safe place of birth for mothers and babies.	45-60 minute travel time to primary maternity facility; higher risk of baby born before arrival. **Mitigations**: Fast labours stay to birth in Wanaka at home or Hub (but not always predictable).
Longer emergency transport to base hospital (10-15 additional minutes each way) compared to Cromwell or Clyde. A factor in rare obstetric emergencies such as cord prolapse and massive obstetric haemorrhage. **Mitigations**: Careful admission criteria, two midwives present for births, avoid artificial rupture of membranes, training of midwives and local PRIME responders.	Shorter emergency transport to base hospital. Beneficial for rare in-labour emergencies. Out-of-labour emergencies likely handled in Wanaka due to travel time to primary maternity facility.
Not currently an option for co-location with 24/7 medical service. **Mitigations:** as above.	CLYDE ONLY: co-location with 24/7 rural hospital with rural generalists and blood bank. Helpful with unstable new-born or mother, obstetric haemorrhage.
Lower utilisation means 24/7 on-site staffing not affordable. Factor in out-of-labour emergency (preterm labour) or rapid labour when LMC not immediately available. **Mitigation:** Robust on-call system, always second midwife present at birth.	Higher utilisation means 24/7 staffing more affordable. Potential benefit for out-of-labour emergencies however out-of-labour emergencies likely handled in Wanaka due to travel time to primary maternity facility.

Recommendation

The DHB project team met with the CLLN on 2nd October and jointly considered each of the 4 options against the themes and issues identified in the consultation.

The following factors were considered as part of the recommendation making process:

- stakeholder and public feedback, their preferred option and weighting given to the considerations included in our online survey.
- the requirements of the Service Schedule
- safety and quality
- workforce availability
- sustainability
- affordability.

Our aim is to deliver a facility that is the preferred place of birth for healthy, well, low-risk women, the preferred place of postnatal care for all women/families in the area and a safe place for coordinated emergency maternity care.

The consensus view of the group in relation to a recommendation was as follows:

Option 1 – Single facility based at Cromwell

This option offers improved access for some of the population (such as Wanaka women) in terms of time of travel to the facility. As an option, it would be a stand-alone facility at least initially, so would not be able to offer the other safety benefits such as co-location with a rural hospital. Other health professionals may however be interested in co-location if this was selected as the preferred option. As a preferred site in Cromwell has not been identified there would be a longer implementation timeline than for the other single facility option. A decision to base a facility in Cromwell would be likely to attract opposition both from Wanaka residents and from Alexandra residents. The CLLN considers that in the longer term, Cromwell may be a potential site for a birthing facility especially if other health infrastructure is developed.

Option 2 – Single facility based at Dunstan

This option offers the greatest benefits and improvements in safety given the access to helipad and ability to co-locate with a rural hospital. Dunstan Hospital option is strongly supported by the health professionals consulted and the emergency services. Some feedback has suggested that a single facility option at Dunstan Hospital would be perceived by the public as not representing any meaningful change to the status quo. However, the group considers that a fit for purpose building allowing expanded services and improved safety, co-location opportunities and faster access to emergency transport and some reduction in driving times to the facility for more of the population represents a significant improvement for maternity services in the area.

It also offers the ability to proceed quickly with a development as the Southern DHB owns the land and other buildings on this site and the Board of Central Otago Health Services Limited have indicated they are supportive of the DHB proceeding on this site. It should be noted that a decision has not been taken on who would provide the service and this could be provided either by Southern DHB, COHSL or an alternative provider. However, this option offers only a marginal improvement in travel time for the Wanaka population which means that there is little reduction in the risk of born

before arrival for women travelling from Wanaka to Dunstan to birth. A decision to recommend this option is likely to be strongly opposed by Wanaka residents.

Note: This recommendation makes no assumptions about who the provider of the service onsite at Dunstan Hospital could be. It could be delivered directly by the SDHB or by a rural trust or private providers.

Option 3 – Retain the Charlotte Jean facility and develop a new facility in Wanaka

The Charlotte Jean facility cannot accommodate a helipad on the site and would need significant remodelling to ensure better access for stretchers. It should be noted that this is a decision about the physical facility rather than the provider who clearly provide a highly valued service and would be welcome to bid to provide a service in a new facility. While the facility operates very well and manages risk well, we considered that the opportunity to redesign services for the population of Central Otago and Wanaka needs to look forward and make a future proofed recommendation. The current facilities are likely to be considered as not fit for purpose in the future so the group thinks we should take the opportunity now to improve this.

Option 4 – Develop facility at Dunstan Hospital and a facility at Wanaka – Preferred Option

This option offers greatest improvement in travel times for the population of the whole area. In addition, it ensures a facility is available within a rural hospital for Central Otago and Wanaka and a Wanaka option can be developed to facilitate rapid transfers either by locating close to the existing helipad or by developing at a new site. The population of Wanaka is growing and there are 160 pregnancies a year in this remote area and this figure is likely to remain at least constant and may increase over time. This population will inevitably include women annually who develop pregnancy related complications or experience preterm births or rapid normal births.

However, there is a caveat on this recommendation. The group considers that safe and sustainable services are only possible if delivery models can be agreed with the local LMCs whereby they agree to work together to deliver the services using a case loading model such as that used in Oamaru or Balclutha. Given the distances involved and the low utilisation of the facilities, it would be difficult for the DHB to sustainably staff and manage the facilities remotely and the utilisation level means that running these facilities may not be attractive to a private provider. Initial conversations have taken place with the Upper Clutha Maternity Charitable Trust (a Trust formed by local LMCs and members of the public) and the Trust is willing to work with Southern DHB to explore this option in Wanaka.

If Southern DHB is unable to reach agreement with the local LMCs to provide a sustainable model of care, then the Board would need to reconsider alternatives. The group recommend that these alternatives are narrowed down to consider either option 1 or option 2 above.

The benefits of proceeding with Option 4 are improved safety, improved quality and we anticipate improved outcomes across the following areas:

- Closer-to-home delivery of care
- Improved access to birth in primary setting, reduced unnecessary intervention rates
- Decreased risk of unplanned birth outside of facility
- Decreased delay in emergency transport
- Improved support to remote rural LMC midwives, retention of workforce

- Improved employment conditions for facility midwives, retention of workforce
- Improved access to acute antenatal assessment
- Improved maternal outcomes: satisfaction with birth experience, maternal-child attachment, support for initiation and establishment of breastfeeding, ease of accessing range of maternal-child supports
- Improved neonatal outcomes of initiation and maintenance of exclusive breastfeeding, and maternal-child attachment.
- Improved family outcomes: partner and whānau satisfaction with birth experience and attachment, confidence with care of a new-born
- Improved equity outcomes: increased satisfaction with pregnancy, birth and postnatal experience of care, support for maternal-child attachment, culturally appropriate and whānau -centred care, and ease of accessing range of maternal-child supports
- Improved coordination and collaboration with rural generalist medical services

Capital and operating costs of proposal

Appendix 5a sets out a high level specification for buildings. The costs have been assessed at estimated $7k per square metre including project management and fixtures and fitting. We have assumed that the recommended 2 unit option would be 300sqm each. There will be no land acquisition required for a build on the site of Dunstan Hospital but land will be required in Wanaka. The estimated total capital cost of the two units is between $4.2m and $5.6m.

If a single unit is developed at Dunstan Hospital, then a larger unit will be developed of approximately 700 sqm. The cost of this build is estimated at $4.9m.

Appendix 5b sets out estimated operating costs of the potential operating models available. The models costed are:

- 24/7 staffed model (Option A)
- 13 hours of midwife cover is rostered daily with the balance being on call (Option B)
- case loading model (Option C)

The case loading model (Option C) operating costs for 2 units is an estimated $2,060k per annum. These costs would be met through a mix of Section 88 Maternity Services Notice funding and funding from the Southern DHB. DHB funding sources include those used for the Charlotte Jean Maternity Hospital and the current Wanaka Maternal and Child Hub (as the Hub functions would be absorbed by the primary maternity facility). In addition, as the Ministry of Health has significantly increased the funding via the S88 notice, this gives us the opportunity to redirect the budgets currently used for sustainability payments to supporting primary maternity facilities. This combination of funding sources means up to $898k is available within current DHB budgets to support 2 units operating in a caseloading model. This leaves the DHB needs to identify an estimated $174k in additional funding to support 2 units. Further work will be needed to ensure this is achievable and to test the assumptions made about the level of Section 88 funding that may be available.

Other work arising

Throughout the course of this work, some issues have been raised with the project team that require further investigation and discussion. These include:

- Support for families who need to arrange to birth in Dunedin or Invercargill

- Improvements for Māori – improving bi cultural competency, looking at ways we can work with Uruuruwhenua
- Informed decision making – developing consistent admission criteria to Southern primary maternity facilities
- Exploring the suggestion of a Rural Maternity/Midwifery Educator for the area
- Ensuring that women and whānau have excellent information on both the benefits and risks of primary birthing in rural locations, including information about what happens in an emergency, so they can make fully informed decisions

Appendix 1: Data tables

A) The table below shows where Southern district mothers were living during pregnancies in 2015 – 2019. They did not necessarily give birth in that location.

Number of births by Territorial Authority[1]

TLA	2015	2016	2017	2018	2019
Central Otago	154	189	183	212	207
Clutha	188	182	198	174	219
Dunedin	1,150	1,099	1,128	1,074	1,112
Gore	153	133	134	128	142
Invercargill	623	626	669	611	606
Queenstown Lakes	263	278	294	266	325
Southland	380	363	378	335	333
Waitaki	236	219	211	208	216
Wanaka & Surrounds	106	109	123	111	134
Undefined	<5			<5	
Grand Total	**3,256**	**3,198**	**3,318**	**3,120**	**3,294**

B) The table below shows us where babies were delivered in 2015 - 2019.

Number of births by Facility

Facility	2015	2016	2017	2018	2019
Dunedin Hospital	1642	1606	1655	1592	1663
Southland Hospital	1184	1212	1243	1143	1227
Gore Health Limited	78	70	81	75	90
Oamaru Hospital	80	73	64	64	68
Lakes District Hospital	64	59	72	71	74
Charlotte Jean Maternity Hospital[2]	53	58	60	57	68
Clutha Health First	45	44	55	43	42
Winton Maternity Centre	35	32	31	29	20
Lumsden Maternity Centre	41	16	32	19	
Tuatapere Maternity Unit	9	7			
Maniototo Health Services	<5	<5			
Dunstan Hospital			<5		
Non-Southern[3]	22	20	24	27	42
Total	**3,256**	**3,198**	**3,318**	**3,120**	**3,294**

[1] These figures are from the National Minimum Data Set, however they have been adjusted to include data supplied directly by Charlotte Jean Maternity Hospital.
[2] These figures are supplied by Charlotte Jean Maternity Hospital. All other figures in the table are from the National Minimum Data Set.
[3] These figures represent southern mothers who birthed out of the district.

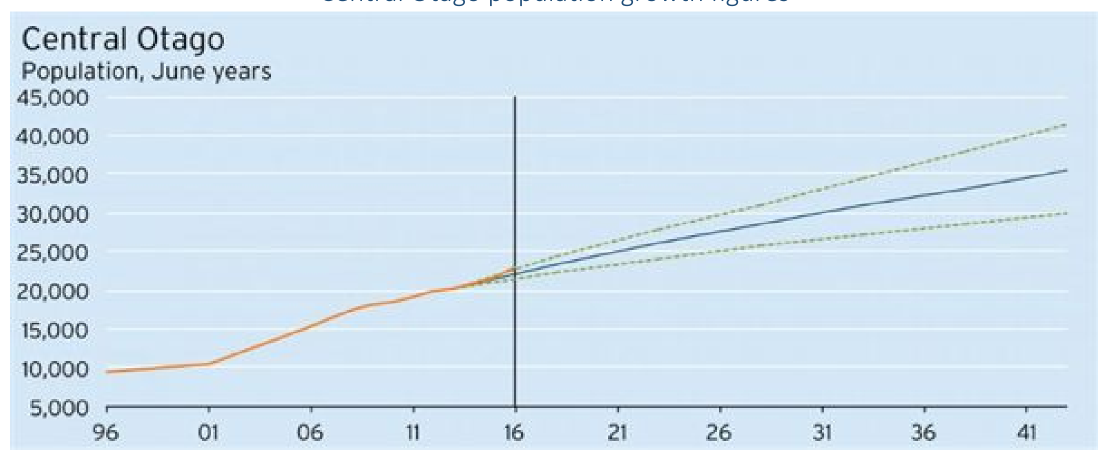
C) The table below shows us the ethnicity of babies that were delivered in 2015 – 2019.

Number of births by Ethnicity[4]

		Ethnicity	2015	2016	2017	2018	2019
Southern	**Primary**	Asian	25	21	24	24	39
		Māori	51	37	51	39	36
		Other	310	279	303	277	264
		Pacific	21	17	17	11	16
	Secondary	Asian	195	215	260	264	303
		Māori	281	283	288	291	344
		Other	2249	2228	2262	2075	2134
		Pacific	101	92	88	105	109
Non-Southern	**Non-Southern[5]**	Asian	<5	<5	<5	<5	<5
		Māori	<5	6	9	6	<5
		Other	17	13	14	18	33
		Pacific	<5			<5	<5
Grand Total			**3255**	**3192**	**3317**	**3113**	**3287**

D) Central Otago population growth figures.

Central Otago population growth figures



Source: https://www.infometrics.co.nz/otago-central-otago/

[4] These figures are from the National Minimum Data Set.
[5] These figures represent southern mothers who birthed out of the district.

E) Queenstown Lakes population growth figures.

Queenstown Lakes population growth figures

Variable	2021	2031	2041	2051	2021 to 2031 Change	2021 to 2031 Annual change	2021 to 2031 % Change	2021 to 2051 Change	2021 to 2051 Annual change	2021 to 2051 % Change
Wanaka Ward										
Residents	13,640	18,720	24,080	28,240	5,080	508	3.2%	14,600	487	2.5%
Total Houses	8,530	10,890	13,350	15,410	2,360	236	2.5%	6,880	229	2.0%
Total Visitors (Average Day)	2,290	8,050	9,740	11,460	5,760	576	13.4%	9,170	306	5.5%
Total Visitors (Peak Day)	19,500	30,310	37,590	44,000	10,810	1,081	4.5%	24,500	817	2.7%
Total Population (Average Day)	15,930	26,770	33,820	39,700	10,840	1,084	5.3%	23,770	792	3.1%
Total Rating Units	10,010	12,710	15,540	17,920	2,700	270	2.4%	7,910	264	2.0%

Source: https://www.qldc.govt.nz/community/population-and-demand

F) The below is a summary of data that was supplied to the Southern DHB by Wanaka based LMCs Deb Harvey and Peta Hosking.

Location	Total
Home	31
Charlotte Jean	24
Base Hospital, In District	95
Base Hospital, Out of District	7
Out of District	4
Total	**161**

- 161 women received care from Deb and Peta July 2019 – July 2020
- 104 (65%) of women had uncomplicated pregnancies
- 55 (34%) of births took place in Wanaka or at Charlotte Jean Maternity Hospital

G) The below is an excerpt from data that was supplied to the Southern DHB by Charlotte Jean Maternity Hospital. We have used the 2018 total in-patients figure to inform utilisation estimates.

Charlotte Jean Maternity Hospital	**2018**	**2019**
Total Births In Facility	57	68
T/F IN for p/n care	152	146
Intrapartum T/F OUT to base hospital	15	18
Total in-patients (Births and PNs)	209	214
Total birth in catchment *	315**	
In-patients % of catchment	66%	

*as provided by the DHB.

**Please note that this figure has since been revised to 323

Appendix 2: Options Paper

Attached separately.

Appendix 3: Topics and questions from public meeting in Cromwell 25th July 2020

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

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

Appendix 4: Questions asked in second webform issued on 21 July 2020

Respondents were asked to:

1. Identify themselves from a grouping
2. Rate the relative importance of each of the following statements from 1 (least important) to 4 (most important):
    a. Offers acceptable travel times to primary birthing facilities for the most people
    b. Co-located with existing health services, 24/7 support and access preferred
    c. Can allow for highest level of midwifery staffing at a primary facility
    d. Expedited transport to secondary care in an emergency
3. Their first and second preferences from four options:
    a. Single new facility and Cromwell
    b. Single new facility at Dunstan hospital in Clyde
    c. Two facilities – Charlotte Jean and Wanaka
    d. Two facilities – Clyde and Wanaka
4. Identify where they are from
5. Submit any other comments

Appendix 5a: High level capital specification and costs

Item	Single unit (700 sqm)	Small unit (300 sqm)
Bed numbers	5/6 ensuite post-natal rooms 2 birthing rooms with pools	2/3 ensuite post-natal rooms 1 birthing room with pool
Other clinical service spaces	3 consulting rooms for antenatal appointments or urgent assessments 1 treatment / assessment room Area for medicine / equipment and linen storage Area for clinical waste / equipment cleaning items etc	2 consulting rooms for antenatal appointments or urgent assessments 1 treatment / assessment room Area for medicine / equipment and linen storage Area for clinical waste / equipment cleaning items etc
Other non-clinical spaces	Waiting room Rooms for parenting groups, breast feeding groups, LMC meetings	Waiting room 1 multi-use room for parenting groups, breast feeding groups, LMC meetings
Kitchen	Facilities for tea/coffee and heating meals. Full kitchen not required if meals delivered from off site.	Facilities for tea/coffee and heating meals. Full kitchen not required if meals delivered from off site.
Staff facilities	Staff shower and toilet	Staff shower and toilet
Est. build costs	Potential capital build cost of $4.9 million ($7k sqm including project costs) Land acquisition (if required) $1.5 - $2m **Total cost: $4.9 to $6.9m (depending on land)**	Potential capital build cost of $2.1 million ($7k sqm including project costs) Land acquisition (if required) $1.0 - $1.5m **Total cost for 2 small units: $4.2 to $5.6m (depending on land)**

Appendix 5b: Estimated operating costs per site

	Option A[6]	Option B[7]	Option C[8]
FTE per site (excluding unit manager)	5.22 FTE - 24/7 staffed cover	2.90 FTE + On Call	5.30 FTE - caseload midwife
Anticipated S88 Revenue	**$ -**	**$ -**	**$ 494,128**
Staffing			
Midwifery workforce	$ 571,307	$ 303,365	$ 543,027
On-call cost	$ -	$ 32,950	$ -
Call-back cost	$ -	$ 17,992	$ -
Unit Manager	$ 44,625	$ 44,625	$ 106,386
Sub-total	**$ 615,932**	**$ 398,932**	**$ 649,413**
Care costs			
Medical Supplies	$ 12,000	$ 12,000	$ 24,000
Meals	$ 14,940	$ 14,940	$ 14,940
Cleaning	$ 15,421	$ 15,421	$ 15,421
Laundry	$ 10,925	$ 10,925	$ 10,925
Community Care Costs	$ -	$ -	$ 148,238
Subtotal	**$ 53,286**	**$ 53,286**	**$ 213,525**
Facilities			
Rates/Insurance	$ -	$ -	$ -
Repairs & Maintenance	$ 7,359	$ 7,359	$ 7,359
Energy	$ 7,476	$ 7,476	$ 7,476
Other	$ -	$ -	$ -
Subtotal	**$ 14,835**	**$ 14,835**	**$ 14,835**
Administration & Other			
Office expenses	$ 2,500	$ 2,500	$ 2,500
Travel	$ 2,500	$ 2,500	$ 2,500
Subtotal	**$ 5,000**	**$ 5,000**	**$ 5,000**
Sum of expenditure	**$ 689,053**	**$ 472,053**	**$ 882,773**
20% Overheads[9]	$ 137,811	$ 94,411	$ 146,907
Grand Total Expenditure	**$ 826,864**	**$ 566,464**	**$ 1,029,680**

[6] This assumes a facility that is open 24/7.
[7] This assumes a facility that is partially open. It would be staffed for 13 hours per day and anytime there is a birth and/or postnatal stay.
[8] This assumes a facility that is only open as needed.
[9] Overheads are 20% of the sum of expenditure, except for Option C where overheads equal 20% of the sum of expenditure minus the Community Care Costs. This is because “Community Care Costs” are in essence the overhead for the community side of the Caseload Model of Care.

Expenses minus Revenue	**$**	**826,864**	**$**	**566,464**	**$**	**535,552**

OPTIONS PAPER

Where should we locate primary maternity facilities in Central Otago/ Wanaka?

https://www.engage.southernhealth.nz/maternity
maternity@southerndhb.govt.nz

Contents

Background 2

Current System of Primary Maternity Services in the Southern District 4

Consultation 9

Options design and decision making 10

Option 1 - Single new facility at Cromwell 12

Option 2 – Single new facility at Dunstan Hospital in Clyde 14

Option 3 – Two facilities, Charlotte Jean and Wanaka 16

Option 4 – Two facilities, Clyde and Wanaka 18

Options Comparison 20

Next Steps 21

Appendix: Summary of Consultation 23

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

Background

The Central Otago district of Alexandra, Cromwell, Clyde, Ranfurly and Roxburgh is currently serviced by a Primary Birthing Unit in Alexandra, Charlotte Jean Maternity Hospital. This facility also services Wanaka, being located approximately 60 minutes away by road. There is also a Primary Birthing Unit at Lakes District Hospital in Queenstown and there are maternal and child hubs in Wanaka and Ranfurly. It should be noted that we intend to keep the unit at Queenstown Lakes hospital in all scenarios presented in this paper.

A Primary Birthing Unit provides a physical setting for assessment, labour and birth, and postnatal care. It may be a stand-alone facility or a unit within a Level 1 or 2 general hospital. The Primary Birthing Unit, in conjunction with the LMC or DHB-funded Primary Maternity Services Provider, provides primary maternity inpatient services during labour and birth and the postnatal period until discharge or transfer. Primary Birthing Units have no inpatient, secondary or tertiary maternity services such as epidural, Caesarean section or usage of medications to induce or augment labour.

The Ministry of Health estimates that 30% of pregnant women should be eligible for primary birthing. In addition, women who travel to the base hospitals for labour and birth can then choose to return to their local primary maternity facility for postnatal care.

Prior to reviewing our primary maternity system of care in recent years, the configuration of primary maternity facilities had evolved through historical circumstances. The need to look at the maternity facilities of the whole southern health district led to Southern District Health Board (DHB) creating the Integrated Primary Maternity System of Care in 2018 which recommended the best long-term location of a Primary Birthing Unit in Central Otago/ Wanaka be explored. The new system of care aims to provide more equitable care for women across the district by addressing service gaps and better distributing resources and facilities across our wide geographic area.

The new system recognised that ensuring the sustainability of the primary maternity system required more than considering specific facilities. In 2018 resources were directed towards the sustainability of the LMC workforce, through providing additional payments to remote rural midwives to recognise the additional costs they faced. Throughout 2018 and 2019, additional support was also provided through establishing and funding Maternal and Child Hubs, alleviating some business costs for rural midwives, and providing well equipped environments that could be used in the event of urgent or emergency births.

During this process we established principles for a reformed configuration of services, and we continue to apply these as we make a decision for the Central Otago/ Wanaka area.

These are:

- Critical mass – this means understanding our populations and birthing numbers across the district; meeting Ministry of Health birthing population standards; and ensuring there are sufficient numbers for a viable service and sustainable workforce, supported by a transfer/transport system
- Equity for disadvantaged communities
- Acceptable travel distances to a facility – in the context of improved support for home birthing and acknowledging the preference for travel towards secondary care locations.

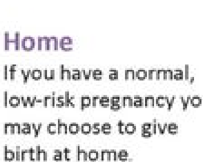
This led to the development of a variety of facilities and options that function interdependently as an overall network of care. The transportation system (St John and helicopter) also remains an integral part of the health care delivery system of a district as large as ours.

City (Base) Hospitals

Base hospitals in Dunedin and Invercargill provide care for women with normal, healthy pregnancies as well as care and facilities for more complex pregnancies that may require obstetric care. You can have a postnatal stay once your baby is born.

Dunedin Hospital also provides care for women with higher-risk pregnancies. It has a neonatal intensive care unit (NICU) You may see this described as tertiary care.

Southland Hospital provides primary and secondary care.



Primary Birthing Units

Suitable for giving birth if you have a normal, low-risk pregnancy and you can have a postnatal stay once your baby is born.

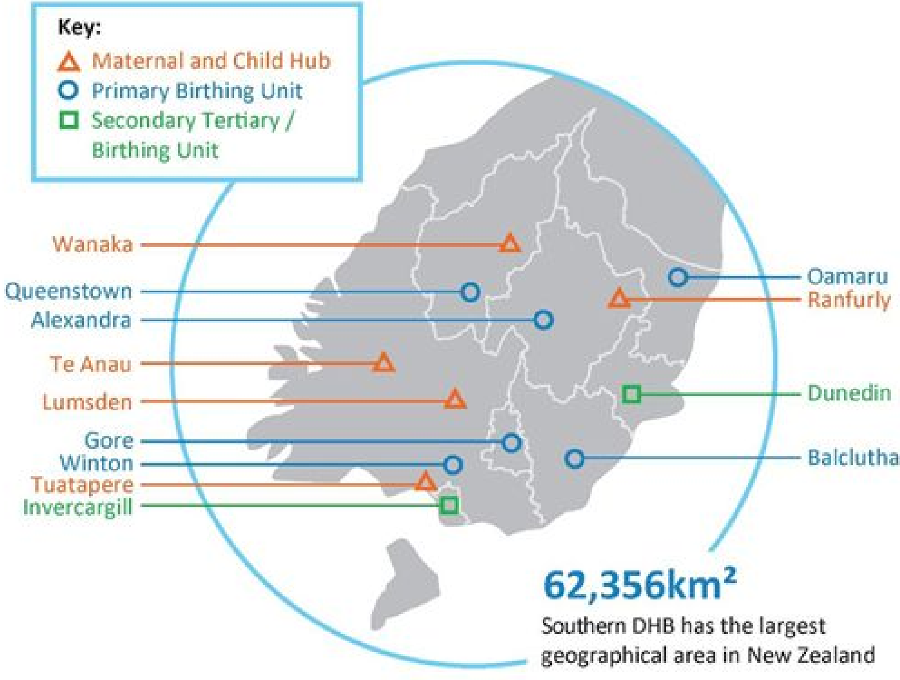
Maternal and Child Hubs

Maternal and Child Hubs provide an additional layer of support for women in areas further from primary maternity inpatient care. They provide antenatal and postnatal support, and although not intended for planned births, they have midwifery equipment and are accessible to LMC midwives in case of rapid births. Some hubs include access to medical specialists through teleconferencing.

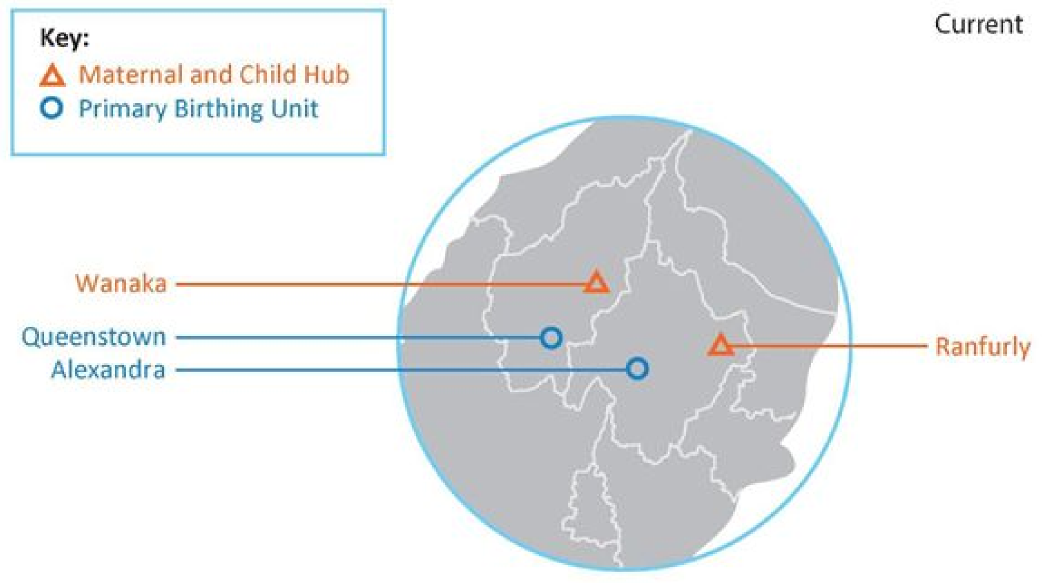
The hubs in each area may look slightly different from each other because they have flexibility to meet the local community's needs.

Current System of Primary Maternity Services in the Southern District

Under the Integrated Primary Maternity System of care, facilities are currently configured across the district as follows.



Focusing on the Central-Lakes area, below is the current configuration of facilities.



Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

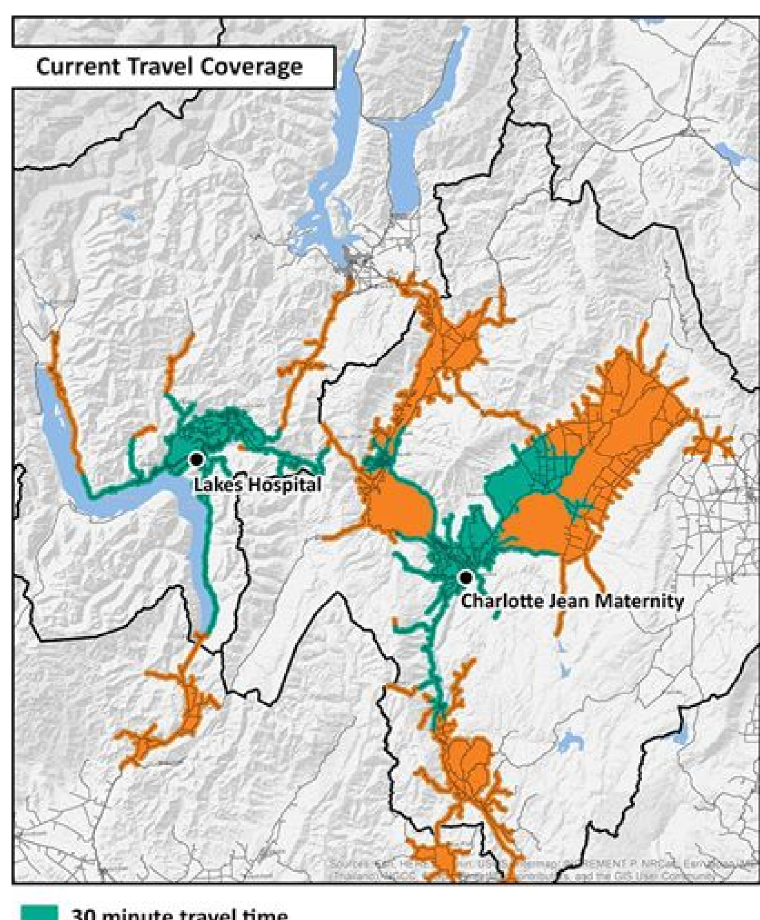
Southern DHB has the largest geographical area in New Zealand and has a challenging remote and rural landscape. Population growth in Wanaka, as well as in the Cromwell/Clyde area, provides impetus to consider primary maternity facilities within this area to better service ongoing and future demand.

The DHB is required to provide or fund primary maternity facilities for urban or rural communities with a catchment of:

• 200 pregnancies per annum where the facility is 30 minutes from a secondary service,

• 100 pregnancies per annum where the facility is 60 minutes from a secondary service

Because of the burgeoning populations in Central Otago and Queenstown Lakes District, depending on how the identified are ‘catchments’ are treated, it is entirely probable that for sub-localities within this part of the District that we are no longer meeting this part of our requirement. There could be a case for two separate facilities or, if we define the catchment as combined, then one larger centrally located facility could be considered.



This map below illustrates the current coverage within travel times of 30 and 60 minutes from Primary Birthing Units.

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

The table below shows where Southern district mothers were living during pregnancies in 2015–2018. They did not necessarily give birth in that location. The 2019 data was not available at the time of writing this paper.

Number of births by Territorial Authority

TLA[1]	2015	2016	2017	2018	Grand Total
Dunedin	1,150	1,099	1,128	1,074	4,451
Invercargill	623	626	669	611	2,529
Southland	380	363	378	335	1,456
Queenstown Lakes (excl. W/H/M)	263	278	294	266	1,101
Wanaka/Hawea/Matukituki	106	109	123	110	448
Waitaki	236	219	211	208	874
Clutha	188	182	198	174	742
Central Otago	153	183	182	205	723
Gore	153	133	134	128	548
Undefined	3			1	4
Grand Total	**3,255**	**3,192**	**3,317**	**3,112**	**12,876**

[1] Queenstown Lakes TLA split out Wanaka/Hawea/Matukituki area units

The table below shows us where babies were delivered in 2015 - 2018. The 2019 data was not available at the time of writing this paper.

Number of births by Facility

Facility	2015	2016	2017	2018	Grand Total
Dunedin Hospital	1,642	1,606	1,655	1,592	6,495
Southland Hospital	1,184	1,212	1,243	1,143	4,782
Gore Health Limited	78	70	81	75	304
Oamaru Hospital	80	73	64	64	281
Lakes District Hospital	64	59	72	71	266
Charlotte Jean Maternity Hospital	53	58	60	57	228

Clutha Health First	45	44	55	43	187
Winton Maternity Centre	35	32	31	29	127
Lumsden Maternity Centre	41	16	32	19	108
Non-Southern	22	20	24	27	93
Tuatapere Maternity Unit	9	7			16
Maniototo Health Services	3	1			4
Dunstan Hospital			1		1
Grand Total	**3,256**	**3,198**	**3,318**	**3,120**	**12,892**

Based on Statistics New Zealand projections, we estimate there will be between 42 and 66 births per year that are appropriate for primary birthing in Central Otago and a further 126-132 births in the Queenstown-Lakes area, which includes Wanaka. The medium projection is considered the most suitable for assessing future population change. As with other data presented in this paper, there is a possibility that COVID-19 may impact on growth rates.

Projected number of births							
Projection	**Territorial Authority**	**2021**	**2022**	**2023**	**2028**	**2033**	**2038**
Low	Central Otago district	180	180	180	160	140	140
	Queenstown-Lakes district	440	440	440	440	420	420
	DHB Total	3,060	3,060	3,060	2,910	2,700	2,550
Projected number of births							
Projection	**Territorial Authority**	**2021**	**2022**	**2023**	**2028**	**2033**	**2038**
Medium	Central Otago district	200	200	200	180	180	180
	Queenstown-Lakes district	480	480	480	480	480	480
	DHB Total	3,320	3,320	3,320	3,260	3,160	3,070
Projected number of births							
Projection	**Territorial Authority**	**2021**	**2022**	**2023**	**2028**	**2033**	**2038**
High	Central Otago district	220	220	220	220	220	220
	Queenstown-Lakes district	520	520	520	540	540	560
	DHB Total	3,600	3,600	3,600	3,640	3,630	3,660

Projected number of births appropriate for primary birthing (30% of total)							
Projection	**Territorial Authority**	**2021**	**2022**	**2023**	***2028***	***2033***	***2038***
Low	Central Otago district	54	54	54	*48*	*42*	*42*
	Queenstown-Lakes district	132	132	132	*132*	*126*	*126*
	Central + Queenstown Total	**186**	**186**	**186**	***180***	***168***	***168***
Projected number of births appropriate for primary birthing (30% of total)							
Projection	**Territorial Authority**	**2021**	**2022**	**2023**	***2028***	***2033***	***2038***
Medium	Central Otago district	60	60	60	*54*	*54*	*54*
	Queenstown-Lakes district	144	144	144	*144*	*144*	*144*
	Central + Queenstown Total	**204**	**204**	**204**	***198***	***198***	***198***
Projected number of births appropriate for primary birthing (30% of total)							
Projection	**Territorial Authority**	**2021**	**2022**	**2023**	***2028***	***2033***	***2038***
High	Central Otago district	66	66	66	*66*	*66*	*66*
	Queenstown-Lakes district	156	156	156	*162*	*162*	*168*
	Central + Queenstown Total	**222**	**222**	**222**	***228***	***228***	***234***

A large component of the services delivered by Primary Birthing Units involves women transferring to them, after birthing in another location, for a postnatal stay. Often partners and family are able to join new mothers. Data on the volumes of postnatal stays was not available at the time of writing this paper but this important aspect of care is acknowledged.

Consultation

Southern DHB has worked alongside the Central Lakes Locality Network to engage with stakeholders and local communities to develop options to meet the need for primary birthing facilities.

In February 2020, an online submission form was launched and face to face or online engagement meetings were held with key stakeholders through to July.

More than 330 submissions were received through the online submission form where stakeholders were asked what they thought the most important issues were for the DHB to consider when deciding on a location for primary maternity facilities. Submissions were received from members of the community including LMCs, GPs and parents. A detailed summary of the consultation process, including webform feedback and a stakeholder meeting, is included as Appendix One.

In addition to the webform, meetings were held with LMCs, core midwives, wellchild providers, primary care practitioners, Māori healthcare provider and the Southern District Maternity Quality and Safety group.

Key considerations that have emerged from consultation to date are:

- 24/7 midwifery availability at birthing facilities is preferred by LMCs as this provides additional back up in remote rural areas
- Rapid access to urgent transport, especially a helicopter is essential. A significant proportion of the online feedback focused on safety and the importance for women and whānau to know that there are excellent arrangements to deal with emergency situations
- Equity of travel times and access to primary birthing facilities for all parts of the region is important
- Co-location with other health services, especially medical support, is highly valued by public and professionals
- Need to take account of pace and locations of population growth and develop a future proofed proposal
- Quality of the whole pathway of maternal care emerged as a key theme. While people want to know facilities are available, many respondents focused on care quality and availability of a highly skilled workforce
- Feedback from Māori respondents noted that Māori have experienced care that was not respectful e.g. 'being talked down to' and in particular have not always received supportive care in the weeks following birth
- Charlotte Jean Maternity Hospital is highly valued by women and the community.

Southern DHB is hugely grateful to all the people, both members of the public and professionals, who have taken the time to contribute to consultation so far. The contributions were thoughtful and show the passion people feel for this important area of health care. The themes that have emerged show the complexity of the issue and that a number of different options could meet the requirements.

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

Options design and decision making

Informed by consultation and the themes that emerged from the webform submissions (Appendix One) we have designed four options that attempt to address a balance of the issues in a variety of locations.

As part of our design process we considered:

- current configuration of services
- potential co-location of services
- where the population is growing
- the requirements of the Service Schedule
- workforce availability
- affordability.

Before we set out the options, it is important to note the criteria that will be used to make a final decision.

As part of our decision making process we will consider:

- Stakeholder and public feedback, their preferred option and in particular weighting given to the considerations outlined on page 19:
  - the option chosen offers acceptable travel times to primary birthing facilities for the most people
  - the option chosen is co-located with existing health services, 24/7 support and access preferred
  - the option chosen can allow for highest level of midwifery staffing at a primary facility
  - the option chosen expedited transport to secondary care in an emergency

- the requirements of the Service Schedule
- safety and quality
- workforce availability
- sustainability
- affordability

Our aim is to deliver a facility that is the preferred place of birth for healthy, well, low-risk women, the preferred place of postnatal care for all women/families in the area and a safe place for coordinated emergency maternity care. In making a decision, there will need to be trade-offs.

For example, some options provide a Primary Birthing Unit within a 60 minute drive time for Wanaka women, some options provide this within 40 minutes and some provide an option within Wanaka itself. What drive times will be acceptable to mothers and their whānau?

Safety considerations were a strong theme in feedback. Some options offer co-location potential with GPs (with and without after hours support) and one option offers co-location on a hospital site.

A single unit lends itself to a wider service scope at the facility. An expanded service scope might look like:

- potential for 24/7 cover
- a "hub" for wider services i.e. maternal mental heath

We received considerable feedback from health care providers that 24/7 midwifery cover at the unit would provide greater support for LMC midwives, and provide greater certainty for postnatal care, improving the overall sustainability of the maternity services in the district.

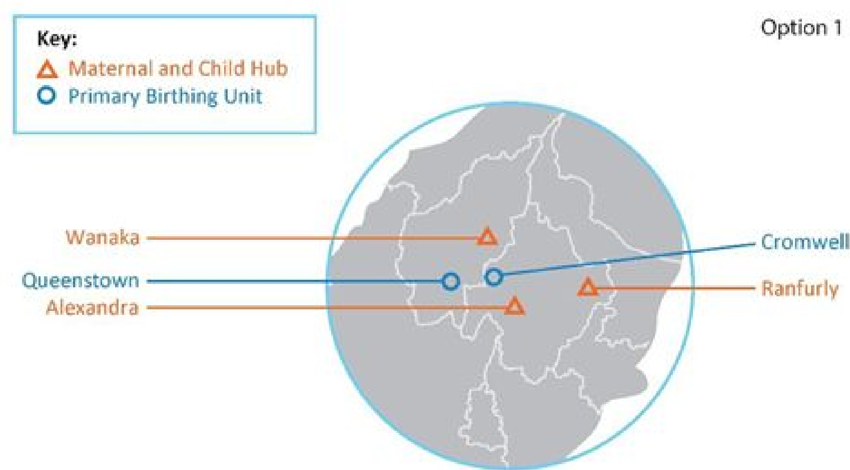
However, workforce availability to achieve this is an issue that will require further exploration. To implement the desired 24/7 staffing model at a single unit requires 4.2 FTE. In reality, given part time hours and willingness to work on a 24/7 roster, we estimate needing eight available midwives, in the area, all willing to work at least 0.6 FTE and some available for extra cover.

Affordability is another issue that impacts all options that we describe. For example, the capital costs associated with new builds will be higher than using an existing facility. Options that present two facilities will incur higher operational costs and this will also impact on the ability to offer a 24/7 service model.

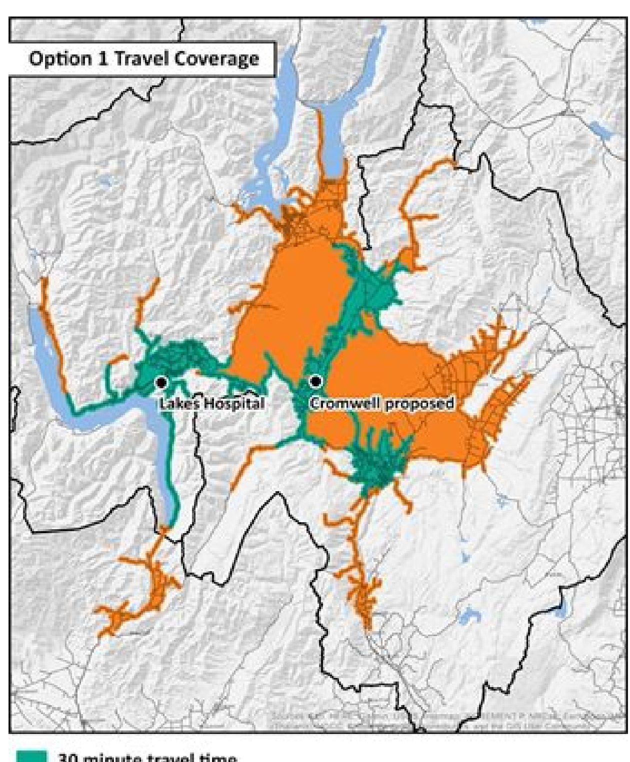
Our aim is to clearly articulate in our decision making how these criteria were considered and weighted. Your feedback is key to informing a robust decision.

Option 1 - Single new facility at Cromwell

Locate a single new Primary Birthing Unit, with helipad in Cromwell catering for the population of Central Otago and Wanaka. This would be supplemented by provision of Maternal and Child Hubs in Wanaka, Alexandra and Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.



Cromwell is a central location within 30-50 minutes of all the larger population groups. This location is further away from a base secondary hospital than the current facility in Alexandra (Charlotte Jean Maternity Hospital) that would be decommissioned.



This image shows coverage based on travel time. The green shows areas covered by 30 minutes of travel from the facilities and the orange 60 minutes.

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

11

Under this option, coverage of the female population (aged 15-49) living within a 30 minute travel radius of a Primary Birthing Unit increases from 73.6% to 74.4%, and within a 60 minute travel radius of a Primary Birthing Unit increases from 79.9% to 97.8%.

Scenario	15-49 Female population covered			
	n covered		% covered	
	≤30 min	≤60 min	≤30 min[1]	≤60 min[1]
Current: CMJ + Qtown	11,670	12,670	73.6%	79.9%
Opt 1: Cromwell + Qtown	11,792	15,502	74.4%	97.8%

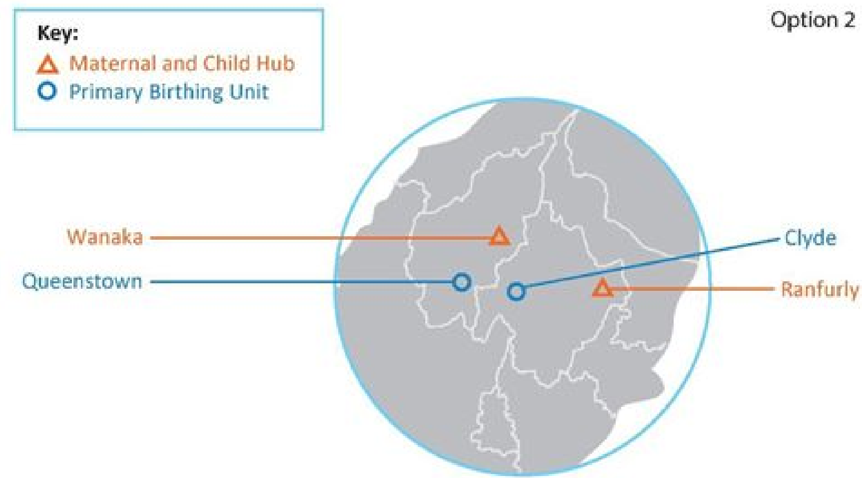
[1]Denominator: 15,858

Looking towards the future, the unit would be located in an area that will continue to grow and there is the potential to create synergies for other needed health developments in Cromwell. Noting this would be a possible location if it were determined in the future to develop a facility that could deliver increasing elements of secondary care to the community. There is also the potential to co-locate the Primary Birthing Unit with a general practice.

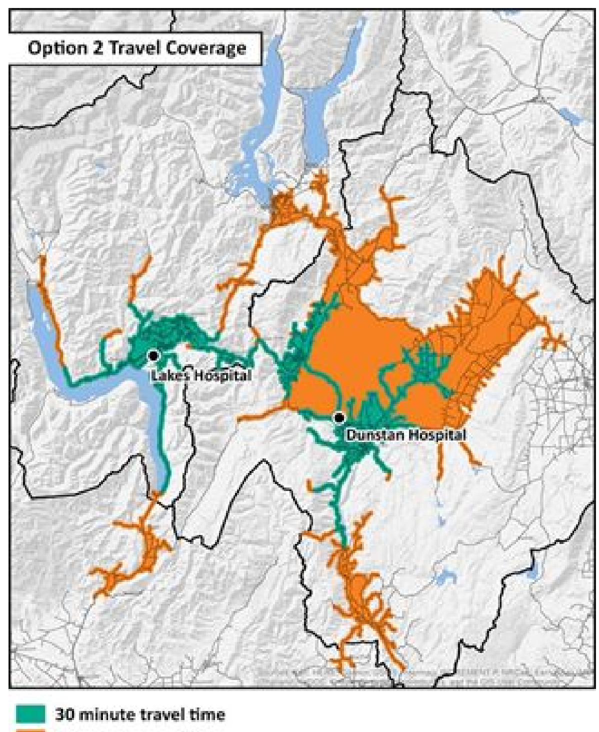
Early work undertaken by the DHB indicates that the capital cost of this option is viable.

Option 2 – Single new facility at Dunstan Hospital in Clyde

Locate a single new Primary Birthing Unit, with helipad on the Dunstan hospital site in Clyde, catering for the population of Central Otago and Wanaka. This would be supplemented by provision of Maternal and Child Hubs in Wanaka and Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.



Clyde is within 60 minutes of all the larger population groups. This location is further away from a base secondary hospital than the current facility in Alexandra (Charlotte Jean Maternity Hospital) that would be decommissioned.



This image shows coverage based on travel time. The green shows areas covered by 30 minutes of travel from the facilities and the orange 60 minutes.

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

Under this option, coverage of the female population (aged 15-49) living within a 30 minute travel radius of a Primary Birthing Unit increases from 73.6% to 74.4%, and living within a 60 minute travel radius of a Primary Birthing Unit increases from 79.9% to 91.4%.

Scenario	15-49 Female population covered			
	n covered		% covered	
	≤30 min	≤60 min	≤30 min[1]	≤60 min[1]
Current: CMJ + Qtown	11,670	12,670	73.6%	79.9%
Opt 2: Dunstan + Qtown	11,802	14,492	74.4%	91.4%

[1]Denominator: 15,858

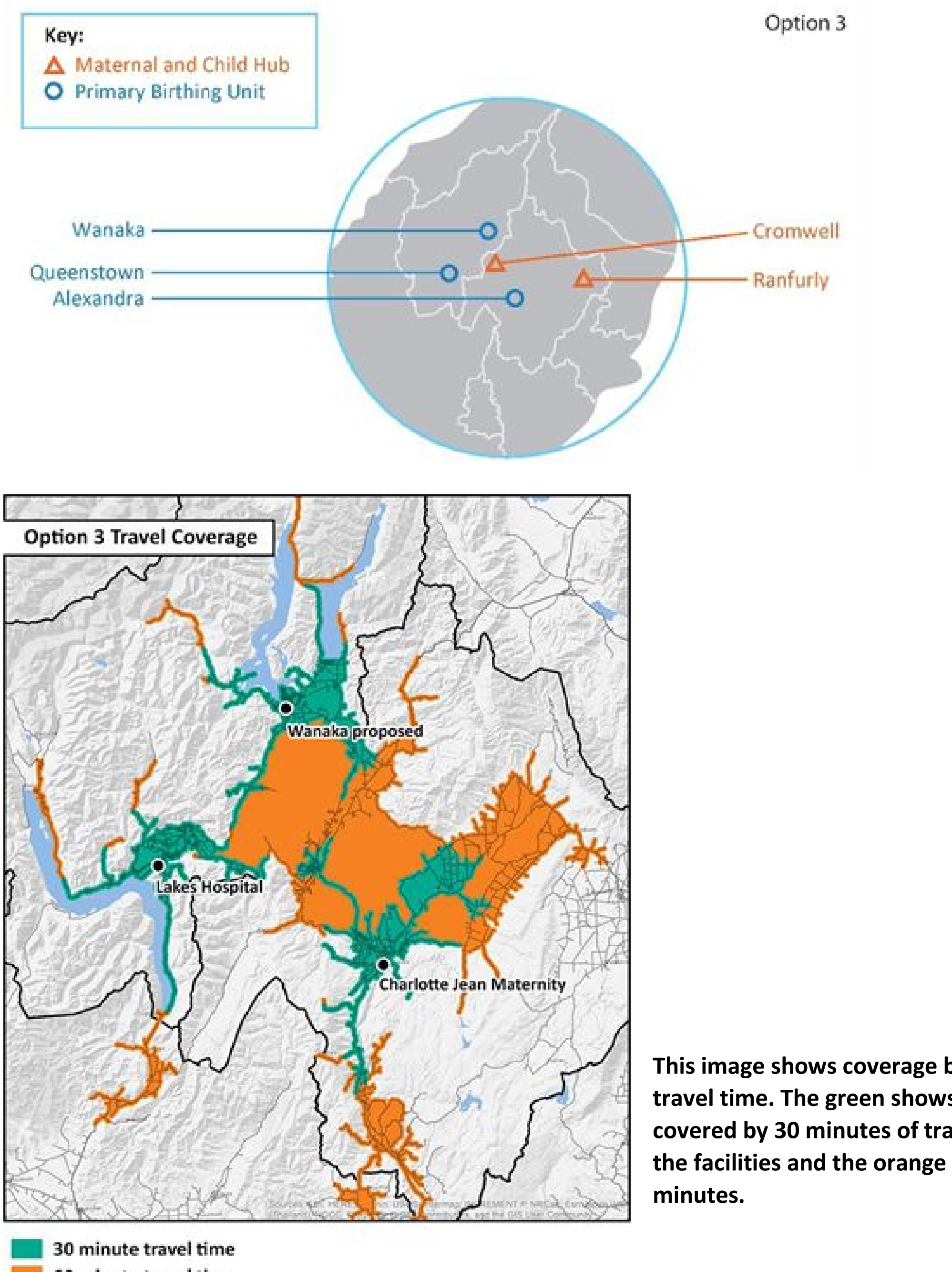
Dunstan Hospital is an established rural hospital with a 24 acute bed inpatient ward and provides secondary health services to around 25,000 people living in the wider Central Otago and Wanaka regions.

There was strong support in the online consultation for maternity services to be located here as there are perceived benefits to co-location with other services and to allow easier access to the helipad for emergency transfer and retrievals.

Early work undertaken by the DHB indicates that the capital cost of this option is viable.

Option 3 – Two facilities, Charlotte Jean and Wanaka

Locate a new Primary Birthing Unit in Wanaka and retain the current birthing unit in Alexandra (Charlotte Jean Maternity Hospital) to cater for the population of Central Otago and Wanaka. This would be supplemented by provision of a Maternal and Child Hub in Cromwell and Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.



This image shows coverage based on travel time. The green shows areas covered by 30 minutes of travel from the facilities and the orange 60 minutes.

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

Under this option, coverage of the female population (aged 15-49) living within a 30 minute travel radius of a Primary Birthing Unit increases from 73.6% to 94.9% and living within a 60 minute travel radius of a Primary Birthing Unit increases from 79.9% to 98.6%.

Scenario	15-49 Female population covered			
	n covered		% covered	
	≤30 min	≤60 min	≤30 min[1]	≤60 min[1]
Current: CMJ + Qtown	11,670	12,670	73.6%	79.9%
Opt 3: Wanaka + CMJ + Qtown	15,047	15,643	94.9%	98.6%

[1]Denominator: 15,858

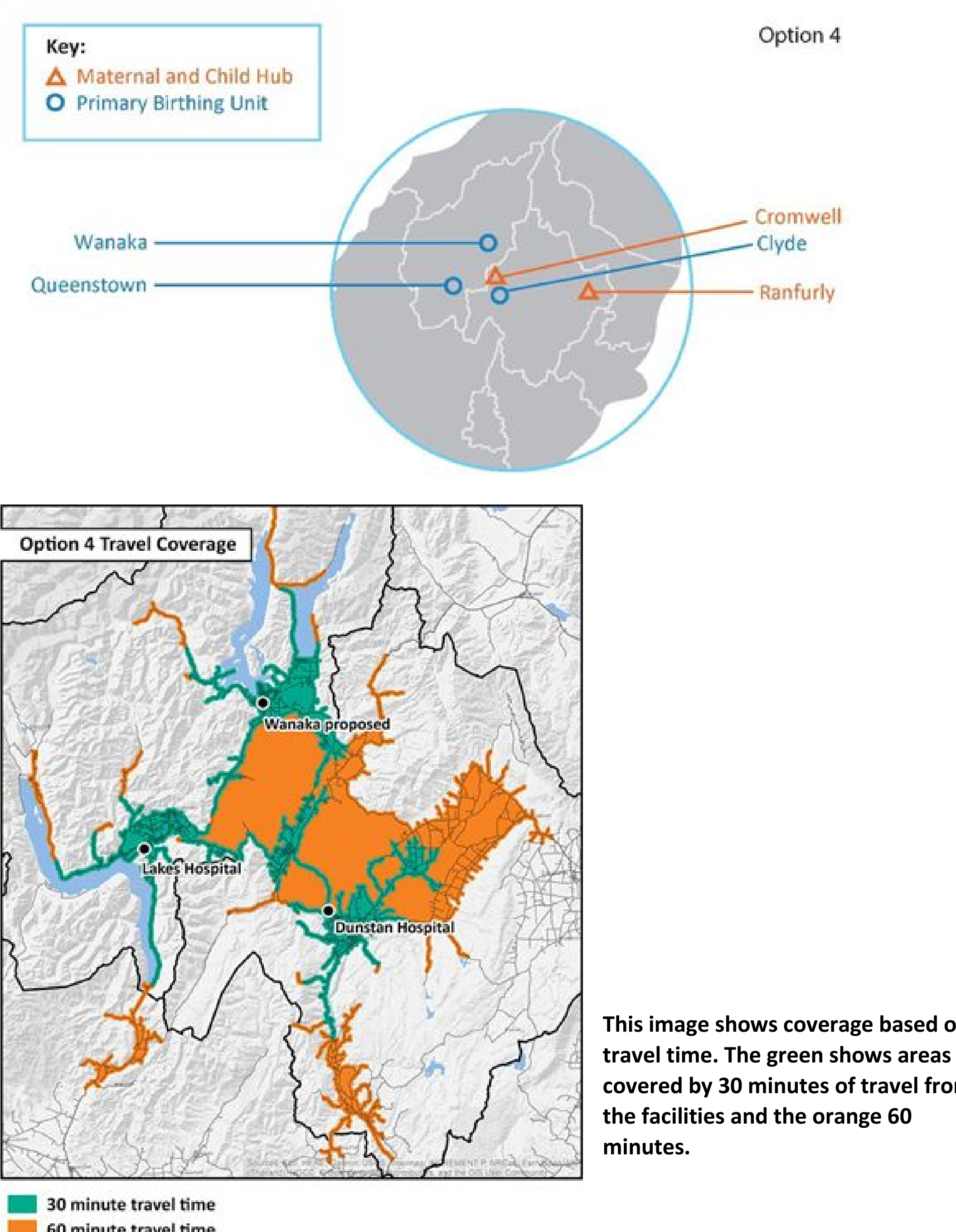
In Wanaka, there is potential to co-locate with general practice and be close to an existing helipad for urgent transfers. Charlotte Jean relies on a road ambulance transfer to the helipad at Dunstan Hospital in Clyde.

Locating a primary birthing facility in Wanaka may result in it not being utilised to its full potential due to its distance from secondary services. Research in 2013 into the travel patterns of women giving birth noted that women are reluctant to travel away from regional and city hospitals to attend a primary facility. In addition, only 30% of women are estimated as suitable for birthing in a primary facility and under this option that group of women would be shared across two facilities.

Early work undertaken by the DHB indicates that the capital spend on this option is viable and the DHB notes that the operating costs for this option would be higher than option one and two.

Option 4 – Two facilities, Clyde and Wanaka

Locate a new Primary Birthing Unit in Wanaka and relocate the current Primary Birthing Unit in Alexandra (Charlotte Jean Maternity Hospital) to be co-located with Dunstan Hospital in Clyde, to cater for the population of Central Otago and Wanaka. This would be supplemented by provision of a Maternal and Child Hub in Cromwell and Ranfurly. Some emergency birthing facilities (access to a safe place to birth plus emergency equipment) could also be made available in Lawrence.



This image shows coverage based on travel time. The green shows areas covered by 30 minutes of travel from the facilities and the orange 60 minutes.

Options Paper for Primary Maternity Facilities in Central Otago/ Wanaka, July 2020, Southern DHB

Under this option, coverage of the female population (aged 15-49) within a 30 minute travel radius of a Primary Birthing Unit increases from 73.6% to 95.7%, and within a 60 minute travel radius of a Primary Birthing Unit increases from 79.9% to 98.6%.

Scenario	15-49 Female population covered			
	n covered		% covered	
	≤30 min	≤60 min	≤30 min[1]	≤60 min[1]
Current: CMJ + Qtown	11,670	12,670	73.6%	79.9%
Opt 4: Wanaka + Dunstan + Qtown	15,179	15,643	95.7%	98.6%

[1]Denominator: 15,858

There would be good access at both locations to a helipad for emergency transfers and retrievals. In Wanaka, there is potential to co-locate with general practice and be closer to an existing helipad for urgent transfers. Dunstan Hospital has a helipad on site.

Relocating Charlotte Jean Maternity Hospital to Clyde will achieve co-location with other medical services. There was strong support for this co-location in the online submissions.

Locating a primary birthing facility in Wanaka may result in it not being utilised to its full potential due to its distance from secondary services. Research in 2013 into the travel patterns of women giving birth noted that women are reluctant to travel away from regional and city hospitals to attend a primary facility. In addition, only 30% of women are estimated as suitable for birthing in a primary facility and under this option that group of women would be shared across two facilities.

The DHB notes that this option has both higher capital and operating costs than any other option.

Options Comparison

The image below summarises key elements of the four options for ease of comparison.

	Option One (Cromwell)	Option Two (Clyde)	Option Three (Wanaka & Alexandra)	Option Four (Wanaka & Clyde)
24/7 cover possible	✓	✓	✗	✗
% service schedule coverage achieved	✓ 30 mins - 74% 60 mins – 98%	✓ 30 mins - 74% 60 mins – 91%	✓ 30 mins - 95% 60 mins – 99%	✓ 30 mins - 96% 60 mins – 99%
Helipad onsite	✓	✓	✓ Wanaka ✗ Alexandra	✓ Clyde ✓ Wanaka
Co-location with medical facilities	**Future potential**	✓	Potential in Wanaka ✗ Alexandra	Potential in Wanaka ✓ Clyde

11

Next Steps

There is still time to have your say and help us determine the best configuration of primary maternity facilities in Central Otago/Wanaka.

We welcome feedback on the four options presented in this paper.

As we weigh up the options, we are particularly interested in hearing:

A) Your first and second preference out of the four options put forward.
B) Your views on the relative importance of these four factors in our decision making.

   We acknowledge that all of these factors are important. However, in your opinion is it most important that:

   1. the option chosen offers acceptable travel times to primary birthing facilities for the most people
   2. the option chosen is co-located with existing health services, 24/7 support and access preferred
   3. the option chosen can allow for highest level of midwifery staffing at a primary facility
   4. the option chosen expedited transport to secondary care in an emergency

You can supply your thoughts on this by:

- Emailing maternity@southerndhb.govt.nz
- Using the submission form at https://www.engage.southernhealth.nz/maternity
- Attending the Public Meeting:

  Where should we locate primary birthing facilities in Central Otago/ Wanaka?
  23 July, 2020
  4pm
  Cromwell Presbyterian Church, 10 Elspeth Street

  Feedback open until 22 August 2020.

About the Central Lakes Locality Network

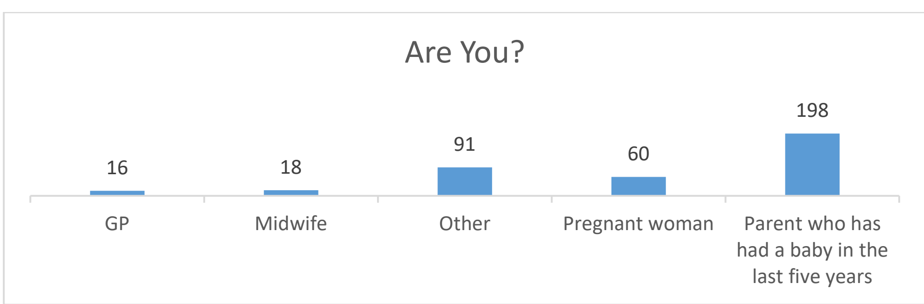
The creation of Locality Networks was outlined in the Primary and Community Care Strategy and Action Plan, with the purpose of ensuring models of care align with population health needs and service requirements in different areas of the district. The network plays a vital role in prioritising and planning health services so they meet the needs of local communities and are well-integrated with the broader health system. Central Lakes Locality Network (CLLN) is the first of these networks to be established. Helen Telford, Queenstown resident and expert health consultant and programme manager is the Chair of the Network. Other members include local residents including patients and healthcare consumers, general practitioners and rural hospital clinicians, a general practice nurse and a health promotion advisor. Further information about the network and its members can be found https://www.southernhealth.nz/publications/central-lakes-locality-network-members-appointed.

Appendix: Summary of Consultation

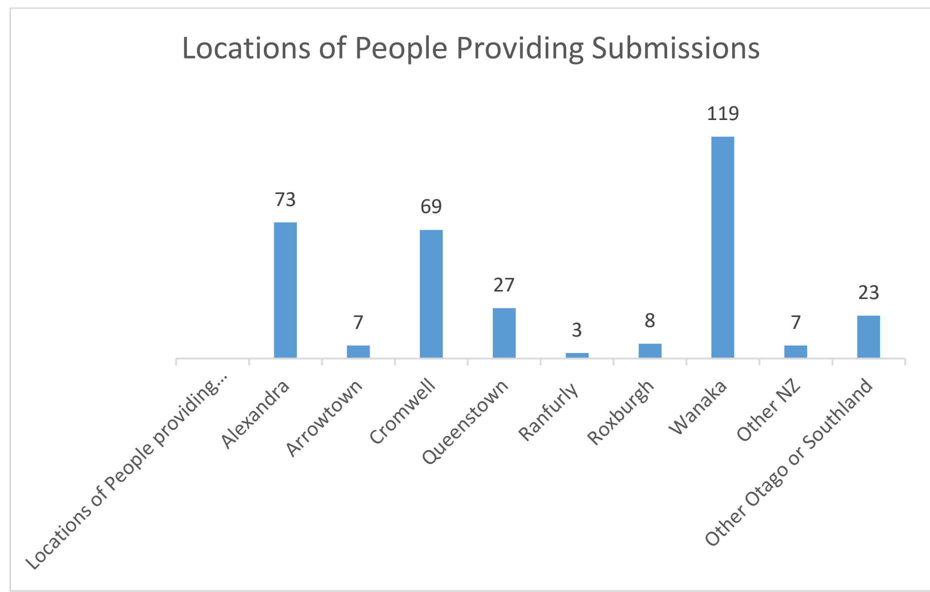
Webform feedback analysis

The Southern District Health Board (SDHB) launched a webform in February 2020 asking people what issues they felt were most important in considering the location of primary birthing facilities in Central Otago/ Wanaka area. We received 336 responses.

The majority of respondents are parents who have had a baby in the last 5 years. 60 pregnant women responded and 34 respondents identified as either midwives or GPs. The breakdown of respondents is provided below. It should be noted that many people identified as being more than one category which is why the total number in the graph below adds up to higher than the total number of responses.



We also asked people where they are from. 81% of respondents identified as being from Central Otago/ Wanaka, with 10% from Queenstown and Arrowtown and 9% from other parts of Otago, Southland and the rest of NZ. The breakdown of this is provided below.



What the feedback told us

Theme 1: Primary v's secondary facilities

There is confusion about what we mean by primary birthing and many people would like to see availability of secondary birthing facilities in the area. The comments below are an example of the feedback where people are expressing a desire for secondary care birthing provision:

Response 45 '*There needs to be upgraded care with paeds and OB available for at risk labors. This needs to be sorted immediately before any more emergencies occur that may lead to fatalities.'*

Response 66 *'And I believe secondary facilities are needed just as much. The issues in this region will not be fixed by another primary unit.'*

Response 126: '*We need access to modern, emergency maternity facilities locally, Paediatric Staff and Specialists on hand at the drop of a hat. The margin for error is far too great currently. Mums, babies and unborn babies are at risk with our current remote facilities that are outdated.'*

11

A primary maternity facility provides a physical setting for assessment, labour and birth, and postnatal care. It may be a stand-alone facility or a unit within a Level 1 or 2 general hospital. The primary maternity facility, in conjunction with the LMC or DHB-funded Primary Maternity Services Provider, provides primary maternity inpatient services during labour and birth and the postnatal period until discharge or transfer. Primary maternity facilities have no inpatient Secondary or Tertiary Maternity Services - such as epidural, caesarean section, usage of medications to induce or augment labour.

Some respondents noted that primary birthing is not well understood and that more education and support is needed to ensure that women who are suitable for primary feel confident choosing this option. The responses below illustrate this:

Response 73 *'Support and passion of support by the wahine and whānau for primary birthing'*

Response 267: *'An understanding of women/families in the community what constitutes a primary birth facility and the research that supports normal birth in this environment.*'

At this point we are not in a position to have secondary care birthing available in the area. While there are some examples in New Zealand (such as West Coast) where there is limited access to some secondary birthing options available rurally, the DHB considers that we cannot provide the level of quality and safety required for secondary birthing in rural hospital environments. Clearly this region is experiencing significant population growth – although is it acknowledged that the projections available before the Covid pandemic are likely to change as a result of this world event. This consultation is focused on primary birthing options only. However, we recognise that within this we need to address the concerns and aim to deliver future proofed options that will allow for services to evolve as the population changes.

Theme 2: Maternal and child safety

Safety is a significant theme across the responses with people referencing the distances to base hospitals and challenges experienced by people in the area due to weather and geography as shown in the responses below:

Response 90: *'access to a safe birthing environment equipped with the right equipment / safe transport in an emergency situation'*

Response 42 '*Driving 4 hours through areas without cell reception whilst in labour away from whānau and support is not safe or reliable. Therefore, the location should be in Wanaka*.'

Response 148 *'Winter driving conditions and access to emergency services'*

Response from Uruuruwhenua rohe: *"Had baby in Christchurch as felt it was a safer option"*

Therefore, safety is a key issue. In particular, we need to have good arrangements for dealing with precipitous (rapid) birth situations for women who would be indicated for secondary care and dealing with the situations where complications arise with a birth that had been considered suitable for primary environment. People also talked about safety for partners who have to drive in potentially dangerous conditions in winter when a woman has to be transferred by helicopter in an emergency situation. Some of the comments below, illustrate further some of the complexities in delivering safe services and the concerns that are experienced both by women and their health care providers:

Response 120 *'The issue is that it scares me to get pregnant up here!! My last pregnancy ended in an emergency c section. Luckily I lived in Dunedin then and there wasn't an issue. But now with living in Cromwell I worry… not many midwives up here and young families are at an all-time high… central isn't somewhere people just go to retire anymore'*

Response 175*: 'A birthing unit in Wanaka may be more unsafe because it creates the illusion of safe birth when in fact a 5 hour delay getting to a caesarean section can create terrible outcomes. Speed of transfer in an emergency'.* (GP response)

Response 243: '*Paramount should be the safety of mother and baby. That includes taking away the uncertainty and fear of potentially having to travel massive distances if necessary to give birth. This is not like having to travel for scheduled procedures. '*

Concerns about distance, weather and safety mean that some people are choosing to birth outside of the district or incurring significant cost and personal inconvenience to birth safely in Dunedin or Invercargill.

Response 60: '*I chose to fly to [another New Zealand location] and stay up there instead but not everyone has that luxury of extended family. The weather can have a huge impact on whether helicopters or ambulances can travel as needed.'*

Response 153: *Requiring scared mothers to travel long distances and then stay in Dunedin at huge personal cost and without support networks is inappropriate. Imagine the outcry if you asked Dunedin mums to travel to Wanaka and stay in a motel at their own cost up to 2 months before their baby was born because they needed monitoring. That is what you are asking of women in the lakes district every week!*

Response 213: *'I decided to birth both my children in Invercargill as I did not want to travel during birth if things went wrong. I was lucky to be able to drive there between snow storms.'*

What the responses above have told us?

- Any changes we make or development of a new unit needs to enhance the safety of the maternity services available in the area
- A primary birthing unit must be developed in a way that supports rapid transfer of women and babies in emergency situations
- Women, partners and whānau needs the best possible information and support around safe birthing choices as there are significant implications on the choice of birth location

Theme 3: Location and numbers of units

We didn't ask people to express a preference on location in the webform but significant numbers of people discussed locations. Many factors influence people's views on the best location or numbers of units as illustrated in the range of comments below:

Response 76: '*It must be placed as centrally as possible, i.e. equidistant from centres of population. The location of Cromwell places it equidistant from Alexandra, Wanaka and Queenstown, less than 40 minutes from each of those, plus covering Cromwell itself.'*

Response 106: *'It needs to be at Dunstan hospital let's use what we have instead of spending millions creating another facility. Very rarely are roads to Dunstan closed'*

Response 112: *'Do it once do it right. None of this hub nonsense we need a birthing facility in Wanaka at the medical centre. The population justifies it, the projections for growth justify it. We shouldn't have to choose between locations for a basic facility if a town has a recreational complex or event centre it should have a birthing unit.'*

Response 113 '*As a region we can be 2- 3.5 hrs from Dunedin depending on the area you are in, so we need first class facilities to be closer for all. Wanaka definitely needs its own facility especially in the winter and Alexandra needs to be a hub for the eastern towns.'*

Response 170: *'Facility needs to be central to areas of population density, taking into account different age brackets in different locations, minimising average travel time for those most likely to need the services. Needs to be a decision based on the most sensible spend of healthcare dollars, to maximise positive outcomes for the greatest number of families, not driven by politics'*

Response 217: *Population base, ease of access - particularly in winter on icy/snow roads. For this reason Wanaka would not be a good option.*

Response 229: *'Minimal driving distance for maximum amount of people.'*

Response 232: *'I believe the current primary units (Queenstown and Alexandra) should be upgraded and utilised… improve on what we already have before adding another option!'*

Response 314: '*I think Cromwell would be a good compromise if only one primary facility is being built in this area as it is a central location for mothers in both Central Otago and QLDC to reach within a short drive.'*

Response from Uruuruwhenua rohe: *"Provide more medical things in Alex – epidural. Jaundice – blue lights so you don't have to travel to Dunedin"*

"If Hospital facilities were closer and more equipped, it could have been a lot less stress"

There was also discussion about how people will behave and how that might impact on utilisation of facilities. Research in 2013 into the travel patterns of women giving birth noted that women are reluctant to travel away from regional and city hospitals to attend a primary facility.

Response 49: '*People don't want to drive away from the route to Dunedin. For example people are not going to travel from Alexandra to Wanaka and then turn back to drive to Dunedin if needed'.*

Response 251*: 'Unlikely Alex family will want drive an additional 20 mins to a postnatal stay after leaving Dunedin.'*

Response 286: *'I do not believe that women will travel backwards to Cromwell if Charlotte Jean is moved, therefore a number of births will be lost and decrease the sustainability of the unit.'*

In summary, it's clear there are good arguments both for and against different locations. It should be noted that we intend to keep the facility at Queenstown Lakes hospital in all scenarios.

Theme 4: Good services are about more than just physical facilities

Many responses talked about the quality of the services and the workforce needed to support them. Many factors contribute to the viability and sustainability both of a birthing unit and the wider system of maternity care. The responses below illustrate the key issues raised.

Response 94: '*local midwives should have the support they need - more midwives/facilities within the region.'*

Response 152: *'Each town in the region e.g. Wanaka, Queenstown, Cromwell, Alexandra, should have enough midwives to provide peer support for each other, sufficient time off and they should be adequately paid to cover high living costs and extended hours to make the work worthwhile for them.*'

Response 175: *'To get midwives they need to be paid well. Rural and remote midwifery is an advanced skill set and responsibility.'*

Response 200 *'Is it viable to have a primary maternity facility here when there is such a shortage of midwives? They are already so overworked. First off, they need far greater numbers to just do the basic work, never mind staffing a facility that needs to offer sufficient facilities for birth and post birth needs.'*

Response 246*: 'at least 1 main facility in Central Otago should be staffed 24/7. Not only does this allow women to have a central point of access it also supports the community midwifery system.'*

Response 295*: 'Other maternity/child services (such as pelvic floor specialists, Plunket, toy library) could also work from this premises to make it a more viable option and to provide wonderful care in our ever-growing community.'*

In addition to the above there were many comments about factors that people consider important in a Primary Birthing Unit such as availability of car parking, the size of units, importance of factors such as food, birthing pool, ability of post-natal facilities to accommodate partners and children etc. This data will be used to inform planning of any proposed new unit.

Theme 5: There is a strong preference for maternity services to be co-located with other medical services

This theme links with the safety theme as many respondents feel that safety is enhanced in an emergency situation if services are co-located particularly having medical support available. It was also noted that co-location with helipads in particular is critical to support rapid transport in an emergency.

Response 179: *'Near the medical centre would be sensible in case extra hands are required and it would be close to a heli pad.'*

Response 263: *'Advice to have it located at Dunstan, if a medical emergency, there will always be a doctor around and there is a helipad (and flight time to DPH is a bit shorter)'*

Response 269: *'Close to 24hr medical assistance in case of emergency.'*

Response 306: *'Must be located in or alongside the existing medical centre. Must have ambulance and helipad access. Must have emergency facilities. Would be designed by practising midwives to meet their needs so they can support mothers in the safest way possible.'*

Response 337: *Safety and close proximity to backup medical/hospital care in case of unexpected medical emergencies/crisis for either baby, mother or both. (This is not to detract from the care that is provided by LMCs, rather an acknowledgement that there are rare occasions of unpredictable emergencies).*

Theme 6: The solution needs to be future proofed

This theme links also to the first theme about secondary care facilities. People recognise the costs involved in developing new healthcare facilities and are encouraging us to think about the long term situation and aiming for a solution that can evolve over time.

Response 167: *'We should also be considering long, long term - could the facility in 50 years expand to have specialists / emergency operating facilities on site? The population of this area is exponentially growing - at some point it will warrant a hospital, where would that hospital be?'*

Theme 7: The current facility – Charlotte Jean in Alexandra is highly valued

Response 258: '*Charlotte Jean is a huge part of our community, we love our outpatient visits there and the staff. We feel do blessed to have been first time parents who used Charlotte Jean'*

Response 263*: 'Alexandra has a fantastic maternity facility in Charlotte Jean definitely need to keep it here.'*

Uruuruwhenua Rohe: "*Charlotte Jean is amazing and I think it should stay open for us local mama's."*

The SDHB is hugely grateful to all the people, both members of the public and professionals who have taken the time to contribute to this engagement exercise. As the above summary hopefully shows, the contributions were thoughtful and measured and show the passion people feel for this important area of healthcare. The themes that have emerged show the complexity of the issue and that a number of different options could meet the requirements.

Summary of the consultation with midwives in Cromwell on 25th February 2020

The workshop was facilitated by SDHB staff and members of the Central Lakes Locality Network and a group of midwives and key stakeholders.

The group formed 3 smaller groups for discussion and shared their discussions in an open forum with all participants which allowed for a rich discussion and debate of ideas.

We used the GROW model to frame the discussion which is shown below:

Questions the groups considered were:
Goal: What do we want?
Reality: What is happening now?
Options: What could we do / provide?
Way forward: What is the preferred solution? – noted that on the day the first 3 questions used all of the time but the participants were comfortable that preferences could be discussed later in the engagement process

Key themes and discussion points –

Goal - What do we want?

Participants described their preferred primary birthing unit in many ways.

The desired goal is a service that delivers excellent, high quality, safe and equitable care for women, whānau and babies. It's important that as many women as possible in the area have access to a primary birthing unit within one hour. This will allow more women to birth and / or receive post-natal care safely, closer to home in a primary setting.

There was a strong preference for a model that is staffed 24/7 by midwives who are always available to act as the 'second pair of hands' for LMCs and to provide assistance with ante natal and post-natal care. Facilities must include a birthing pool, CTG, space and equipment to manage emergency situations, a kitchen that whānau can use, double rooms for post-natal stays to support partners to be able to stay. The group noted that in this area many people don't have whānau locally so having family rooms to accommodate toddlers / other children should be considered.

The unit should also provide space for ante natal and post-natal appointments and assessments, adequate waiting area and space for antenatal education, breastfeeding support groups and other community activities.

Space for ambulance access and a helipad is essential and many participants expressed a preference for co-location with other health services such as primary care, or a community hub or rural hospital.

LMCs described a service where they are offered back up support, not just for births, but for emergency assessments, additional antenatal care (such as where additional BP monitoring is required) or a place they can refer women to in certain circumstances. The type of scenarios described included:

- Where they are attending a home birth and another one of their women goes into labour and needs assessment or a period of monitoring during labour
- Where they are out of area for a birth at DPH and another woman needs a CTG to check reduced foetal movements

They also described a place that would act as a Hub for maternal and child care with potential to offer physiotherapy, phlebotomy (and lab collections) vision and hearing checks, immunisation clinics, B4 school checks, obstetric and paediatric outpatients (face to face or by telemedicine), breastfeeding support and education for women, whānau and professionals.

There was a sense of creating a place of belonging for the LMCs and midwives and other people involved in maternal and child care recognising that isolation from colleagues can be a factor for professionals working in this rural environment. A place to drop in, have a cup of tea and connect with colleagues. The LMCs and midwives talked about the importance of collaboration and support and an ethos that is midwifery and women led. They also discussed the importance of a space and service model that is co-designed with the community.

Reality – What is happening now?

The current reality is of variable services and facilities. The lack of a birthing pool at Lakes hospital was noted as a significant issue.

The location of the Charlotte Jean can be a problem as in emergencies women have to be transferred by ambulance to Dunstan hospital to get to a helipad. Staff also worry about partners who in emergency situations drive alone to Dunedin as they cannot travel in the helicopter.

Not all LMCs are able to offer to be available to birth their women in Dunedin and this places additional pressure on availability of Dunedin LMCs. The LMCs who do travel with their women to birth in Dunedin described the fatigue and the associated stress of being out of area brings especially if you have other women due at the same time.

LMC's are taking on a lot of secondary care work such as additional monitoring and assessment of complex pregnancies. The impact of women having babies' later in life was noted. Care provision is often fragmented and there isn't equitable access across the area to outpatient services (either face to face or by telehealth).

Despite the sustainability payment some LMCs in rural areas are still struggling financially due to a funding model where the birth attracts the bulk of the payment and high overhead costs particularly for travel to deliver post-natal care. Additionally, the funding provided to Charlotte Jean is not sufficient to enable them to provide 24/7 midwifery support.

Charlotte Jean can accommodate partners to stay but cannot always accommodate children. The service offered at Charlotte Jean is highly rated with LMCs noting that it is well run, homely environment, with good food and facilities such as a birthing pool. Breastfeeding support at Charlotte Jean is excellent and vision and hearing checks and hip checks are available.

Options – what could we do / provide?

In this discussion participants talked about core principles as well as options for primary birthing unit locations and service models

Principles

- All PBU has same staffing and resources i.e. that if there is a birthing unit in Wanaka and in Alexandra they should have equitable resources and staffing levels
- Ring-fenced money for Rural PBU (cover 24/7 at MECA rates)

Options considered / put forward

Retain the Charlotte Jean and develop a PBU in a new build in Wanaka. This option was considered to give more equitable access across the area in terms of travel times and keeping the unit in Alexandra meant that fewer women are travelling away from a base hospital. However, it was recognised that this model would have higher staff costs and higher 'cost per birth'.

Have one PBU for the area located in Cromwell – noted that a development in Cromwell should be undertaken in a 'future proofed' way on a site that could eventually accommodate a community hub or secondary hospital. This option was seen as offering good access across the area and offering the best opportunity to make a 24/7 staffing model affordable. However, it meant that more women would be travelling away from base hospital and this might make primary birthing less attractive to women from Alexandra / Roxburgh. Cromwell is also further away from a base hospital than Alexandra which could increases transfer times for some women.

There was some discussion about potential for an extended Maternal and Child Hub model available at Wanaka and Cromwell which would have all the facilities of a Maternal and Child Hub plus the ability for women to have a booked birth with post-natal care available for these women at Charlotte Jean.

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 ▪ 22 October 2020 Verbal Report b) Hospital Advisory Committee ▪ 2 November 2020 Verbal Report c) Iwi Governance Committee ▪ 5 October 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.
WellSouth Primary Health Network	To allow activities and negotiations to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.
CEO's Report - Public Excluded Business ▪ Specialist Services Financial Performance ▪ FTE Pressure ▪ Legal Issue	To allow activities 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	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.
Forecast 2021	To allow activities and negotiations to be carried on without prejudice or disadvantage	Section 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.

*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.